

National Assembly for Wales
Health and Social Care Committee

Residential care for older people in Wales

December 2012



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Health and Social Care Committee

Residential care for older people in Wales

December 2012



Health and Social Care Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

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Welsh Labour
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Chair's foreword

The Inquiry into residential care services for older people is the most extensive piece of work to have been undertaken by the Health and Social Care Committee during the first eighteen months of the fourth Assembly. We learned much that surprised us, as well as being reminded of some deep seated and enduring policy challenges. Having amassed a formidable amount of material, we have done our best to distil our conclusions and recommendations into a small number of key propositions which, we hope, will have a real influence in shaping policy and practice in the future.

There are reasons to be optimistic about what has already been achieved in providing for people in later life, and can continue to be achieved in the future. Members of the public in Wales are likely not to be aware that the number of older people being placed in residential care by local authorities has been falling steadily for more than a decade, and is expected to go on falling for the rest of the present council term. That has happened because public services in Wales have succeeded in meeting the wishes of more older people to remain in their own homes. New reablement approaches provide real hope for living more independently for longer, and at lower public cost. Most, but not all, older people tell us that is what they would prefer.

It is a further source of optimism, we believe, that new, imaginative and high quality residential services have been developed in Wales – often brought together under the umbrella of ‘Extra Care’ – which provide a new sort of future for those older citizens who choose, or who need, to live collectively. Our Report aims to identify promising ways in which policy development and provision can be accelerated here in Wales. We believe that Welsh Ministers need to take an active part in making this happen, moving beyond encouraging the lead taken by others, to taking more of a lead themselves.

Just as there are real gains to be made, so we are aware of the real challenges which will have to be faced, if we are to provide for people in later life, in the way in which we would wish. The whole future funding for care in later life is a decision which cannot go unmade for much longer. The response to growing levels of dementia needs much further work. The changing nature of an older population, now

encompassing a far wider range of particular needs, means that new services will be required in the future. Our Report cannot always provide readily-to-hand solutions to all the policy challenges we discovered, but we hope, at the very least, to help generate the debate which will be necessary to reach those solutions in the future.

In all of this we have been very much helped by the advice of the External Reference Group established to work alongside us in this Inquiry. The Health and Social Care Committee has been committed, since our inception, to carrying out our work in new and innovative ways. In this, our first major piece of work, we wanted to make sure that our views and conclusions could be tested against the experiences and reactions of a group of people who are recent and current users of the services we are investigating. We wanted to set up a group which would be part of the whole Inquiry process and are really grateful to those who gave up huge amounts of their time and energy to help us in this way. I would also like to thank Age Cymru and the Carers Trust for their expert facilitation of the External Reference Group's work.

As ever, I would like to thank those who took the time to give written and oral evidence to this Inquiry, and to the Committee's staff for their work.

A handwritten signature in black ink that reads "Mark Drakeford". The signature is written in a cursive, slightly slanted style.

Mark Drakeford AM

Chair of the Health and Social Care Committee
December 2012

Residential care in Wales: Glossary of terms

Community-based care

Health and/or social care provided to a person in their own home, including in Extra care schemes.

Domiciliary care

Social care provided to a person in their own home, typically including help with everyday tasks such as personal care and preparation of meals.

Extra care housing

Rented or owner occupied housing in specialist developments, usually for older people, which offer varying levels of care and support on site. Includes a range of models and types and may also be referred to as 'very sheltered housing', 'assisted living' or 'housing with care'.

Intermediate care

Care provided in a setting between acute care and the community, e.g. a community hospital or care home, to support recovery, often through a reablement approach. Sometimes referred to as 'step up' or 'step down' care.

Reablement

A range of interventions by health and social care professionals to help people to learn or relearn skills necessary for daily living that have been lost through a deterioration in health or as a result of increased support needs.

Registered Social Landlord (RSL)

Social housing provider registered with the Welsh Government. The vast majority of Registered Social Landlords are also known as Housing Associations.

Residential care/care home

A residential setting in which care services are provided on-site. Care homes are registered with the Care and Social Services Inspectorate Wales (CSSIW) to provide different levels of care including, in some

cases, nursing care. Our Inquiry did not include care homes providing nursing care.

Self-funders

People who pay the whole cost of their social care. A means test is applied to determine whether a person is eligible for local authority financial support. The NHS pays for nursing care.

Telecare

The use of technology to monitor the wellbeing of people living independently. Alarms, sensors and other equipment can register changes and alert the person and health and social care staff to any problems.

Telehealth

The use of technology to remotely monitor the health of people living independently, collecting physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management.

Residential care in Wales: Key facts

The number of older people is growing more quickly than any other age group.

Between 2010 and 2035 the number of people aged 65 and over in Wales is projected to increase by around 306,000 or 55 per cent. In 2010, people aged 65 and over accounted for 18.6 per cent of the population. By 2035, people aged 65 and over are expected to represent 25.6 per cent of the population.¹

Dementia is becoming more common.

There are more than 42,000 people with dementia in Wales² and by 2021 the number is projected to increase by an average of 30 per cent and by as much as 44 per cent in some rural areas.³ Two thirds of older people in residential care have dementia.⁴

The number of care homes is falling but their average size is increasing.

The number of registered care homes for all adults declined by more than seventeen per cent from 1,409 in March 2004 to 1,162 in June 2012. The number of places in care homes declined by only four per cent from 27,745 to 26,627 over the same period.⁵

Most care homes are operated by the private sector.

Eighty three per cent of care homes for older people are owned by the private sector, fifteen per cent by local authorities and two per cent by voluntary sector bodies.⁶

¹ Welsh Government, Statistical Bulletin SB 103/2011 [2010-based National Population Projections for Wales](#) 26 October 2011 [accessed 13 November 2012]

² Alzheimer's Society, written evidence to Health and Social Care Committee Inquiry into residential care [RC50, p2](#)

³ Welsh Government, [Together for Mental Health. A strategy for mental health and wellbeing in Wales](#) October 2012, p26 [accessed 14 November 2012]

⁴ Alzheimer's Society, written evidence to Health and Social Care Committee Inquiry into residential care [RC50, p2](#)

⁵ Care and Social Services Inspectorate Wales: [Care Standards Inspectorate for Wales Annual Report 2003-04](#), p19 [accessed 13 November 2012]; [Quarterly Release: Regulated settings and places 30 June 2012](#) [accessed 13 November 2012]

⁶ At February 2012. *Source:* Care and Social Services Inspectorate Wales Note that Registered Social Landlords are counted as private sector bodies.

A significant proportion of older people in residential care are self-funders.

More than a third of older people in residential care pay all the costs of their care.⁷

The average age of care home residents is rising.

In March 2003 fifty two per cent of older adults supported by local authorities in residential care were over 85 years old. In March 2012 sixty per cent were over 85 years old.⁸

Most older people stay in residential care for a relatively short period.

The average length of stay in residential and nursing homes is less than two years, and is likely to fall further.⁹

Local authorities support fewer older people in residential care than in the past as more are cared for in the community.

Between 2002-3 and 2010-11 the number of people over 65 years per 1,000 population supported by local authorities in Wales in residential care fell from 30 to 21.¹⁰

⁷ Carr West, J. and Thraves, L., [Independent Ageing: council support for care self-funders](#) Local Government Information Unit, 2011, p5 [accessed 26 October 2012]

⁸ Welsh Government, [Statistics First Release: Assessments and Social Services for Adults, Wales 2011-12](#) p5, 4 September 2012 [accessed 14 November 2012]; Welsh Government [Social Services Statistics Wales 2002-03](#) tables 2.6 & 2.7 [accessed 14 November 2012]

⁹ [The changing role of care homes](#) by Nat Lievesley and Gillian Crosby CPA and Clive Bowman Bupa pp29-30 [accessed 15 November 2012]

¹⁰ Data Unit Wales, [table SCA/002b](#) 2011; National Statistics SDR 59/2003 [Local Authority Social Services Performance Statistics 2002-03](#)

The Committee's key recommendations and conclusions

The Committee's key recommendations

Key recommendation 1: The Welsh Government should take action to ensure that older people in Wales have access to effective advocacy. We believe that this is particularly important for those older people who are:

- in hospital and likely to require on-going social care; or
- residing in a care home that is at risk of closure. (Page 30)

Key recommendation 2: More should be done to provide advice and information to support older people, their families and carers in making decisions about their long-term care. We believe the Welsh Government should consider re-aligning existing budgets to create a simple information service. This service should offer simple, timely and accessible information in a way that older people, their families and carers find easy to use. All professionals and others providing support to older people should be made aware of this advice and information service to enable them to signpost older people to it when it is most needed. (Page 31)

Key recommendation 3: The Welsh Government should ensure that local authorities offer an assessment of need to all older people who are considering admission to residential care. This should specifically include those with sufficient resources to fund themselves. A requirement to offer a needs assessment prior to undertaking a financial assessment would ensure that those with resources in excess of the current threshold for support are not denied sufficient information and advice to make appropriate long-term care decisions. (Page 31)

Key recommendation 4: The NHS in Wales must do more to ensure that common disabling conditions experienced by older people – such as incontinence, stroke recovery, falls, and dementia – are managed and treated more effectively in the community. We believe that this will reduce their impact and the likelihood that they will trigger the need for older people to require long-term care. (Page 35)

Key recommendation 5: The Welsh Government should ensure that older people are always offered a period of reablement or intermediate care following a period of illness, particularly when this has involved hospital treatment. Care decisions should take full account of a person's potential for maintaining and increasing their independence. Entry to permanent residential care straight from hospital should not occur. Furthermore, the Welsh Government should produce guidance to improve the clarity and consistency of local authority and health board definitions of reablement. We believe this will help ensure that meaningful data is collected to measure outcomes and drive improvements. (Page 45)

Key recommendation 6: The Welsh Government should work with partners to develop new initiatives that give residents, their families and carers greater voice and control. The aim of this should be to influence the shape and direction of services *and* exert continual pressure on service quality. Once an individual care home reaches a certain size (to be determined by the Welsh Government in consultation with the sector), it should be obligatory to have resident and family/carer forums within the home. Such an arrangement could be built into contracts with providers by service commissioners. (Page 57)

Key recommendation 7: Residential care should not be viewed simply as an option where irreversible decline is the only outcome. We believe that the Welsh Government should work with the sector to ensure that residents are enabled to experience a more stimulating and purposeful life that encompasses their spiritual needs. This would help prevent or delay the negative aspects of institutionalisation as well as improving quality of life. Greater involvement of carers in an individual's residential home life and stronger links with local communities would help achieve this. (Page 62)

Key recommendation 8: Given the Welsh Government's significant contribution to the costs of staff training in social care, it should require that a greater proportion of funding is devoted to enhancing levels of skills and awareness of specialist conditions, particularly dementia, amongst care staff. There is scope for an enhanced role for third sector bodies with particular expertise, such as the Alzheimer's Society, Parkinson's UK Cymru and those representing people with sensory loss and learning disabilities, in supporting this. (Page 82)

Key recommendation 9: In order to better reflect changing patterns of service provision:

- care home registration categories should be reformed to increase flexibility and reduce the need for older people to move when their needs change. This reform should retain the important safeguards the current system provides for individuals to have their changing needs assessed and met. Specifically, the separate category of provision for people diagnosed with dementia should be discontinued.
- the arrangements for the regulation and inspection of new and emerging models of care, including Extra care housing schemes should be re-examined and clarified. (Page 92)

Key recommendation 10: The Welsh Government should take action to reduce the incidence and impact of a breakdown of services by:

- working with CSSIW to ensure that arrangements for the financial scrutiny of independent providers are strengthened. This should be done by requiring providers to submit annual accounts to CSSIW for individual care settings.
- re-visiting and re-assessing current ‘fit and proper person’ arrangements in cases of care home acquisition to ensure that they include consideration of financial sustainability and are applicable to corporations as well as individual managers / owners. (Page 100)

Key recommendation 11: The Welsh Government should strengthen the *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults* guidance to local authorities on care home closure in a way which clarifies the arrangements and responsibility for informing residents and their families regarding the impending closure. A fixed point in the process, at which residents and families have a right to be informed about such an event, should be established. (Page 100)

Key recommendation 12: The Welsh Government has already done much to promote Extra care schemes. As a consequence of the public money already invested in this area, it has become clear that Extra care is an effective and workable model. More now needs to be done by the Welsh Government to scale up the role of Extra care in Wales. This will require a more flexible deployment of public funds across

more than one ministerial portfolio. This will allow Extra care providers to maximise their own capacity to raise funds and develop a substantial programme for the future jointly with the Government.

(Page 106)

Key recommendation 13: The Welsh Government needs to move from being simply an enabler in the field of social care to taking an active role in shaping and delivering a model that is fit for purpose for future generations. The Government must move more urgently from its current analysis and idea development to a position where it is implementing policy and delivering action on the ground. To enable this, the not for profit and co-operative sector should be given a stronger and separate voice in discussions with the Welsh Government. We believe that this will help ensure that the sector can make a full contribution to the provision of care services for older people in Wales.

(Page 111)

The Committee's conclusions

Conclusion 1: The Welsh Government's current direction of policy focuses on enabling older people to remain independent for as long as possible and receive care and support at home. We fully support this direction of travel but believe that more could and should be done to reduce our reliance on residential care in Wales. The use of residential care ought to be less important in the future as alternative care models in both residential and community settings are developed further.

(Page 23)

Conclusion 2: The role of carers and families is crucial to the care of older people in Wales. Their work is often undertaken at their own financial and emotional expense; yet their dedication is maintained, in the majority of cases, over a period of many years. Although the views of the older person will always remain paramount, we must improve our support for the carers and families of older people to ensure that their valuable contribution is at the centre of any short or long term care decisions.

(Page 24)

Conclusion 3: We believe that earlier diagnosis of dementia would better equip older people, their families and carers to plan for and manage the condition and reduce or delay the need for long term care, including residential care. Investment in better community health services can therefore produce savings in other service areas, an

approach that is consistent with the Welsh Government's policy of refocusing health services away from acute settings towards community based services. (Page 35)

Conclusion 4: We support the Welsh Government's approach to prevention and early intervention. We believe this is an area in which the further development of policy and services would produce long term benefits, both for older people and for the more effective use of public funds. We acknowledge that the capacity of local authorities to provide preventative services for older people is limited in the current financial climate. We believe, however, that local government has the potential to:

- use its influence to encourage older people to consider and seek preventative services; and
- work with partners in the third and private sectors to help people identify trustworthy and reliable providers.

We believe that will increase people's awareness of such services and increase their confidence in purchasing them. (Page 387)

Conclusion 5: Whilst we are encouraged by the direction of travel of local authorities in terms of planning residential care provision and engaging more actively with the market, we believe more could be done. The development of market position statements will provide important information to providers about what is required and allow them to plan. These statements should be finalised and published as soon as possible. (Page 50)

Conclusion 6: How we pay for care is crucial to its quality. Funding of social care in Wales is closely linked to broader policy issues such as welfare benefits and taxation, responsibility for which remains with the UK Government. As such, we urge the Welsh Government to work with its UK counterpart on this urgent issue with a view to finding a suitable funding resolution for social care in Wales as soon as possible. We believe the Welsh Government's Ministerial Task and Finish Group for Welfare Reform, which is assessing the impact of the current UK Government's welfare reforms in Wales and responding to them, should be aware of the issue of paying for care and the potential impact of any changes in Wales. (Page 55)

Conclusion 7: We believe that action is needed to ensure that older people in residential care have access to the same standards of healthcare services as the wider community. (Page 64)

Conclusion 8: There is a need to ensure that staff recruitment and training helps to ensure that good communication between care staff and care home residents is facilitated, both in terms of language and sensitivity to the particular communication needs of people with conditions such as dementia, Parkinson's disease, sensory loss or autism. (Page 66)

Conclusion 9: Given the increased care needs of those within residential care, such as dementia or sensory loss, and the need for a continuum of care to minimise disruptive moves, we are encouraged by the development of innovative approaches to design and believe the sector should promote the sharing of good practice. (Page 67)

Conclusion 10: There is a need to improve the safeguarding and protection of older people in residential care through improvements to inspection around care quality, staffing levels and improvements to the training of care staff. We welcome the Welsh Government's plan to provide a legislative footing for this in the forthcoming Social Services Bill. (Page 69)

Conclusion 11: There is a need to increase awareness of care staff, though better training, of statutory duties under the *Mental Capacity Act 2005* and Deprivation of Liberty Safeguards. We welcome the proposals in the forthcoming Social Services Bill to put adult safeguarding on a statutory footing. However, we are concerned that the new arrangements eventually enacted through the Bill/Act should be closely monitored and assessed to ensure they are fully effective in improving adult safeguarding. (Page 70)

Conclusion 12: Improving the status of care workers and promoting their professionalisation are key considerations for improving services for older people in residential care. These should be priorities for the Welsh Government and should include work to further develop career pathways for social care staff. To this end the Committee welcomes the re-establishment of the Academy of Care Practitioners. (Page 74)

Conclusion 13: In light of the strong views expressed to us about registration during our evidence gathering, we believe that the Welsh Government should keep the case for registration of all care staff under active consideration. (Page 75)

Conclusion 14: Care homes are required by regulations to provide up-to-date information on staffing numbers, relevant qualifications and experience. This information should be made more easily available to prospective residents and their families. Greater efforts should also be made by residential care homes and relevant bodies to encourage prospective residents and their families to seek this information when making decisions about an older person's future care. (Page 77)

Conclusion 15: There is a need to raise the level of knowledge and skills of care staff to meet the increasing demands placed on them. Given the pivotal role of registered managers we believe future training strategies should prioritise training for them. The Welsh Government and the Care Council for Wales need to be confident that they regularly consider and refresh their approach to training to ensure that the best outcomes are achieved for both staff and residents. We would emphasise the importance of ensuring comprehensive recording of training activity undertaken by staff to encourage progress in this area. (Page 81)

Conclusion 16: We acknowledge the importance of trade union representation for staff working in residential care and the valuable work they undertake in promoting the interests of their members and highlighting their concerns about the quality of services provided in the sector. We also note the potential value to care home providers of formally recognising the role of trade unions. (Page 83)

Conclusion 17: We welcome the improvements outlined by CSSIW to the inspection process to focus on the quality of care and to capture the views and experiences of older people, their families and carers, and care staff. We are particularly pleased to learn that lay assessors will be recruited to undertake inspections and urge the Welsh Government and CSSIW to ensure that they are adequately trained and equipped to undertake their work. We believe there will be a need for on-going monitoring and evaluation to ensure that these improvements achieve the required changes. We are concerned that the reforms are progressed and not delayed by the announcement of a

separate Welsh Government Bill on the regulation of social care services and staff. We welcome the reassurances from the Deputy Minister for Children and Social Services on this matter. (Page 87)

Conclusion 18: The Committee agrees that, as a key method for gaining information, inspection reports need to be easily accessible both in terms of how they are drafted and where they are located. Consideration should be given to where inspection reports are made available. In addition to internet access, reports should be available in public places and at each care home to allow older people and their carers and families to easily access them. Reports need to be drafted in a manner which is easily understood and clear about the services provided by each home. Given the prevalence of visual impairment amongst older people it is important to ensure that reports are published in a range of accessible formats. (Page 88)

Conclusion 19: A mixed economy of ownership can help to foster a more diverse and innovative sector and provide a stronger foundation for providing choice and high quality services for the growing number of older people who will need them. As a key part of that the not for profit sector can make a valuable contribution to care provision in terms of innovation, value for money, and stability of provision. We therefore welcome the Minister's work with relevant organisations to develop options for future models of residential care provision. (Page 111)

1. Introduction

1. The Health and Social Care Committee agreed to undertake an inquiry into residential care in Wales in September 2011. The aim of our inquiry was to examine the process by which older people enter residential care and how effective the residential care sector is at meeting their needs. The Committee was also keen to consider the future direction for residential care in Wales and alternatives to it, particularly in the context of an ageing population and new patterns of service provision.

2. This inquiry has been the main focus of the Committee's work over the last year. The time we have taken to gather evidence is testimony to the importance we attach to this subject. Many people will, at some point during their lives, require care. The source of such care will vary from the formal care sector – through the NHS, social care and social housing – to the informal, yet equally important, support of committed family and friends. This is a matter that is likely to touch more of us, more often, and more significantly as we live longer lives. However, as we were told on numerous occasions during this inquiry, entry to residential care remains a 'once-in-a-lifetime' decision. It is incumbent upon us, therefore, to shine a light on how we care for our older people and what we are doing to provide them with services of the highest quality.

About our inquiry

3. In undertaking this inquiry the Committee decided to look at service users' current care journey. The Committee considered the care options available for older people; the capacity of the sector to meet demand; the quality of residential care services and the experiences of service users and their families; what it is like to work in the sector; and the effectiveness of the regulation and inspection arrangements in place for residential care.

4. The Committee did not wish, however, to look at the present situation alone. How a future care journey may – and should – look for generations to come was a crucial consideration for us. As such, we also sought to explore new and emerging models of care provision, including the balance of public and independent sector provision.

5. The Committee's full terms of reference are attached at annex A.

How we gathered our evidence

6. The Committee called for written information over a 9 week period in winter 2011, receiving 81 responses from individuals and organisations. Oral evidence was gathered between February and July 2012 over the course of 11 committee meetings.

7. In addition to gathering formal evidence, the Committee was eager to hear about the experiences of people affected by, and involved in, residential care first hand, and to learn about the challenges faced by the sector and its users. To this end we visited a number of care facilities, both as a Committee and as individual Members. Committee representatives held informal meetings with officials in health boards and local authorities, helping to inform our thinking on many of the issues covered in this report. We also hosted an informal session in North Wales to speak with care sector workers and other interested parties.

8. Capturing the views and experiences of those families who have direct and recent experience of residential care services was a key priority for us during this inquiry. We established an External Reference Group made up of people with family members who were either still, or had recently been, in residential care. This group shadowed the work of the Committee and considered the same evidence in light of their own experiences. We have drawn on the views of the group throughout our inquiry, and their own conclusions can be found in their entirety at annex B. The Committee would like to put on record our sincere thanks to the group's members and facilitators for the substantial amount of work they undertook as part of this inquiry. Their contributions have provided an invaluable insight into the reality of life as a carer and have helped us frame our conclusions and recommendations with the service user at the forefront of our minds.

9. We would like to thank all those who have taken the time to contribute to this inquiry by giving evidence and hosting our visits. A list of those who gave oral evidence is provided in annex C to this report; a list of all written submissions is provided in annex D; and a list of the external engagement undertaken is provided in annex E.

2. Care options for older people

10. Moving into residential care is life changing. For the person concerned it involves leaving home and adjusting to an entirely new setting and way of life. It is a decision that is made only once or possibly twice in a lifetime, yet it is often made at a time of crisis. At this critical point, it is vital there is sufficient support and guidance to allow older people, their carers and families to consider all available options and make informed decisions. It is also important that all preventative measures and a range of care options are made available to older people to reduce the numbers who otherwise enter residential care because of an absence of alternatives.

11. Witnesses to the inquiry spoke about the emotional impact a move into residential care can have on older people. Tom Owen, Director of My Home Life UK, told the Committee:

“...the transition into a care home is probably the biggest life change in our time on this planet. It is a huge emotional upheaval, because you will have lost your health, and it often involves the loss of a loved one who has been looking after you. You are losing your home and being told that you have to go into a care home, and perhaps all you know about care homes is what you have read in the newspapers, which is not always great news. So, it can be a very frightening thing for older people.”¹¹

12. The Committee fully supports the current direction of policy in terms of enabling older people to remain independent for as long as possible and receive care and support at home. More could and should be done to reduce our reliance on residential care for older people in Wales. However we recognise that, in some instances, there is a need to move into residential care. Indeed, for some people, entering residential care is a positive choice. The single most important point in the transition to residential care is the point of entry and it is at this time that older people need most support. We believe more could be done to ease this transition. These issues are explored in this chapter.

¹¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 144\]](#) 23 February 2012 [accessed 19 October 2012]

Reliance on residential care

13. In the mid to late twentieth century residential care played a major role in meeting the needs of frail older people. For many such older people moving to a care home, where care and accommodation are provided together, has been the best way to have their needs met. Over the last thirty years, however, the landscape has changed significantly. Services have increasingly been delivered to people at home. Those who still do turn to residential care stay on average for less than two years and tend to have higher levels of frailty and need than in the past.¹²

14. Evidence to our inquiry pointed to a clear preference on the part of most older people to be supported in maintaining their independence and remaining in their own homes.¹³ Evidence also identified the much wider variety of care options now available to older people (many of which are explored in this report). We acknowledge however that, for some, residential care will be a necessary and preferred option.

15. As noted by the Deputy Minister for Children and Social Services:

“The nature of residential care for older people today is far removed from that which existed a decade ago or will need to exist in 10 years’ time. The increasing demography of older people in Wales makes this a necessity, but the changing needs and expectations of older people also make this a priority, if we are to rise to the challenge of providing services that meet older people’s needs in a way and at a time that they require them. What we hear from older people is that they wish to live independently for as long as possible, but there will always come a time when, for some individuals, that is no longer possible and a form of residential care will be required. What we as a Government are doing is to encourage and support commissioners of services and service providers so that the sector is flexible, diverse and responsive to meet the need.”

¹² See a study of Bupa residential and nursing care homes: Nat Lievesley, Gillian Crosby, Clive Bowman (2011) *The changing role of care homes* Bupa/Centre for Policy on Ageing, pp3 & 25 [accessed 25 October 2012]

¹³ See for example Wanless D (2006) [Securing Good Care for Older People: Taking a long term view](#). Kings Fund, cited in written evidence by Community Housing Cymru and Care & Repair Cymru [RC45](#) p5

Conclusion 1: The Welsh Government’s current direction of policy focuses on enabling older people to remain independent for as long as possible and receive care and support at home. We fully support this direction of travel but believe that more could and should be done to reduce our reliance on residential care in Wales. The use of residential care ought to be less important in the future as alternative care models in both residential and community settings are developed further.

The role of the carer and family

16. As noted by the inquiry’s External Reference Group, carers and family members are at the forefront of providing support and care for older people.¹⁴ During our inquiry we sought to hear from those with direct and recent experience of caring for their loved ones. Our aim was to ensure that their roles and views were considered and recognised throughout our deliberations.

17. We were told by Carers Wales that approximately 120,000 people in Wales provide care for more than 20 hours a week, and 90,000 for more than 50 hours a week.¹⁵ Furthermore, about 97% of all community care is not provided by social services or the health service, but by family members.¹⁶

18. We agree with the External Reference Group that, when long-term care options are being considered,

“Carers often act as advocates and sources of advice for those for whom they care and have a vital role to play in assessment of care needs. Carers should be enabled and supported to undertake these crucial and valuable roles.”¹⁷

19. Angela Roberts, Director of the Carers Trust in Wales and Vice Chair of Age Alliance Wales, argued that support for carers is currently inadequate:

“There is not sufficient support at the moment [...] We need to continue to support this unpaid, untrained workforce. My drive

¹⁴ See Annex B to this report

¹⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 164\]](#) 29 February 2012 [accessed 19 October 2012]

¹⁶ Ibid

¹⁷ See Annex B to this report

would be that we ensure that we have a decent training programme available to carers should they need it. To allow them to carry on, we need to ensure that they have the breaks that they need, and the emotional and psychological support to continue. Getting this right would be a sign in our society, if this group of people on whom we depend to support the NHS and social services could get proper recognition and could be included in all discussions and debates surrounding the person who has the care needs.”

20. During oral evidence we also heard that provision to allow respite for carers is insufficient at the moment. Roz Williamson, Director of Carers Wales, told the Committee:

“The issue of respite care is crucial. The nature of respite care is something that we have not really cracked yet [...] A caring situation can break down and somebody will have to go into residential care for two reasons: one is that there is a crisis with the person who is ill or who has the condition and the other is that there is a complete breakdown in the health of the carer. One of the purposes of respite care needs to be to maintain the health and wellbeing of the carer sufficiently so that they can continue for as long as they feel that it is right for them to do so and right for the person who they look after.”¹⁸

Conclusion 2: The role of carers and families is crucial to the care of older people in Wales. Their work is often undertaken at their own financial and emotional expense; yet their dedication is maintained, in the majority of cases, over a period of many years. Although the views of the older person will always remain paramount, we must improve our support for the carers and families of older people to ensure that their valuable contribution is at the centre of any short or long term care decisions.

Information, support and guidance

21. We believe that older people, their families and carers need to be able to exercise meaningful choice about the options available to them when considering long-term care. Throughout our evidence gathering we were told that this is only possible with adequate information and

¹⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 177\]](#) 29 February 2012 [accessed 14 November 2012]

support, the lack of which has been consistently highlighted in written and oral evidence, and also by the External Reference Group.

22. Evidence to our inquiry indicated clearly that admissions to residential care are often crisis led, allowing little time for informed choices about care options. Ideally older people, their families and carers need to plan in anticipation of such an eventuality, and we were told that better information and support would help enable this. Evidence we heard suggested, however, that many families and carers will encounter difficulties when attempting to have these conversations with their loved ones. The sensitivities associated with long-term care decisions deter many from discussing the options they face.¹⁹

23. We believe that those providing health and social care services must be alert to the sensitivities associated with these difficult, but necessary, conversations. Health and social care professionals must be helped to encourage these conversations and act accordingly to provide support and advice at a suitable time. We recognise however that, in reality, most people do not plan for such an eventuality. Services therefore need to be able to respond to the crisis situations that ensue and provide the most effective support possible.

24. The need for better support, information and guidance was a clear theme that emerged from our evidence. Angela Roberts, Vice Chair of Age Alliance told the Committee that:

“There is a lack of information, advice and advocacy available to people and their families during the process of choosing and entering residential care. The process is not clearly explained and, in many cases, there is a lack of support and assistance in making decisions about care options and choosing the right residential or nursing home.”²⁰

25. Members of the Committee’s External Reference Group also highlighted the need for better information and guidance based on their personal experiences of having to try to find a suitable placement for their loved ones in residential care. They felt that discussions about care needed to be held at an appropriate time, before it had reached crisis point. They noted:

¹⁹ External Reference Group meeting [24 May 2012](#), see Annex B to this report

²⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 102\]](#) 2 May 2012 [accessed 19 October 2012]

“As a person’s care needs start to increase, it is vital that information on a range of services and options is available and easily accessible. This is particularly important for those who self-fund their care, who are often left to make important decisions on their own.”²¹

26. The External Reference Group emphasised the need to understand that information, if provided, is often received by families and carers at a time when they are feeling particularly pressurised and vulnerable. This is particularly the case when carers or family members are themselves physically and emotionally worn by the process of seeking and considering care options for their loved ones and, quite often, at a substantial geographic distance from the individual for whom they are seeking support.

27. Witnesses told us that it is difficult for carers and families to know what to look for in a care home. Rosie Tope from Carers Wales said:

“Carers do not know what to look for in a good residential or nursing home; it is all about people being nice and the place smelling okay. They need clear advice, and they need help for when they go to see one.”²²

28. The External Reference Group expressed concern about what they believe is a lack of helpful information for prospective residents in CSSIW care home inspection reports. This is discussed further in Chapter 6 which considers the regulation and inspection arrangements for residential care.

29. In her oral evidence to the Committee, the Deputy Minister highlighted the Welsh Government’s guide *Thinking about a care home? A guide to what you need to know*. This document sets out areas of consideration for choosing a care home. However, Members of the External Reference Group and witnesses were unaware of this guide and we would suggest that better promotion is needed.

30. We welcome the Deputy Minister’s commitment through the forthcoming Social Services Bill to require local authorities to publish information and offer advice and assistance about services for people

²¹ See Annex B to this report

²² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 189\]](#) 29 February 2012 [accessed 19 October 2012]

in their area. This is an issue we will follow up should the proposed Social Services Bill be remitted to us for scrutiny.

Self-funders

31. The term “self-funders” is used to describe individuals who pay the full cost of the care they receive. In Wales, those with assets exceeding £23,250 are deemed to be self-funders; individuals with assets lower than this figure are likely to qualify for financial support from their local authority.

32. Those entering residential care who receive support from local authorities have their needs assessed. This provides an opportunity to consider the options available to them. However, a significant number of care home residents are self-funders (see paragraph 34 below). Evidence to our inquiry suggested that some self-funders receive no information or advice from their local authority, nor any assessment of their needs, despite a requirement on local authorities to provide these where requested.²³ Similarly, self-funders will often fail to seek the advice of their local authority, turning instead to their GP or solicitor who may not hold the same level of information.²⁴

33. It is important that those with the means to pay for their care are aware of the availability of information from their local authority and know how to access it. We were told that the minority of self-funders who do contact their local authority are often financially assessed before having a needs assessment, thus establishing early in the process that they are ineligible for financial support. Some do not proceed to a needs assessment which would offer a professional assessment and information and advice about the available care options and their costs.

34. Estimates of the proportion of self-funders vary from 32 per cent to 41 per cent of the care home population. A survey of local authorities in England and Wales in a recent Local Government Information Unit (LGIU) report²⁵ suggested a figure of 34 per cent. As noted above, in Wales, individuals with assets below £23,250 are likely

²³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 185\]](#) 23 February 2012 [accessed 19 October 2012]

²⁴ Ibid [RoP \[para 7\]](#) 22 March 2012 [accessed 19 October 2012]

²⁵ Carr West, J. and Thraves, L., [Independent Ageing: council support for care self-funders](#) Local Government Information Unit, 2011, p5 [accessed 21 September 2012]

to qualify for financial support from their local authority. Some older people who initially self-fund may therefore require public support when their own resources are depleted. The LGIU report argues that many local authorities are ill-prepared for the significant number of self-funders who later require support, having not had the benefit of a care assessment and advice on the level of fees local authorities are willing to pay.

35. Rhondda Cynon Taf Borough Council told us they offer a needs assessment to anyone enquiring about care, whether or not they are eligible for financial support; this is a practice we commend. We were told that local authorities have an interest in ensuring that self-funders entering residential care are fully aware of the financial support offered by them since they may later depend on it.²⁶ For some people the level of fees paid by their local authority may be lower than their home of choice, requiring a move later on if support is sought. However, evidence indicates the information and advice that may help them to make better decisions is not available to all self-funders.²⁷

36. It was suggested by a number of witnesses that a needs assessment is particularly important as self-funders may enter care at an earlier stage than necessary and may subsequently require public funding when their own resources are depleted.²⁸ Val Baker, who cared for her mother and father told the Committee:

“We were self-funding and I certainly had no information. I was given a sheet of paper with a list of homes, many of which had no places anyway. I tried to look at inspection reports on the internet, but I did not pick up a lot of what I was looking for regarding whether certain homes had expertise in this area or knew about a Parkinson’s specialist nurse, for example.”²⁹

37. Steve Ford, the Chief Executive of Parkinson’s UK Cymru told the Committee that:

²⁶ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 185\]](#) 23 February 2012 [accessed 19 October 2012]

²⁷ Carr West, J. and Thraves, L., [Independent Ageing: council support for care self-funders](#) Local Government Information Unit, 2011, p12 [accessed 21 September 2012]

²⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 185\]](#) 23 February 2012 [accessed 19 October 2012]

²⁹ Ibid [RoP \[para 180\]](#) 2 May 2012 [accessed 19 October 2012]

“There is an issue about the availability of information for everyone, but certainly we have had a lot of feedback from self-funders that it is a real challenge. ... People who have Parkinson’s would really like to know which care homes have made use of that education, have built it into their ongoing programmes and have a focus on Parkinson’s, so that people have confidence that the homes will have some understanding of the issues. However, there is no way, really, for people to get hold of that information.”³⁰

38. Evidence from Local Authorities suggested that information is available but that there is scope for improvement. Susie Lunt, Service Manager at Flintshire County Council, told us that her local authority had taken the welcome step of providing information in key places such as GP surgeries, libraries and hospitals. However, Emily Warren from the Welsh Local Government Association acknowledged that:

“... we should hold our hands up to say that the provision of information and support is probably not consistent across Wales.”³¹

Advocacy

39. The Committee heard evidence about the important role that advocates can play in ensuring that people can access information on and make decisions about residential care. Age Concern Cardiff and the Vale told the Committee about the value of their advocacy work with older people, helping them to raise issues of concern when in residential care.³²

40. Giving evidence to the Committee, the Deputy Minister assured Members that matters relating to advocacy will be taken up in the forthcoming Social Services Bill:

“The Bill commits us to developing a business case for advocacy. It is important, and we need to be absolutely clear about advocacy information, assistance and everything else across the board. There are excellent examples of advocacy being provided, but it is patchy and I am not happy with it.

³⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 179\]](#) 2 May 2012 [accessed 19 October 2012]

³¹ Ibid [RoP \[para 193\]](#) 22 March 2012 [accessed 19 October 2012]

³² Ibid [RoP](#) 29 February 2012 [accessed 19 October 2012]

Therefore, the development of a more coherent structure is pressing.”³³

41. The Older People’s Commissioner for Wales undertook a review of advocacy arrangements in care homes and published her report in September 2012.³⁴ The Commissioner has emphasised the importance of ensuring older people have a voice and can exercise choice and control in their lives and that support is particularly important when making major life decisions, such as entry to residential care. It was highlighted during the inquiry that ensuring the voices of residents are advocated is particularly important when issues relating to protection and safeguarding arise.

42. We agree that the sector needs to be more responsive to advocacy and that more should be done to facilitate the work of those with an advocacy role. We nevertheless believe that all professionals in existing services – not advocates alone – should ensure that the views of older people, their families and carers are being heard at this critical and often traumatic time.

Key recommendation 1: The Welsh Government should take action to ensure that older people in Wales have access to effective advocacy. We believe that this is particularly important for those older people who are:

- **in hospital and likely to require on-going social care; or**
- **residing in a care home that is at risk of closure.**

43. As highlighted at the beginning of this chapter, the single most significant step in the transition to residential care is the point of entry, and it is at this time that older people need most support. We believe that more needs to be done to reduce the pressures on older people, their families and carers to make such life-changing decisions in an atmosphere of crisis. We therefore suggest that simple information ought to be provided to those considering entry into long-term care for themselves or their loved ones. Amongst the elements a simple information service could include are:

³³ National Assembly for Wales, Health and Social Care Committee [RoP \[para 111\]](#) 20 June 2012 [accessed 16 November 2012]

³⁴ Older People’s Commissioner for Wales [Voice, Choice and Control: Recommendations relating to the provision of independent advocacy in Wales](#) 18 September 2012 [accessed 16 November 2012]

- the wider availability of written material in frequently visited places such as doctors surgeries, public libraries and community centres;
- the introduction of web-based information that people who are computer literate can access easily;
- the provision of face-to-face advice.

44. We believe that the introduction of a simple information service of this kind can be achieved, for example, by providing a small amount of funding to third sector organisations to raise the awareness of their staff sufficiently to allow them to advise those seeking information about care options. We envisage that a service of this nature would act as a first port of call to highlight to individuals the things they ought to be thinking about and to signpost them to where they can find further information and advice.

Key recommendation 2: More should be done to provide advice and information to support older people, their families and carers in making decisions about their long-term care. We believe the Welsh Government should consider re-aligning existing budgets to create a simple information service. This service should offer simple, timely and accessible information in a way that older people, their families and carers find easy to use. All professionals and others providing support to older people should be made aware of this advice and information service to enable them to signpost older people to it when it is most needed.

Key recommendation 3: The Welsh Government should ensure that local authorities offer an assessment of need to all older people who are considering admission to residential care. This should specifically include those with sufficient resources to fund themselves. A requirement to offer a needs assessment prior to undertaking a financial assessment would ensure that those with resources in excess of the current threshold for support are not denied sufficient information and advice to make appropriate long-term care decisions.

Prevention and alternatives to residential care

45. Supporting older people to maintain their independence has been the preferred option in care policy for some years. This is reflected in

work by local authorities to reconfigure their services for older people away from traditional residential care towards community based services.³⁵ Professor John Bolton, author of the Social Services Improvement Agency's (SSIA) *Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales* report, told the Committee that:

“...admissions of older people to residential care funded by councils have been falling for over a decade. In fact, it is interesting to note that, in Wales, this number has been falling faster than it has in other parts of the UK. In part, that is related to Welsh Government policies, which have a very strong emphasis on preventive measures and helping people to live in their own homes. There is still variance between Welsh authorities as to how far they have made progress in delivering that agenda. However, all Welsh authorities have made some progress.”³⁶

46. Allowing older people to remain in their own homes for as long as possible was a principle advocated by most contributors to our inquiry. Chris Synan from the College of Occupational Therapists told the Committee that:

“The important thing is that we listen to older people’s preferences. Some research published recently asked older people their preference, and what they actually want at the point when they need care, and 62% of them wanted to stay in their own homes and be supported by their family and friends, where possible, with a second group who, where that was not possible, would be supported by paid care workers.”³⁷

47. The Committee fully supports the development of services to maintain older people’s independence. Allowing people to remain at home for as long as they would like to, and for as long as it is safe to do so, is a principle that should be at the heart of policy and service development. During our inquiry, we identified a number of key areas

³⁵ Social Services Improvement Agency (SSIA) [Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales](#) Executive Summary [accessed 19 October 2012]

³⁶ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 162\]](#) 23 February 2012 [accessed 19 October 2012]

³⁷ Ibid [RoP \[para 18\]](#) 16 May 2012 [accessed 19 October 2012]

where early intervention and preventative measures need to be implemented to fully realise this ambition. These are explored below.

Community healthcare

48. Evidence provided to our inquiry indicated that a number of health conditions commonly experienced by older people act as a trigger for entry to residential care.³⁸ It was also suggested by members of the reference group that the development of such conditions can also lead to loneliness and isolation for those residing at home. Professor John Bolton argued that better treatment and management of these conditions would help reduce the use of residential care:

“...the triggers are, not surprisingly, dementia care; not very far behind that, and sometimes equal to it, incontinence; falls; stroke recovery; and then podiatry and dental care as slightly lower triggers. [...] the general indication is that the Welsh health services are not performing particularly well in those areas. Therefore, that will be contributing to admissions to residential care.”³⁹

49. As part of *Growing old my Way*; a joint review looking at the impact of the National Service Framework for older people in Wales, Healthcare Inspectorate Wales (HIW) and the Care and Social Service Inspectorate Wales (CSSIW) concluded:

“When examining health promotion, well-being and prevention, which helps older people to stay well and keep living life the way they want to for longer, we found that greater investment is needed at a local level in health promotion, prevention and community services if older people are to be supported to live healthy and longer lives. This provides a dilemma for statutory agencies as the impact and benefits of such investment for them will not be immediate but longer term.”⁴⁰

50. The Alzheimer’s Society stated in written evidence that people with dementia often enter residential care as a result of insufficient

³⁸ For further details see paper by Professor Andrew Kerslake provided to the Committee for the meeting on 26 April 2012 [HSC\(4\)- 12 -12 paper 5](#)

³⁹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 165\]](#) 23 February 2012 [accessed 19 October 2012]

⁴⁰ Ibid [HSC\(4\)-16-12 paper 2 – Care and Social Services Inspectorate Wales and Health Inspectorate Wales](#), p16 30 May [accessed 19 October 2012]

support to remain independent in their own homes. They argued that a move to an unfamiliar environment can be unhelpful:

“The ideal place for someone with dementia is their own home. If someone is confused, they need a secure and safe environment that they are familiar with.”⁴¹

51. They went on to suggest that better coordination of care, greater rates of diagnosis and earlier intervention are essential to preventing unnecessary entry to residential care. It was argued that strengthened community health services would help to address the health issues that can precipitate entry to residential care. In particular, we were told that the early diagnosis of dementia, together with support to manage the condition, can help reduce the need to move from home to residential care. The Alzheimer’s Society explained that simple adaptations to prompt the memory, for example glass fronted fridges to remind the person to eat, could maintain an individual’s ability to remain in their own home.

52. Wales has the lowest percentage of people with dementia with a diagnosis in the UK.⁴² In 2011 37.4% of those believed to have dementia had a diagnosis, compared with 41.1% in England, 61.5% in Northern Ireland and 64.5% in Scotland. We believe this shows that there is considerable scope to improve rates of diagnosis in Wales which, in turn, could lead to better support for people in their own homes.

53. In written evidence to the Committee, John Bolton outlined that:

“In England the Department of Health’s Dementia Care strategy in 2010 claimed that early provision of support provided within a patient’s home can decrease institutionalisation by 22 per cent, while carer support and counselling at diagnosis can reduce care home placement by 28 per cent. Even in complex cases where highly skilled mental health teams are required,

⁴¹ National Assembly for Wales, Health and Social Care Committee [RoP \[para 154\]](#) 2 May 2012 [accessed 19 October 2012]

⁴² Alzheimer’s Society [Mapping the Dementia Gap 2011](#) February 2012 [accessed 18 September 2012]

the DH claims that proper case management can reduce admissions to care homes by 6 per cent.”⁴³

Conclusion 3: We believe that earlier diagnosis of dementia would better equip older people, their families and carers to plan for and manage the condition and reduce or delay the need for long term care, including residential care. Investment in better community health services can therefore produce savings in other service areas, an approach that is consistent with the Welsh Government’s policy of refocusing health services away from acute settings towards community based services.

Key recommendation 4: The NHS in Wales must do more to ensure that common disabling conditions experienced by older people – such as incontinence, stroke recovery, falls, and dementia – are managed and treated more effectively in the community. We believe that this will reduce their impact and the likelihood that they will trigger the need for older people to require long-term care.

Partnership working

54. Throughout our inquiry we heard examples of work being undertaken to reduce the need for older people to enter residential care. Much of this work suggests that success is often best achieved through collaborative working between statutory agencies and the third sector. In Powys, for example, the local health board has introduced the Powys Urgent Response at Home Service (PURSH). This is a third sector-led development supported by both health and social care services. Its aim is to support patients and/or carers with immediate care to prevent hospital admission and allow statutory services to arrange suitable, sustainable care options.

55. We were told that other relatively modest levels of support can help promote a preventative approach and enable older people to remain independent within their own homes and communities. Age Alliance called for better home maintenance and supported the development of the rapid response adaptations programme through

⁴³ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-07-12 paper 5 – Evidence from Professor John Bolton](#) 23 February 2012, p11 [accessed 19 October 2012] p10

Care and Repair.⁴⁴ In oral evidence the Deputy Minister emphasised the need to support older people with the ‘little things’ such as cleaning, decorating and gardening which contribute to maintaining independence.⁴⁵

56. There is some emerging evidence, however, to suggest that providing these more modest levels of support can lead to increased dependence, as opposed to the intended increase in independence.⁴⁶ Although we do not believe that there is sufficient evidence to throw into doubt whether services of this nature should be provided at all, we do believe that it raises questions about the manner in which they are designed and delivered. Further research is needed to inform practice and service design to ensure that the current direction of policy development does not lead to unintended consequences.

57. In oral evidence BUPA highlighted an example of integrated health and social care services for older people in the Torbay Care Trust, the benefits of which have included reduced use of hospital beds and of residential and nursing care homes.⁴⁷ However, the evidence⁴⁸ presented to us indicates that the integration of health and social care services in other parts of England have been less successful. Therefore, whilst the benefits of better co-ordinated health and social services are beyond doubt, we are not persuaded that wholesale restructuring of health and social services is the best way of improving outcomes for older people in Wales.

58. We welcome the Welsh Government’s plans to promote prevention and early intervention approaches by local authorities and their partners through the *Social Services (Wales) Bill*. The Deputy Minister’s written evidence stated:

“Through the *Social Services (Wales) Bill* we also plan to provide Ministers with the powers to make regulations or issue guidance requiring local authorities to demonstrate how they are discharging their wellbeing duties for people in need

⁴⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 95\]](#) 2 May 2012 [accessed 19 October 2012]

⁴⁵ Ibid [RoP \[para 66\]](#) 20 June 2012 [accessed 19 October 2012]

⁴⁶ Health Services Utilization and Research Commission (2000) [The Impact of Preventive Home Care and Seniors Housing on Health Outcomes Summary Report no.14](#) from HSURC archive [accessed 19 October 2012]

⁴⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 107\]](#) 14 June 2012 [accessed 19 October 2012]

⁴⁸ Ibid [RoP \[paras 40-42\]](#) 22 March 2012 [accessed 19 October 2012]

through implementation of prevention and early intervention strategies; and will couple this with powers to strengthen partnership working. This will include the use of pooled budgets and other flexibilities that will require partnerships between, and across, local authorities and the NHS.”⁴⁹

59. We also note the Deputy Minister’s view, expressed to us during evidence on 3 October, that further partnership working and collaboration across health and social services is needed:

“On integration between social services departments and health boards, I do not think that we have reached a satisfactory position, but a great deal of work has gone into developing that integration.”⁵⁰

60. We believe that preventative services which can intervene early to maintain an older person’s independence are best developed through more effective joint working between statutory agencies and with the third sector. There are opportunities to develop suitable services through social enterprise which should be further explored (this is considered further in chapter 7 – *Future options for residential care*). Finding alternative routes like social enterprise for the provision of preventative services is particularly important given the current financial climate faced by statutory agencies, particularly local authorities, in Wales.

Conclusion 4: We support the Welsh Government’s approach to prevention and early intervention. We believe this is an area in which the further development of policy and services would produce long term benefits, both for older people and for the more effective use of public funds. We acknowledge that the capacity of local authorities to provide preventative services for older people is limited in the current financial climate. We believe, however, that local government has the potential to:

- **use its influence to encourage older people to consider and seek preventative services; and**

⁴⁹ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-18-12 paper 3 – Evidence from the Deputy Minister for Children and Social Services](#), 20 June 2012 [accessed 19 October 2012]

⁵⁰ Ibid [RoP \[para 52\]](#) 3 October 2012 [accessed 16 November 2012]

- **work with partners in the third and private sectors to help people identify trustworthy and reliable providers.**

We believe that will increase people’s awareness of such services and increase their confidence in purchasing them.

Telecare and domiciliary care

61. The Committee heard evidence of the important role played by community-based services in providing alternatives to residential care and allowing older people to remain in their own homes, including telecare and domiciliary care. The contribution of these services has expanded in recent years, reflecting the trend for older people with care and support needs to remain at home. The more recent development of telecare schemes has been underpinned by Welsh Government capital funding.

62. Some witnesses questioned the capacity of the domiciliary care sector to provide an effective service to people with increasingly high needs (including dementia) in terms of staff skills and local authority funding for such services. We are concerned that the UK Home Care Association described the domiciliary care sector as:

“under stress, like never before. [...] something like one in five homecare providers now think that they will be out of business within a year.”⁵¹

In some areas continuity of homecare services is disrupted by changes of ownership as the sector consolidates⁵² or local authorities reduce the number of providers they contract with⁵³.

63. Although staff training is increasingly important to support the higher levels of need of older people remaining at home, it was suggested that the level of fees paid by local authorities is affecting this. Dr Pauline Ruth of the Royal College of Psychiatrists emphasised the specialist skills needed to support older people with dementia:

⁵¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 95-96\]](#) 26 April 2012 [accessed 19 October 2012]

⁵² IPC Market Analysis Centre, *Where the Heart is... a review of the older people’s homecare market in England* October 2012, p14 [accessed 25 October 2012]; BBC News, 14 October 2012 [Home care staff under pressure, warns MP Ann Clwyd](#) [accessed 19 October 2012]

⁵³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 96\]](#) 26 April 2012 [accessed 19 October 2012]

“When home carers go in, they go in for 20 minutes and do everything for them. However, we should be working alongside the person to try to maintain their skills for as long as possible. So, it is a change of orientation, and it requires specialised home carers, particularly when people become obstreperous, difficult and a bit behaviourally disturbed as part of their dementing illness. It requires people who have some knowledge and understanding. In some areas, we already have a specialised homecare workforce, but not across the whole of Wales, and that is a gap in services that needs to be filled.”⁵⁴

64. Other witnesses have expressed concerns that some telecare⁵⁵ and telehealth⁵⁶ services are at risk from loss of funding⁵⁷ since the Telecare Capital Grant ended. The grant was awarded to local authorities between 2006 and 2009 to provide 10,000 homes with telecare services and ongoing funding is required to maintain them. However, although financial pressures on local authorities may force them into making difficult decisions around service priorities, we believe they have a strong interest in maintaining telecare schemes given the significant savings in other service areas that can be generated by them. Clear and robust evidence of the benefits of telecare, in particular its impact on demand for other services, is needed.

Hospital discharge and assessment

65. Witnesses told us that admission to residential care usually occurs in a crisis and often following an admission to hospital. We were told that, although discharge planning should begin on admission to hospital, subsequent assessments and discharge processes can be undertaken too hurriedly and result in poor decisions, with long-term consequences for the person and carers concerned.

⁵⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 22\]](#) 16 May 2012 [accessed 19 October 2012]

⁵⁵ Telecare uses a combination of alarms, sensors and other equipment to help people live more independently by monitoring for changes and warning people themselves or raising an alert at a control centre.

⁵⁶ Telehealth covers the remote monitoring of physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management.

⁵⁷ See [written evidence](#) from Cymorth (RC65, p10) and Tunstall Healthcare (RC62, p1) [accessed 19 October 2012]

66. The importance of planning for discharge as soon as possible after admission to hospital was emphasised during evidence. We were told that people in hospital quickly lose skills and confidence and become dependent on others, making the option of returning to independent living appear less realistic. Mandy Collins from Health Inspectorate Wales told the Committee that:

“There is research that shows that if you have an elderly, fairly fragile person in a hospital bed for longer than 20 days, they are highly unlikely to go home again, because they lose their confidence. In hospital, everything is done for people and we are not encouraging them, when they are there, to maintain a level of independence.”⁵⁸

67. Although we acknowledge the need to ensure that no individual stays in hospital for longer than is necessary, this should not be done at the expense of providing a comprehensive assessment. Allowing sufficient time to fully explore the options available to an individual to regain independence following a crisis is crucial to identifying a suitable care pathway. We were concerned to hear David Street from the Association of Directors of Social Services suggest that the pressure health boards face to discharge people from hospital inevitably leads to some people going into residential care who do not need to do so.⁵⁹ Sue Davis from the Social Care Association said:

“...the hurry to get them out of hospital now means that they often end up not having a full assessment, but being transferred.”⁶⁰

68. Catherine Poulter from the British Association of Social Workers told us that some people may have no assessment at all and may not be made aware of all the options available to them.⁶¹ She went on to highlight that, even when available care options are explained to those in need, they are often limited:

“...the older person does not have the opportunity to go to look at somewhere and make a definite choice. Sometimes, it may not be at all their choice—it will be a matter of finding

⁵⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 170\]](#) 30 May 2012 [accessed 19 October 2012]

⁵⁹ Ibid [RoP \[para 154\]](#) 22 March 2012 [accessed 19 October 2012]

⁶⁰ Ibid [RoP \[para 172\]](#) 16 May 2012 [accessed 19 October 2012]

⁶¹ Ibid [RoP \[para 166\]](#) 16 May 2012 [accessed 19 October 2012]

somewhere with a vacancy. We do not do this to children...We are very careful about the way in which we match children and foster parents; with older people, there is pressure to get them out of hospital. I am not advocating that people should stay in hospital indefinitely, but our system is very much about making the best use of what we have, but is this done at the expense of older people's choices and what is best for them?"⁶²

69. Furthermore, concerns about the risk-averse nature of professionals when making decisions around discharging older people from hospital were raised during evidence. Dr Pauline Ruth of the Royal College of Psychiatrists told us:

"In secondary care, there is a huge problem of being risk averse. It is not just doctors, but nurses and occupational therapists and all the people working in general hospitals who are not familiar with the services available in the community. It is because secondary care has been too divorced from the community until now."⁶³

70. Dr Ruth went on to argue that expert assessment in hospital with input from community based staff is necessary.⁶⁴ Eve Parkinson from the College of Occupational Therapists, who works within the Gwent Frailty Programme, highlighted the benefits, as did other witnesses, of increasing the involvement of community based staff in patient discharge, given their knowledge of both the patient and community services. The Committee was told that this is being addressed in different ways across Wales, including via the use of specialist discharge liaison nurses⁶⁵ and nurse co-ordinators to link community services with secondary care in specific areas⁶⁶.

71. In addition to the impact of inadequate discharge and assessment processes on the older person and his or her carers and family, witnesses highlighted the negative impact on care homes too. The Social Care Association told the Committee that the lack of adequate

⁶² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 167\]](#) 16 May 2012 [accessed 19 October 2012]

⁶³ Ibid [RoP \[para 24\]](#) 16 May 2012 [accessed 19 October 2012]

⁶⁴ Ibid [RoP \[para 24\]](#) 16 May 2012 [accessed 19 October 2012]

⁶⁵ Ibid [RoP \[para 31\]](#) 16 May 2012 [accessed 19 October 2012]

⁶⁶ Ibid [RoP \[para 16\]](#) 14 March 2012 [accessed 19 October 2012]

assessment in hospital often leads to pressures on care homes and unrealistic expectations about what a home may be able to deliver.⁶⁷

Reablement

72. As well as hearing that improved hospital assessment and discharge arrangements are needed, we were told that entering residential care straight from a hospital bed means there is little opportunity to fully assess a person's capabilities. Luisa Bridgman from Rhondda Cynon Taf County Borough Council told the Committee that:

“... anecdotally and from what we see in residential services, where people are admitted straight from hospital, after a period of recuperation and recovery, their skill base improves. You then question the decision, but it is often not an option for them to return to the community at that point.”⁶⁸

73. Evidence to our inquiry and comments from our External Reference Group strongly suggested that, given the difficulties of undertaking effective assessments in hospital, there is a strong case for ensuring older people who have suffered ill health are given the opportunity to rebuild their strength before decisions about future care are made. This is often referred to as “reablement”. Access to reablement, we were told, is particularly important when older people's independence and skills may have declined due to the relatively institutional nature of hospital care.

74. According to a Social Services Improvement Agency report,⁶⁹ reablement “represents the single biggest change for older people's services in Wales over the last decade”. The report explains that the concept of reablement:

“...is built on the simple premise that when older people become ill or have a medical intervention they can get better. Its basis lies in the disciplines of occupational therapy (OT) and physiotherapy, helping older people rebuild their strength both

⁶⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 171\]](#) 16 May 2012 [accessed 19 October 2012]

⁶⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 236\]](#) 22 March 2012 [accessed 19 October 2012]

⁶⁹ Social Services Improvement Agency (SSIA) [Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales](#) p33 [accessed 19 October 2012]

physically and emotionally after a critical event so that they can live independently once again. The evidence shows that many older people can be aided to a full recovery after a 6 week period of intensive support.”

75. Evidence to our inquiry suggests, however, that there is some uncertainty about what reablement is and what a reablement service should comprise. Our External Reference Group welcomed the concept of reablement, but believed that more clarity about what it can offer is needed. The Welsh Reablement Alliance suggested that apparently wide discrepancies in spend per head between local authorities in Wales may partly result from differences in what are defined as reablement services. The Alliance called for:

“...a steer from the Welsh Government to local authorities about what the Welsh Government considers to be reablement—which services should be included, and what local authorities should be seeking to provide.”⁷⁰

76. The Committee also received evidence which suggested that fresh thinking is needed about applying the principle of reablement to those with dementia. The Royal College of Physicians’ written evidence stated:

“There appears to be no community-based model for reablement in patients with dementia. Current reablement teams often have dementia as an exclusion criteria.”⁷¹

We endorse the view that the needs of those with dementia within the context of reablement services require further consideration as soon as possible.

77. Despite the variation in the provision of reablement services, evidence from committee members’ visit to Carmarthenshire County Council was striking. Staff there told us that it is now exceptional for anyone to go straight from hospital into residential care, and almost everyone goes through a six-week period of assessment and reablement, referred to in that authority as “convalescence”. At the end of those six weeks, seven out of 10 people go home; under the

⁷⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 16\]](#) 26 April 2012 [accessed 19 October 2012]

⁷¹ Ibid [Consultation response RC44 – Royal College of Physicians](#) section 4, para 6 [accessed 16 November 2012]

previous system, seven out of 10 people went into residential care.⁷² Other evidence cited by the Wales Reablement Alliance indicated that 60 per cent of older people who receive reablement do not require further services after a six-week intensive period of help and treatment. Moreover, they also argued that effective reablement services can reduce demand for domiciliary care by between 10 and 20 per cent.⁷³

78. We were told that reablement of this sort can be delivered in a variety of locations. We heard from local authorities, both during evidence sessions and as part of our committee visits, about how they had started to provide beds in their care homes for this purpose. David Street, from the Association of Directors of Social Services told the Committee that:

“A number of authorities, including my own [Caerphilly], have brought in the concept of intermediate care, or ‘step down’, or what we call assessment beds. People can go into a care home for a six-week period to receive reablement services, and to give them and their family more time to make a fundamental judgment about where they want to be for the rest of their lives.”⁷⁴

79. Furthermore, Kevin Hughes from Pennaf Housing Group suggested this could be explored with Registered Social Landlords and third sector housing providers.⁷⁵

80. The Social Service Improvement Agency (SSIA) report *Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales* states:

“Best practice suggests that assessment of an older person’s long term care needs should not be made whilst that person is in hospital. A period of intermediate care, either in a community setting, community hospital or a residential care bed, is often the best solution, as long as the focus of the

⁷² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 50\]](#) 16 May 2012 [accessed 19 October 2012]

⁷³ National Assembly for Wales, Health and Social Care Committee [RoP \[para 11\]](#) 26 April 2012 [accessed 19 October 2012]

⁷⁴ Ibid [RoP \[para 154\]](#) 22 March 2012 [accessed 19 October 2012]

⁷⁵ Ibid [RoP \[para 71\]](#) 2 May 2012 [accessed 19 October 2012]

service provided is to support the older person's recovery through a reablement approach."⁷⁶

81. We agree that, as a default position, an older person should not enter permanent residential care directly from a hospital bed. We believe that people should be supported, through reablement, to recover their skills following a period in hospital. This, we believe, will allow appropriate time for them, with the help of their families and carers, to make an informed decision about their future care needs. The evidence we heard, both formally and during our visits, about the difficulty of returning home after an admission to residential care, due to the upheaval and confusion this can cause, suggests to us that this should not be happening as a matter of course. We do accept, however, that in a limited number of individual cases there will be a need to transfer directly into residential care, but this should be the exception rather than the rule.

82. Whilst we would not want to inhibit innovation and local flexibility with an overly prescriptive definition of reablement, we believe that a broadly consistent definition would be helpful. In our view, greater clarity about what reablement is would help provide a meaningful assessment of the level of reablement service provision and expenditure across Wales. We believe that this would improve our ability to assess and improve outcomes for individuals.

Key recommendation 5: The Welsh Government should ensure that older people are always offered a period of reablement or intermediate care following a period of illness, particularly when this has involved hospital treatment. Care decisions should take full account of a person's potential for maintaining and increasing their independence. Entry to permanent residential care straight from hospital should not occur. Furthermore, the Welsh Government should produce guidance to improve the clarity and consistency of local authority and health board definitions of reablement. We believe this will help ensure that meaningful data is collected to measure outcomes and drive improvements.

⁷⁶ Social Services Improvement Agency (SSIA) [Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales](#) p50 [accessed 19 October 2012]

3. The capacity of the residential care sector in Wales

83. The landscape of residential care has changed significantly over the last thirty years. Services have been re-orientated towards community based care, with many local authorities focusing on commissioning rather than direct provision of residential care. Evidence throughout our inquiry indicated that care home residents are now more likely to have higher levels of need than ever before with more being accommodated in private sector homes.

84. The capacity of the residential care sector in Wales is heavily dependent on the finances it receives from local authority commissioned places on the one hand and self-funding individuals on the other. Issues relating to the planning and commissioning of residential care and crucially, how we pay for it, are addressed in this chapter.

Planning and commissioning residential care

85. Local authorities are responsible for planning, and providing or commissioning residential care for older people who do not have sufficient resources to pay for their own care. However, an emphasis on community-based care and tighter local authority eligibility criteria are reducing the proportion of publicly funded older people in residential care. Self-funders now comprise an increasing proportion of care home residents.

86. Direct provision of residential care by local authorities has declined; only 15 per cent of adult placements in Wales are now in local authority run homes.⁷⁷ In most areas care is likely to be commissioned from independent sector providers.

87. A long term decline in the number of care homes is evident in Wales, as in other parts of the UK. The number of registered care homes for all adults declined by more than 17 per cent from 1,409 in March 2004 to 1,162 in June 2012. The number of places in care homes declined by only four per cent from 27,745 to 26,627 over the

⁷⁷ Welsh Government, [Statistics First Release: Assessments and Social Services for Adults, Wales 2011-12](#) p4, 4 September 2012 [accessed 2 October 2012]

same period.⁷⁸ This suggests that care homes are becoming larger, and this is borne out by information in the Welsh Government briefing paper⁷⁹ to the Committee in July 2011 which stated:

“The last decade has seen a reduction in the number of smaller care homes and an increase in larger 60-100 bed homes more often than not owned by corporate national companies.”

88. Local authorities are placing fewer people in residential care: the number of adults of all ages supported by them in care home placements fell from 17,249 in 2003 to 13,837 in 2011.⁸⁰ The profile of the care home population is changing too: in March 2003 fifty two per cent of older adults supported by local authorities in residential care were over 85 years old. In March 2012 sixty per cent were over 85 years old.⁸¹ Two thirds of older people in care have dementia.⁸² An increasing number also have sensory impairment and other support needs such as a learning disability or substance misuse problems.⁸³ This has implications for staff training which we discuss in chapter 5.

89. We were told that, in general, there is enough – and, in some cases, more than enough – capacity in the residential care sector to meet the demand in Wales, although specialist residential care may be scarce in some areas. However, it strikes us that a lack of comprehensive data on supply and demand is hindering effective planning. Professor John Bolton indicated in evidence that Wales has a sufficient supply of residential care and potentially an over-supply:

“Laing and Buisson is very confident that there is sufficient supply in Wales of residential care via a formula it uses to look at what supply ought to look like. Actually, based on my work,

⁷⁸ Care and Social Services Inspectorate Wales: [Care Standards Inspectorate for Wales Annual Report 2003-04](#), p19 [accessed 13 November 2012]; [Quarterly Release: Regulated settings and places 30 June 2012](#) [accessed 13 November 2012]

⁷⁹ Welsh Government, *Residential care: A Briefing Paper for the Health and Social Care Scrutiny Committee: meeting 28 July 2011*.

⁸⁰ Welsh Government, [Statistics First Release: Assessments and Social Services for Adults, Wales 2011-12](#) p2, 4 September 2012 [accessed 14 November 2012]; National Statistics SDR 59/2003 [Local Authority Social Services Performance Statistics 2002-03 p6](#) [accessed 14 November 2012]

⁸¹ Welsh Government, [Statistics First Release: Assessments and Social Services for Adults, Wales 2011-12](#) p5, 4 September 2012 [accessed 14 November 2012]; Welsh Government [Social Services Statistics Wales 2002-03](#) tables 2.6 & 2.7 [accessed 14 November 2012]

⁸² National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC50 – Alzheimer’s Society](#) p2 [accessed 19 October 2012]

⁸³ Ibid [Consultation response RC65 – Cymorth Cymru](#) p3 [accessed 19 October 2012]

that might suggest that, if we got the preventive agenda right, there may be an oversupply.”⁸⁴

90. This view was echoed by respondents to the Committee’s written consultation particularly regarding care for non-EMI residents. Bridgend County Borough Council, for example, pointed to an over provision of residential care in their area.⁸⁵

91. However, other evidence suggests that specialist care – particularly for those with dementia – is not always available for those who need it.⁸⁶ For example, David Street from the Association of Directors of Social Services, told us in his authority of Caerphilly that:

“I think that you have to differentiate between residential care for older people and residential care for people with dementia. There is certainly an oversupply of general residential care, if I can use that phrase, but that certainly is not the case for residential care for people with dementia; either the supply is adequate or there is an undersupply.”⁸⁷

92. Although we would caution against assuming that specialist dementia care will always be residential in nature, we acknowledge the need to consider the sector’s capacity to provide specialist care at this time.

93. A number of witnesses to the inquiry highlighted the need for better intelligence on current and future patterns of demand to allow local authorities and providers to better plan provision. The External Reference Group⁸⁸ suggested that there is a need to gather information at the national level on the views and likely needs of people who are currently in middle age. It was their view that the changing needs and expectations of younger generations ought to be scoped and that the sector should be encouraged to do market research in this area.

⁸⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 168\]](#) 23 February 2012 [accessed 19 October 2012]

⁸⁵ Ibid [Consultation Response RC39 – Bridgend County Borough Council](#) p2 [accessed 29 October 2012]

⁸⁶ See [written evidence](#) from Flintshire County Council (RC 7, p3); Rhondda Cynon Taf County Council (RC 63, paragraph 3.6) and Ceredigion County Council (RC 19, p6) [accessed 19 October 2012]

⁸⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 147\]](#) 22 March 2012 [accessed 19 October 2012]

⁸⁸ External Reference Group meeting [12 June 2012](#), see Annex B to this report

94. In oral evidence Care Forum Wales emphasised the need for independent providers to be better engaged with local authorities in their planning and commissioning activities.⁸⁹ They suggested that better collaboration is needed, particularly for the large number of small and medium sized providers of social care. In his written evidence⁹⁰ Professor John Bolton recommended that all local authorities produce a “market position statement” which sets out the state of local care provision and the predicted future demand for services to enable better planning by care providers. The Welsh Local Government Association (WLGA)⁹¹ indicated that work to develop market position statements at the national level is being undertaken over the next 12 months. This should therefore be delivered by spring 2013.

95. David Street from ADSS told the Committee⁹² that his local authority is ‘fully transparent’ with providers about where there is over or under capacity. He noted that his authority encourages providers to move away from standard residential care towards more specialist services for people with mental health needs, although some are reluctant to do so.

96. We understand from evidence we received that the Welsh Government and local authorities are currently developing regional commissioning arrangements across local authority boundaries to improve efficiency and economy. An inter sector Commissioning Board and Provider Forum are being established with the aim of improving communication between the commissioners and providers.

97. Written evidence from the Deputy Minister provided details of the Welsh Government’s guidance to local authorities: *Commissioning Framework Guidance and Good Practice* on the commissioning of social services. The guidance states that the planning process should involve stakeholders including the private and independent sector. It also states:

“The guidance is supplemented by a Procurement Route Planner developed by Value Wales and includes a full set of on-

⁸⁹ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 5 and 11\]](#) 14 June 2012 [accessed 19 October 2012]

⁹⁰ Ibid [HSC\(4\)-07-12 paper 5 – Evidence from Professor John Bolton](#) 23 February 2012, p11 [accessed 19 October 2012]

⁹¹ Ibid [RoP \[para 134\]](#) 22 March 2012 [accessed 19 October 2012]

⁹² Ibid [RoP \[para 137\]](#) 22 March 2012 [accessed 19 October 2012]

line, step by step guidance specifically for the contracting of social care and housing related services. It is further supported by the 'Daffodil' database, a care needs projection system designed to assist the modelling of future service demand by analysing the prevalence of a range of health and social conditions and projecting them across population changes over a number of years within each local authority and local health board area."⁹³

98. In oral evidence the Deputy Minister told the Committee that the forthcoming Social Services Bill will require local authorities to plan services for their areas:

"...the Bill will be very strong on the requirement for local authorities to identify need, now and anticipated, as best they can in their areas. I believe that, practically, that needs to come down to a ward level in order to understand the need now and the need that is likely to occur".⁹⁴

Conclusion 5: Whilst we are encouraged by the direction of travel of local authorities in terms of planning residential care provision and engaging more actively with the market, we believe more could be done. The development of market position statements will provide important information to providers about what is required and allow them to plan. These statements should be finalised and published as soon as possible.

Resources for care

99. The level of resources available to pay for care has a fundamental impact on the quality, scope and effectiveness of the services offered by the residential care sector. There are a number of issues around resourcing care services, including the level of local authority fees to independent providers, and the balance between the contributions of individuals and the state in meeting the costs of care. These impact on the ability of the sector to recruit, train and retain high quality staff, modernise facilities, develop new models of care, and therefore to deliver high quality care.

⁹³ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-18-12 paper 3 – Evidence from the Deputy Minister for Children and Social Services](#), 20 June 2012 [accessed 19 October 2012]

⁹⁴ Ibid [RoP \[para 80\]](#) 20 June 2012 [accessed 19 October 2012]

Local Authority fees

100. Although fee levels are a sub-set of a much wider and more general issue of how we pay for care, concerns about the level of fees paid by local authorities for residential care were expressed by a number of witnesses to the inquiry. Evidence we received suggested that local authority fees are insufficient to allow many providers to recruit and retain high quality staff, given the current levels of pay, and as a consequence, to offer high quality care.⁹⁵

101. BUPA Care Homes stated in written evidence that the current system is underfunded and unsustainable.⁹⁶ Peter Regan from Haulfryn Care Home described a “constant struggle between fee levels and the job that we are asked to do”.⁹⁷ The Wales Co-operative Centre also identified fee levels as an issue for co-operative providers.⁹⁸

102. Some families are asked to pay top-up fees to supplement local authority fees. Age Cymru stated that families are not always aware of this practice and often have little choice but to pay. This can be a particular problem in rural areas where the choice of care homes is limited.⁹⁹ A 2009 review by CSSIW of the practice of charging top up fees highlighted the restrictions on choice and access and the confusion it creates for users and carers at a time of stress.¹⁰⁰

103. A Memorandum of Understanding has promoted co-operation in Wales between local authorities and care providers on sustainable services, including fees. Following recent difficulties¹⁰¹ we are encouraged to learn that the WLGA is developing a ‘refreshed’ memorandum of understanding that is wider in scope and that will facilitate dialogue between local authorities, the NHS and the range of third and independent sector providers.

⁹⁵ National Assembly for Wales, Health and Social Care Committee, [Consultation response RC65 – Cymorth Cymru](#) p5 [accessed 19 October 2012]

⁹⁶ Ibid [Consultation Response RC28 - BUPA](#) p2 [accessed 19 October 2012]

⁹⁷ Ibid [RoP \[para 35\]](#) 14 June 2012 [accessed 19 October 2012]

⁹⁸ Ibid [Consultation Response RC 81 – Wales Co-operative Centre](#) p8 [accessed 19 October 2012]

⁹⁹ Ibid [Consultation Response RC 41 – Age Cymru](#) p4 [accessed 19 October 2012]

¹⁰⁰ Ibid [HSC\(4\)-16-12 paper 3 – Update from Care and Social Services Inspectorate Wales](#), 30 May 2012 [accessed 19 October 2012]

¹⁰¹ Ibid [RoP \[para 83\]](#) 20 June 2012 [accessed 19 October 2012]

Paying for care

104. The need to reform the way in which social care is funded was an issue raised by nearly all our witnesses. The Welsh Government published a Green Paper on paying for care in Wales and consulted on it in 2009-10. However, the funding of social care in Wales is closely linked to broader policy issues such as welfare benefits and taxation, responsibility for which remains with the UK Government.

105. A commission to examine the issue of paying for care in England, chaired by Andrew Dilnot, reported in July 2011. Given the implications for non-devolved policies, the work of the Dilnot Commission on funding social care in England has significance for Wales. However, the Committee has been unable to consider its implications in the absence of further progress on addressing the recommendations in the Dilnot report.

106. Currently, people in Wales with assets exceeding £23,250 must pay the full cost of their care which, in some cases, can mean selling their home. The relatively high level of home ownership in Wales, combined with a shift towards community-based care and more restricted access to services by local authorities, is likely to result in a higher proportion of self-funders in residential care in the future.¹⁰² However, given the relatively low average value of property in Wales, older people contribute a larger proportion of their assets to care home costs than in many other parts of Britain. Implementation of the recommendations in the Dilnot report, which include raising the assets threshold to £100,000 and introducing a lifetime contributions cap of between £25,000 and £50,000 (with a recommended level of £35,000), would therefore have a major impact on older people in Wales.

107. During the process of evidence gathering and drafting the final report there were some announcements around the Dilnot review, but the issues around funding remain unresolved. The UK Government has expressed¹⁰³ support for the principles of the Dilnot Commission's model – financial protection through capped costs and an extended means test – as the basis for any new funding model, but it has not

¹⁰² National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-07-12 paper 5 – Evidence from Professor John Bolton](#) 23 February 2012, pp3-4 [accessed 19 October 2012]

¹⁰³ Department of Health website, [Government publishes progress report on social care funding](#) [accessed 24 July 2012]

made a commitment to introducing any new system before the next spending review in autumn 2013.

108. However, the Deputy Minister for Children and Social Services has stated that Wales cannot implement the Dilnot recommendations alone:

“We estimate that the cost of implementing similar changes in Wales to those outlined in the Commission’s Report, should we wish to do so, would be around £100 million a year at today’s costs and rising with the impact of demographic change in coming years. We would therefore be restricted from taking action on this scale without an investment of new money coming to Wales under the Barnett formula, comparable to the significant sums that will be sought for England under the UK Government’s next spending review.”¹⁰⁴

109. We welcome assurances from the Deputy Minister that, having met with the then UK Government Minister for Care, Paul Burstow, during the course of our inquiry to impress upon him the urgency of resolving this issue, she is now seeking a meeting with the newly appointed UK Minister, Norman Lamb MP.¹⁰⁵ We would wish to stress the need for continuing dialogue with the UK Government to ensure the interests of Wales are reflected in the decisions made.

Paying for domiciliary care

110. There was a suggestion in evidence that local authorities may have a preference for commissioning residential care over community-based services. This assertion was made in part due to the Welsh Government policy of capping individual contributions to the cost of domiciliary care at £50 a week. Rhondda Cynon Taf County Council’s written evidence identified what it describes as a ‘perverse incentive’ to support people in residential care:

“Generally the cost to the public purse is significantly less for those in residential care opposed to those supported in the

¹⁰⁴ Welsh Government, Gwenda Thomas (Deputy Minister for Children and Social Services) [UK Government Progress Report on Paying for Social Care](#) Cabinet Written Statement, 12 July 2012 [accessed 25 July 2012]

¹⁰⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 16\]](#) 3 October 2012 [accessed 19 October 2012]

community, the current maximum charge of £50 per week for domiciliary services exacerbates this position.”¹⁰⁶

111. This view was echoed by Professor John Bolton in his written evidence¹⁰⁷ to the inquiry.

112. The WLGA stated that the £50 per week cap is causing “considerable concern” for local authorities. The cost of placing a person in residential care is equivalent to between 15 and 20 hours per week of domiciliary care.¹⁰⁸

113. On 20 June 2012 the Deputy Minister told the Committee that the Welsh Government is reimbursing local authorities for their lost income and that the results of a review will help to inform the future development of the policy:

“I really cannot think what incentive there would be for local authorities to move to residential care because of the £50 limit, because we are recouping their loss. [...] One thing that I am sure about it that has benefited people in Wales who are paying for non-residential care provided or commissioned by local authorities. I cannot see how that perverse incentive would work. In any case, speaking off the top of my head, to the best of my understanding, local authorities are required to assess the needs of people in terms of care and to provide it. Not to provide non-residential care, if that is the assessed need, but to provide residential instead, could put a local authority in a position of not carrying out its statutory responsibilities.”¹⁰⁹

114. However, during a general scrutiny session on 3 October this year, the Deputy Minister acknowledged an emerging overspend amongst some local authorities on the £50 domiciliary care cap:

“Some local authorities are telling us that they have overspent significantly, while others have overspent a little and some have not overspent at all. So, there is a diversity of effects on local authorities.

¹⁰⁶ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC63 - RCT County Borough Council](#), para 2.3 [accessed 19 October 2012]

¹⁰⁷ Ibid [HSC\(4\)-07-12 paper 5 - Evidence from Professor John Bolton](#) 23 February 2012, p9 [accessed 19 October 2012]

¹⁰⁸ Ibid [RoP \[paras 203-205\]](#) 22 March 2012 [accessed 19 October 2012]

¹⁰⁹ Ibid [RoP \[para 108\]](#) 20 June 2012 [accessed 19 October 2012]

“[...] There is some evidence that more people are seeking non-residential care. I cannot comment further. I have seen the press coverage on this, but I will wait until I get a report on the overspend of each local authority and until I am satisfied with the reasons for that [...] This is ongoing and I intend to negotiate openly with local authorities on this. If more people are benefiting from good quality non-residential care, then we have to ask whether that will result in a saving of more expenditure on residential care. There are many ways of looking at this, but until I get the final estimate and advice from officials, I do not think that I can comment further this morning.”¹¹⁰

Conclusion 6: How we pay for care is crucial to its quality. Funding of social care in Wales is closely linked to broader policy issues such as welfare benefits and taxation, responsibility for which remains with the UK Government. As such, we urge the Welsh Government to work with its UK counterpart on this urgent issue with a view to finding a suitable funding resolution for social care in Wales as soon as possible. We believe the Welsh Government’s Ministerial Task and Finish Group for Welfare Reform, which is assessing the impact of the current UK Government’s welfare reforms in Wales and responding to them, should be aware of the issue of paying for care and the potential impact of any changes in Wales.

¹¹⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 17-18\]](#) 3 October 2012 [accessed 19 October 2012]

4. Living in residential care

115. As outlined in chapter two, there are a range of options that provide alternatives to residential care and, as these become increasingly available, the provision of residential care is likely to diminish. We welcome this development and the opportunities it offers older people to retain their independence and exercise choice. However, there will remain a significant number of older people who will need and want to use residential care.

116. Written and oral evidence received by the Committee has highlighted a poor public perception of residential care services, and individuals' low expectations of life in care more generally. These concerns were also echoed by the External Reference Group.¹¹¹ Haydn Evans from Pensioners Forum Wales told the Committee that a major problem with residential care is that it can be:

“... a situation that Judi Dench referred to lately as ‘warehousing’ - people scattered around the room, staring at the television or staring into space, where each day is exactly like the day before. No-one wants to enter that sort of situation at the end of their life, and that is why we all dread going into homes.”¹¹²

117. If there is to be a continuing and positive role for residential care, a range of issues around quality of care, identified in evidence and by the External Reference Group, need to be addressed. These are explored in this chapter.

The voice of service users, their families and carers

118. Evidence to this inquiry has consistently highlighted the need for the views and wishes of residents, their families and carers to be heard. This is a concern across the whole spectrum of care services, and particularly important in care home settings where older people may be at their most vulnerable and least able to communicate their needs. The Older People's Commissioner told the Committee:

“It is absolutely imperative that people feel protected and safe, as well as happy, in their homes, and that residents' voices are

¹¹¹ External Reference Group meeting [17 April 2012](#), see Annex B to this report

¹¹² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 11\]](#), 29 February 2012 [accessed 19 October 2012]

heard at all stages of people's experience of living in their home, which happens to be either a residential care home or a nursing home."¹¹³

119. In written evidence, the British Association of Social Workers Cymru noted that once in a care home, there is little chance that residents with concerns about the care they receive will be able to share them unless they have supportive family or friends.¹¹⁴ The Royal College of Psychiatrists highlighted the importance of residents/relatives groups within care homes to improve communication and influence of service users.¹¹⁵

120. We believe that the quality of residential care would be enhanced by strengthening the voice of residents, their families and carers. There is a role for the Welsh Government, CSSIW, the Older People's Commissioner, local authorities and care home providers in enabling service users to contribute to improving services in a meaningful way, by further developing ways of incorporating their views into service planning and delivery. The specific issue of capturing the experiences of residents in CSSIW inspection reports is considered in chapter six - *Regulating and inspecting residential care*.

Key recommendation 6: The Welsh Government should work with partners to develop new initiatives that give residents, their families and carers greater voice and control. The aim of this should be to influence the shape and direction of services *and* exert continual pressure on service quality. Once an individual care home reaches a certain size (to be determined by the Welsh Government in consultation with the sector), it should be obligatory to have resident and family/carer forums within the home. Such an arrangement could be built into contracts with providers by service commissioners.

¹¹³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 4\]](#), 23 February 2012 [accessed 19 October 2012]

¹¹⁴ Ibid [Consultation Response RC79 - British Association of Social Workers Cymru](#) p2 [accessed 19 October 2012]

¹¹⁵ Ibid [Consultation Response RC44 - Royal College of Psychiatrists in Wales](#) p5 [accessed 19 October 2012]

A fulfilling life in care

Meaningful and suitable activity

121. Evidence received by the Committee described how entering care can lead to a loss of identity, and emphasised the importance – for mental and physical wellbeing – of being able to pursue hobbies, take part in appropriate activities and engage with the wider community. Provision of meaningful and suitable activity within care homes was highlighted as a key issue by the External Reference Group.

122. The Alzheimer’s Society in their written evidence referred to research showing that residents with more severe cognitive impairment had their physical needs attended to, but little time was given to social, emotional or occupational needs.¹¹⁶ The College of Occupational Therapists told us that engagement of people with dementia in activities, graded to their capabilities, increases their quality of life, preserves their own identity and provides them with a positive emotional outlet.¹¹⁷

123. Nancy Davies from Pensioners Forum Wales explained:

“It is not just about activities, but the ethos within the home: it is about asking how someone is and what is going on and about the general interaction with people. This is sadly missing. Activities do not have to be several people sitting in one room painting or drawing; it can involve quick quizzes, and every member of staff should be engaging, perhaps asking whether they have seen something in the news—the kind of normality that we have in our daily lives. That interaction seems to be missing in care homes. Some people do not want things to be done to them, but the situation is variable; that is the problem.”¹¹⁸

124. The interaction between staff and residents was felt to be key to the quality of care. The Alzheimer’s Society highlighted survey findings showing that the typical person in a home spent only two minutes interacting with staff and other residents over a six-hour period of

¹¹⁶ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC50 - Alzheimer’s Society](#) p5 [accessed 19 October 2012]

¹¹⁷ Ibid [Consultation Response RC36 - College of Occupational Therapists](#) p6 [accessed 19 October 2012]

¹¹⁸ Ibid [RoP \[para 51\]](#), 29 February 2012 [accessed 19 October 2012]

observation, excluding time spent on care tasks. Evidence suggests that, in some circumstances, care in residential settings can be very task orientated with staff doing things ‘to’ rather than ‘with’ users.

125. Chris Synan, from the College of Occupational Therapists, told us:

“We absolutely cannot accept that people must be in a downward spiral, and the way to do that is to show the benefits of an enablement approach within even the most traditional, paternalistic settings. There are all sorts of benefits, not only to the individual, but from an economic point of view. You will prevent admissions to hospital from residential homes if you can encourage that enablement approach. It is down to education and training and showing the effect on the mental health and wellbeing of that individual. You can change the approach and the ethos of the more traditional homes, so we cannot and must not accept it, and it is in everybody’s interest—the individual and the provider of the care.”¹¹⁹

126. The important role of dedicated activity co-ordinators was emphasised during oral evidence and by the External Reference Group. Organisations such as the College of Occupational Therapists¹²⁰ and the Alzheimer’s Society¹²¹ emphasised the importance of allocating a member of staff to the role of activities co-ordinator in order to ensure that residents have access to meaningful activities of interest to them personally. Age Concern Cardiff and the Vale went further, arguing that allocating responsibility for coordinating activities should not merely be an ‘add-on’ to a care worker’s other core tasks:

“Very often, a care home will nominate a member of staff to become the activities co-ordinator, but, in reality, they are not given the time, the resources or the authority to do that.”¹²²

Community engagement

127. We have heard that, all too often, a move into residential care can lead to isolation from the community. In their written evidence, My Home Life, the UK-wide initiative which seeks to promote quality of life

¹¹⁹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 57\]](#) 16 May 2012 [accessed 19 November 2012]

¹²⁰ Ibid [RoP \[paras 59-60\]](#) 16 May 2012 [accessed 19 November 2012]

¹²¹ Ibid [RoP \[para 99\]](#), 2 May 2012 [accessed 19 November 2012]

¹²² Ibid [RoP \[para 51\]](#), 29 February 2012 [accessed 19 November 2012]

in care homes for older people, called for greater engagement with communities:

“Care homes are often isolated from the wider community and can benefit hugely in terms of quality by having better community engagement. Care homes typically do not have the capacity to identify or support volunteers and sometimes avoid opening their doors to the outside world for fear of criticism and poor press coverage. Greater community engagement leads to a higher quality therapeutic environment.”¹²³

128. The College of Occupational Therapists told the Committee:

“Residents also need to be able to access local services such as leisure and transport, library or social settings. If people move to homes in their locality, more needs to be done to ensure that they retain their local connections and networks- still going to the pub, church or shop if they wish to.”¹²⁴

129. Links with outside organisations can also help to address the specific needs of some residents, for example those with sensory loss, who may often feel isolated even in group settings and may struggle with communal activities. Ansley Workman from RNIB Cymru suggested that improving links with the local community could help:

“A prime example in Cardiff is what everybody knows as Cardiff Institute for the Blind, which is now Cardiff, Vales and Valleys Institute for the Blind. It goes into registered care homes and offers befriending support, and peer support, and brings activities in, but it is also able to talk to the staff in the homes about the kinds of activities that are on offer, and what adjustments need to be made for people with sight loss. It can be really simple things—the obvious thing that people think about is large print books, but, nowadays, we are talking about care homes with Wii Fit, and all those different types of things.”¹²⁵

¹²³ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-06-12 paper 3 - Evidence from the My Home Life programme](#) 23 February 2012, p4 [accessed 19 October 2012]

¹²⁴ Ibid [Consultation Response RC36 - College of Occupational Therapists](#) p7 [accessed 19 October 2012]

¹²⁵ Ibid [RoP \[para 142\]](#), 29 February 2012 [accessed 19 October 2012]

130. The work of My Home Life UK and My Home Life Cymru aims to improve links between care homes and local communities. Age Cymru described how this has helped increase volunteer activity in care homes:

”My Home Life Cymru have provided grants to local Age Cymru partners to stimulate volunteer schemes with care homes, for example, Age Cymru Swansea Bay have established a project with Mumbles nursing home. In Age Cymru Gwynedd a Mon’s research, all care home managers reported that they would welcome a formal system whereby volunteers could come into the home, at regular intervals, to talk to residents and possibly, take them on outings.”¹²⁶

131. The Committee commends the work of the *My Home Life* project which we believe makes a valuable contribution to improving quality of life in residential care.

132. We have heard some positive stories about care settings successfully integrating with their local communities. During our visit to Llys Enfys in Llanishen, we were told how residents had hosted a local meeting and undertaken fundraising, even working with partners in the community to re-route a bus into the housing estate. Although this example is from an Extra care scheme, there is no reason why better community links, that are appropriate to the needs of residents, could not be developed in residential care homes.

133. Another issue relating to community involvement is the provision of adequate spiritual care. Witnesses from Pensioners Forum Wales told the Committee that it is quite common for local clergy to pop into care homes, but that there is not enough formality to these arrangements. The provision of spiritual care is broader than religious needs, as John Moore from My Home Life told the Committee:

“On the spiritual aspect and the spiritual wellbeing of an individual, that is wrapped in with the My Home Life approach to quality of life and wellbeing, in which people are able and are supported to be at peace with themselves, to enjoy their

¹²⁶ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC41 – Age Cymru](#) p11 [accessed 19 October 2012]

lives and to have goals to attain. That is part of the whole approach.”¹²⁷

Key recommendation 7: Residential care should not be viewed simply as an option where irreversible decline is the only outcome. We believe that the Welsh Government should work with the sector to ensure that residents are enabled to experience a more stimulating and purposeful life that encompasses their spiritual needs. This would help prevent or delay the negative aspects of institutionalisation as well as improving quality of life. Greater involvement of carers in an individual’s residential home life and stronger links with local communities would help achieve this.

Access to health services

134. A number of witnesses¹²⁸ highlighted the importance of care home residents having good access to healthcare services, including GP services, dental care, pharmacist advice, physiotherapy, occupational therapy and wheelchair and appliance services.

135. Aneurin Bevan Local Health Board stated in their written evidence that ensuring appropriate access to NHS primary and secondary care services would mean that people would not necessarily have to move to a different home as their needs changed. CSSIW supported this view:

“There are also moves in some areas to explore greater use of community health service support going in to care homes to avoid moving individuals to alternative care settings as their health needs increase towards the end of life.”¹²⁹

136. BUPA argued for better communication and co-operation between health and social care services:

“As an example, we regularly experience considerable problems in obtaining the medical support, to which our residents are entitled, from the NHS primary care system. This appears to be

¹²⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 134\]](#), 23 February 2012 [accessed 19 October 2012]

¹²⁸ See for example written evidence from British Geriatrics Society, Cymru Branch [RC38](#)

¹²⁹ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC52 – Care and Social Services Inspectorate for Wales](#) p6 [accessed 19 October 2012]

a result of the surprisingly common but mistaken view that when users are in residential care, all their healthcare and social care requirements will be provided, or at least funded in whole or in part, by the social care provider when, in fact our residents' healthcare remains the responsibility of the NHS."¹³⁰

137. We were also told that an individual's care needs should continue to be assessed and monitored on an ongoing basis once in residential care. Peter Higson, Chief Executive of Healthcare Inspectorate Wales told us:

"Put simply, we should see assessment as a process, not an event. It is too often an event that happens in response to something going wrong. We should be building up profiles and a 'passport' almost - so that there is a statement of a person's needs which is assessed and updated so that people know what they are and so that the person has a say about the choices they want to make."¹³¹

138. Witnesses from third sector bodies representing people with sensory loss emphasised the importance of ongoing support for residents with sensory impairments to monitor and manage deterioration in hearing or sight loss:

"Many people in residential care have not had proper assessments because the assumption is that, because they are in residential care, the job is done and everything is sorted.

"You can get the test done, but then someone has to do something about it. So, it is about the follow-up and addressing the fact that, say, Mrs Jones has this particular eye condition and therefore needs to wear glasses, which will provide her with a much better quality of sight."¹³²

139. In addition to being able to access services such as GPs, the Committee heard evidence about residents in care homes losing, and not having replacements of, basic items such as glasses or dentures. This was an issue of concern to the Committee's External Reference

¹³⁰ BUPA [Bupa response to the Social Care Green Paper consultation](#) February 2010 [accessed 19 October 2012]

¹³¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 177\]](#) 30 May 2012 [accessed 19 October 2012]

¹³² Ibid [RoP \[para 148\]](#) 29 February 2012 [accessed 19 October 2012]

Group, who provided further examples of relatives losing essential items, including dentures, hearing aids and glasses, and of difficulties in accessing opticians, dentists and other professionals to arrange replacements. The Group argued that access to these services is fundamental to achieving a basic and acceptable level of dignity. This is, in part, linked to the quality of health assessments on entry to the care setting, and the need for a better understanding amongst staff of the importance of taking steps to ensure individuals' sensory and dental needs are monitored as a matter of course. This is an area in which the Group believed improvements are needed.

Conclusion 7: We believe that action is needed to ensure that older people in residential care have access to the same standards of healthcare services as the wider community.

Communication

140. A significant area of concern raised by witnesses and our External Reference Group, is the need for staff to communicate appropriately with residents and the effect this can have on their quality of life in care. This is a particular issue in Wales, where Welsh is the first language for many people, but it also affects those who are suffering from sensory loss or dementia and who have different communication needs.

141. Haydn Evans from Pensioners Forum Wales told the Committee:

“On the communication point, it is right to point out the trauma involved for somebody coming from a Welsh-speaking community and going into a home that is largely English speaking. The problems of settling down and living with a lot of strangers, which is what you are doing when you go into a home, are aggravated by the change in language background.”¹³³

142. The Alzheimer's Society also highlighted a need for bilingual provision of services, noting that as their illness progresses, some

¹³³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 42\]](#) 29 February 2012 [accessed 19 October 2012]

dementia sufferers will only be able to understand or communicate in their first language.¹³⁴

143. In addition to this language issue, we heard about the difficulties sufferers of Alzheimer's and Parkinson's, as well as those with autism, sensory loss and other conditions of this nature, may have in expressing themselves, and the failure of staff to communicate effectively with them. Val Baker from Parkinson's UK described a personal experience:

“...there was a tremendous uproar in the Royal Gwent Hospital years ago because my father, who had Alzheimer's, was said to be 'performing'. When I went in to investigate, he was not being co-operative when they wanted him to get into bed, and I said 'Yes, but from his perspective, you are coming up and taking his clothes off him, so how do you expect him to react?'.”¹³⁵

144. Members of the External Reference Group highlighted the need to ensure that staff whose first language may not be English or Welsh have a suitable level of proficiency in English, or Welsh where this is used by residents. This issue has been identified in other user surveys.¹³⁶ It is important that the recruitment and training of staff in care homes is sensitive to the need for good communication between staff and residents.

145. The Deputy Minister acknowledged the importance of delivering services for older people in languages other than English and told the Committee that the Welsh Government taskforce on the Welsh language has been working on these issues and that joint health and social care strategies are being developed:

“We need to recognise that there is this need with other languages as well. There are excellent projects developing this.”¹³⁷

¹³⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 212-213\]](#) 2 May 2012 [accessed 19 October 2012]

¹³⁵ Ibid [RoP \[para 193\]](#) 2 May 2012 [accessed 19 October 2012]

¹³⁶ Department of Health, ['Dignity in care' public survey, October 2006 - Report of the survey](#), October 2006 [accessed 19 September 2012]

¹³⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 77\]](#) 20 June 2012 [accessed 19 October 2012]

Conclusion 8: There is a need to ensure that staff recruitment and training helps to ensure that good communication between care staff and care home residents is facilitated, both in terms of language and sensitivity to the particular communication needs of people with conditions such as dementia, Parkinson’s disease, sensory loss or autism.

Design features

146. There is an increasing awareness of the impact of building design on the quality of life experienced by those living and working in residential care settings. Age Cymru told us in their written evidence:

“The layout of care homes can have a bearing on the quality of life of residents. Age Cymru Gwynedd a Mon reported that at some homes, residents were seated in the more ‘traditional’ care home lounge, with a number of chairs arranged in a semi-circle, all facing a large TV, which was on, but with very few really watching it or being able to hear it. Some residents appeared bored, whilst others were sleeping and it did not appear to be a very satisfying way of spending the day. Staff supervision and interaction with residents was considered to be easier to achieve in some care homes due to the physical layout of the building. There appeared to be more interaction between staff and residents in care homes where staff areas were adjacent to the residents’ communal lounge, as opposed to those where the staff were more remotely based. The research noted that smaller lounges encouraged more interaction with residents.”¹³⁸

147. The Committee visited Llys Enfys, an Extra care facility in Llanishen run by Linc Cymru. Built into this facility are features designed to improve accessibility and navigation. Linc Care outlined some of these in their written evidence:

“Attention is paid to colour contrast, the minimalising of confusing shadow patterns, good signage and adequate light lux levels. Linc’s approach ensures that all tenants and residents, regardless of disability, maintain a high quality of living. We also believe that good design can enhance dignity.

¹³⁸ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC41 – Age Cymru](#) p12 [accessed 19 October 2012]

We have designed Extra Care, Sheltered Housing and Nursing Homes to deliver room sizes which exceed space standards with en-suites in all bedrooms, and suitable equipment which is functional but not institutional in appearance.”¹³⁹

148. Research in Specialist and Elderly Care suggested that:

“We also need to consider how we set about designing and building residential care homes of the future in Wales. As we will have cohorts of comorbid people in one particular place, the opportunity to provide good quality care may mean building a residential care home near or on the site of an acute hospital, so that good transition of care is established. It could also mean examining US and some European models of care which combine community, health and social care provision all on one site, within one facility. We believe that the model created by the Extra Care Charitable Trust in England, is a good baseline to start from and should be examined further.”¹⁴⁰

Conclusion 9: Given the increased care needs of those within residential care, such as dementia or sensory loss, and the need for a continuum of care to minimise disruptive moves, we are encouraged by the development of innovative approaches to design and believe the sector should promote the sharing of good practice.

Safeguarding and protection

149. Written evidence provided by CSSIW to this inquiry highlighted concerns around safeguarding and protection:

“CSSIW publishes a yearly monitoring report about safeguarding vulnerable adults. The most common victims of alleged abuse in Wales during 2009 -10 were older women. 36% of all the alleged victims of abuse were living in care homes at the point of referral.¹⁴¹ The proportion of the population living

¹³⁹ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC76 - Linc Care](#) p9 [accessed 19 October 2012]

¹⁴⁰ Ibid [Consultation Response 61 - Research in Specialist and Elderly Care \(RESEC\) Cymru](#) p4 [accessed 19 October 2012]

¹⁴¹ Refers to 1,785 cases of alleged abuse in residential or nursing homes from a total of 4,995 cases across all settings. See CSSIW, [Protection of Vulnerable Adults Monitoring Report 2009-2010](#), p15 [accessed 19 October 2012]

in care homes that were identified as alleged victims has increased over the last two years.

“Physical abuse is the most commonly referred concern, followed by neglect. Staff who care for older people made up the largest category of person alleged to be responsible for the abuse (42%) followed by relatives (27%). These findings indicate the importance of minimising risk of harm, and ensuring the safety of residents of older peoples care homes.”¹⁴²

150. We were also concerned to note the increasing incidence of reported financial abuse experienced by vulnerable adults which comprised 22 per cent of adult abuse referrals in 2009-10.¹⁴³ The high levels of mental frailty amongst older people in residential care can leave them particularly vulnerable to this form of abuse.

151. In oral evidence CSSIW told the Committee:

“The best way forward is in the proposed legislation in the social services (Wales) Bill, which is to put the protection of vulnerable adults on a statutory basis for Wales. That would improve the infrastructure for everything to do with safeguarding and raising the standards on the safeguarding.”¹⁴⁴

152. CSSIW witnesses emphasised the role of good inspection in the early identification of issues around care quality and neglect to prevent safeguarding issues from arising.¹⁴⁵ Levels of staffing and staff training are factors. CSSIW’s written evidence notes that staffing is one of the themes that future inspections will focus on, and which will be mapped against relevant regulations and any applicable national minimum standards.

153. Age Cymru recommends that the Welsh Government bring forward adult safeguarding legislation, which places the individual at

¹⁴² National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC52 - CSSIW](#) pp4-5 [accessed 19 October 2012]

¹⁴³ See CSSIW, [Protection of Vulnerable Adults Monitoring Report 2009-2010](#), p11 [accessed 22 November 2012]

¹⁴⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 154\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁴⁵ Ibid [RoP \[para 158\]](#) 30 May 2012 [accessed 19 October 2012]

risk of harm truly at the centre of any assessment, decision or action taken.¹⁴⁶

Conclusion 10: There is a need to improve the safeguarding and protection of older people in residential care through improvements to inspection around care quality, staffing levels and improvements to the training of care staff. We welcome the Welsh Government’s plan to provide a legislative footing for this in the forthcoming Social Services Bill.

Mental capacity

154. Joint written evidence from CSSIW and Healthcare Inspectorate Wales (HIW) highlighted weaknesses in the application of the *Mental Capacity Act 2005* for people who lack the capacity to make decisions:

“[...] we would like to highlight the need to ensure that decisions regarding individuals who do not have the capacity to make their own decisions are made following the legal framework of the 2005 Mental Capacity Act (MCA). We have found that whilst there are pockets of expertise in all organisations, the understanding and knowledge of the MCA amongst many health staff was still limited and sometimes led to uncertainty about what needed to be done.”¹⁴⁷

155. The Older People’s Commissioner also identified concerns about the operation of Mental Capacity Advocacy, including misunderstanding and lack of awareness of statutory duties under the *Mental Capacity Act 2005* and Deprivation of Liberty Safeguards.

156. CSSIW stated in oral evidence:

“The safeguarding for vulnerable adults is complicated, and it can happen through different parts of legislation, and the Mental Capacity Act is one part of that. We report each year on how the Mental Capacity Act is working. It is a piece of legislation that is not regarded sufficiently within the social care sector. People are not aware that, for example, locking someone in a room would be a deprivation of liberty, and they

¹⁴⁶ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC41 – Age Cymru](#) p2 [accessed 19 October 2012]

¹⁴⁷ Ibid [Consultation Response RC68 - Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales](#) p7 [accessed 19 October 2012]

are not aware enough of the issues to do with capacity to set about getting appropriate advocacy on behalf of that person. It is about understanding the legislation and the roles and responsibilities that it gives to everyone and putting them into practice on a regular basis. Returning to where I started, putting the protection of vulnerable adults on a statutory basis in Wales could capture all of that in a more coherent way.”¹⁴⁸

Conclusion 11: There is a need to increase awareness of care staff, though better training, of statutory duties under the *Mental Capacity Act 2005* and Deprivation of Liberty Safeguards. We welcome the proposals in the forthcoming Social Services Bill to put adult safeguarding on a statutory footing. However, we are concerned that the new arrangements eventually enacted through the Bill/Act should be closely monitored and assessed to ensure they are fully effective in improving adult safeguarding.

¹⁴⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 154\]](#) 30 May 2012 [accessed 19 October 2012]

5. Working in residential care

157. There is no shortage of negative stories in the media about unacceptably low standards of care, and in some cases the abuse of older people in residential homes. However, throughout this inquiry we have heard a great deal of positive evidence about the excellent work done by those working in residential care, often with little recognition. We would like to place on record our appreciation of all those who work in this sector and provide such a valuable service.

158. Witnesses have told us of the pivotal role the workforce plays in determining the standards of care and the quality of life experienced by care home residents. The need for greater value to be placed on staff working in the residential care sector was also emphasised by our External Reference Group. From their experiences of interacting with staff in homes, they felt there was little recognition or appreciation of the broad range of skills needed to do the job well.

159. John Moore from My Home Life Cymru explained:

“The role of care workers is not just to look after people; that is not their job. It is about supporting older people to get the best out of their lives. That is what those workers are there to do, but we do not really value some of the great work that is going on.”¹⁴⁹

160. Tom Owen, director of My Home Life UK, went further to suggest there was almost a sense of shame associated with working in a care home:

“There is a sense that care assistants can be slightly embarrassed about telling their friends that they work in an older people’s home or a care home. However, those who work with animals as veterinary assistants or who work as hospice assistants are happy to say so.”¹⁵⁰

161. Despite this, we also heard about the pride felt by those working in this sector when we visited care facilities and took evidence in committee.

¹⁴⁹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 99\]](#), 23 February 2012 [accessed 19 October 2012]

¹⁵⁰ Ibid [RoP \[para 97\]](#), 23 February 2012 [accessed 19 October 2012]

162. Given that the role of care home staff extends beyond merely providing for the basic care needs of residents and can impact significantly on the quality of life experienced by older people, we are concerned that the sector is able to attract and retain sufficient numbers of committed and motivated people, and that it devotes the necessary resources to adequately train and support them. This chapter sets out some of the issues that we believe need to be addressed in order to achieve this.

Recruitment, retention and professionalisation

163. A major theme in evidence received during this inquiry has been the impact that low pay and status of the residential care workforce can have on the recruitment and retention of staff.

164. Although the current economic climate has eased some recruitment problems, witnesses from the independent sector were concerned about the sector's ability to retain high quality staff when the job market improves. Sandra Regan from Haulfryn Care Home described the current recruitment situation:

“...because of unemployment being as it is at the moment, no, it is not a struggle. Two or three times a week we are having someone phoning us looking for employment, but as soon as things start to progress, unless we make this a professional environment to work in, we will have problems. To keep your quality up, and to keep good quality staff, we need to be professionalising the environment.”¹⁵¹

165. Bob Gatis from Rhondda Cynon Taf Council told the Committee:

“It is about the value we place on social care staff, and the value we place on them is actually very low. We pay them low wages, and that is because of pressures on resources. The opportunities for that level of social care worker in Asda and Tesco are well reported. Those companies will provide you with security of employment, 30 or 40 hours a week, steady time, agreed shifts, known shifts and so on. For me, that is the

¹⁵¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 56\]](#) 14 June 2012 [accessed 19 October 2012]

bottom line. This is about how we value the people that you and society are charging us to look after.”¹⁵²

166. We believe that the remuneration of staff in residential care should reflect the skills needed and the value of the work which is being undertaken. It has been suggested that current levels of pay do not achieve this. However, until the issues around paying for care and fee levels paid by commissioners to care homes are resolved there is little likelihood of progress in this area. Nevertheless, ensuring that staff feel valued and provide a high standard of care involves more than just adequate remuneration – it is also about altering perceptions of care work and promoting it as a profession. Witnesses emphasised the importance of valuing the contribution staff can make to service development. Luisa Bridgman from Rhondda Cynon Taf Council told the Committee:

“We are looking at projects that can improve the quality of care and therefore provide greater staff satisfaction, because it is about that as well. It is not just about recognition through qualification, but the opportunity to be involved in a new way of working, which is often something to be proud of. It is about the whole culture of the way we view care staff. We must make the drive to change that. We need to see care staff as very valued members of society who contribute a great deal.”¹⁵³

167. Carol Shillabeer, director of Nursing at Powys Local Health Board, outlined steps taken in the NHS to improve staff satisfaction:

“If I was to look at what satisfies nurses in the workplace—let us deal with the pay issue—pay is on the list of issues from one to 10, but it is not number one, two or three. People feel more respected if they are involved in decisions about their work environment, feel that they are making a difference and that their voice is being heard. [...] We believe that they have ideas for improvements and seeing those through makes a difference.”¹⁵⁴

¹⁵² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 270\]](#) 22 March 2012 [accessed 19 October 2012]

¹⁵³ Ibid [RoP \[para 272\]](#) 22 March 2012 [accessed 19 October 2012]

¹⁵⁴ Ibid [RoP \[para 83\]](#) 14 March 2012 [accessed 19 October 2012]

168. However, further work is needed in the sector to develop career pathways for care staff. The British Geriatric Society Cymru highlighted in their written evidence:

“Many homes only survive with agency and foreign workers as salaries are low. If Wales wants to establish high quality care workers, then it must establish a proper career pathway with training, standards, status and salaries.”¹⁵⁵

169. Work by the Care Council for Wales has contributed to the professionalisation of care staff and witnesses have generally welcomed this. The Care Council for Wales told the Committee that its work on career development for all care staff will help to professionalise the work and make it a more attractive career option, particularly for young people.

170. The Deputy Minister stated in oral evidence:

“We sponsor the Dignity in Care Award, for example, and we have a National Care Award to recognise good practice out there. We need to do that and to encourage more of it. Care Forum Wales has a dignity charter, and that points us in the same direction. We all realise that training is particularly important.”¹⁵⁶

171. During the course of our inquiry the Academy of Social Care Practitioners was re-established as a professional body representing those working in the care sector. Some Members of the Committee met representatives from the Academy during our visit to Wrexham, and were pleased to hear about the impact it is already having. We welcome this positive step to support those working in social care, and would urge the continuing development of this body.

Conclusion 12: Improving the status of care workers and promoting their professionalisation are key considerations for improving services for older people in residential care. These should be priorities for the Welsh Government and should include work to further develop career pathways for social care staff. To this end the Committee welcomes the re-establishment of the Academy of Care Practitioners.

¹⁵⁵ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC38- British Geriatrics Society Cymru](#) p4 [accessed 19 October 2012]

¹⁵⁶ Ibid [RoP \[para 74\]](#) 20 June 2012 [accessed 19 October 2012]

Registration of care staff

172. Currently care home managers are the only staff working in care homes who are required to be registered with the Care Council for Wales. Some witnesses have called for the mandatory registration of all residential care staff, suggesting this may help promote better recognition of the workforce.¹⁵⁷ Care Forum Wales, for example, stated in written evidence:

“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.”¹⁵⁸

173. When asked about the need to register staff working in care homes, Lisa Turnbull from the Royal College of Nursing told the Committee:

“The bulk of the care is currently very personal, intimate care and very important care in terms of dignity and reablement [...] That care is being provided by a group of people that is currently unregulated and we think that that is where we need to direct attention.”¹⁵⁹

174. The need to register care home staff was echoed by our External Reference Group, who dismissed the suggestion put forward by some witnesses that the cost of registration might be prohibitive. The Group felt that people’s lives should be worth the cost of registration.

Conclusion 13: In light of the strong views expressed to us about registration during our evidence gathering, we believe that the Welsh Government should keep the case for registration of all care staff under active consideration.

Staffing levels and resources

175. Evidence to the inquiry has suggested that staffing levels in care homes are not always sufficient to meet the needs of residents. In oral

¹⁵⁷ See the Care Council for Wales [website](#) for further information on registration requirements for social care staff.

¹⁵⁸ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC60- Care Forum Wales](#) p6 [accessed 19 October 2012]

¹⁵⁹ Ibid [RoP \[paras 72-76\]](#) 16 May 2012 [accessed 19 October 2012]

evidence¹⁶⁰ for example, the GMB union expressed concerns about levels of night time staffing cover.

176. Nick Johnson from the Social Care Association referred to a toolkit to help providers calculate appropriate staffing numbers. He told the Committee about the difficulty in setting staff levels given the fluctuating levels of need in care homes:

“However, managers, owners and inspectors need to have a vague idea of what is okay - what you would expect to see when you go into a care home and how many people you would expect to see. You could say that you would expect to see at least two care assistants in a room of people. However, if one person needs two people to take them to the toilet, for example, then there are no carers left in the room.”¹⁶¹

177. CSSIW told us that there are no set requirements for staffing ratios:

“Staffing ratios is a really interesting issue. There are no staffing ratios. There are no legal powers to set staffing ratios. The regulations say that staffing must be ‘appropriate’ to the assessed needs of the people concerned rather than that there must be X number of staff for Y type of resident.”¹⁶²

178. The Chief Inspector of Social Services told the Committee¹⁶³ that CSSIW undertakes unannounced inspections at all times, including at night, where there are concerns about staffing levels.

179. The Committee is not minded to recommend the introduction of minimum staffing levels, as there is a danger that these can become seen as maximum staffing levels and we want to see the highest possible standards of care. However, we believe that more prominent and accessible information on the staffing levels for each care home should be made available to prospective residents, their families and carers. Regulations¹⁶⁴ require care homes to publish a Statement of Purpose, and we believe this can form the basis for better sharing of

¹⁶⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[paras 89\]](#) 16 May 2012 [accessed 19 October 2012]

¹⁶¹ Ibid [RoP \[para 208\]](#) 16 May 2012 [accessed 19 October 2012]

¹⁶² Ibid [RoP \[para 68\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁶³ Ibid [RoP \[paras 72-74\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁶⁴ [Care Homes \(Wales\) Regulations 2002](#) Regulation 4; Schedule 1(3) [accessed 25 October 2012]

information. Homes are currently required to produce statements which include information on the numbers, relevant qualifications and experience of staff working at the home, and to make this information available on request. We believe that these statements should be made more easily available to the public and greater efforts should be made by residential care homes and relevant bodies to raise prospective residents' and their families' awareness of its existence. This would increase transparency about the numbers of staff service users should expect to see in the care home at any particular time. The information should be updated according to changes in staffing to reflect the needs of residents.

Conclusion 14: Care homes are required by regulations to provide up-to-date information on staffing numbers, relevant qualifications and experience. This information should be made more easily available to prospective residents and their families. Greater efforts should also be made by residential care homes and relevant bodies to encourage prospective residents and their families to seek this information when making decisions about an older person's future care.

Training

180. Concerns were raised during the inquiry about the adequacy of staff training, and a lack of development pathways for staff. The Care Council for Wales highlighted in written evidence that 'qualification and training for the workforce is central to excellence in provision'. Evidence has highlighted the increasing frailty of the residential care home population, and emphasised the importance of staff training keeping pace with the changing needs of the sector.

181. CSSIW's written evidence noted that their inspection findings generally indicate that staff are trained and qualified in accordance with registration requirements, but identifies inadequacies in training for some 'specialist' situations, including infection control, medicines management and a lack of accredited training for care staff working with people with dementia. Other witnesses identified a need for improved training in other areas such as food and nutrition, oral hygiene and working with interpreters.

182. Training in the care of older people with specific health needs such as stroke, Parkinson's and dementia is considered less than

adequate in the sector and is an issue of concern given the increasing prevalence of these conditions.¹⁶⁵ The Royal College of Psychiatrists in Wales recommended that all care homes should have mandatory training in dementia care. Julie Jones from SCIE told the Committee that:

“All care homes need sufficient knowledge and experience to manage dementia care well. That is also true of people in healthcare settings and of acute hospitals. The prevalence of dementia in our older population as it currently stands means that anybody in those front-line jobs has a responsibility to know what good dementia care looks like and we need to make that easier for front-line staff and their managers.”¹⁶⁶

183. Cymorth Cymru also referred to the need to improve the training of staff to deal with issues that arise as a consequence of learning difficulties, or alcohol and substance misuse.¹⁶⁷

184. The need for better training in relation to the needs of those with sensory loss was also highlighted. Sue Brown from Sense Cymru told the Committee:

“In the research that we did in care homes, we found that less than half of the staff who we interviewed had had any training in sensory loss. The ones who had, had training in hearing aids, but not in any other sort of equipment. They all knew about large print, but not about any other way of providing written information. The numbers of older people with sensory loss, either single or dual, are so large that no-one should be working with older people without some level of understanding of sensory loss.”¹⁶⁸

185. Care home providers are responsible for ensuring that the staff they employ are trained to meet the needs of residents for whom they are caring and we have heard there is significant room for improvement in some settings.

¹⁶⁵ National Assembly for Wales, Health and Social Care Committee, [Consultation response RC65 – Cymorth Cymru](#) p6 [accessed 19 October 2012]

¹⁶⁶ Ibid [RoP \[para 180\]](#) 23 February 2012 [accessed 19 October 2012]

¹⁶⁷ Ibid [Consultation response RC65 – Cymorth Cymru](#) p6 [accessed 19 October 2012]

¹⁶⁸ Ibid [RoP \[para 126\]](#) 29 February 2012 [accessed 19 October 2012]

186. Care home registered managers have a key role to play in ensuring staff are suitably trained, and indeed for determining the overall quality of service. This was highlighted by My Home Life, which argued that managers need better support to enable them to undertake their roles.

“Another message is to do with how managers need that ongoing independent professional support to cope with the huge amount of anxiety and stress, so that they can share that and support their staff. They also need the support of the health and social care system to help them to deliver that care.”¹⁶⁹

187. CSSIW¹⁷⁰ likewise emphasised the importance of culture and leadership in care homes as an influence on quality of care.

188. Local authority representatives told the Committee¹⁷¹ that the training they provide to independent sector providers is not always taken up and the WLGA suggested¹⁷² that staff training may not always be given sufficient priority by independent sector providers. The challenges for small businesses were acknowledged by local authority witnesses; innovative methods such as e-learning are being explored which facilitate workplace learning.

189. We also heard about the role third sector organisations could play in delivering appropriate training. Sue Phelps, acting director of the Alzheimer’s Society in Wales, told us:

“Mandatory dementia awareness training should be relatively easy to do. As an organisation, we provide training. We are asked for it, and there is a growing demand for us to go in to do that type of awareness work. I have been to training events with extra care staff, for example, where they have been very reluctant at the beginning of the two-day session—you can almost see that they have been dragged there—but by the end of the two days they all say, ‘Gosh, if we had known this when

¹⁶⁹ National Assembly for Wales, Health and Social Care Committee [RoP \[para 83\]](#) 23 February 2012 [accessed 19 October 2012]

¹⁷⁰ Ibid [RoP \[para 132\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁷¹ Ibid [RoP \[para 151\]](#) 22 March 2012 [accessed 19 October 2012]

¹⁷² Ibid [Consultation Response RC69 - WLGA](#) p15 [accessed 19 October 2012]

we first started, it would have made our lives so much easier’.”¹⁷³

190. Care Forum Wales suggested that the current emphasis on minimum qualification levels for care staff should be re-orientated towards training to develop particular skills. They also called for better quality assurance of training providers.¹⁷⁴ In oral evidence CSSIW told the Committee that training staff to NVQ level 2 or 3 does not guarantee good quality care.¹⁷⁵

191. The GMB union commented in written evidence:

“In our experience the previous training of staff in some care homes has been nothing more than a paper exercise.”¹⁷⁶

192. In January 2011, the Qualification and Credit Framework (QCF) was introduced. According to the Care Council for Wales this has been designed to bring clarity and flexibility to the qualifications that are available to the workforce, enabling people to build on their achievements in a formally recognised way. Bob Gatis from Rhondda Cynon Taf Council told us:

“The QCF is very helpful. It helps us to provide the theoretical knowledge to staff and provides an evidence base for the fact that they have the skills we need.”¹⁷⁷

193. The Deputy Minister’s written evidence stated:

“We know that care workers themselves also play a vital role in the provision of any service and so we will provide for the regulation of training of social care workers in much the same way as training for social workers is already regulated. This will help to provide a more consistent standard of training that is more clearly relevant to the needs of service users and employers alike. High standards of training will support the

¹⁷³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 191\]](#) 2 May 2012 [accessed 19 October 2012]

¹⁷⁴ Ibid [Consultation Response RC60 - Care Forum Wales](#) p6 [accessed 19 October 2012]

¹⁷⁵ Ibid [RoP \[para 132\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁷⁶ Ibid [Consultation Response RC78 - GMB](#) [accessed 19 October 2012]

¹⁷⁷ Ibid [RoP \[para 271\]](#) 22 March 2012 [accessed 19 October 2012]

development of professionalisation amongst the social care workforce.”¹⁷⁸

194. The Deputy Minister also highlighted the requirement for care home managers to be registered with the Care Council for Wales and to have minimum levels of qualifications.¹⁷⁹ The Welsh Government is contributing £8.4 million to a total £12 million planned expenditure on the Social Care Workforce Development Programme in 2012-13.

195. Local authority witnesses suggested that the current age restriction of 18 to enter the social care workforce means that there is potential to miss a significant group of people such as school leavers who express an interest in working in the sector. Susie Lunt from Flintshire County Council told the Committee about work they have undertaken with Deeside College to develop apprenticeships. Sarah Owen from the Social Care Association, who works as a registered manager at a Cardiff care home, told the Committee:

“It may be a good idea to offer apprenticeships so that when they get to 18, instead of going straight into social care and think that they have to make a career out of it, they could have a trial run and see how they get on and get the necessary knowledge during those first couple of years and make a career out of it then.”¹⁸⁰

Conclusion 15: There is a need to raise the level of knowledge and skills of care staff to meet the increasing demands placed on them. Given the pivotal role of registered managers we believe future training strategies should prioritise training for them. The Welsh Government and the Care Council for Wales need to be confident that they regularly consider and refresh their approach to training to ensure that the best outcomes are achieved for both staff and residents. We would emphasise the importance of ensuring comprehensive recording of training activity undertaken by staff to encourage progress in this area.

¹⁷⁸ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-18-12 paper 1 - Evidence from the Deputy Minister for Children and Social Services](#), para 21 [accessed 19 October 2012]

¹⁷⁹ Ibid [HSC\(4\)-18-12 paper 1 - Evidence from the Deputy Minister for Children and Social Services](#), para 22 [accessed 19 October 2012]

¹⁸⁰ Ibid [RoP \[para 179\]](#) 16 May 2012 [accessed 19 October 2012]

Key recommendation 8: Given the Welsh Government’s significant contribution to the costs of staff training in social care, it should require that a greater proportion of funding is devoted to enhancing levels of skills and awareness of specialist conditions, particularly dementia, amongst care staff. There is scope for an enhanced role for third sector bodies with particular expertise, such as the Alzheimer’s Society, Parkinson’s UK Cymru and those representing people with sensory loss and learning disabilities, in supporting this.

Trade Union representation for social care workers

196. The Committee took evidence from the trade unions GMB and Unison who represent a large number of care workers, and heard concerns about limits to their ability to represent the interests of staff in care homes, particularly in relation to the collapse of Southern Cross and the transfer of their homes to other providers:

“Only one or two of them have continued to recognise us. [...] The rest of the companies, Four Seasons in particular, do not recognise us as an organisation, and, as a result, we have seen terms and conditions eradicated and people’s pay being dropped to the minimum wage. More importantly, we cannot get access to these members any more to come back to fight for their case. We are having to talk to people at the gates in the early hours of the morning and late evening. It is almost getting clandestine, because the employers are bullying their staff not to come to talk to us. Until we can get back to a situation where we can talk to the employers and improve their circumstances these guys will continue on a downwards spiral, and we will not get the best people in there to do the job.”¹⁸¹

197. The Committee questioned Jim McCall from Four Seasons about the transferring of the GMB’s recognition agreement with those previously employed by Southern Cross. He told the Committee:

“...as an organisation Four Seasons across the UK respects the right of any member of staff to be in a trade union, and, where there is trade union membership, that is understood and

¹⁸¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 94\]](#) 16 May 2012 [accessed 19 October 2012]

respected as part of employment in our homes. We do not have a recognised agreement with any particular trade union.”¹⁸²

198. The trade unions also expressed some concern to the Committee that CSSIW does not formally consult with them during inspections. CSSIW pointed out that unions can approach them with concerns at any time, but did confirm that they did not formal consult with the unions around inspections:

“We have not featured that. One of the challenges that we have is that we do get drawn into staff, manager and provider disputes. Therein lies some difficulty for us because the evidence is not as reliable—there are a lot of personal issues going on within some of these care settings and they are quite intense in the way that they are. So, we do not do that; that does not feature.”

199. We are encouraged by the Deputy Minister’s assurances that preliminary steps are being taken by CSSIW to engage, as part of a staged approach, with trade unions.¹⁸³

Conclusion 16: We acknowledge the importance of trade union representation for staff working in residential care and the valuable work they undertake in promoting the interests of their members and highlighting their concerns about the quality of services provided in the sector. We also note the potential value to care home providers of formally recognising the role of trade unions.

¹⁸² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 165\]](#) 14 June 2012 [accessed 19 October 2012]

¹⁸³ Ibid [HSC\(4\)-25-12 paper 4 - Letter from the Deputy Minister](#) 3 October 2012 [accessed 19 November 2012]

6. Regulating and inspecting residential care

200. One of the issues that prompted us to undertake this inquiry was the collapse of Southern Cross Healthcare in 2011 and the impact of this on the residential care sector, which raised issues about the scrutiny of service providers' financial viability. We therefore wished to explore with witnesses the scope for strengthening financial scrutiny and the related issue of the arrangements for care home closures.

201. In addition, evidence submitted to the inquiry suggested that the regulation and inspection process needed both to reflect the views and experiences of residents and the families and carers, and offer more helpful information to those moving into residential care. This suggested there is room for improvement. We also wished to examine whether the current regulatory regime is responding to the changing needs of older people and the range of settings in which they now receive care.

202. However, the inquiry coincided with a programme of reform and development of the regulation and inspection regime for social care in Wales. A number of the issues identified in evidence have been recognised by the inspectorates and the Welsh Government and plans for change have been drawn up. Some of the Welsh Government's plans for reforming the regulatory framework for social care will be enacted in legislation.

203. Following the conclusion of our evidence gathering for this inquiry the Welsh Government announced that inspection and regulation would no longer form part of its Social Services Bill as originally planned, but instead would be the subject of a separate Bill which will be issued during the second half of this Assembly. We regret this development. Given the delay we sought assurance that reforms to the regulation and inspection regime outlined by CSSIW in evidence would not be affected or postponed by this decision. We are grateful for confirmation from the Deputy Minister that this work will proceed without the need for legislation.¹⁸⁴

¹⁸⁴ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-25-12 paper 5 - Letter from the Deputy Minister for Children and Social Services - Social Services \(Wales\) Bill / Modernisation of CSSIW](#) 3 October 2012 [accessed 19 October 2012]

Capturing the experiences of service users, families and staff

204. We received a considerable amount of evidence, from a range of organisations such as Age Cymru, Cymorth Cymru and Care Forum Wales which stressed the importance of capturing service users' views and increasing the involvement of residents and their families in the inspection process. Many witnesses believe that the regulation and inspection regime does not reflect the experiences of those living in residential care and is too process-orientated.

205. This view was echoed by the External Reference Group which felt that the current inspection process does not adequately capture the quality of service experienced by residents and their families. The group was also concerned that inspections do not reflect the views and experiences of care staff, and that care home inspection reports do not provide a useful guide for people who are choosing a care home.

206. The need to consider how to involve the views of families in inspection reports was highlighted by Age Alliance Wales. Vice Chair, Angela Roberts told the Committee that:

“The issue we have in Wales is that many people are caring at a distance. Many of them are in employment and can rarely get to the home, and perhaps only at a weekend, when certain staff are not there and when there would certainly be no-one from the inspectorate available for them to talk to. We also need to take that into account.”¹⁸⁵

207. Some respondents to the Committee's written consultation noted that the current regulatory and inspection arrangements tend to focus on process, and that there is a need for a change of emphasis to outcomes and the quality of service provided. Professor John Williams noted in his written evidence that the current regulatory framework is driven by detail.¹⁸⁶ Such a traditional regulatory approach, he stated, does not necessarily drive up standards; it creates a compliance culture rather than an enhancement culture. The Royal College of Psychiatrists in Wales' evidence stated that the current inspection

¹⁸⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 122\]](#) 2 May [accessed 19 October 2012]

¹⁸⁶ Ibid [Consultation Response RC58 – Professor John Williams](#) p1 [accessed 19 October 2012]

process is often a tick-box, paper-based exercise, and inspections should be based on observation of care.¹⁸⁷

208. Age Cymru suggested in their evidence that there is significant variation in how inspectors work. They may have differing areas of expertise and can often be inspecting services they have limited experience of. Age Cymru believes that better training is needed to improve consistency.¹⁸⁸

209. The written evidence from CSSIW outlined its plans for a new approach to regulation, inspection and enforcement which includes a “strong commitment to a more people focused inspection”.¹⁸⁹

210. CSSIW told the Committee that future inspections will have four themes. These will be mapped against the relevant current regulations and any applicable national minimum standards to ensure that statutory standards are checked. The themes are:

- quality of life;
- quality of staffing;
- quality of leadership and management;
- quality of environment.

211. In oral evidence CSSIW told the Committee that, following modernisation work:

“...the focus of our inspections is now on spending time with people and hearing about their experiences and the outcomes of their care, as well as on hearing from the staff who are providing the care.”¹⁹⁰

212. The inspectorate has developed a risk assessment tool and a “quality and judgement framework” to allow inspection reports to judge the quality and safety of services within each theme.¹⁹¹

213. In addition, CSSIW are planning to recruit lay assessors to undertake inspections, a development that was welcomed by the

¹⁸⁷ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC44 – Royal College of Psychiatrists in Wales](#) para 19 [accessed 19 October 2012]

¹⁸⁸ Ibid [Consultation Response RC41 – Age Cymru](#) p13 [accessed 19 October 2012]

¹⁸⁹ Ibid [Consultation Response RC52 – CSSIW](#) para 30 [accessed 19 October 2012]

¹⁹⁰ Ibid [RoP \[para 82\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁹¹ Ibid [Consultation Response RC52 – CSSIW](#) para 32 [accessed 19 October 2012]

External Reference Group who believe that families and carers with experience of residential care should be included amongst them. The Chief Inspector, Imelda Richardson told us:

“We want a community-based model; we want to go into our regions and attract people who will become the eyes and ears of the community in terms of care homes. We do not want to build up a lay assessor group that just tags on behind our inspectors. We want people who we can go to and say, ‘We want to contract with you for x number of inspections over a wide period of time, within these care homes, out of hours. So, you go and see what you find, we will do the training and supporting, you write us an inspection report and we will add it our report’[...] We want to set up regional advisory panels for people within the community, so that we can engage with them and so that they can provide an external challenge to our work. We will also look at putting together a national advisory panel.”¹⁹²

214. In ensuring that care is focused around the needs of residents and their families, it is essential that reports reflect the views of those living within the home. As discussed in chapter two, there is a need for more guidance and information for those entering residential care and inspection reports have a role to play in providing this.

Conclusion 17: We welcome the improvements outlined by CSSIW to the inspection process to focus on the quality of care and to capture the views and experiences of older people, their families and carers, and care staff. We are particularly pleased to learn that lay assessors will be recruited to undertake inspections and urge the Welsh Government and CSSIW to ensure that they are adequately trained and equipped to undertake their work. We believe there will be a need for on-going monitoring and evaluation to ensure that these improvements achieve the required changes. We are concerned that the reforms are progressed and not delayed by the announcement of a separate Welsh Government Bill on the regulation of social care services and staff. We welcome the reassurances from the Deputy Minister for Children and Social Services on this matter.

¹⁹² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 166\]](#) 30 May 2012 [accessed 19 October 2012]

Accessibility of inspection reports

215. The External Reference Group expressed concerns that care home inspection reports do not provide a useful guide for people who are choosing a care home.¹⁹³ Such reports could offer valuable insights into the services provided by individual care homes, information that cannot be obtained from any other source.

216. This view was echoed in the evidence we received. Grwp Gwalia for example stated:

“It is felt that the current CSSIW reporting method is not user friendly as it does not allow families and clients to easily identify good quality residential care services.”¹⁹⁴

217. The Chief Inspector of Social Services told the Committee that CSSIW is changing the style of its inspection reports:

“We are writing a new style of inspection report. We want it to be in plain language, and we want it to be readable and accessible for everyone. We also want to move to a point in the next year where we give a judgment rating on each of those themes. Within those themes, there are four domains so we look at 16 domains, and we will make a judgment so that everybody will be very clear which part of the home is working really well, which part may need some improvement and which parts are not working very well.”¹⁹⁵

218. In addition, information about concerns raised by individuals which were previously dealt with between the individual and providers will in future be placed in the public domain.¹⁹⁶

Conclusion 18: The Committee agrees that, as a key method for gaining information, inspection reports need to be easily accessible both in terms of how they are drafted and where they are located. Consideration should be given to where inspection reports are made available. In addition to internet access, reports should be available in public places and at each care home to allow older people and their carers and families to easily access

¹⁹³ External Reference Group meeting [17 April 2012](#), see Annex B to this report

¹⁹⁴ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC33 – Grwp Gwalia](#) p8 [accessed 19 October 2012]

¹⁹⁵ Ibid [RoP \[para 131\]](#) 30 May 2012 [accessed 19 October 2012]

¹⁹⁶ Ibid [RoP \[para 66\]](#) 30 May 2012 [accessed 19 October 2012]

them. Reports need to be drafted in a manner which is easily understood and clear about the services provided by each home. Given the prevalence of visual impairment amongst older people it is important to ensure that reports are published in a range of accessible formats.

Regulating and inspecting new and emerging models of care

219. Evidence highlighted the need for greater clarity around the regulation and inspection of new and emerging models of care such as Extra care housing. Although CSSIW inspects domiciliary care services provided to people living in Extra care schemes, the accommodation element does not fall within its remit. In oral evidence the CSSIW Chief Inspector commented:

“In terms of extra-care sheltered housing, some are absolutely excellent, which are of very good quality and are very well run. However, we must be careful, because, as I understand it, legally, the alternative futures judgment is still in place, which states that tenancy is to be separated from the provision of care. If there is no separation, then I would have to look at them as unregistered care homes. I do not want to do that, so I want to make that point clear. I have seen some that have come close, but I am not going to go there, because they are a good provision but that element needs tidying up. A wider discussion needs to be held about how that should be done.”¹⁹⁷

220. We believe that further consideration is needed of how emerging models of care are regulated since the distinction between the inspection requirements for tenants in Extra care facilities and a placement in residential care is insufficiently clear.

221. A further example of the need for the regulatory framework to better reflect changing services is the registration of dementia services in residential care, an issue we discuss in the next section.

Flexible registration

222. A key issue raised in written and oral evidence was around the registration requirements for care settings, which can mean that

¹⁹⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 165\]](#) 30 May 2012 [accessed 19 October 2012]

homes do not have the flexibility to meet a person's changing needs, for example following the onset of dementia. The negative impact on individuals and their families of a forced move of home was highlighted, particularly in rural areas where accessing specialist provision may mean moving a considerable distance.

223. Having to move home can be a stressful and disorientating experience for anyone. For someone with dementia or another debilitating condition it is especially distressing. Rosie Tope, from Carers Wales told the Committee that:

“When people have to move out of their home, with all the heartbreak that that causes, it seems to me that they should move just the once to where they can receive a continuum of care right through to the end of their journey. There will always be exceptions to the rule, but you should not be moving from a residential home to a nursing home to a hospital, back to a nursing home to a residential home and then for the whole thing to start all over again. To me, that is not treating people as individuals: the service user in particular, but also the family members.”¹⁹⁸

224. Witnesses argued that residential care homes should have the flexibility to offer different levels of care provision without having to register separately for dementia care, thus avoiding unnecessary disruption and helping to provide a continuum of care. The Committee's External Reference Group felt strongly that this issue needs to be addressed, reflecting their experiences of the distress caused when people are required to move care settings due to a change in their care needs. It was also suggested by the Group that provision should be made to allow flexibility for nursing staff to enter a residential home for a time limited period when a resident has suffered a medical setback; they believed this could help avoid unnecessary and disruptive hospital admissions. During a visit to Linc Care's Llys Enfys Extra care development, we were told that such flexibility is already being achieved for its residents as a change of personal care or support needs does not necessarily have to mean a

¹⁹⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 200\]](#) 29 February 2012 [accessed 19 October 2012]

change in lifestyle or address for them.¹⁹⁹ In addition, greater flexibility in the categories of care provided can reduce the risk of couples who both require residential care being separated as a result of their differing needs.²⁰⁰

225. We further discuss the ways in which continuity of care can be improved through Extra care models of provision in chapter 7 *Future options for residential care*.

226. The Royal College of Psychiatrists in Wales²⁰¹ suggested there should be a move away from the use of diagnostic categories as the primary influence in considering the type of care home a client should access. The process of selecting a care home, they stated, should be person-centred and consider the needs of the individual and how these needs can be met in a particular environment.

227. The British Geriatrics Society²⁰² emphasised the importance of ensuring that all residential settings in future have the capability of caring for people with dementia, as these are likely to comprise the main users of care homes.

228. Conversely, other witnesses²⁰³ cautioned against the complete removal of the category of dementia care which, they argue, helps to secure the necessary standards of care. Luisa Bridgeman of Rhondda Cynon Taf council told the Committee that:

“In terms of deregistering the category of dementia altogether, I would have some concerns about that, because I think that that it is also about quality of care. Where you have specific units that are registered, you can set more stringent requirements in terms of training and what you would expect as a quality mark.”²⁰⁴

¹⁹⁹ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-15-12 paper 6 - Note of committee visit to Linc Care's Llys Enfys development](#) para 8 [accessed 14 November 2012]

²⁰⁰ Ibid [HSC\(4\)-15-12 paper 6 - Note of committee visit to Bethel House residential care home in Dinas Powys](#) para 14 [accessed 14 November 2012]

²⁰¹ Ibid [Consultation Response RC44 - Royal College of Psychiatrists in Wales](#) para 2 [accessed 19 October 2012]

²⁰² Ibid [Consultation Response RC38- British Geriatrics Society Cymru](#) p4 [accessed 19 October 2012]

²⁰³ Ibid [RoP \[para 262\]](#) 22 March 2012 [accessed 19 October 2012]

²⁰⁴ Ibid [RoP \[para 262\]](#) 22 March 2012 [accessed 19 October 2012]

229. CSSIW told the Committee²⁰⁵ that the separate dementia registration category could be discontinued and that it had commissioned the Dementia Service Development Centre for Wales at Bangor University to undertake a consultation on this issue in 2011. The resulting report²⁰⁶ pointed out that only one third of care home places in Wales are registered within the dementia category and, given that approximately two thirds of care home residents have dementia, there are likely to be as many of these in places outside the category as within it. The report recommended discontinuing the separate dementia registration category and instead using the care home Statement of Purpose to set out its capability of meeting the needs of residents with dementia, including levels of staff training.

230. We agree that more flexibility is needed around meeting the range of needs of older people in individual care homes given the prevalence of dementia and the importance of ensuring continuity of care. The requirement for a separate registration category for people with dementia in residential care is a barrier to achieving this and we would therefore wish to see registration categories reformed in order to minimise the need to move care settings when needs change.

Key recommendation 9: In order to better reflect changing patterns of service provision:

- **care home registration categories should be reformed to increase flexibility and reduce the need for older people to move when their needs change. This reform should retain the important safeguards the current system provides for individuals to have their changing needs assessed and met. Specifically, the separate category of provision for people diagnosed with dementia should be discontinued;**
- **the arrangements for the regulation and inspection of new and emerging models of care, including Extra care housing schemes should be re-examined and clarified.**

Management of care home closures

231. Whilst care homes generally offer secure long-term accommodation to their residents, there are instances of care home closures which may occur on policy grounds or as a result of service or

²⁰⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 103\]](#), 30 May 2012 [accessed 19 October 2012]

²⁰⁶ Ibid [Additional Evidence RC A13 - CSSIW](#) [accessed 19 October 2012]

financial failure. Given that, for most people the care home is their permanent residence, it is clearly of paramount importance that any closure is managed carefully and sensitively, but there is evidence that improvements to the process are needed.

232. The Welsh Government has produced guidance to local authorities on managing the process of care home closure due to service failure: *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults*. CSSIW believes that the guidance is effective in these circumstances; its written evidence stated:

“The escalating concerns protocol has provided a good framework for a multi-agency approach to services that require improvement. In some cases it has proved to be effective in stimulating and sustaining improvement. In others it has provided a framework to manage a process of decommissioning and / or closure.”²⁰⁷

233. However, in evidence the Deputy Older People’s Commissioner expressed the view that the guidance is unsuitable for closures made on policy grounds and has written to the Welsh Government highlighting her concerns:

“Our view is that, although it is an improvement on the situation in other places that we have this guidance in place at all, the guidance needs reviewing. Its current applicability to, for example, the planned closure of care homes where there is not a financial crisis or an issue about quality is a real matter of concern.”²⁰⁸

234. In January 2011, the Older People’s Commissioner wrote to the Welsh Government requesting a review of its guidance which it has agreed will be undertaken with the Commissioner’s assistance.²⁰⁹

235. Respondents to the written consultation highlighted inconsistencies in approaches to communicating and consulting with residents and their families and carers about care home closures. Age Cymru stated that it:

²⁰⁷ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC52 - CSSIW](#) para 18 [accessed 19 October 2012]

²⁰⁸ Ibid [RoP \[para 16\]](#) 23 February 2012 [accessed 19 October 2012]

²⁰⁹ Ibid [HSC\(4\)-06-12 paper 1 - Evidence from the Older People’s Commissioner for Wales](#) Appendix 1, 23 February 2012 [accessed 19 October 2012]

“...frequently receives requests for information and support from families of residents who are concerned about the impact of care home closures. Unfortunately there is not always good communication and consultation with residents and the community before decisions are made. We accept that some closures will be necessary or justified by service reconfiguration, however it is paramount that communication, engagement and consultation is made a priority in all cases and steps are taken to minimise disruption to residents.”²¹⁰

236. The closure²¹¹ of Hafan Tywi care home in Carmarthenshire at short notice at the start of Easter bank holiday 2012 highlighted the difficulties of ensuring that residents are informed and prepared for such an eventuality and that suitable alternative arrangements can be made.

237. In oral evidence CSSIW told the committee that when a home is under threat of closure it would be helpful to have a point built into the process at which families and residents have a right to be notified. The current regulations state that when an owner decides to close a care setting, or CSSIW gives notice of a proposal to close a setting, there is a requirement for a 30-day consultation period. CSSIW also highlighted the difficulty in identifying who was responsible for notifying residents and relatives, in particular given the differing relationships the owners may have with publicly funded and self-funding residents. Although individual circumstances may dictate who is responsible, there is a role for the inspectorate in making sure that the information is provided to residents and relatives clearly and in a timely fashion.

238. In addition to informing residents, there is also a need for appropriate discussions with the local community. David Street representing the Association of Directors of Social Services Cymru told the Committee that:

“In my experience of closing a local authority care home, everyone accepted that there was overcapacity in the system and that a care home needed to close, but the question that

²¹⁰ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC41 – Age Cymru](#) p13 [accessed 19 October 2012]

²¹¹ BBC News, 11 April 2012 [Hafan Tywi private care home in Ferryside, Carmarthenshire, shut by court](#)

was always asked was ‘Why this one? Why can’t it be the one up the road or the one across the county?’ So, there is political resistance, but there is also substantial public resistance.”²¹²

239. The External Reference Group and other witnesses expressed concern that it was difficult to know how under what circumstances a care home would or could be closed. Phil Vining from Age Concern Cardiff and the Vale told the Committee that:

“What we are seeing is that it is very rare for a care home to be closed because of negative things going on there. We hear of care homes being closed because the local authorities have decided that they can no longer operate them, because they are no longer cost-effective or the buildings are not fit for purpose, but very rarely do we hear of CSSIW closing down a care home because of poor care, allegations of abuse and so on. It is only in very extreme cases, perhaps when things get into the media, that a care home is closed.”²¹³

240. The Centre for Innovative Ageing recommends that the period for considering and implementing closure should not exceed six months, thus limiting the uncertainty that residents, relatives and other stakeholders experience.

241. We agree that, since for most residents a care home is their permanent home, it is vital that communication with them and their families is carried out at an appropriate time and in an appropriate manner to minimise the distress caused by closures. We would therefore like to see the Welsh Government guidance on care home closures enhanced and strengthened to ensure that informing and supporting residents through this difficult time is given sufficient priority. We also believe there are issues to be addressed around the financial scrutiny of independent care homes, and we discuss this in the next section.

Financial scrutiny of providers

242. Concern about the problems experienced by Southern Cross Healthcare in 2011 was reflected in written and oral evidence to the inquiry and which included some discussion about the desirability and

²¹² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 184\]](#) 22 March 2012 [accessed 19 October 2012]

²¹³ Ibid [RoP \[para 77\]](#) 29 February 2012 [accessed 19 October 2012]

practicality of strengthening the financial scrutiny of independent care providers. Following financial difficulties in 2011, Southern Cross Healthcare, the UK's largest care home operator, transferred all its homes to other providers. It had operated thirty three care homes in Wales. Four Seasons Healthcare, which acquired seven of the former Southern Cross homes in Wales, was itself purchased by private equity firm Terra Firma in 2012.

243. In the consultation responses received by the Committee, there was broad support for strengthening the assessment of the financial viability of care homes as part of the regulation and inspection process. The *Care Homes (Wales) Regulations 2002* state:

26.-(1) The registered provider shall carry on the care home in such manner as is likely to ensure that the care home will be financially viable for the purpose of achieving the aims and objectives set out in the statement of purpose.²¹⁴

244. This is reflected in the *National Minimum Standards for Care Homes for Older People* which states that Standard 29: Financial procedures should achieve the following outcome:

“Service users are safeguarded by the financial procedures in the home, and by its continuing viability.”²¹⁵

245. However, the tools available to CSSIW appear to be limiting its ability to effectively scrutinise the financial health of care providers, and local authorities, as commissioners of residential care, also experience difficulties in monitoring the financial health of independent providers. David Street representing the Association of Directors of Social Services Cymru told the Committee:

“Initially, when a home first comes into being, it is an issue for the Care and Social Services Inspectorate for Wales to ensure that the business planning and the methodology for setting up a home are sound and robust. Beyond that, it is a joint responsibility between the care standards inspectorate and

²¹⁴ [Care Homes \(Wales\) Regulations 2002](#) [accessed 19 October 2012]

²¹⁵ CSSIW [National Minimum Standards for Care Homes for Older People](#) March 2004 p25 [accessed 19 October 2012]

local authorities. Clearly, that requires an element of trust, which, if I am honest, is lacking at the moment.”²¹⁶

246. In some instances financial information may not be forthcoming to local authorities. David Street told the Committee:

“I find it difficult to get providers to provide me with things like profit and loss accounts. So to monitor the financial viability of a provider is difficult. That comes down to some tensions around the fee-setting process, and perhaps a reluctance on behalf of some providers to demonstrate that they are doing okay. Perhaps they feel that being seen to be doing okay will be viewed negatively by local authorities, whereas, in reality, we would be far more worried if we had a home that was in the red, as that would be indicative of more serious problems down the road.”²¹⁷

247. In oral evidence CSSIW witnesses agreed that a requirement to provide annual accounts for each care setting, rather than for the business as a whole would be helpful, as would open book accounting.²¹⁸ Ceredigion council told the Committee it is moving towards an open book approach which helped both to monitor the financial viability of homes and to set fee levels. The council believed this would help care homes to function sustainably in the future.²¹⁹

248. In oral evidence on 30 May CSSIW described some of the challenges of gauging the financial viability of providers and their experiences in relation to the collapse of Southern Cross Healthcare:

“We spend a lot of time checking with Companies House to see how companies are changing, where they are going and so on. We would need a forensic accountant. We keep in touch with the financial pages as well. I remember following the Southern Cross stuff through *The Guardian*, but it lost the company in Gibraltar. These are debt traders, they are bond holders; we are way out of our depth here, but we do our best.”²²⁰

²¹⁶ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 165\]](#) 22 March 2012 [accessed 19 October 2012]

²¹⁷ Ibid

²¹⁸ Ibid [RoP \[paras 96-101\]](#) 30 May 2012 [accessed 19 October 2012]

²¹⁹ Ibid [RoP \[para 255\]](#) 22 March 2012 [accessed 19 October 2012]

²²⁰ Ibid [RoP \[para 122\]](#) 30 May 2012 [accessed 19 October 2012]

249. Representatives from Local Authorities also expressed concerns about the difficulties of monitoring large providers like Southern Cross. Bob Gatis from Rhondda Cynon Taf told the Committee that:

“The Southern Cross example is one where the financial funding of social care is called into question because of the manner in which those large companies are themselves funded”²²¹

250. Jim McCall, representing Four Seasons, which now owns some of the former Southern Cross care homes, told the Committee that his company would support greater levels of public transparency regarding its financial health, including an open-book approach to negotiating fees with local authorities

“I can refer to specific examples to which I have had exposure in negotiating an arrangement for a service in a particular locality, where the books were opened and given to the local authority to look at how we costed the packages of care for individuals or groups of individuals in a care home. They could satisfy themselves that there was no sense of an obscene take out of what was being provided by the local authority in terms of the care package. [...] I found that to be a very useful exercise on a number of occasions.”²²²

251. Eithne Wallis from the Terra Firma bid team, which is purchasing Four Seasons, told the Committee that they would work within the regulation and inspection requirements. In order to cover the debt from Four Seasons, Terra Firma will issue a bond which will mean that:

“There will have to be regular reports on the financial health on Four Seasons and the investment not just to the bond holders, but that information in itself will be made public.”²²³

252. There was mixed evidence from other independent sector providers about the need for more financial regulation. BUPA stated in written evidence:

²²¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 238\]](#) 22 March 2012 [accessed 19 October 2012]

²²² Ibid [RoP \[paras 149-150\]](#), 14 June 2012 [accessed 19 October 2012]

²²³ Ibid [RoP \[para 160\]](#), 14 June 2012 [accessed 19 October 2012]

“Our view is that further regulation of the social care sector, following the collapse of Southern Cross, is not necessary and would not work in practice. [...]

“Whilst it would be in the interests of the sector and care users for there to be fewer instances of operators getting into financial difficulty, we believe that there is already sufficient regulation in place and we disagree that the sector is lightly regulated.”²²⁴

253. Written evidence from Care Forum Wales stated:

“... 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.”²²⁵

254. The written evidence²²⁶ from the Deputy Minister indicated that the Welsh Government is considering the options for strengthening the financial assessment of care home providers. In oral evidence she emphasised the importance of addressing such issues at the UK level:

“You mentioned the collapse of big providers, and I really think that this is a UK issue. It is a wider issue as well, but we are seeing big providers that are UK-wide. It is very important that the devolved nations, and England, work together to take an overview of the market, because we know that company law and financial services are not devolved. [...] I am encouraged by the joint working between officials of the devolved nations and England on understanding this overview. I have asked for a meeting with Paul Burstow on this very issue, because we need to explore it further and ensure that we play our part in

²²⁴ National Assembly for Wales, Health and Social Care Committee, [Consultation response RC28 - BUPA](#) p5 [accessed 19 October 2012]

²²⁵ Ibid [Consultation Response RC60 - Care Forum Wales](#) p10 [accessed 19 October 2012]

²²⁶ Ibid [HSC\(4\)-18-12 paper 1 - Evidence from the Deputy Minister for Children and Social Services](#) para 23, 20 June 2012 [accessed 19 October 2012]

understanding how we move to the future given the complexity, sometimes, of the funding of providers.”²²⁷

255. We are aware of the distress that the financial failure of care home providers can have on residents and we believe that financial scrutiny should be improved to help try and prevent or plan for financial difficulties. A requirement on providers to submit annual accounts for each care setting and business plans for any acquisitions to CSSIW would create an opportunity to assess their financial health and to plan for any future difficulties. However, we do not underestimate the complexities of this undertaking and we believe that further work is required by the Welsh Government and CSSIW, care commissioners and the sector itself to develop a more rigorous approach to financial scrutiny.

256. Where there is no alternative to closing a care home, whether on grounds of service or financial failure or for policy reasons, we believe that improvements should be made to the arrangements for informing residents and their families.

Key recommendation 10: The Welsh Government should take action to reduce the incidence and impact of a breakdown of services by:

- **working with CSSIW to ensure that arrangements for the financial scrutiny of independent providers are strengthened. This should be done by requiring providers to submit annual accounts to CSSIW for individual care settings;**
- **re-visiting and re-assessing current ‘fit and proper person’ arrangements in cases of care home acquisition to ensure that they include consideration of financial sustainability and are applicable to corporations as well as individual managers / owners.**

Key recommendation 11: The Welsh Government should strengthen the *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults* guidance to local authorities on care home closure in a way which clarifies the arrangements and responsibility for informing residents and their families regarding the impending closure. A fixed point in the process, at

²²⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 95\]](#) 20 June 2012 [accessed 19 October 2012]

which residents and families have a right to be informed about such an event, should be established.

7. Future options for residential care

257. It is clear that a new landscape is emerging for the provision of services for older people with care needs, with a move away from traditional care homes towards more flexible and responsive approaches such as enhanced domiciliary care services and Extra care housing schemes. We believe that such new approaches are needed in order to ensure that older people can retain their independence for as long as possible and not be forced to move home in order to receive the care they need. We were therefore encouraged to receive evidence of a range of innovative schemes in Wales that are seeking to address these needs. In addition to developing new models of care, the shift away from direct public provision of social care services means that there are issues to consider around the balance between public, private and not for profit provision of care services. We discuss some of these issues in this chapter of the report.

New and emerging models of care

258. The inquiry received evidence about new approaches being taken to providing services for older people with care needs, including those with dementia. Such models generally aim to offer appropriate care whilst allowing older people to retain a greater measure of independence than would be possible in residential care. They include models in which flexible and responsive care is provided to older people in their own homes, sometimes in care villages or Extra care housing schemes, thus avoiding the need for a move to residential care when care needs become more acute.

259. Such schemes have often developed in response to local circumstances and are characterised by integrated working between health, social care and housing services. They may also include input from voluntary sector organisations.

260. The need for flexibility and joint working is particularly evident in rural communities where accessing specialist services may mean travelling a considerable distance. Meeting the needs of older people, particularly those with dementia, in the small and widely dispersed communities of Powys, for example, presents significant challenges. A

range of methods is being employed to address these needs,²²⁸ including: extended district nursing; the introduction of Care Transfer Co-ordinators to track and support older people leaving hospital; rehabilitation and reablement; and a third sector-led Powys Urgent Response at Home Service to prevent hospital admission. In addition, low level volunteer input in small communities helps to identify older people in need. Following the development of this new approach, delayed transfers of care from hospital have been significantly reduced.

261. The Gwent Frailty Programme is a joint health and social care service offering flexible home based support to older people with a strong focus on reablement. The Welsh Government has provided £9 million Invest to Save funding over three years to develop the programme, although its financial sustainability rests on the savings it generates from reduced episodes of hospital treatment and admissions to care homes, and fewer long-term care packages.²²⁹

262. We received much evidence of the effectiveness and popularity of Extra care housing schemes which combine housing with care and are designed to respond to the changing care needs of the older people living in them. Cymorth Cymru told the Committee in their written evidence, that the independence offered by such schemes means that:

“...many people are choosing Extra Care as their preferred option of dealing with their increasing care needs as it allows individuals to have their own tenancy or ‘own front door’, allowing them the control to dictate who does or does not enter their home at any given time.”²³⁰

263. Given the security offered by the flexible care options and the independence provided by a tenancy it is no surprise that Extra care housing is proving popular, and we were impressed by the quality of the schemes we visited during the inquiry. There are now a number of Extra care schemes in Wales: twenty seven have been developed and a further nine are under construction or at an advanced stage of planning.

²²⁸ National Assembly for Wales, Health and Social Care Committee, [Consultation response RC11 – Powys Teaching Health Board](#) [accessed 19 October 2012]

²²⁹ Ibid [Consultation response RC13 – Welsh Reablement Alliance](#) p4 [accessed 19 October 2012]

²³⁰ Ibid [Consultation response RC65 – Cymorth Cymru](#) p8 [accessed 19 October 2012]

264. Some witnesses expressed doubts about the capacity of Extra care schemes to meet the needs of all older people and questioned its ability to substitute for residential care where people have higher levels of need, such as those with dementia.²³¹ This claim was not borne out, however, when the Committee visited a number of Extra care schemes, all of which appeared to actively seek to support people across the spectrum of need.

265. Research²³² suggests that Extra care schemes offer better outcomes than residential care at similar or lower costs, even for older people with similar characteristics. Despite this, written evidence from Cymorth Cymru suggested that the current funding arrangements may be limiting the flexibility of such schemes:

“...limitations are sometimes caused by the pre-conceived level of need that comes with the block contract of funding. It appears that that [the Extra care] model itself is able to meet increasing and decreasing support, care and health needs but current funding arrangements may be limiting this flexibility.

“We suggest that further work needs to be done to consider how financial arrangements could be configured to allow greater flexibility in terms of what is offered to residents to ensure the changing range of needs are met over their lifetime.”²³³

266. Witnesses from Community Housing Cymru suggested that current design standards may need to be reviewed to improve the affordability of such schemes.²³⁴

267. Professor John Bolton told the Committee²³⁵ that new forms of tenure in Extra care housing may be needed in Wales for homeowners who do not wish to move to rented accommodation in an Extra care scheme. Registered Social Landlords could develop mixed tenure

²³¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 15\]](#) 23 February 2012 [accessed 19 October 2012]

²³² Netten, A., Darton, R., Baumker, T. and Callaghan, L. (2011) [Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing](#), p3, Personal Social Services Research Unit, University of Kent, Canterbury [accessed 19 October 2012]

²³³ National Assembly for Wales, Health and Social Care Committee, [Consultation response RC65 – Cymorth Cymru](#) p8 [accessed 19 October 2012]

²³⁴ Ibid [RoP \[para 31\]](#) 2 May 2012 [accessed 19 October 2012]

²³⁵ Ibid [RoP \[para 96\]](#) 22 March 2012 [accessed 19 October 2012]

schemes in future, as in England, both to meet this need and to help fund new schemes:

“It is a perfectly viable financial model for that association without any state grant. I think that the grant regimes, from the housing corporation, as was, or from the Welsh Government or the Department of Health, did not originally encourage that model, so many of the extra-care facilities that I have visited and seen in Wales already have a model that is entirely tenanted. For some older people, that will not be their choice.”²³⁶

268. Although we acknowledge the potential of mixed tenure schemes, it is clear to the Committee that their success is highly influenced by:

- the state of the general housing market at any given time; and
- the form of tenure held by the resident before moving to Extra care.

This was illustrated to us by the example of Hafod Care’s Brocastle scheme, where houses that were available for purchase remained as rented accommodation for some time due to prospective residents being unable to sell their own homes.

269. Representatives of the social housing sector expressed a willingness to expand the provision of housing with care in Wales, emphasising their ability to raise their own finance and to maximise the effectiveness of public funds. Better cross sector working is needed if such new models are to work effectively, a point made by the College of Occupational Therapists in its written evidence.²³⁷ Nick Bennett, chief executive of Community Housing Cymru told us:

“The cultures of health and housing are different—the accountabilities are in separate silos, and that means that there is almost a constant challenge to bring those barriers down and

²³⁶ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 96\]](#) 22 March 2012 [accessed 19 October 2012]

²³⁷ Ibid [Consultation Response RC36 - College of Occupational Therapists](#) pp4-5 [accessed 19 October 2012]

provide cheaper but higher quality services for increasingly older citizens in Wales.²³⁸

270. It is clear that future care models for older people will increasingly need to offer health and social care services to older people in their own homes, whether in their existing homes or in purpose built Extra care schemes. Wherever they are located future services must offer continuity of care and minimise the need for disruptive moves.

271. We acknowledge that further work is needed to refine some aspects of Extra care such as funding mechanisms and the scope of care provided in some schemes, but we nevertheless believe that it has much to offer as an alternative to traditional residential care. However, although there is no single model to suit all circumstances, the success of new services is dependent on effective cross sector working.

272. We believe there is now a need for a commitment to practical action by the Welsh Government to foster the development of new models of care that cut across service boundaries. Only in this way can serious alternatives to costly long term care in hospital or residential settings be developed. Given the financial interdependence of the health, housing and social care sectors, in which the impact of service provision in one area can directly affect demand for services in another, we believe there is a strong case for joint ministerial action across these policy areas. The deployment of some NHS capital resources, for example, to fund the development of new Extra care housing schemes would reduce demand in the longer term for hospital beds.

Key recommendation 12: The Welsh Government has already done much to promote Extra care schemes. As a consequence of the public money already invested in this area, it has become clear that Extra care is an effective and workable model. More now needs to be done by the Welsh Government to scale up the role of Extra care in Wales. This will require a more flexible deployment of public funds across more than one ministerial portfolio. This will allow Extra care providers to maximise their own capacity to raise

²³⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 7\]](#) 2 May 2012 [accessed 19 October 2012]

funds and develop a substantial programme for the future jointly with the Government.

The balance of public, private and not for profit ownership

273. The recent financial difficulties experienced by some larger care providers such as Southern Cross and Four Seasons Healthcare has focused attention on the mix of public and independent provision of residential care. In Wales, as elsewhere in the UK, most residential care is now provided by the private sector, reflecting a trend that has been apparent in the UK for more than 30 years.²³⁹ As of February 2012, 84 per cent of care home places in Wales were provided by the private sector, 13 per cent by the public sector and 3 per cent by the voluntary sector.²⁴⁰

274. Some witnesses expressed concern that the balance between private and public/not for profit provision has tipped too far in favour of the private sector and that greater diversity is needed.²⁴¹ Nevertheless, there was an acknowledgement that, in many instances the private sector has replaced public sector provision because it can offer lower operating costs, and that it will continue to make a significant contribution to the residential care sector.²⁴²

275. Local authority provision is unlikely to expand for the foreseeable future and, in addition to commissioning independent sector services, some authorities are transferring their services to other providers. Neath Port Talbot Council, for example, has transferred the management of its care homes to a Housing Association, Grwp Gwalia. (See example box below). Rhondda Cynon Taf Council stated its view in written evidence:

²³⁹ See Lievesley, N. Crosby, G. and Bowman, C. [The Changing Role of Care Homes](#) January 2011, BUPA and Centre for Policy on Ageing, pp12 and 14 [accessed 28 June 2012]

²⁴⁰ Figures from CSSIW, see *Scene setting paper for the inquiry into residential care for older people in Wales*, p6 provided by the Research Service for the Committee's meeting on 23 February 2012. Note that Registered Social Landlords are counted as private sector bodies.

²⁴¹ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-06-12 paper 1 – Evidence from the Older People's Commissioner for Wales](#) 23 February 2012; and [Consultation Response RC9 - Pensioners Forum Wales](#) p3 [both accessed 19 October 2012]

²⁴² Ibid [Consultation Response RC25 – Conwy County Borough Council](#) p3 [accessed 19 October 2012]

“There is a need for a balance and range of provision to support older people’s accommodation and support needs. Increasingly local authorities have difficulty in raising capital for new projects and we will look to a range of providers such as those suggested in your terms of reference. We do not have a particular view at this time on which is the preferred future model other than to recognise the importance we place on public sector provision in providing benchmarks for the delivery of quality care.”²⁴³

Grwp Gwalia and Neath Port Talbot Council

On the 1st April, 2012 Gwalia took on the running of Neath Port Talbot Council’s 8 residential and respite care homes for older people. The 25 year contract involved the TUPE+ transfer of 361 staff. The contract requires Gwalia to reprovide seven of the homes into four new purpose built facilities within four years.

This was a significant exercise which required long term planning and consultation by the Council. The procurement process was complex involving the transfer of care services, staffing and buildings. From Gwalia’s perspective it required the evaluation of significant risks in relation to finance, TUPE and the delivery of care.

Not for profit providers

276. Some witnesses highlighted the potential for increasing the contribution of not for profit providers. The Older People’s Commissioner emphasised the importance of a diversity of providers and suggested that the not for profit model could play a bigger role. Nick Bennett of Community Housing Cymru provided evidence of developments in this area:

“Some registered social landlords have started to respond to that social market, not through any political imperative, but as social enterprises that have seen a social need and responded to the opportunity. [...] Of more than 40, about four RSLs have

²⁴³ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC63- RCT County Borough Council](#) p5 [accessed 19 October 2012]

really looked into the potential for residential care, but there is a deeper interest in the care agenda more broadly.”²⁴⁴

277. Community Housing Cymru made a case for increasing the involvement of Registered Social Landlords in care provision:

“[...] First, can we access cheap private finance? Yes, we can, and that is quite an advantage at present, given the behaviour of the banks and the difficulties that small and medium-sized enterprises and others are having in accessing cash. The costs and the risks are lower and there is not the same pressure and hot breath from shareholders to achieve value in other areas through, perhaps, driving down labour costs and so on [...]

“The other thing I would add to that is that our focus also is not on particular parts of the continuum, but on the whole continuum, and on our ability to finance, design and build things and deliver care and support with an integrated person-centred approach.”²⁴⁵

278. Nevertheless, representatives of the not for profit sector believe they need a stronger voice in their relationship with the Welsh Government.²⁴⁶ In written evidence, Linc Cymru argued that the third sector has an important contribution to make to social care in Wales, but that:

“There is no voice for the not for profit care sector in Wales because the private sector is so large. We would very much welcome the Welsh Government’s support to set up a formal Third Sector Care Group similar to what the National Care Forum provides in England.”²⁴⁷

Co-operatives

279. Co-operatives may offer another potential model of ownership. Written evidence from the Wales Co-operative centre highlighted that there are currently no co-operative residential care homes in the UK. However:

²⁴⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 6\]](#) 2 May 2012 [accessed 19 October 2012]

²⁴⁵ Ibid [RoP \[para 34\]](#) 2 May 2012 [accessed 19 October 2012]

²⁴⁶ Ibid [RoP \[paras 84-85\]](#) 2 May 2012 [accessed 19 October 2012]

²⁴⁷ Ibid [Consultation Response RC76 – Linc Cymru](#) p16 [accessed 19 October 2012]

“Co-operatives are well placed to run residential care for older people. A consideration of the co-operative approach as an alternative model of care can draw on past lessons learnt. This will help shape appropriate policy and the economic environment necessary for the model to thrive. If provided with pump priming investment, it would find an operational model that allows a society to generate a sufficient surplus to reinvest, while securing wider stakeholder engagement and participation.”²⁴⁸

280. There are international examples, such as in Mondragon, Spain and Quebec, Canada where co-operatives have been used in the provision of social care. The Committee heard evidence from Jean-Pierre Girard²⁴⁹ about domiciliary care co-operatives in Quebec. He told the Committee that the co-operatives provide a wide range of support services to older people in their homes and are founded on a “multi-stakeholder” model with service users, staff and supporting organisations. Service users are means-tested (on income but not assets) to determine their contribution to the cost of the service but no-one receives the service for free. The service is subsidised by the Quebec Government and was instigated centrally but developed locally. However, he indicated that the co-operative approach is limited to domiciliary care and that residential care in Quebec is poorly developed at present.²⁵⁰

281. The Deputy Minister and her officials confirmed during oral evidence that work is ongoing with the Welsh Government, local authorities and organisations involved with Social Enterprises to consider the role of co-operatives and social enterprises in delivering social care. Steve Milsom told the Committee that:

“This is a longer term issue. You have to look at the percentage of independent sector ownership of care in Wales—it is over 85%, I think. So, making inroads with new social enterprise models will not happen overnight. We are working very closely with a range of people in the co-operative world to look at how Government can facilitate it, but it really has to be a bottom-up approach. Co-operatives and social enterprises are not

²⁴⁸ National Assembly for Wales, Health and Social Care Committee, [Consultation Response RC81 - Wales Co-operative Centre](#) p3 [accessed 19 October 2012]

²⁴⁹ Ibid [RoP](#) 8 February 2012 [accessed 19 October 2012]

²⁵⁰ Ibid [RoP \[para 38\]](#) 8 February 2012 [accessed 19 October 2012]

something that a Government would dictate on; it has to be the partnership route that the Deputy Minister talked about.”²⁵¹

Conclusion 19: A mixed economy of ownership can help to foster a more diverse and innovative sector and provide a stronger foundation for providing choice and high quality services for the growing number of older people who will need them. As a key part of that the not for profit sector can make a valuable contribution to care provision in terms of innovation, value for money, and stability of provision. We therefore welcome the Minister’s work with relevant organisations to develop options for future models of residential care provision.

282. However, it is important to promote a genuinely mixed market of providers and we believe that the Welsh Government has not yet acknowledged its capacity to help determine future provision by shaping the market. In our view the bulk of residential care will continue to be provided by the private sector and we acknowledge the valued contribution the sector makes. Nevertheless, we believe that the not for profit sector has a valuable role to play in developing new and innovative models of care and that the Welsh Government should be proactive in supporting not for profit providers. Welsh Government encouragement would send out a strong message about quality and innovation and about its commitment to the sustainability of the care sector.

Key recommendation 13: The Welsh Government needs to move from being simply an enabler in the field of social care to taking an active role in shaping and delivering a model that is fit for purpose for future generations. The Government must move more urgently from its current analysis and idea development to a position where it is implementing policy and delivering action on the ground. To enable this, the not for profit and co-operative sector should be given a stronger and separate voice in discussions with the Welsh Government. We believe that this will help ensure that the sector can make a full contribution to the provision of care services for older people in Wales.

²⁵¹ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 101\]](#) 20 June 2012 [accessed 19 October 2012]

Annex A – Terms of reference

The terms of reference for the inquiry were as follows:

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

- 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 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;
- 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;
- the effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.
- new and emerging models of care provision;
- 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 Committee agreed to focus the inquiry on residential care, although noting that nursing care would inevitably be touched upon during discussions. The Committee also decided to focus its attention on the provision of services for older people for the purpose of this inquiry.

Annex B – The views of the External Reference Group

Our reference group

1. We were established as a group in March 2012 to assist the Health and Social Care Committee with its inquiry into residential care for older people in Wales. The aim of our work was to articulate the views of current and prospective residential care users about future services from the perspective of those with first-hand experience of existing provision.

Our key statement

2. As a group of people who are supporting, or have supported, family members within the residential care system, we believe the current system is not fit for purpose. When the concerns we have about the system are considered in the light of forecast demographic change, we believe action must be taken as a matter of urgency. We would like to see a care system develop which is based on early intervention to address care needs. A fully integrated approach to care is needed which places the individual, their family and carers at the centre.
3. We believe that everybody on the journey to - or within - the residential care system has the right to access quality care which guarantees that their dignity is maintained. This includes the right to access good quality and meaningful activities and stimulation, including those with dementia and sensory loss. It should also include the right for the individual to shape the care they receive and how it is provided, involving family/carers or independent advocates in these important decisions.
4. This rebalancing of power towards the individual, and away from services and structures, is crucial to give meaning to the concept of person-centred care. It is only when action is taken in the areas identified within this report that the necessary improvements will occur and the negative perception of care - amongst older people and the wider public - may improve.

Our key issues

5. Having considered the evidence received by the Committee and our own experiences of the care system, we believe that the following

areas should be addressed so that anybody on the journey to - or within - the residential care system can access the quality and range of services to which they should be entitled.

Adequate and appropriate information, support and guidance

- As a person's care needs start to increase, it is vital that information on a range of services and options is available and easily accessible. This is particularly important for those who self-fund their care, who are often left to make important decisions on their own.

A system built around the needs of the individual

- The care system needs to be centred on the individual. It must involve early assessment and planning for future care needs, and should include reablement where necessary.
- Everybody should be entitled to home care if this is an appropriate option for them. This should not be influenced by whether an individual lives in a rural or urban location.
- The services delivering care must be integrated at the point of delivery – people should not be passed from pillar to post trying to establish who is responsible for delivering the different aspects of their care.
- Once somebody has begun their care journey there should be on-going assessment and a continuum of care – there should be no need to move between residential and nursing care settings which causes upheaval and distress.
- The needs of individuals should be at the forefront of considering what care is most appropriate including the need for social interaction, activities and limiting the risk of loneliness.
- People should receive sufficient time with the staff providing their care.

Staffing

- Those working in residential care need to have greater recognition and value placed on the work they do. More training and development for staff is needed on the range of issues facing care provision, particularly conditions such as dementia and Parkinson's. This should help address the poor public perception of care homes and care work as a profession.

- There is a tendency for health and care professionals to be risk averse. The focus must be on what is best for the person, not the least risky option for the professional.

Inspection and regulation

- Inspecting and regulating a care home should be done for the benefit of those living or considering living in a home. To achieve this, the group believes that lay inspectors, recruited particularly from families and carers with experience of residential care, should be involved in the process.
- Reports produced from inspections must provide the information needed by the individual, their families and carers to enable them to make an informed decision about their futures.

Funding

- There must be sufficient funding for care services whether delivered at home or in residential care.
- Action needs to be taken to address how continuing healthcare funding is allocated. Everyone entitled to NHS funding should receive it, including those with mental as well as physical conditions.
- More funding should be given to the development of social enterprise models for care provision.

Design of care services

- As new models of care develop, consideration should be given to the needs of future generations who will be utilising these services. More thought and imagination should be applied to developing services for the future, including how people could buy into their own care. As the proportion of self-funders increases, this is likely to become a more significant issue.
- Residential care policies need to be future proofed where possible. To achieve this, research is needed into the requirements of prospective users and new models of care.
- There needs to be greater support for the not-for-profit sector.
- We believe that better designed services – and more joint working between such services – will prove to be more cost effective and will deliver savings in the future.

Support for - and recognition of - carers

- Carers are at the forefront of providing support and care for people before entering residential care, and maintain a key role once they have entered care. Greater recognition of this role is needed.
- Carers often act as advocates and sources of advice for those for whom they care and have a vital role to play in the assessment of care needs. Carers should be enabled and supported to undertake these crucial and valuable roles.
- More consideration of the role of carers is needed by those delivering public services and more work needs to be undertaken to incorporate them into the delivery of services. For example, in implementing plans for extending GP opening hours, consideration should be given to carers/families who often need to take time off work to attend appointments with their relatives and would benefit from such policy initiatives.

The inquiry's reference group met formally on 5 occasions. Notes of all meetings are available via the following links:

Meeting 1 (14 March 2012) - As this was an introductory meeting of the reference group, no formal note was taken.

Meeting 2 (17 April 2012)

<http://www.senedd.assemblywales.org/documents/s7949/Paper%209.html?CT=2>

Meeting 3 (24 May 2012)

<http://www.senedd.assemblywales.org/documents/s9113/HSC4-23-12%20paper%205%20Reference%20group%2024%20May.html?CT=2>

Meeting 4 (12 June 2012)

<http://www.senedd.assemblywales.org/documents/s9114/HSC4-23-12%20paper%206%20Reference%20group%2012%20June.html?CT=2>

Meeting 5 (2 August 2012) - This annex was produced as a note of the meeting.

The work of the External Reference Group was facilitated by Age Cymru and the Carers Trust.

Annex C – Oral evidence

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of the oral evidence sessions can be viewed, in full, at:

<http://www.senedd.assemblywales.org/mglIssueHistoryHome.aspx?Ild=1309>

8 FEBRUARY 2012	
Session 1	
Jean-Pierre Girard	Specialist in the development and management of co- operative, non-profit and mutual organisations (nominated by the Wales Progressive Co-operators)
23 FEBRUARY 2012	
Session 2	
Ruth Marks	Older People’s Commissioner for Wales
Sarah Stone	Office of the Older People's Commissioner for Wales
Alun Thomas	Office of the Older People's Commissioner for Wales
Session 3	
John Moore	My Home Life Cymru
Tom Owen	My Home Life
Session 4	
Prof John Bolton	Institute of Public Care, Oxford Brookes University
Julie Jones	Social Care Institute for Excellence
29 FEBRUARY 2012	
Session 5	
Nancy Davies	Pensioners’ Forum Wales
Haydn Evans	Pensioners’ Forum Wales
Linda Thomas	Age Concern Cardiff and Vale
Phil Vining	Age Concern Cardiff and Vale
Session 6	
Dr Rosie Tope	Wales Committee of Carers Wales
Roz Williamson	Carers Wales
Session 7	
Sue Brown	Sense Cymru
Rebecca Woolley	Action on Hearing Loss Cymru
Ansley Workman	RNIB Cymru
14 MARCH 2012	
Session 8	
Carol Shillabeer	Powys Teaching Health Board
22 MARCH 2012	
Session 9	
Prof John Bolton	Institute of Public Care, Oxford Brookes University

Session 10	
David Street	Association of Directors of Social Services Cymru
Emily Warren	Welsh Local Government Association
Session 11	
Bob Gatis	Rhondda Cynon Tâf County Borough Council
Luisa Bridgman	Rhondda Cynon Tâf County Borough Council
Susie Lunt	Flintshire County Council
Parry Davies	Ceredigion County Council
26 APRIL 2012	
Session 12	
Ed Bridges	WRVS
Philippa Ford	Chartered Society of Physiotherapy
Session 13	
Francis McGlone	UK Home Care
Yvonne Apsitis	UK Home Care
2 MAY 2012	
Session 14	
Nick Bennett	Community Housing Cymru
Richard Davies	Gwalia Housing Group
Kevin Hughes	Pennaf Housing Group
Session 15	
Rachel Lewis	Age Alliance Wales
Angela Roberts	Age Alliance Wales
Session 16	
Sue Phelps	Alzheimer's Society
Chris Quince	Alzheimer's Society
Val Baker	Parkinson's UK Cymru
Steve Ford	Parkinson's UK Cymru
16 MAY 2012	
Session 17	
Dr Pauline Ruth	Royal College of Psychiatrists
Dr Kathryn Williamson	Royal College of Psychiatrists
Sue Thomas	RCN Wales
Lisa Turnbull	RCN Wales
Ruth Crowder	College of Occupational Therapists
Eve Parkinson	College of Occupational Therapists
Chris Synan	College of Occupational Therapists
Session 18	
Paul Gage	GMB South Western Region
Donna Hutton,	Unison
Session 19	
Dr Catherine Poulter	British Association of Social Workers
Sue Davis	Social Care Association
Nick Johnson	Social Care Association
Sarah Owen	Social Care Association

30 MAY 2012	
Session 20	
Imelda Richardson	Care and Social Services Inspectorate Wales
David Francis	Care and Social Services Inspectorate Wales
Kevin Barker	Care and Social Services Inspectorate Wales
Peter Higson	Health Inspectorate Wales
Mandy Collins	Health Inspectorate Wales
Session 21	
Rhian Huws Williams	Care Council for Wales
Gerry Evans	Care Council for Wales
14 JUNE 2012	
Session 22	
Mario Kreft	Care Forum Wales
Mary Wimbury	Care Forum Wales
Peter Regan	Haulfryn care home
Sandra Regan	Haulfryn care home
Session 23	
Matthew Flinton	BUPA
Eithne Wallis	Terra Firma
Jim McColl	Four Seasons
20 JUNE 2012	
Session 24	
Gwenda Thomas AM	Deputy Minister for Children and Social Services
Steve Milsom	Welsh Government

Annex D – Written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at <http://www.senedd.assemblywales.org/mglIssueHistoryHome.aspx?lId=2222>

<i>Organisation</i>	<i>Reference</i>
City and County of Swansea	RC 1
Carol Roberts	RC 2
National Association Of Old Age Pensioners of Wales	RC 3
Lynne Russell	RC 4
BDA	RC 5
Monmouthshire County Council	RC 6
Flintshire County Council	RC 7
National Leadership and Innovation Agency for Healthcare (NLIAH)	RC 8
Pensioners Forum Wales	RC 9
Susheela Lourie	RC 10
Powys Teaching Health Board	RC 11
Cardiff and the Vale of Glamorgan Community Health Council	RC 12
Welsh Reablement Alliance	RC 13
Public Health Wales and Cardiff University	RC 14
Sian Gardner	RC 15
All Wales Continence Forum	RC 16
Age Concern Cardiff and the Vale of Glamorgan	RC 17
Lesley Gleave	RC 18
Ceredigion County Council	RC 19
Welsh Refugee Council	RC 20
WRVS	RC 21
Aneurin Bevan Health Board	RC 22
Ceredigion County Council Social Services Overview and Scrutiny Committee	RC 23
Pendine Park Care Organisation	RC 24
Conwy County Borough Council	RC 25
Parkinson's UK Cymru	RC 26
The Princess Royal Trust for Carers and Crossroads Care, Wales	RC 27
BUPA	RC 28
Cwm Taf Health Board	RC 29
UK Home Care Association	RC 30
RCN Wales	RC 31
Morfa Newydd Care Home	RC 32
Grŵp Gwalia	RC 33
Chartered Society of Physiotherapy	RC 34
Cardiff and Vale University Health Board Falls and	RC 35

Bone Health Programme	
College of Occupational Therapists	RC 36
Dementia Services Development Centre for Wales	RC 37
British Geriatrics Society, Cymru Branch	RC 38
Bridgend County Borough Council	RC 39
Royal College of General Practitioners	RC 40
Age Cymru	RC 41
Sense Cymru	RC 42
Health and Safety Executive	RC 43
Royal College of Psychiatrists in Wales	RC 44
Community Housing Cymru and Care & Repair Cymru	RC 45
Betsi Cadwaladr University Health Board	RC 46
Royal College of Physicians	RC 47
Cwm Taf Health Board	RC 48
Care Council for Wales	RC 49
Alzheimer's Society	RC 50
Public Health Wales	RC 51
Care and Social Services Inspectorate for Wales	RC 52
Bwrdd Cymru BDA and The All Wales Dietetic Managers Committee	RC 53
Action on Hearing Loss Cymru, RNIB Cymru and Sense	RC 54
Royal Pharmaceutical Society	RC 55
British Geriatric Society -Falls Sub Group of the Welsh Branch	RC 56
Vale of Glamorgan Care Home Association	RC 57
Professor John Williams	RC 58
Bridgend CBC - withdrawn due to RC 39 having been received	RC 59
Care Forum Wales	RC 60
Research in Specialist and Elderly Care	RC 61
Tunstall Healthcare	RC 62
Rhondda Cynon Tâf County Borough Council	RC 63
Community Pharmacy Wales	RC 64
Cymorth Cymru	RC 65
Wales Progressive Co-operators	RC 66
Welsh Language Board	RC 67
Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales	RC 68
Welsh Local Government Association and Association of Directors of Social Services Cymru	RC 69
Cardiff Council	RC 70
Hywel Dda Health Board	RC 71
Centre for Innovative Ageing, Swansea University	RC 72
Supplementary evidence commissioned by Wales Progressive Co-operators from Jean-Pierre Girard	RC 73

Pembrokeshire County Council	RC 74
Social Care Institute for Excellence	RC 75
Linc Care	RC 76
Age Alliance Wales	RC 77
GMB	RC 78
British Association of Social Workers	RC 79
UNISON	RC 80
Wales Cooperative Centre	RC 81

Additional written evidence was submitted by the following organisations:

<i>Organisation</i>	<i>Reference</i>
Welsh Local Government Association and Association of Directors of Social Services Cymru	RC - AI 1
Powys Teaching Health Board	RC - AI 2
Care and Social Services Inspectorate for Wales	RC - AI 3
Royal College of Psychiatrists and College of Occupational Therapists	RC - AI 4
Welsh Reablement Alliance	RC - AI 5
Community Housing Cymru Group	RC - AI 6
Community Housing Cymru Group	RC - AI 7
Community Housing Cymru Group	RC - AI 8
Older People's Commissioner for Wales	RC - AI 9

Annex E – External engagement

As part of this inquiry, members of the Committee undertook a number of external visits and meetings. The purpose of this was to enhance the Members understanding of the issues facing the residential care sector, and those providing care for the older generation. In addition to the listed events below Members of the Committee visited care homes within their regions as local Members to help build up a wide base of knowledge for this inquiry.

Date	Engagement Activity
8 February 2012	Visit to Woodcroft - Hafod Care run residential care facility in Cardiff
28 March 2012	Visit to Bethel House - a residential care home in Dinas Powys
	Meeting with Mark Jones, Cwm Taf Health Board
26 April 2012	Visit to Llys Enfys - Linc Care run Extra care facility in Cardiff
10 May 2012	Meeting with Carmarthenshire County Council Social Services
14 June 2012	Informal coffee morning with representatives from Academy of Social Care Practitioners; Cymorth Cymru; Care Forum Wales