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College of Occupational Therapists Coleg Therapyddion Galwedigaethol

Health and Social Care Committee

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Inquiry into residential care for older people – Evidence from the College of Occupational Therapists

Introduction

The College of Occupational Therapists (COT) is pleased to provide a response to the consultation on 'Residential Care for Older People' which has been assisted by COT's Specialist Section in Older People and by occupational therapists working with older people throughout Wales. The COT is the professional body for occupational therapists and represents around 29,000 occupational therapists, support workers and students from across the United Kingdom and 2,400 in Wales. Occupational therapists work in the NHS, Local Authority housing and social services departments, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties across the whole health and social care sector.

Occupational Therapy

Occupational therapists play a key role in supporting older people in maintaining health and well being; enabling them to continue to live independently at home and cope with daily tasks which can become more difficult with age. They offer solutions and options to enable older people to continue doing leisure activities that have become difficult and to get the most from life through maintaining social networks, helping with physical challenges and developing strategies to either prompt memory or adapt to memory deficits. (Craig &Mountain, 2007; Hay et al, 2002; Jackson et al, 1998; Mountain et al, 2008)

The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, living independent lives in their own homes, caring for themselves and others, working, and learning, playing and interacting with others. Being deprived of or having limited access to occupation affects physical and psychological health. Therapy seeks solutions to barriers which prevent people carrying out valued occupations. It might include increasing capability through reablement, graded therapy and other interventions, analysing and amending the demands of occupations, developing alternative occupations or ways of coping and adapting the environment in which the occupation occurs, for example through adaptation or equipment provision.

1. Preventing dependence and keeping people at home

The decision to enter long term residential or nursing care is often made following an admission to hospital or other crisis. The profession supports the conclusion in 'Better

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Support at Lower Cost' (Social Services Improvement Agency {SSIA} 2011) that no-one should be admitted to residential care for a new long term placement directly from a hospital bed.

Home based occupational therapy for older adults leads to significantly lower mortality rates and hospital admissions (Gitlin *et al* 2006a) and can result in greater self efficacy, less fear of falling, fewer home hazards and greater use of adaptive strategies. Gitlin *et al (*2006 b.) found most outcomes benefits were persistent at 12 months. The long term outcomes of this can be a reduction in the need for care packages and support and a delay in admission to long term residential or nursing home care. Too often, there is insufficient early, preventative intervention from a multi professional team of health and social care practitioners to prevent admission or inconsistent access to services to truly rehabilitate people and return them to their homes.

There are key opportunities for supporting older people to maintain their lives which should be prioritised to ensure that the decision to enter residential care is made at the right time for that individual and their family, after all other alternatives have been explored. Those alternatives include:

- Access to a preventative community multi professional team which includes therapists
- Integrated enabling services which work across traditional health, social care and housing boundaries.
- Access to occupational therapy led reablement services.
- Access to a comprehensive Telecare/Telehealth assessment.

Preventative, early intervention, community services

Primary care based preventative services are only slowly developing following the publication of "Setting the Direction" (Welsh Assembly Government 2010). Community Resource Teams will be able to direct the right service to people very quickly, bypassing traditional referral routes. Community based therapists offer GPs an alternative to admission and can help prevent crises. They 'pull' people back home from hospital using their knowledge of that person's community and resources. Occupational therapists work across health and social care, across the statutory, independent and third sectors, and across mental and physical health services. Their core skills are key in preventative services and are underpinned by an evidence base that demonstrates clear cost benefits and successful patient reported outcomes (COT 2010). For example:

- Occupational therapists in accident and emergency departments, and 'turnaround teams' are able to prevent people being admitted from A&E, getting them straight home once their medical crisis is resolved. One 6 month pilot in 2000 concluded that even with set-up costs, the early intervention team had made a saving of 22.2 bed days, equating to a saving of approximately £25,000. There was also a difference of 21.2 days in length of stay between those seen and not by the early intervention team Howard 2010). In January 2010, the Queen Alexandra Hospital in Portsmouth found that following an occupational therapy assessment 81% of people returned home, 10% transferred to rehabilitation services, 9% admitted into hospital (Eckford et al 2010).

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- Elderly Care Assessment Services and other types of services such as social care short term intervention services can also prevent unplanned admission, offer rapid response to avoid admissions, keep people at home and resolve emergencies.
- Early Supported Discharge and specialist rehabilitation teams can provide complex specialist rehab in people's own homes.
- Integrated occupational therapy services work across health and social care, providing NHS and social services interventions to give a whole systems approach which reduces duplication and gaps.
- The assessment and provision of telecare/telehealth equipment, which in many local authorities is undertaken the occupational therapist, can be an essential aspect of enabling a person to remain in their own home.
- Creative and flexible use of respite beds can help with long term planning so that occupational therapists can facilitate a seamless transition into long term care. For example, being able to develop a relationship with a home for respite periods before a final commitment to a permanent move.

Occupational therapy enables older people to live their lives the way they want. Central to this is ensuring that they are able to maintain their skills and abilities through targeted individualised support. Occupational therapists are the only allied health profession working in significant numbers in social services organisations. They deal with between 35–45% of local authority referrals and yet only make up 2% of the workforce (Department of Health 2008). Occupational therapists work with older people to adapt their environment in order that they can carry out their chosen activities safely in their own homes thus reducing the need for complex and costly care packages or admission to residential care (DH 2008).

Integrated services

Integration is frequently used in reference to secondary health and social services; often in terms of facilitating hospital discharge. However, integration needs to be much wider to provide effective support for older people. Closer working between primary and secondary care is vital, as are improvements between specialities, physical and mental health services, hospital and secondary community services, housing and health services as well as statutory and non-statutory provision.

Equally important is the relationship between carers, families and statutory services. Families often struggle to access support for themselves where services are highly focussed only on the service user. Better support for carers will strengthen their ability to continue to support people in their own homes.

Issues around who pays for care can add a significant barrier and many policies identify the service user should not be able to see this interface. Yet this remains a major problem. Debates about continuing care, social services or hospital responsibility can delay and interrupt good quality services and lead to dependence on inappropriate packages of care- because that is the only solution available. At times, transfer to residential or nursing care before necessary is the simpler solution because it is too complex for organisations to support someone at home. This needs to stop if Wales is to achieve sustainable effective affordable services which enable people to also achieve their own wishes.

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Good quality housing support

Housing stock quality in Wales does not support older people or those with disabilities to remain at home. Far too little is built to lifetimes standards and the terrain around Wales often results in steps and steep slopes to approach or leave homes. Housing has a huge impact on health and better links between housing, health and social care will deliver sound outcomes for health and social inclusion. Occupational therapists are the only allied health professional to bridge these three areas.

A greater supply of well designed flexible housing which meets a range of needs through people's life will deliver greater independence for older people. In the meantime, high quality equipment and adaptation services can ensure that home does not become a prison. One study which explored the relationship between provision of equipment and reduction on care package costs and residential care found that over an eight week period cost savings to care packages through provision of equipment were over £60,000 (Hill 2007). Housing adaptations reduce or remove costs for home care. Heywood et al. (2007) found that savings range from £1,200 to £29,000 a year. Postponing entry into residential care by just one year through adapting peoples home saves £28,080 per person (Laing and Buisson, 2008).

Adaptations processes in Wales are improving, but more remains to be done. The profession believes a single tenure blind non- means tested process would deliver good quality adaptations in a timely and coherent manner. This would make the process more efficient, transparent and cost effective. For many older people repair and maintenance are overwhelming responsibilities and this is where agencies such as Care and Repair are invaluable in supporting people o remain at home. Telecare services offer highly effective support for older people, especially those with dementia and can make the difference between safe independent community living and institutionalised care.

Creative alternatives are being developed, such as extra care schemes, equity release and shared ownership which gives older people opportunity to find the right housing option for them. For many, these can be an important alternative to full residential care. However, the separation between housing and health means that few health workers are able to signpost people to these solutions.

Once admitted to hospital, older people frequently face a complex set of circumstances to get them back home. The inappropriate phrase 'bed blocker' is sometimes used when in fact health services are taking an overly medicalised approach, or are particularly 'risk-averse'. This can mean that older people and their families feel pressured to make a major decision too quickly in order to get someone out of hospital. Residential or nursing care could be perceived as a 'safer' or easier solution rather than the complexities of returning someone to their home. This is unacceptable and policies of no direct discharge to long term residential settings can help to focus services on solving problems for the individual. The development of community reablement and other enabling services will support people to return to and remain in their own homes.

Reablement

Reablement services maximise an older person's potential to recover. Reablement either prevents the need for hospital admission or post-hospital transfer to long term care, or

appropriately reduces the level of ongoing home care support required and associated costs. Occupational therapists have a role key in delivering reablement services (Welsh Assembly Government 2011). They promote individuals' self-reliance and resourcefulness, engaging with them as active participants in their communities and services. 60% of older people who enter a reablement service do not require further services after a 6 week intensive period of help and assistance (SSIA 2011). The Welsh Reablement Alliance, of which the COT is a member, campaigns to promote the benefits of consistent, effective, integrated services which enable people to maximize their ability to live as independently as possible. The alliance identifies that enablement and reablement should be the starting point for all interventions.

Reablement has been shown to deliver cost efficiencies. A 2007 study for Care Services Efficiency Delivery Programme (CSED) found that following reablement up to 68% of people no longer needed a home care package and up to 48% continued not to need home care two years later (CSED Programme, Homecare Re-ablement Workstream 2007). The added expertise and involvement of occupational therapists in reablement teams contribute to successful reablement services (Rabiee and Glendinning 2010).

An effective reablement service can deliver between 10-20% reduction in demand for domiciliary care (SSIA 2011). Although this can vary, in Bridgend for example, members of the profession report far higher reductions with around 66% of those referred not needing any home care at all after occupational therapy led reablement. The occupational therapist's strengths in assessment and goal planning are integral to service users achieving personalised outcomes and a range of models exist for involving occupational therapists in reablement. Occupational therapists may be core team members or they could work collaboratively with a reablement service – an arrangement that could be aided through co-location (Scie 2011)

The Social Care Institute for Excellence (Scie) (Scie 2010, 2011) and Glendinning et al (2010) identify that a strong priority should be placed on the involvement of occupational therapy in planning and delivering reablement in order to achieve optimum outcomes for service users. Whatever model of involvement is established, it is crucial that occupational therapists' expertise can be rapidly accessed.

Occupational therapists are able to provide enhanced training to home care and other staff to deliver efficient and effective reablement services (Glendinning and Newbronner 2008). Advice on rehabilitation techniques from occupational therapists can assist the continuous reablement process for people with complex conditions and is particularly valued by care workers at progress reviews (Scie 2011). This particular point has been noted by occupational therapists across Wales. Reablement can be run alongside traditional domiciliary care where necessary, while the person recovers from an episode of care, but the skills and approach of staff are very different and care must be taken to maintain the reablement approach. If staff are very task orientated or are pressured to deliver within tight timescales; or are not trained to appreciate the principles of reablement they can begin to 'do for' instead of 'working with' someone. This can happen very quickly and once dependence on care is established it is very difficult to undo. Staff must maintain a rehabilitative and not a 'care' approach.

Dementia
It is important for older adults to participate in mentally, socially and physically stimulating activities as this may postpone the onset of dementia (Fratiglioni et al 2007). 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. This is a further supported by NICE guidance 16 *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care* (NICE2008). Evidence to support a rehabilitation programme is cited by Graff *et al* (2006) Chard *et al* (2008) and McGrath and Passmore (2009).

> 'Ten sessions of community occupational therapy over five weeks improved the daily functioning of patients with dementia, despite their limited learning abilities, and reduced the burden on their informal care givers' (Graff et al, 2006a).

Telecare also enables a person with dementia to stay for longer in their own home; The CSED summary of evaluations of Telecare in England suggested a 37% impact on escalation of care to a care home setting. This would translate to an **average four and a half month deferment in going into residential care**, or could be viewed as **potentially preventing one in three prospective admissions**. This is achieved via such non-intrusive equipment as activity sensors, falls detectors, smoke/heat and Carbon monoxide detectors. In addition to maintaining the person in their own home, this has a significant cost saving of approximately £216 per person per week. (CSED 2007)

2. The process for entering residential care

Good quality preventative services with community support will lead to better decision making for older people and their families. Concerns about quality, cost and location to family all need to be balanced if the right selection is to be made. When a decision is forced at a crisis point it is extremely difficult for people to plan, select the right home or to psychologically prepare themselves. It often results in a move to wherever has space rather than where is right. Where partners have different needs it can be extremely difficult to find care to suit both so that life partners can remain together. New models of extra care housing and multi-level homes offer the opportunity for a single move which can support changes in the future.

Concerns about who will pay are inevitable and the difficulties of potential funders arguing about who is responsible for paying or how much they will pay makes this process even more stressful. Entering residential or nursing care has long term consequences and people need to be able to feel confident about their ability to continue to remain there, not only from a financial and safety perspective. Rarely are families aware of the need to consider financial or long term viability of the home and this is particularly so if they are making a decision at a time of crisis.

One concern for members of the occupational therapy profession is that homes and residents need to be recognised as part of the community: residents should still be able to access local services, such as reablement and therapy if appropriate for them. The COT is currently

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developing a position statement about access to occupational therapy for care home residents as it is recognised that this is not always prioritised. 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 too.

Good quality community services can maximise the person's ability, and create the space to make a planned, sustainable move to care when it is appropriate. There is a lack of open honest debate about care for older age. It is often reported that older people do not wish to enter care. This can means families have not had conversations about what might happen, what they might want, and may not have planned for ageing. This ranges from buying or renting housing that may limit their abilities, to thinking about when they might be very frail. It would be really useful for the Assembly to stimulate a national conversation about how to help yourself avoid difficulties as you age: For example, if people are going to retire to the sea or country: what kind of housing might be best? What happens when you can no longer drive? How will you develop networks friends if you move away from your family? Too often people move to new areas, buy dream homes with steps, down country lanes or away from any support. Then a crisis happens and they are left with great difficulties which a little forward planning would help avoid.

3. Maintaining capability and independence in residential care

Part of the above debate should include what life should be like in residential care. The best are truly homes, they are safe supportive environments which keep people active and engaged in their community. Sadly, some homes are not and leave people with little activity or role or ability to contribute to decisions about their life.

One of the key concerns around maintaining people's independence in residential care is the lack of power and control for residents about even simple decisions in their daily life. For example, too often 'health and safety' is held as a barrier to doing a simple everyday task. Homes could adopt a less risk adverse culture where appropriate, so residents can participate in and maintain their activity levels. Care staff could include residents in the functional tasks around the home for example, making their own cup of tea or a sandwich, setting the tables for all, ironing, or doing some dusting or gardening. Fine (2000) found that older adults who engage in leisure activity whether physical exercise or more sedentary activity were less depressed than older adults who did not engage in leisure activity. Maintaining opportunities for occupation and pleasure in care homes for older adults contribute to survival and mood state nine months after admission (Mozley C, 2001).

Reablement is rarely available for people in residential care. This might be among hospital staff who fail to prioritise rehabilitation for those they know to be returning to institutional care, or lack of access to community services for those who may have had a temporary drop in function, for example following an acute infection or small stroke. Access to the same therapy as would have been provided for someone living at home may not be available, so those in homes lose their optimal level of function and become increasingly dependent - because there is always someone there who could do it for them.

In care homes the rate of falls is almost 3 times that of older people living in the community. Injury rates are also considerably higher, with 10-20% of institutional falls resulting in a hip fracture. 30% of people admitted to an acute hospital with a hip fracture coming directly from a care home. (Department of Health, 2009)

Appropriate use of telecare in residential/nursing homes can have a significant impact in the reduction of falls in these establishments, for example by immediately notifying care staff when a resident gets out of bed. Occupational therapists around Wales also report that the effects of the therapy received when someone is in active occupational or physiotherapy or via reablement is not continued as effectively when an element of care is required. Staff who work in a care model struggle to act therapeutically and people's skill level can then deteriorate. Training, supervision and direction for care staff is vital to help them enable people to maintain their level of ability and independence. Where occupational therapists are employed in residential and nursing homes they are able to influence activity and participation, continue rehabilitation and a reablement ethos, train staff and adapt environments to enhance independence.

Reablement and access to therapy should not end on admission to residential or even nursing care. Members report that community therapy may be limited to only one assessment and one further visit. This is not enabling people to access services they would have been done had they remained in their 'community' yet the benefit of such input is significant. It is vital that if someone in a care home has a stroke, for example, that they remain eligible and able to access therapy and rehabilitation to enable them to maximise their recovery. There should never be a presumption that they do not get therapy because they are already being looked after. Dignity and respect for people's independence must be paramount.

The way medication is used can also have an impact on activity levels. Research is currently underway examining the use of antipyschotic medication versus the use of social and physical activity. Care home staff need access to training and advice from therapists to help them use an alternative model.

The COT and National Association of Activity Providers (NAPA) have published activity benchmarks to help homes audit their activity levels and how they enhance residents' quality of life (COT 2007). These are currently being reviewed and COT is willing to discuss this if called to give oral evidence. It offers a framework of person-centred quality indicators and outcome measures to inform guide and encourage those who are responsible for and take part in managing, developing, providing, purchasing and inspecting activity provision within care homes.

The correct social and physical environment can also make a great difference to participation in occupation, and communal spaces in care homes can be evaluated by occupational therapists who can then use their knowledge to enable better care environments and improve quality of life for people with dementia (Morgan-Brown *et al.* 2011). Good accessible inclusive design in residential or nursing homes will help people retain their independence.

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4. Remaining Terms of Reference.

Support for people able to fund their own care.
Occupational therapists are also aware of the difficulties for people who are identified as being over the financial threshold for funding for residential care and who therefore totally fund their own care. They can be left to manage their own without advice and may then not be made aware of other alternatives to residential care (for example, use of telecare, reablement, environmental changes, disability equipment, and the provision of home care) which would facilitate a planned approach if the need for residential care remains.

Once people do enter residential care, expenditure on care home fees may reduce the individual's capital funds to a level that they then have to apply for funding from the local authority. This may result in disruptive change of home if the individual is in a care home with higher rates than the local authority will pay, a need for that local authority to assume a charge it had not planned for and a host of other issues which can inhibit good quality long term stability for people. Not least among these is the additional stress on family. Access to good financial advice and planning as well as awareness of options would help people protect or spread their care costs; potentially enabling them avoid running out of money and remain self funding so that there is no eventual long term cost to the public purse, nor disruption to their life.

The COT has restricted this evidence to areas within the scope of the profession and therefore is not presenting evidence on financial viability of homes at this time.

Conclusion

Moving to residential or nursing care is a major life event, and one that is widely reported to create anxiety for older people. While many homes provide excellent care, support, security and independence for older people we believe that more could be done to:

- Keep people at home longer by the use of appropriate occupational and other therapy and specifically by taking a reablement approach to all interventions
- Support people through their transition into residential care by ensuring older people have a greater awareness of alternatives, services and by discussing and preparing for greater frailty before crisis events occur
- Enable people to retain their personal control and responsibility for their life and their contacts outside the home environment by better use of reablement and rehabilitation within homes and by greater focus on activity and therapy for residents.

We hope this evidence is useful to the committee and are eager to support the inquiry in any other way. We would be very prepared to give oral evidence to the committee at any time. If you have any queries of require anything further please do not hesitate to contact the Policy Officer at the address below.

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