Draft Paper

Improving the quality of information to inform the integrated commissioning of services from Care Homes for Older People

1.Purpose

1.2. This paper is designed to help commissioners develop effective management and financial information systems to improve the quality of commissioning. The paper identifies steps to decide what information needs to be collected, how it will be collected and the frequency of collection. It also attempts to prioritize information in that some information may be desirable but not essential at this stage.

1.3 The proposals within the paper are very ambitious in that they involve the development of a national reporting template which will facilitate the collection and aggregation of management and financial information at both the local, regional and if required at a national level. Both standard and bespoke reports can then be generated at regular intervals without the pain of conducting one off research exercises such as the market analysis. The reports will also facilitate the development of trend data to capture changes over time.

1.4. Local authorities and health boards are required to develop an integrated approach to commissioning through the development of formal partnerships and pooled budgets. Effective partnerships are built and depend upon trust and confidence. The development of effective management information systems will service the Regional Partnership Boards and relevant management groups with regular reports to ensure each partner that their statutory responsibilities are being met effectively through the partnership. The information should facilitate the update of any market position statements.

1.5. Furthermore, the development of a national reporting template will also facilitate the development of reports at the national level. This will support the work both in relation to the development of local market stability reports (requirement of local authorities under the Regulation & Inspection Act); the operation of a market oversight regime and will allow for benchmarking and shared learning.

1.6. These developments will also contribute to the implementation of the Parliamentary Review of Health and Social Care in Wales. The review recommends' that Welsh Government should work with stakeholders to redesign organization accountability and reporting arrangements on an integrated health and social care basis'. The principles of these proposals can be extended across all services.

1.7. The development of a national reporting template will also enable each regional partnership board to develop a profile of each home at least as far as Welsh publicly funded placements are concerned and with information provided by care homes will include information on vacancies, numbers of self-funders and publicly funded placements made commissioners from outside Wales. In time with the development of

appropriate acuity/ dependency measures this could include a profile of each home in terms of acuity.

1.8. These developments will also benefit providers in that they will assist commissioners to identify their commissioning intentions and provide a clear indication of demand both in relation to publicly funded placements and with the assistance of providers in relation to those who fund their own care – self-funders. This should inform the business plans of providers. More importantly it will benefit those individuals for whom the care and support they require to maximize the quality of their life will be most effectively provided through a placement in a care home.

1.9. The development and implementation of a national report template involves the development of an information base or framework which can generate standard and bespoke reports. This paper will focus on the information required by regional partnership boards on a monthly and quarterly basis – the standard reports to be pulled off the framework.

1.10. The first step is to agree the contents of the national reporting template. This paper includes recommendations on the content and frequency of collection. We will need to get agreement across Wales on the contents.

1.11. Data Unit Wales designed the reporting templates for the market analysis – one to be completed by local authorities, one by health boards and one in relation to information received from providers. The guidance for populating the templates attempted to ensure that there was no double counting of residents. This was a challenge because there are numerous placements which are joint funded and therefore have placement records held by multiple organizations which can result in duplication and double counting.

1.12. The proposal is to merge the health and local authority reporting templates into one template and add some additional information fields. This will avoid the risk of double counting and will be more efficient with one template. At this stage Data Unit Wales can be approached to build on their previous work to develop a single unified reporting template. This will also require discussion concerning funding. The draft templates can be progressed through the National WCCIS governance arrangements as appropriate to support implementation and to ensure that there is a consistency in the data that is collected through the admission, review and discharge processes.

1.13. The development of a common reporting template will require discussion with those responsible for information governance within health and local authorities in each region but given the development of formal partnership agreements alongside the benefits to residents and the business case in terms of improved efficiency this should not be a major problem.

1.14. There may have to be a second national reporting template to capture information from providers. The template used for the market analysis (in relation to information from providers) included:

- Number of registered beds by category of care
- Number of Vacant beds by category of care
- Number of self-funding clients from within local authority area; from another Welsh authority area or from outside Wales.
- Residents funded by health bodies / local authorities outside Wales
- Number of clients on waiting list
- Information relating to embargos.

This information proved essential to get a complete picture of demand which included self-funders. We may wish to add to this list. It will be important to ensure that providers contribute to this project. Information in relation to local authority homes must be included to develop this overall picture of demand.

1.15. Populating the template will be challenging. It will involve the same effort as that required to complete the initial market analysis in the first instance. The paper has been drafted with some trepidation because it has serious workload implications whilst appropriate systems are being developed. The reward will be that it will be much easier to maintain the system and generate the information required on a regular basis including information on trends – e.g. rising or falling demand, numbers of third party payments, changes in funding patterns, etc. This is preferable to repeating the market analysis without the systems to support it. In relation to other services it is suggested that the design of the market analysis and the design of future data requirements be completed at the same time so that the data only has to be collected once and then kept up to date. This is outlined in a discussion paper in relation to supported living services for people with learning disabilities.

1.16. This will not only improve planning but will also enable elected members and public officials to account for their actions in relation to commissioning with up to date meaningful information.

1.17. We need to identify the most effective means of collecting the information on individuals at the point of admission to care homes or at the point when the public sector takes responsibility for funding the placement. Similarly, we need to develop procedures to capture changes of circumstances such as transfers between residential and nursing homes, changes of funding stream such as self-funding to local authority funding or local authority FNC funding to CHC funding,

1.18. The initial market analysis report contained the following recommendation:

“The Welsh Government to commission a project designed to develop appropriate systems for determining the data requirements together with the system for collecting it. This will involve a range of stakeholders – National Commissioning Board, Data Unit,

Wales Health & Community Care Information Systems, representatives of those developing population needs assessment, CSSIW, Social Care Wales and Care Home Providers “.

This group needs to be established as a matter of urgency to take this work forward. The following steps need to be taken:

1. Consult on proposal to develop national reporting template and its contents
2. Data Unit Wales to add value to work undertaken for the market analysis by designing one integrated national reporting framework for health boards and local authorities.
3. Identify role and contribution of WCCIS Board / project towards implementation.
4. Identify existing sources of information that can help populate the template drawing on experience of previous market analysis.
5. Identify methods for addressing gaps in information to source the template e.g. design methods for collecting information at the point of admission and change of circumstances.
6. Identify the assistance required by the regions to aggregate and analyze data and generate reports.

1.19. We need to engage with stakeholders as soon as possible to add value and inform these proposals and finalize our approach.

1.20. The market analysis provided a lot of quantitative information. This does not diminish the need for qualitative information which is often provided by inspections, service reviews and individual reviews. The Older Person’s Commissioner has also made the experience of older people in care homes the focus of her attention over the last few years. There is nothing to stop commissioners putting in place a simple, confidential survey of residents over time could offer important clues to the functioning of the market. If service users were asked to score their general wellbeing, their impression of their accommodation and the care they receive, including areas such as food and drink, this could offer a valuable picture across Wales. Further work is required to capture measures of outcomes. Audit tools such as those developed by Dementia care Matters could also be used.

1.21. Finally, commissioners may wish to gather further information, for example, more detailed information in relation to workforce to inform the development of a workforce strategy. This is important and will require further discussion.

2. Background

2.1. The market analysis of care homes for older people in Wales undertaken in 2016 included a chapter identifying the management and financial information required and equally important the rationale for collecting it. Most of the information from this chapter has been drawn into this paper.

2.2. This was discussed at a workshop in October 2017 with representatives from the regions. Colleagues agreed that the information collected for the market analysis with some minor improvements around definitions needed to be collected on a regular basis. Some additional requirements were also identified during the market analysis and these have been added to the proposals within this paper alongside others. Colleagues agreed that every effort should be made to achieve consistency in basic reporting requirements which will allow for some benchmarking and shared learning across Wales.

2.3. The market analysis contains information on every placement made by Welsh local authorities and health boards in care homes for older people both inside Wales and outside Wales. It does not encompass placements of older people presently living in care homes for younger adults but does capture information on placements of younger adults (aged below 65) in care homes for older people. It also captures information from providers on placements for self-funders, placements made by public bodies from outside Wales together with information on vacancies and waiting lists. Information was also collected in relation to fees and third-party payments.

2.4. The information gathered for the analysis was therefore extremely comprehensive and we have not exhausted all the possibilities in terms of its analysis. The information for the market analysis was however based upon two census studies – a pilot in North Wales in May 2016 rolled out across the rest of Wales in August 2016. The limitation of this analysis is that it is based on a one-off exercise so there is no trend data to indicate trends. Trend data could usefully be tested against a range of assumptions such as how the change in specific provision over time reflects policy, demand and changes in practice. For example, if the number of EMI beds in one area decreases, does this represent a reduction in service provision or an improvement in another area, reducing demand. Answering this type of question might be more qualitative, e.g. requiring local authorities and health boards to advise on policies being developed and implemented and their own local research into changes in demand/supply and outcomes. If this was included in the data set and supported, it might offer a very powerful series of comparisons across Wales.

2.5. Trend data may also help us make more sense of projections of demand based upon population growth against actual placement practice. At present this information is contradictory and would benefit from analysis over time. The weakness of a census study is that it cannot provide information on trends or changes in demand without being repeated. When we examine actual placements over a period of time, we can see a down turn in demand for residential care by 8% over 10 years up until 2015. There has also been a decline across Wales in placements in nursing homes over the same period. There has been a small increase across Wales in relation to Continuing Health Care placements between 2014/15 and 2016/17 but this is not consistent across Health boards. Projections of demand based on a one - off census can therefore be misleading. We need to measure changes in demand as part of an ongoing process.

2.6. The development of a system that will help us understand changes of time will therefore enable us to commission more effectively.

3. Information to be collected

3.1. The purpose of developing formal partnerships and pooled budgets for the integrated commissioning of services from care homes for older people is to ensure that health boards and their local authority partners work effectively together and with providers to develop and maintain an appropriate range of services in each area.

3.2. The outcome is to ensure that there is an appropriate range of good quality care home services to respond to the needs and preferred outcomes of older people and their families. Ideally, care homes should be available which avoid the need for the individual having to move unacceptable distances from their families and communities against their wishes. This means planning services for each locality. This is important because it will help to specify the information required for commissioning.

3.3. The Regional Partnership Board will be developing an integrated approach to commissioning which will involve developing common approaches to contracts/ specifications/ quality assurance arrangements, fee setting, and reporting. In the short-term there will be seven regional approaches to commissioning and hopefully we can share and implement good practice. This regional and integrated approach between the health board and their local authority partners will hopefully improve the quality of commissioning and will reduce unnecessary bureaucracy for providers.

3.4. It will nevertheless still be important to plan appropriate service provision at the locality level in relation to care homes. So, for example, it will be important for the health Board and Local Authority to take an integrated approach to commissioning services in a community such as Brecon or Llandrindod Wells. People in Brecon do not want to move 30 miles away into a home in Llandrindod Wells. How are commissioners going to work together with local providers to make the most effective use of local assets e.g. number of long term beds required, short term step down beds?

3.5. Whereas most older people want to stay close to their communities those individuals whose outcomes can only be met by the provision of more specialized services need to be identified. An older deaf individual who uses BSL, for example, may prefer to move into a care home with staff and other residents who can use BSL. We need to improve our intelligence in relation to needs to develop specialist resources where required.

3.5. It makes sense therefore initially to collect information at the County level both for health and local authority placements. Ideally, we want to take into placements of people who fund their own care so we can plan for the total capacity of services required. This allows us to build up a picture of demand from a local area. Information can be aggregated up to provide reports at the regional and health board levels.

3.6. It will be possible to plan at a more local level in terms of localities either using post codes or drawing from a joint list of publicly funded placements for each care home. This will be discussed later. We do not want to be too ambitious too begin with.

3.7. In terms of prioritizing information, the bottom line is that each partner will need to identify its contribution to the pooled budget with regular reports on expenditure to date and projections of spend to year end. Further detail on financial information will be included below. Similarly, each partner will need to understand the demand for placements throughout the year in terms total placements and will also include information on admissions and discharges. Additional information will be required to understand the pattern and drivers of demand. Information on direct admissions from hospital should be a priority. The availability of reablement and home care services will also be important.

3.8. The requirements are divided into management information designed to help us understand demand and financial management. The development of the information framework should facilitate the production of reports. We need to get agreement on priorities and frequency of reporting.

4. Part 1. Management Information to inform demand

4.1. N.B. The national reporting template will have the capacity to generate a wider range of information than that listed below. Examples of all these can be developed over time. These proposals focus on the immediate needs of the regional commissioning boards and their appropriate management groups.

4.2. The following information will be drawn from a local authority and its partner health board monthly unless otherwise stated. Information on vacancies will need to be collected from providers. Ideally this should be done in real time. The frequency of collection is recorded in brackets. The recommendation is to collect information on a county basis for both local authority placements and health placements to develop a picture of local demand. This will include out of county placements.

4.3. Example – Carmarthenshire report to include: Carmarthenshire local authority placements & Hywel Dda Health Board placements (in relation to placements funded by the health board for residents originating / admitted from an address in Carmarthenshire). CHC placements of residents originating from within Carmarthenshire will be included in the monthly report covering the area of Carmarthenshire. Health board placements of residents originating / admitted from an address in Ceredigion will be included in the monthly report in relation to Ceredigion and likewise with Pembrokeshire.

4.4. Long Term Placements – April (Monthly)

1. Number of residents funded by Carmarthenshire Local Authority in residential care without nursing end of April 2018 (_)

2. Number of residents funded by Carmarthenshire local authority and Health Board with FNC in care homes with nursing end of April 2018 (_)
3. Number of Self-funded placements (originating from Carmarthenshire) with HD/LHB paying the Funded Nursing Care element end of April 2018 (_)
4. Number of CHC placements (originating from Carmarthenshire) funded by HD /LHB end of April 2018.
5. Total number of Placements funded by section 117 Mental Health Act (_)

The same information reported for Ceredigion and Pembrokeshire. It will be repeated for May and June and will include an aggregation for each month for the region. This can be extended to a quarterly report.

Rationale: Each partner will need to understand total number of placements funded together with changes over time.

4.5. Categories of care:

Question: Do we still need to record categories of care e.g. nursing homes with EMI, residential with EMI? It could be argued, for example, that all care homes must respond to the needs of individuals with dementia, if not from admission at a later stage in the placement. If so this can be added to the national reporting template. If this is the case the information required will include:

1. Number of residents funded by Carmarthenshire Local Authority in residential care without nursing end of April 2018. _____.
2. Number of residents funded by Carmarthenshire Local Authority in residential *EMI* care without nursing end of April 2018. _____.
3. Number of residents funded by Carmarthenshire local authority and Health Board with FNC in care homes with nursing end of April 2018 _____.
4. Number of residents funded by Carmarthenshire local authority and Health Board with FNC in EMI nursing homes end of April 2018
5. Number of Self-funded placements in *general nursing homes* (originating from Carmarthenshire) with HD/LHB paying the Funded Nursing Care element end of April 2018____.
6. Number of Self-funded placements in *EMI* nursing homes (originating from Carmarthenshire) with HD/LHB paying the Funded Nursing Care element end of April 2018____.
7. Number of CHC placements (originating from Carmarthenshire) funded by HD /LHB in *General nursing homes* end of April 2018.
8. Number of CHC placements (originating from Carmarthenshire) funded by HD /LHB in *EMI* nursing homes end of April 2018.
9. Total number of Placements funded by section 117 Mental Health Act in General Nursing Homes.
10. Total number of Placements funded by section 117 Mental Health Act in EMI Nursing Homes.

4.6. Admissions (Monthly reporting).

1. Total number of new admissions funded by Carmarthenshire local authority into care homes without nursing in April 2018 ____
2. Total number of admissions funded by LA / HB contributing Funded Nursing Care into care homes with nursing in April 2018 ____.
3. Total number of admissions of self-funders with HB providing funded nursing care __
4. Total number of admissions (Carmarthenshire residents) funded by CHC into care homes with nursing in April 2018 ____.
5. Total number of admissions funded by section 117 ___.

4.7. Discharges / Deaths (Monthly)

1. Number of discharges / deaths from long term residential care placements without nursing.
2. Number of discharges / deaths from long term care homes providing nursing funded by LA / FNC.
3. Number of discharges / deaths from long term care homes providing nursing funded by Self Funders and FNC.
4. Number of discharges / deaths from long term care homes providing nursing funded by CHC.
5. Number of people discharged to their home in the community from long term care___.

Rationale: Information on admissions and discharges contribute to a picture of demand, turnover and length of stay.

4.8. Out of Region Placements (Monthly)

1. Number of admissions funded by LA in areas outside of County in residential care homes without nursing: ____.
   Reasons for out of county placements:
   Number due to client choice ____,
   Number due to no appropriate placements within county. ____
   Specialist provision required ___
   Other, please specify. ____

2. Number of admissions involving LA/FNC placements outside of county in care homes with nursing.
   Reasons for out of county placements:
   Number due to client choice ____,
   No appropriate placements within county. ____
   Specialist provision required ____.
   Other, please specify.

3. Number of admissions outside of County of CHC placements in care homes for nursing.
   Reasons for out of county placements:
   Number due to client choice ____,
   No appropriate placements within county. ____
   Specialist provision required ____.
   Other, please specify.

N.B. Establish procedure for notifying other regions of placements made into care homes within their region – name, gender, age of resident, etc. The market analysis captured every placement and location made by each local authority and each health board. We could identify placements made by Carmarthenshire into Pembrokeshire via the data supplied from Carmarthenshire. In this case the regions are collecting the data not the data unit so we need a procedure to inform a region of placements made into the region from other regions in Wales. We could work towards developing a national data base.

Rationale: This offers useful information to help demonstrate whether individual areas have sufficient capacity to support demand.

Some out of county placements will be based on the choice of the individual to be nearer to families. Other out of county placements will be made in the absence of appropriate local provision.

There may be care homes providing specialist services more appropriate to the needs of the individual e.g. head injury or provision of care through British Sign Language (BSL) for deaf residents.

4.9. Placements made direct from hospital (Monthly)

1. Number of long term placements made direct from hospital by Carmarthenshire in residential care homes without nursing during April 2018 (_)
2. Number of Long term placements made direct from hospital into care homes with nursing funded by Carmarthenshire County Council with FNC funded by the LHB during April 2018 (_)
3. Number of CHC placements (resident living in Carmarthenshire) made directly from hospital by the LHB in April (_)

Rationale: Hospitals are not the places to make decisions about long term care. Every effort should be made to return the individual to his or her home or to a suitable facility for further reablement and assessment. If the numbers admitted from hospital to long term care are high this would indicate the need to develop other more appropriate interventions. There are always exceptions where individuals experience such a serious illness or trauma that long term care becomes inevitable but these should be the

exception. This information may also indicate problems in relation to assessments, care pathways and effective decision making.

Poor assessments, ineffective pathways and poor decision making may inflate demand for care homes with inappropriate placements which can eventually block placements for others.

4.10. Short Term Placements – Respite Care, Step-up/ Step-Down intermediate care/ discharge to assess (monthly)

1. Number of residents placed by Carmarthenshire Local Authority in residential care homes without nursing for the primary purpose of providing respite care during April
2. Number of residents placed by Carmarthenshire Local Authority and FNC in care homes with nursing for the primary purpose of providing respite care during April
3. Number of residents placed by HB in nursing homes and funded via CHC for the purpose of respite care

Rationale: Provide some measure of how carers are being supported.

4. Number of placements made for the purpose of assessment (_)
5. Number of placements made from hospital for the purpose of providing step down intermediate care provision (_)
6. Number of placements made from the community in residential care homes without nursing for the purpose of providing step up intermediate care (_)
7. Number of placements made from the community in care homes with nursing for the purpose of providing step up intermediate care (_)
8. Number of placements made from hospital into a joint package involving shared lives and community reablement services (_)

Rationale: Provides an indication of how short term care is being used to assess and reable individuals allowing them to return to their homes or suitable accommodation in the community rather than long term residential care.

4.11. Transfers of care from residential care homes to nursing homes (either directly or indirectly via hospital). (Quarterly)

1. Number of transfers of care from residential care to nursing homes (either directly or indirectly via hospital) (_)

Rationale: We need to make a judgement on the capacity needed in relation to care homes with nursing and care homes without nursing. Some residential care homes will provide care and support to individuals up until they die even in cases where they should technically be transferred to a care home with nursing. Others will refuse to take individuals back from hospital because they cannot meet their needs. This information will help to inform judgements concerning the balance.

4.12. Transfers of funding responsibility (Quarterly)

1. Number of self-funding residents in residential care homes without nursing whose placement became funded via the local authority (_)
2. Number of self-funding residents with FNC became funded by local authority (_)
3. Number of residents who either funded by the local authority or the local authority and LHB (FNC) who became funded by CHC (_)

Rationale: Trend data will help facilitate statutory partners with their financial planning.

4.13. Placements by Sector (quarterly)

1. Total number of placements in Local Authority Care Homes (_)
2. Total Number of placements in independent private sector residential homes (_)
3. Total Number of placements in independent third sector homes (_)

4.14. Statutory Sector- Waiting List Monthly or in real time)

1. Number of residents waiting placement in residential care home without nursing
   (a) Number waiting in hospital
   (b) Number waiting in community
2. Number of residents awaiting placement in care home with nursing via FNC
   (a) Number waiting in hospital
   (b) Number waiting in community
3. Number of residents awaiting placement funded by CHC
4. Number waiting in hospital
5. Number waiting in community

Rationale: This provides very useful information to identify where assessment and allocation may not be working or where demand is not being met by appropriate provision, e.g. where there is unmet demand for EMI care. Such information would be useful for commissioners and providers.

The analysis found that some local authorities and health boards did not maintain waiting lists. Given the importance of choice of accommodation and the part it can play in delayed transfers of care from hospital this requires further consideration. An individual, for example, may accept an interim placement until a placement in their care home of choice becomes available (which may be 15 miles nearer their family). This will not prevent the individual being bumped down the provider's list where a self-funder is seeking a placement and is prepared to pay more but the statutory sector should manage the placements they are responsible for commissioning. Although local authorities may not keep a waiting list they may know of individuals in an interim placement waiting for their preferred placement.

Similarly, a placement may become available in a home with high numbers of very dependent or high acuity residents. It may well be that the home can take a placement but may need to take an individual with less intensive needs. This process has to be managed.

N.B. Cwm Taf have drafted a proposal which includes the reasons for delayed transfers of care relating to care home placements.

4.15. Vacancies

N.B. This information will need to be provided by care home providers ideally in real time.

1. Total number of vacancies in residential care homes without nursing at month end (_)
2. Total number of vacancies in care homes with nursing at month end (_)
3. Number of Residential care homes with 20% or more vacancies (_)
4. Number of care homes with nursing with 20% or more vacancies (_)

Rationale: A percentage of vacancies will offer clues to the performance of the local market. This information could be used by providers to plan – too many vacancies would be unlikely to support investment decisions in a locality; a small number of vacancies may indicate opportunities. They may also provider an indicator of a potential shortfall of services to commissioners. Care homes which have a high proportion of vacancies <u>may</u> also be experiencing financial challenges.

4.16. Age of Residents

We can capture information on date of birth and age of residents upon admission.

1. Average age upon admission (Quarterly)
2. Average age of residents within a home (this should be measured regularly (monthly) to maintain up to date profile of the home????

4.17. Length of Stay (annually)

1. Complete length of stay: This is calculated for residents who left the care home over the past 12 months and whose stay has therefore ended. It excludes length of stay in ant previous homes.
2. Incomplete length of stay: This is calculated for residents still living in a care home at the end of the year and whose stay is therefore not yet ended. It is the length of time spent in their current home up until 31st March. It excludes length of stay in any previous homes.

N.B. To get an accurate measure of length of stay we need to capture date of admission as well as date when public body became responsible for funding the placement. A self-funder, for example, may have been in a placement in residential care for 18 months before a local authority accepted responsibility for funding the placement.

Rationale: Individuals are may be being admitted later (due to efforts of family and community services) with greater needs and more limited life expectancy. Quicker turnover of residents can add significant pressures on care home providers both in terms of getting to know their residents and respond to their greater acuity.

4.17. Embargoes

1. Number of residential care homes subject to an embargo on placements.

2. Number of residential placements / beds subject to an embargo.
3. Number of care homes with nursing subject to an embargo on placements.
4. Number of care homes with nursing placements / beds subject to an embargo.

Such embargos can take significant capacity out of the system and deny local placements of choice for individuals needing these services. The information is required to ensure that commissioners are working with providers to address any concerns regarding the quality of care in a timely manner.

It may also offer signals to providers of possible opportunities in taking on existing care homes.

Part 2 - Financial Information

The operation of pooled budgets.

1.1. Pooled budgets are often misunderstood. Some people argue that we can use pooled budgets to end arguments over contributions from agencies to placements or other services. Whilst it is true that pooled budgets can be used to facilitate effective and timely decision making, decisions are still required regarding the contribution of each agency (each health board and their local authority partner in this case) into the pooled budget.

1.2. Regarding services from care homes for older people this should be relatively simple in that both local authorities and health boards have well defined statutory responsibilities. Local authorities fund placements in residential care homes without nursing (for those eligible) and nursing home placements with the health board funding the FNC component. Where individuals are eligible for continuing health care the placement will be funded 100% by health. There are some variations concerning the funding of section 117 mental health aftercare placements but there are not many of these in Wales and as with LA/FNC placements joint funding commitments can be built into the pool. The only areas which require negotiation concern the funding of:

- respite care
- intermediate care (step up / step down services) within care homes.
- Discharge to assess placements.

1.3. If these issues are difficult to resolve at a regional level the Welsh Government can help to mediate to identify a process for resolving them with a consistent application throughout Wales.

1.4. A further consideration in the construction of the pooled budget relates to concerns regarding cross subsidization. Pooled budgets do not encourage or permit cross subsidization. Local authorities are not allowed to cross subsidize other local authorities or health boards. Legal advice may be required to confirm this point. The National Audit Office is unlikely to promote cross subsidization. More importantly of all is why would we promote cross subsidization where it could promote bad habits?

1.5. If we take a hypothetical example. Most of the local authorities within the partnership together with the health board do their best to manage demand responsibly. They invest, to put in place a range of preventative and rehabilitative services to prevent needs from escalating and supporting older people to continue to live at home. However, one authority in the partnership fails to invest in these services and continues make a higher than average rate of admissions to care homes which in the end turns out to be more expensive. Under financial pressure it requests a higher proportion of the pool budget than it contributes. Why would the partners agree to such cross subsidization?

1.6. We should also mention that particularly during times of austerity those with statutory responsibilities, whilst at the same time coping with the challenges of rising demand and severely limited resources, are clearly anxious that with the requirement to use pooled budgets because they fear they will lose control of both resources and consequently their ability to meet their statutory obligations. This is one of the largest barriers to developing pooled budgets and may partially explain why their use has been severely limited in Wales.

1.7. The effective construction of the pooled budget should address these concerns head on. To begin with we can construct a pooled budget and a system of management that enables the money to follow the client. So, if the health board, for example, estimates that it will need to fund 100 CHC placements during the year but demand rises and it needs to fund 200 CHC placements it will be required to make additional payments to the pooled fund. Similarly, if a local authority estimates that it requires 200 placements in residential care homes but demand rises and it will need to fund 300 it will need to make additional contributions to the pooled budget. If additional joint funded placements are required, the partners will need to make additional contributions in proportion to their respective responsibilities. This is already happening in community equipment services where we have formal partnerships and pooled budgets operating across Wales.

1.8. Some colleagues have questioned that if we construct the budget on this basis why do we need a pooled budget? The rationale for using pooled budgets is that they require health boards and their local authority partners to work together to manage demand and shape services to the best of their joint ability to respond to that demand. They are a tool used alongside common contracts/ specifications/ quality assurance arrangements for health boards and local authorities to work together to plan services.

1.9. The development of partnerships and pooled budgets require agreement and transparency of objectives and resources between commissioners and reduce duplication of commissioning functions. The governance arrangements of partnerships and pooled budgets demand an improvement in the quality of information on performance. This should apply to the performance in relation to commissioning as well as of providers. An integrated approach to commissioning should benefit providers in

terms of removing duplication of processes together with a more accurate picture of demand.

1.10. Strong partnerships are built and develop with trust and confidence. We can help to promote trust and confidence by ensuring that the regional partnership boards and their management groups are serviced regularly with good quality management and financial information reports to provide assurance that the partnership arrangements are improving their capacity to meet their statutory requirements. This means providing information on a regular basis in relation to demand and on what each partner is putting in and getting out of the partnership.

1.11. Whether the pooled budget operates at a regional or local authority basis the reporting arrangements will need to account to each partner both in terms of activity and expenditure. There are therefore advantages to building the budget up from the local level and provide reports at the local and regional level. The local dimension is essential towards developing services as close to the individual and community as possible.

1.12. Given the size of the pooled budgets as they relate to regions this will also mitigate any risks associated with such a large budget and the number of partners involved. Local and regional solutions to any difficulties can be developed accordingly.

1.13. The development of the budget on this basis should address anxieties regarding both loss of control and cross subsidization. It should also improve planning at the locality and local level.

1.14. Contribution to Pooled Budget for Carmarthenshire County Area identified for 2018/18

This will include the contribution from Carmarthenshire Local Authority for local authority placements and for Hywel Dda Health Board in relation to those CHC and FNC residents that originate from addresses in Carmarthenshire i.e. responsibility of health board.

Carmarthenshire County Council £ (_)

Hywel Dda Health Board for the Carmarthenshire Area £ (_)

Regional Pooled Budget £ (_)

1.15. Expenditure

Total expenditure on local authority funded placements in residential care at end of April 2018 £ (_)

Projected spend to end of financial year based on expenditure to date and pattern of placements (_)

Average weekly cost of placement (gross cost) (_)

1.16. (a)Total expenditure by Local Authority on local authority / HB FNC placements in care homes with nursing at 30th April 2018 £ (_)

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) (_)

1.16.(b) Total expenditure by HB on local authority / HB FNC placements in care homes with nursing at 30th April 2018 £ (_) i.e FNC

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) (_)

1.17. Total expenditure by HB on self-funder / FNC placements in care homes with nursing at 30th April 2018 £ (_)

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) £ (_)

1.18. Total Expenditure by HB on CHC placements at end of April

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) (_)

1.19. Total expenditure by LA on section 117 placements at end of April.

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) (_)

1.20. Total expenditure by HB on Section 117 placements at end of April

Projected spend to end of financial year £ (_)

Average weekly cost of placement (gross cost) (_)

1.21. Total expenditure by HB on respite care placements £ (_)

Total expenditure by LA on respite care placements £ (_)

Total expenditure by HB on intermediate care placements or discharge to assess placements £ (_)

Total expenditure by LA on intermediate care placements or discharge to assess placements £ (_)

Total Expenditure of health Board at the end of April £ (_)

Total Expenditure of Local authority at end of April £ (_)

Total expenditure of local health board / Local authority County / Area £ (_)

These figures can be aggregated up across Local Authority areas to provide breakdown at regional level.

Resident Contributions – This could be reported on quarterly.

1. Total contributions of residents to the costs of their placement in residential care homes without nursing £ (_)
2. Total contributions of residents to the costs of their placement in care homes with nursing. £ (_)

Rationale: provides a measure of income and a measure of prosperity/ poverty between areas.

Third Party Payments – This could be reported on quarterly.

1. Number of placements in residential care homes without nursing involving third party payments (_)
2. Number of placements in care homes with nursing involving third party payments (_)
3. Average cost of third party payment per week £ (_)
4. Highest third-party payment per week £ (_)
5. Number of third party payments over £ (_) per week (_)

   We need to agree threshold.

6. Number of CHC placements where additional payments are made
7. Highest additional payment per week £ (_)
8. Number of additional payments over £ (_) per week (_)

Rationale: Information on third party payments and additional payments concerning CHC placements should be monitored. They provide <u>some</u> indication of whether or not the LA and HB payments are sufficient to meet the cost of care.