Health and Social Care Committee

Inquiry into residential care for older people

RC71 – Hywel Dda Health Board

The Health and Social Care Committee's Inquiry into Residential Care for Older People.

Response on behalf of Hywel Dda Health Board.

The below response recognises that the questions outlined by the HSC Committee and the Inquiry into Residential Care is largely a matter for Local Authority partners. The Health Board plays an active part in discussions with Local Authority colleagues around Long Term Care and long term care planning and strategy and this is reflected in the below response.

Joint Health and Social Care posts have been created at a senior level at a County level within the Health Board. This has further increased the level of joint planning and direction around Health and Social Care issues and the development of joint community based service solutions.

Our partner Local Authorities have provided and submitted detailed responses in respect to the above on their specific practices and strategies. The Health Board has not commented on the questions below relating directly to statutory duties on Local Authorities and / or areas of specific planning for LA partners.

A broader response on the general direction with regards to community and Long Term Care (LTC) developments and schemes has been provided as an overview.

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

  Clear processes are in place by all three partner Local Authorities around admission to Residential care. The emphasis, similar to Hywel Dda Health Board (HDHB), is to maintain as many clients within the community setting for as long as possible through the development of community based services. This is in line with the direction outlined in key publications f.e Designed for Life and the locally developed Health and Social Care and Well Being Strategies.

The extended range of community based provision aims to enable older people to live longer independently, within their own homes, delaying the onset of admission to Long Term Care. Service strategies for the partner Local Authorities and the Health Board are concentrated on strengthening service provision in this key area – enabling early identification and , by default, prevention of ill health and mobility issues. The development of low and medium level support for service users and their families aim to promote independence within the community and home environment. Third Sector provision and schemes have also been developed through a partnership arrangement, to ensure a level of support and care for carers and service users on a day to day basis. However, it is acknowledged that a greater level of service for carers is needed to ensure that carers are able to continue with their caring role on a longer term basis and provide a sustainable service solution.

The focus of recent years has been to increase and expand on community provision and services. Greater investment in community based services has been seen both from the Local Authorities and Health Board with the anticipated long term achievement of a reduced need for residential placements – especially longer term. This work has been undertaken in co-junction with HDHB and third sector organisations.

A recent example of this work and the joint vision for the development of community based options are the services developed from the CHC Bids money, made available to LHBs and partners in 2009/10. A joint approach was taken with the LAs and Third sector organisations, and the development of community based alternative to long term care – both low level need (traditional LA funded area) and higher level need (traditionally CHC) were implemented.

A number of the schemes have resulted in less need for early admission to LTC and residential placement due to the increase in targeted community based resources. Schemes such as the *Through the Night Service*, dementia care services etc have resulted in a larger number of older people being supported at home for longer. The overall aim and strategy direction is to reduce the number of older people needing admission to Residential Care through the on-going development and implementation of targeted community based services – such as those developed through the CHC bids money.

As part of the Clinical Services Strategy review within Hywel Dda Health Board, the development of Community based services is a

key objective and work is on-going in identifying services areas for development that will enable greater reablement opportunities within the community setting, especially for older adults.

For service users assessed as not being able to continue to live within the community, provision is available within residential care services. With such cases each LA has a clear process of eligibility and scrutiny of submissions for approval of access to residential care. Clear scrutiny is given to the service users' case – through a joint scrutiny panel, to ensure that any reablement opportunities can, and have been undertaken prior to admission to LTC. This option includes the LA direction of a higher level care and assistance for older people f.e intensive domiciliary care services, respite services and extra care housing. Services around dementia and mental health have been developed with the aim of managing more of this client group in the community for longer. In Pembrokeshire the development of the complex care team has resulted in better management of service users traditionally admitted to Long Term Care through increased domiciliary and reablement provision.

A number of joint meetings and planning opportunities are taking place to ensure where possible a joint approach to service planning and direction across the Health and Social care community. Current plans are being rolled out for wider community care services such as Virtual Wards etc to enable more effective discharge, reduced incidence of DTOC and enable a patient to be managed within their own home for complex chronic conditions, reducing the need for admission to residential care. However, where a clear need for residential placement is demonstrated, processes are well developed and are in place to enable a smooth transition for service users to their preferred home of choice.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

- **New and emerging models of care provision**.

Significant work has been undertaken on developing services aimed at providing intermediate and reablement care within the community setting.

The focus and direction of the Health and Social Care Community has been to increase service provision within the community setting – enabling more and more clients to access these services and maintain their independence and ability to remain in their own homes. Examples of new and emerging models include the following examples:

- **CAT@H Telecare and Response** – assistive technology provision. Enabling a personalised service and management of client through developing technology. Service has been successful in rural areas where provision of domiciliary care workers is timely and costly. Key aims of service are:

- To support people to remain in their own homes safely for as long as possible – reducing the need for admission to Long Term Care.
- To assist in promoting independence
- To reduce avoidable hospital admissions
- To support hospital discharges / reduce DTOC
- To support contingency plans for people in the community
- Support informal carers

- **Through the Night Service** – Developed through CHC bids money. Service enables emergency and non emergency non medical night provision to clients in Carmarthenshire. Previously clients requiring night care provision would be admitted to Residential Care. The service enables clients to continue to live within the community through increased domiciliary arrangements to manage their care.

- Prevention of admission to Long Term Care
- Increased options for service users with low to moderate level needs within the community setting
- Promotes independence for Service users.

- **Complex Care Team** . Pembrokeshire model. Development of four complex care teams made up of health, social care and third sector staff with GPs to identify people at risk of loss of independence or unnecessary admission to hospital.

- Prevention of hospital admission
- Prevention of people falling into crisis
- Seamless service between health and social care.
- Reduction in admissions to Long Term Care.

- **Chronic Condition Management .** The development of a number of schemes targeted at clients with diagnosed chronic conditions. Current schemes and services include:

- **Chronic Condition Specialist nurses** to manage identified clients within the community setting or within a care home setting,
- **Expert patient Programme**, to assist those living with, or caring for a client with a long term chronic condition,
- Development of an **Epilepsy, Diabetes and MSK** service and pathways to help clients with these conditions to manage their conditions outside the hospital setting – reducing the need for specialist and long term care arrangements,
- **Virtual wards** – to manage clients identified at risk with chronic conditions within the community setting – again reducing the need for admission to long term care.
- **Primary Care Mental Health Service**: To better support clients within the community.

- **Provision of specialist Staff – Cross Roads**. The service is aimed at assisting carers with their caring duties.

- Prevent the need to admit the cared for to hospital or nursing home
- Allowing time for alternative care arrangements to be made in emergency situations
- Reduction in agency costs for Emergency respite for this client group

- **Convalescence Beds Service**. A model of care within Carmarthenshire. Services provides rehabilitation within identified care homes for a fixed term basis. The aim is to provide older people a period of convalescence in a care home setting following discharge from hospital. The aim of the service is to enable older people to maintain their independence, gain confidence and progress with their recovery in preparation for their return home or other long term care arrangements. The aim is to allow for a longer period of rehabilitation and reablement

with the end goal of the client being able to return to the community setting.

- **Three Counties Care Home Support project**. Project supports care homes by providing a tailored training programme with on-going support to the care home sector by Health and social care staff . The aim is to improve clinical outcomes for service users in care homes.

  - preventing hospital admissions and decline into ill health within care homes
  - Improving training and care and governance within care homes across the Three Counties
  - Improving the management of physical and mental well being of older people – preventing a decline to ill health.
  - identifying and addressing deterioration in health at an early stage and halting the decline into CHC eligibility.

- **Dementia Day Care Services**: Ceredigion. Project to support clients with dementia in the community. The aim is to improve education and training to reduce the need for admission into long term care for this client group

- **Integrated Independent services** (Rapid Response Care at home service and Acute response service) The development of a Re-ablement and independence service to provide 7am – 5pm rapid response in the Ceredigion area. Service compliments service already operational in Carmarthenshire.

  - Avoid unnecessary hospital admissions
  - Facilitate earlier discharge home
  - Keep people in the community setting for longer.

  - **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.**

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.