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Welsh Local Government Association

Care Homes for Older People: improving the quality of information to inform commissioning

Challenge paper

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OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

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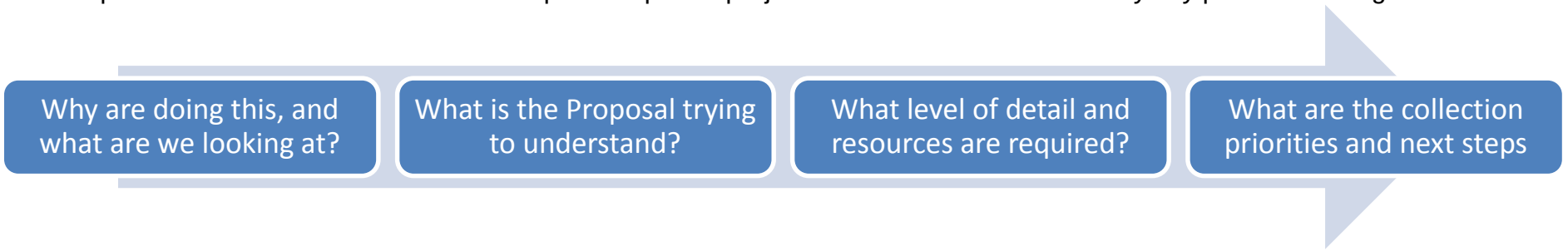
1 Introduction

This paper has been written in response to the proposal for regular collection of data on care homes for older people and is intended to inform thinking about the next steps for this work.

It is comprised of 4 main sections which attempt to scope the project in more detail and to identify key priorities throughout.



2 Why are we doing this, and what are we looking at?

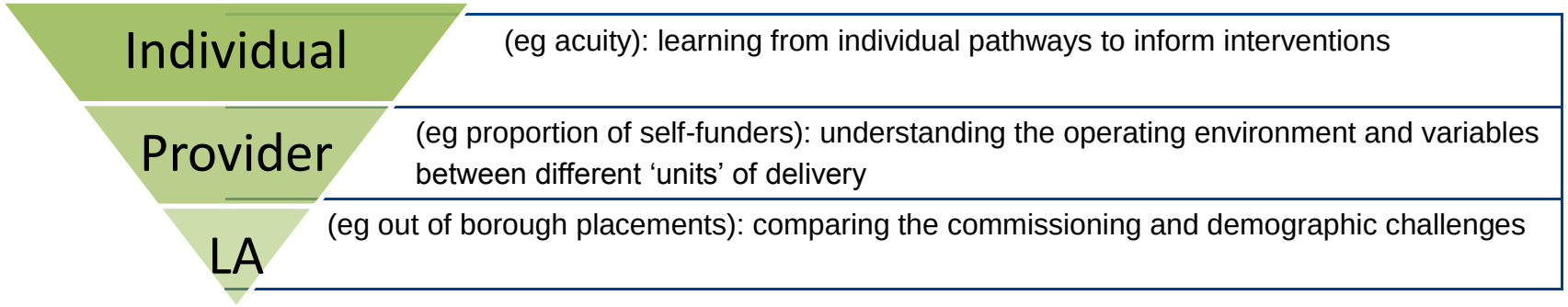
The market intelligence task can be summarised up as reviewing existing provision through analysing 'what are we (and others) buying, from whom, and when, to achieve what outcome, at what cost'. The intention is then to use that information to incentivise and commission a care home sector where:

- What you want to buy is available
- From a provider sector you trust
- At a time appropriate in an individuals care pathway
- That delivers care and support that takes account of individual needs and preferences, and promotes independence
- At a cost that is affordable for the statutory sector and sustainable for the provider

Crudely there are four overlapping themes of information that can help us answer this:

Size and Structure Who provides what, at what cost, where? …so we can identify (and address) gaps in provision	**Stability** What is the cost and predictability of demand, against the costs of supply? …so we can identify (and potentially mitigate) homes at risk of financial collapse
Quality What outcomes are being achieved where and for whom? …so we can see if services are promoting independence (and incentivise / redesign pathway & processes accordingly)	**Workforce** Is the right workforce in place for the outcomes to be achieved and the budget available? …so we can target efforts on roles that pose the most risk to quality and stability

The data has the potential be collected at, and influence practice at three levels:



The quantity of data to be collected and analysed is clearly greater if it is at an individual level. Although this offers the potential to understand what is happening at a system level, the resource requirements to collate this information are massive.

Challenge questions

- Which are primary concerns about care home provision in Wales?
- …and how could data inform a response to those concerns?

3 What is the Proposal seeking to understand?

Understanding the older people's care home market in Wales better is not an end in itself: the data should inform and drive change. The Proposal identifies a number of areas for data collection and the rationale for collecting that data. We have identified from these 3 main hypotheses for why data should be collected. Draft metrics required to answer those hypotheses are then suggested, drawn primarily from those in the Proposal.

Hypothesis / purpose	Audience / beneficiary	Key metrics	Collection Level	Assumptions, Limitations	Notes
Understanding changing needs of service users will enable us to plan / incentivise appropriate provision for the future	Providers LA commissioners Health Boards	4.4, 4.10 Type of placement	LA	Correct 'who funds' decisions are being taken	Longitudinal trends and norms will take a while to establish Danger of conflating current practice with demand
		4.8 Out of area placements	LA	This happens when needs can't be met in LA? For some, OOA placement may be closer to their previous place of residence than in area	
		4.11 Transfer between care homes	LA	This is due to change in care needs rather than family choice etc	
		ADD Acuity at admission	Unclear	Possible to cut acuity by type of placement Consistency of recording acuity Not measuring shifts in need whilst resident	

Hypothesis / purpose	Audience / beneficiary	Key metrics	Collection Level	Assumptions, Limitations	Notes
Understanding the balance of provision in care homes will give us an overview of market stability – which we can use to stimulate / encourage remodelling / support closure of homes	LA commissioners	4.15 Vacancies	By Provider		Will collecting information at LA level provide us with sufficient intelligence to change provision? Without an understanding of quality will this intelligence be able to inform market shaping activity to change provision?
		4.17 Length of stay	By Provider (LA collect?)	Skewed by historical decisions availability of domiciliary care & other alternatives?	
		4.5 Funding source	By Provider (LA + Provider collect?)	Is it possible for an otherwise residential placement to be in a nursing home if residential provision isn't available? Should this be the total of l-t and s't placements?	
		?? Type of home / specialism	By Provider (From CIW?	What is provided may more specialised (eg End of Life)	
		4.12 Transfers of funding responsibility	By Provider (LA collect?)	Could be indicator of inappropriately early placements – needs linking to length of stay?	
		4.13 Placements by sector	LA	Assumes LA knowledge of provider legal status (get from CIW?)	
		4.18 Embargoes	By Provider (LA)	Links to vacancies and financial stability	

Hypothesis / purpose	Audience / beneficiary	Key metrics	Collection Level	Assumptions, Limitations	Notes
Understanding the pathway flow to/from homes will enable us to inform and target inventions	LA commissioners Health Boards	4.6 Admissions		Long-term / short-term split? Could there be double counting in nursing homes for transfers? What about people transferring from short term placements to long term placements within a home?	What about placements to hospital from care homes? Can we understand pathway data if we only collect at a national level?
		4.7 Discharges			
		4.8 Out of area placements		This happens when needs can't be met in LA? For some, OOA placement may be closer to their previous place of residence than in area	
		4.9 Placements from hospital			
		4.11 Transfer between care homes		This is due to change in care needs rather than family choice etc	
		4.14 Statutory Sector waiting list		Do we need to distinguish between waiting lists for long term and short term provision?	
		4.16 Age of residents		Can this capture any more than local variations in morbidity?	
		4.17 Length of stay		Skewed by historical decisions availability of domiciliary care & other alternatives?	

Challenge questions

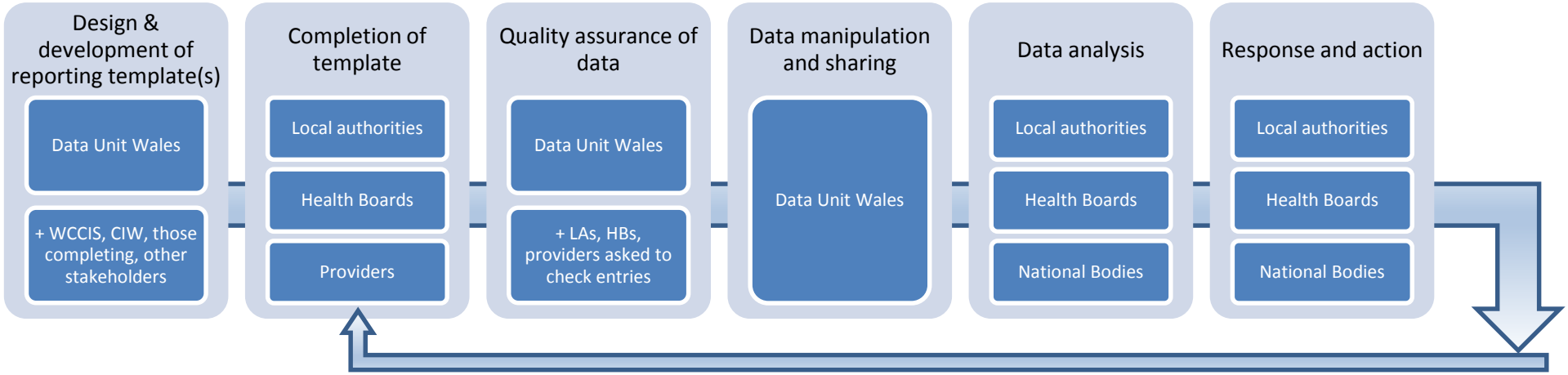
- Are the 3 hypotheses posed the most important at this time?
- Which is the most important?
- Are the assumptions, limitations, notes etc fair?

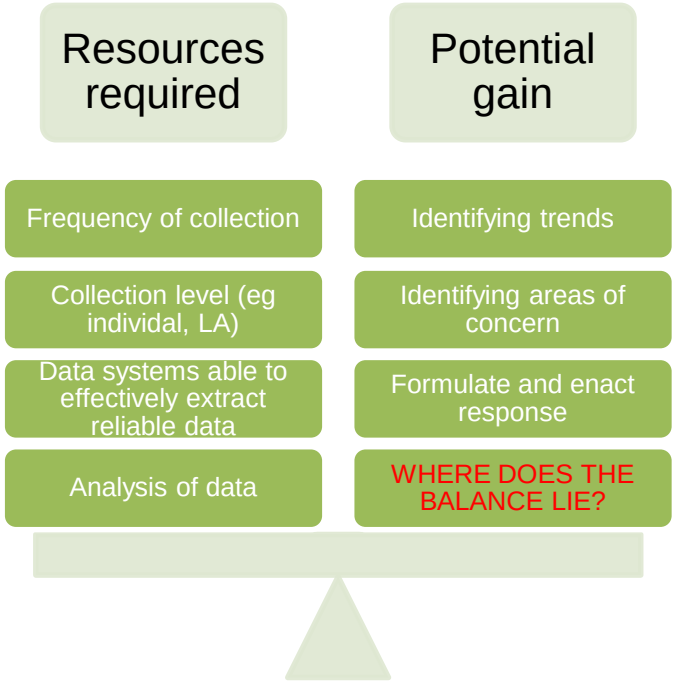
4 What level of detail and resources are required?

Having identified what we need to understand and act on, we must consider the depth of detail required.

We need to be aware of the tension between the resources required to collect and analyse the data, and the potential benefits to the delivery of care home services that it could give us.

Simply there would appear to be 6 stages requiring work from different stakeholders:





Known unknowns?

- To what extent do current local authority and health board systems support simple extraction of this data?
- How long could this take at month / quarter end?
- What is the subsequent central capacity to collate and share?
- What is the local capacity, ability and inclination to act on analysis?

Challenge Questions

- How manageable does this look?
- What feels easier, most problematic?

5 What are our collection priorities and next steps?

In its current state the proposal, represents a major exercise in data collection and analysis. Even with the proposed current data set, we suggest that there are questions about whether the hypotheses suggested can adequately be answered using the data.

An alternative approach could involve both longitudinal monitoring, and ‘task and finish’ research. The latter could take the form of a planned series of time limited project which would seek to understand at a deeper level key information and systems, and generate recommendations on practice change. For example:

<table>
<tr><th></th><th colspan="2">Longitudinal monitoring system</th><th>Task & Finish</th></tr>
<tr><td>What we want?</td><td colspan="2">■ What you want to buy is available
■ From a provider sector you trust
■ At a cost that is affordable for the statutory sector and sustainable for the provider</td><td>■ At a time appropriate in an individuals care pathway
■ That delivers care and support that takes account of individual needs and preferences, and promotes independence</td></tr>
<tr><td rowspan="4">Activity</td><td colspan="2">Key metrics</td><td>Potential projects</td></tr>
<tr><td>Provider location, service type, specialism, capacity</td><td>Collected under CSSIW standard registration information (how often public updates available?)</td><td rowspan="3">■ Acuity of residents, previous support received, and support received in care homes
■ Out of borough placements / road distance from previous place of residence to care home
■ Sufficiency of local reablement support (placements to care homes from hospital) and medical support (admissions to hospital from care home)
■ Quality of provision
■ Embargoes and impact of commissioner quality assurance / control mechanisms</td></tr>
<tr><td>Spend & placements by types of funder, vacancies</td><td>Collect numbers by care home rather than totals per LA (suggest quarterly)</td></tr>
<tr><td>Admissions, discharges, length of stay for l-t & s-t</td><td>Collect at LA level in the first instance (quarterly for l-t, monthly for s-t), allow for identifying transfers of care/funding</td></tr>
</table>

Challenge Questions

- What would be benefits in adopting this approach?
- What would be risks?
- Do some of the metric/projects need to change place ie be in the monitoring system or task & finish?

5.1 Establishing a longitudinal monitoring system

Having the data is one issue, how it is used and by whom is another. Experience by IPC is that the skills to interrogate and understand what data can (and can't) tell us is often limited. If the skills to make use of the information to inform integrated commissioning are not present then the exercise will not achieve the benefits required to warrant the capital and revenue costs of this activity.

We would suggest the following as the characteristics of a good monitoring system. That it:

- is simple and easy to understand
- does not just present data but offers analysis
- is used to make decisions
- is accurate
- is accepted by both commissioners and providers
- is cost effective, ie the cost of collecting and analysing the data is off set by the quality of decisions made and in the long term savings made

Consideration needs to be given as to the capacity in local areas to intelligently use the data, and whether further support may be needed in this area.

Institute of Public Care
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