

DATE: 16 December 2011

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES

RESPONSE TO: Health & Social Care Committee Inquiry into Residential Care for the Elderly

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

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Mark Drakeford, AM
Chair, Health and Social Care Committee
National Assembly for Wales.

16 December 2011

Dear Mr. Drakeford,

Re: Inquiry into Residential Care for Older People

We welcome the Health and Social Care Committee's inquiry into residential care for elderly people and are keen to provide you with our response to your request for evidence based on the Terms of Reference outlined in your letter dated 24 October, 2011.

It is a pleasure to respond to this matter, which is close to our clinical hearts and of vital importance to our expanding elderly population. We hope the Health and Social Care Committee involve a broad range of professionals from different disciplines in Old Age Psychiatry in order to support and inform the ongoing process. We are prepared to provide the Committee with oral evidence to assist with the inquiry.

In drafting our response to the Committee's inquiry, we have consulted with the Association of Directors of Social Services Cymru and the Health Inspectorate Wales.

We have attached a response from the Learning Disabilities Faculty in appendix 1.

OUR RESPONSE

Introduction

We welcome the Health and Social Care inquiry into residential care for elderly people and are keen to provide you with our response to your request for evidence based on the Terms of Reference outlined in your letter dated 24 October, 2011.

There is a need for urgent reform in this and related care sectors as they have not delivered value for money. Also there have been numerous safeguarding issues over the years. We hope the Health and Social Care Committee conducting the inquiry involve a broad range of professionals from different disciplines including representation from Royal College of Psychiatrists in order to support and inform the ongoing process. The College is keen to provide the Committee with oral evidence in the spring.

Key Points

- We think that the Committee must use the opportunity to look at residential, EMI residential and specialist residential placements for the elderly.

- The inquiry must look at the specifics of the three categories as above and see whether they still need to be maintained. As care in the community has evolved the distinction between residential and EMI residential can be arbitrary. By custom and practice many patients in residential homes have cognitive impairment and dementia.
- The inquiry must look at the issue of domiciliary care in the community as it is critical to the transition of patients from their own home to a 24-hour care environment. Domiciliary care and related reablement services has evolved by chance rather than design in various parts of Wales. There is very little regulation of this area of care.

A. 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

1. There is a **lack of transparency or consistency** around the process of entry into residential care homes. The process varies according to the client's circumstances and can appear to be arbitrary rather than follow a standard, consistent practice. This is particularly true in homes with waiting lists where clients are not always considered on a first-come first-served basis. Clients may be "preferred" over others and therefore offered a place. This practice is sometimes known as "cherry picking" where the patients with more needs are denied care. Not all homes assess clients directly themselves but will take a Case Manager's recommendations and information from clients' care plans, while other homes will come to assess and meet the client.
2. We would urge the committee to move away from the use of diagnostic categories as the primary influence in considering the type of care home a client should access. This process should be **person-centred** and consider the needs of the individual and how these needs can be met in a particular environment. Categorising care venues rather than focussing on the homes' ability to deliver person-centred care leads to difficult mixes of clients and the arbitrary moving of clients who are recategorised. Homes should ideally have all levels of care provision on offer to allow clients to remain in one home even as their needs change. For example, there are realistically many clients in ordinary residential homes who suffer from dementia and, provided their needs can be met, this diagnosis should not act as a trigger to a change of home per se. The National Dementia Strategy for Wales discusses the embracing of those with dementia in our community yet the process is such that those with a diagnosis of dementia are labelled, stigmatised and channelled towards an EMI environment.
3. It remains a cause of concern that the provision of homes, especially EMI, is very much a postcode lottery. There needs to be some guidance to local councils of need for adequate provision or alternatives if provision is not met.
4. The increasing practice of private and voluntary care homes to charge variable "top up" fees represents additional un quantified financial burden to families and carers. This segregates those families with greater finance, and thus denies choice for those who are unable to pay. In affluent areas this can divorce lower income families from their area of choice.

5. Discharges from General Hospital settings can sometimes lead to premature placement in residential homes often due to poor understanding of risk. There needs to be an emphasis on assessment of skills of general hospital staff in discharge planning for patients with dementia. There needs to be a common sense approach to risk when supporting older clients at home. Very often, the risks of going into care are either not understood or factored in. Telecare strategies are poorly promoted and could help people being maintained at home.
6. There appears to be no community-based model for reablement in patients with dementia. Current reablement teams often have dementia as an exclusion criteria.
7. Most EMI residential Care homes have waiting lists, and some clients can wait for months before they are admitted. This alone highlights that provision is inadequate in terms of demand. Strategies on demand reduction and adequate provision need to go hand in hand.

B. 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

8. There needs to be structured training for staff in dementia care. It is often the case that at the point of employment staff have only minimal training. We have found evidence where carers working with clients with dementia have reported to Case Managers not knowing what dementia is. And a domiciliary carer, when asked about training said, "Put it this way, last week I was a hairdresser". It is perceived that caring is intuitive and innate to all of us hence needs no specific training. This approach is wrong.
9. We suggest that all carers meet a national level of experience and training. There should be a qualification/NVQ that is mandatory at the point of entry for staff and also linked pay increases. There needs to be a recognisable career structure in the care sector. We strongly recommend that all care homes, EMI or otherwise, should have mandatory training in dementia care for the staff.
10. Each home should have the support of an in-reach specialist mental health teams which adopt a rehabilitative approach to care when care of patient is breaking down. Intensive support is needed by the local team for those clients where the initial period may be unsettling and thus drive down failed placements. The process of acceptance into a home should be carefully prepared with involvement of friends and family, visits to the home by the client and relevant meetings with the home manager, again trying to avoid failed placements.
11. Regarding resource levels, we are concerned at the high level of turnover in care staff and the number of staff working with clients in a one-to-one capacity who are poorly trained. Examples of good practice exist e.g. the Enhanced Dementia Care Project in Cardiff.
12. We would also urge the Committee to focus its inquiry on rural areas, which are experiencing an increasing elderly population coupled with the reduction in workforce as younger people migrate to urban areas where more work is available.

C. 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.

13. It is difficult to measure the “quality” of care services as experiences are subjective and personal. However, we believe that it is fundamental to quality of care that clients are able to exercise as much autonomy as possible over their own lives following admission to a care home. They should not be expected to follow the regimented pattern of life that is offered in so many. Clients should be provided with their own space as and when it is needed or wanted. Lack of privacy remains a problem.
14. We recommend that the provision of formal activities and access to outside services should be mandatory under legislation for all care homes to create a homely environment. Activities would include gardening, ironing, baking and should be according to the clients tastes and wishes. For the able clients, the home should provide day-trips away from the home, and assistance to maintain important interests in their life, such as Sunday church or going to the local pub. These issues are especially important to those who do not have a family nearby to fill gaps in this role to enrich their lives. Clients should be able to access any community service in the same manner as they would were they resident in their own homes.
15. Homes vary in their size, building, ambience and cost and it does not always follow that the most expensive homes are the best caring locally. Families of clients are unclear as to what the costs covers, especially when costs may vary by a few hundred pounds. The care settings can be very unimaginative and in some cases poorly planned environments. There should be minimum standards regarding building environments for people with dementia, particularly for new builds. The diversity of clients is increasing and the one-size-fits-all approach in the culture of care created can be very disappointing and inappropriate. Double rooms for couples or for those who prefer the company of sharing are not readily available.
16. Service user/ relatives groups should be encouraged within care homes to improve communication and influence of the client group.

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

17. There are no formal communications between healthcare staff and inspectorate bodies. Healthcare staff who often place clients in nursing homes are often not made aware of any concerns which arise in particular homes. In this climate of home closures/embargo there is then a panicked response to support the vulnerable elderly and as a result, personal choice is forgotten. We must give consideration to an improvement pathway, with a troubleshooting team from both Health and Social Services, nominated ahead of the critical situation. If emergency placements have to be made following a crisis, the client choices should be actively revisited thereafter. This would involve advocacy for those without support.

18. It is increasingly evident that if care begins to fail, the tolerance to support the acute issues varies greatly in some situations. As an example, where a residential patient develops some behavioural disturbance, Home Managers often say that their registration will be under threat unless such a client is moved on. It is not uncommon that "notice" is served upon these clients. With the development of Inreach Teams, We must allow for reasonable time to address these problems. The client has little personal rights in these circumstances and the Inspectorate needs to demonstrate a more supportive role. The Inspectorate should support Home Managers to responsibly engage with relevant professionals and attempt to sustain the placement which they consider to be their "home", without fear of adverse consequences. In such situations, we must still put the client first.
19. The relevance of the inspectorate's criteria in reports needs to be revised with consideration to less tangible but often more meaningful elements. The inspection often comes down to a tick box paper based exercise which is grossly inadequate. It should be based upon observation of care. The implementation of intelligent targets related to the care homes needs consideration.
20. The inspection arrangements should look at minimum staffing levels of appropriate staff, not just on the end of a phone but directing one-to-one care on the floor. They should observe care being delivered and assess the culture of care within homes by assessing individual care plans and their person-centeredness. They may look at financial viability. A number of Consultants have commented that they have never received any formal communication from regulatory authorities albeit they are key to the placement decision.
21. At the moment, there is no regulation of domiciliary care and quality varies. We would suggest this is looked at urgently.
22. The CSSIW and HIW need joined-up performance indicators because at the moment their indicators differ greatly.

E. New and emerging models of care provision

23. Extra care is in its relative infancy but to date it appears a positive experience for our client group, with a good balance between independence and support. We understand that the Welsh Government was looking into Extracare facilities, which are costly but very effective. We need to address who pays for it and who is responsible. The Committee must look into what has come of the Green Paper "Paying for Care".
24. Learning disability services also have an increasing burden of ageing population.
25. In LD there is a major thrust in new and emerging models of care, particularly in the prevention of further hospitalisation and prematurely putting patients into residential care homes. We have separately enclosed a feedback from the LD faculty in RCPsych (Wales) for perusal.

F. 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

26. We advocate planning new areas of care with supported living in either flats or bungalows with all levels of care in an on-site "home". These

should be provided by housing associations etc and ideally be not for profit set ups. In future we should provide older people the opportunity to move once, familiarise themselves with the area/neighbourhood and then be able to have their needs met as they change in this set of units. The model of provision offered by Southern Cross and the fiasco that came of it is too risky for very vulnerable individuals who may not be able to present their own objections or concerns. We must design safe and future proof solutions in the knowledge that we will be using these facilities ourselves too.

Appendix 1

INQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE

CONTRIBUTION TO THE INQUIRY FROM THE FACULTY OF THE PSYCHIATRY OF LEARNING DISABILITY OF THE ROYAL COLLEGE OF PSYCHIATRISTS IN WALES

INTRODUCTION

Services for People with a Learning Disability in Wales have their own distinct history and exist within a clear policy framework from the Welsh Government (Welsh Assembly Government, 2007). The core principles of this framework are based on the United Nations Declaration of Rights of the Disabled Person and include independence, person-centredness, community presence and fair access to general and specialist services. There is an obligation on Local Authorities to work together with partner organisations, including health services, to develop strategic plans for services for people with a Learning Disability, and particular emphasis is placed on periods of transition between different life stages.

The population of older people with a Learning Disability is growing rapidly (Emerson and Hatton, 2008) and so far there has been a failure of strategic planning to meet the needs of this group (Thompson and Wright, 2001). It is therefore vital that the needs of people with a Learning Disability are considered within this review of residential services for older people and we welcome the opportunity to contribute to this inquiry.

HEADLINE FACTS

- A rapidly increasing population: approximately 40% increase in the number of people with a Learning Disability aged over 60 years between 2001 and 2021
- A population with an increased risk of dementia and of physical and mental health problems
- A population at risk of entering residential care at an earlier age (Foundation for People with Learning Disabilities, 2002)
- A population requiring a substantial commitment of resources: comprising less than 0.25% of the general population but receiving 5% of the total personal care budget (Strydom *et al*, 2010).

THE PROCESS OF ENTRY TO RESIDENTIAL CARE

Older people with a Learning Disability may live in one of various models of supported community living, or in specialist residential care, or with family carers, who may be elderly themselves. When a transition to residential care is required this sometimes takes place through a planned process, but sometimes occurs as an emergency, for example when a family carer is suddenly taken ill. Planning is usually led by the Community Learning Disability Team, who may have little experience of the range of services available for older people. There are often obstacles to joint working with Older People's services and there can be a lack of clarity as to who is responsible for care planning and funding. LD services have a strong ethos of person-centredness, which may not be present in Older People's services, where there can be greater pressure on resources.

Alternative services which could prevent entry to residential care include extra-care housing, enhanced supported living schemes with integrated support and clinical services (including services

for individuals with epilepsy and who require PEG feeding), assistive technology and crisis intervention services.

Requirements:

- Protocols in each Local Authority area for joint assessment and care planning involving both Learning Disability and Older People's services
- Protocols in each Local Authority area for procurement of residential services for Older People with a Learning Disability
- Joint local strategy between Local Authority and NHS for prevention of entry of Older People with a Learning Disability into residential care settings

CAPACITY TO MEET DEMAND FOR SERVICES / QUALITY / SERVICE USER EXPERIENCE

Older people with a Learning Disability frequently present with highly complex needs, which may include physical and mental health problems, epilepsy, communication disorders, sensory impairment, feeding and swallowing difficulties, mobility problems and challenging behaviour. They are at risk of poor access to and a poor experience from health and social care services, including abuse. There is a need for generic residential services to access training and clinical services, and there is also a need for specialist residential services.

Within generic residential care the key issues include discriminatory attitudes from staff and other residents, a lack of meaningful daytime activity and a lack of opportunity to access the community and to build relationships with people who are not paid carers.

Requirements:

- Commissioning policies that include requirements for training for supporting people with a Learning Disability and the prevention of discrimination and abuse
- Quality measures that include social integration and daytime occupation
- The availability of independent advocacy
- Measures of service user experience that can include people with a Learning Disability and communication disorders (for example talking mats, patient stories)
- Availability of specialist clinical services and training through Community Learning Disability Teams (including training in the management of epilepsy, communication disorders, feeding difficulties, dementia and challenging behaviour)
- Joint planning groups between the Local Authorities and NHS for specialist services for people with the most complex needs, that avoid the need for repeated spot-commissioning through the Continuing Health Care arrangements
- Residential services for older people who have a Learning Disability and challenging behaviour that meet specifications for challenging behaviour services in Wales (Challenging Behaviour Community of Practice).

NEW AND EMERGING MODELS OF CARE PROVISION

Community Learning Disability services include diverse and innovative models of care and support that have arisen from the strong ethos of person-centredness and the historical political support for the resettlement of individuals with highly complex needs from institutionalised hospital care into community settings. Many of these models could also match the needs of older people, including:

- Enhanced supported community living (tenancy-based models with integrated clinical services)
- Extra-care housing including core-and-cluster arrangements

- Keyring schemes, comprising local community networks of support, that can provide support to both disabled and non-disabled people

CONCLUSION

The population of older people with a Learning Disability is a diverse and growing population of individuals who frequently have complex needs and are at risk of early entry to residential care and a poor experience of health and social services. There is a requirement for local strategies for commissioning, procurement, care planning and quality control. Individuals with the most complex needs require collaborative strategic planning between Local Authorities and the NHS. There are new and innovative models of community living which provide alternatives to traditional residential care.

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