Draft Findings for Discussion

Wales Market Analysis of Care Homes for Older people

4/05/2017

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1. Overview

This study is designed to analyze and describe the state of the care home market for older people in Wales. The Care Home Steering group commissioned the National Commissioning Board to undertake the study. This is not a final report. The analysis is ongoing so this document provides a position statement on the findings to date to inform discussions on the actions required to achieve a more effective balance between demand and the provision of appropriate services to respond more effectively to the needs of individuals. The recommendations will require further discussion both within the National Commissioning Board and the Care Homes Steering Group; and with Commissioners, Providers and other important stakeholders. This will involve a partnership approach between commissioners, care home providers, regulators, Welsh Government policy makers and improvement agencies.

This brief overview provides an opportunity to establish where we want to be in terms of service provision, where we are now and the steps required to help the sector move forward. Other actions outside this study are also important particularly in relation to developing a methodology for determining appropriate fee levels and the development of a skilled workforce. There are separate work streams addressing these challenges. Clearly we should also acknowledge the considerable amount of work underway towards the implementation of the Regulation and Inspection Act 2016 and the development of the regulatory framework to support it. This will have a positive impact upon the sector.

Where do we want to be in terms of the services provided by care homes for older people?

We want every decision taken by an individual to move into a care home to be a positive choice offering the individual, in need of immediate access to care and support, the most effective means of providing this support and maximizing their quality of life.

We want to commission the most appropriate and effective range of services (both short term and long term) designed to achieve positive outcomes from good quality care homes that are well managed and staffed with a skilled, knowledgeable and a motivated workforce.

We want to develop a relatively stable market where demand and supply are roughly in equilibrium with no sudden forced exits from the market with the negative consequences they involve, not least to the individual resident. We want providers to have good access to information to inform their planning and

investment decisions and we want to agree fee levels that provide the quality of care demanded by the commissioners and to secure future investment.

We need care homes which are resilient enough to cope with complex needs both in terms of physical frailty and dementia; avoiding the need to transfer individual residents from one home to another.

We want care homes that make a positive contribution to the continuum of care alongside other options including accessible accommodation and a comprehensive range of community services.

Where are we now?

We have invested significantly in developing effective arrangements for proportionate assessments which focus on what matters to people as part of the implementation of the Social Services and Wellbeing Wales act 2014. There is still more to do to consolidate good practice and improve decision making. We have also invested in the development of services in the community designed to help individuals recover and maintain their independence and this will continue.

The care home market for older people is far from being in a state of equilibrium with considerable vacancies in the residential care sector together with difficulties in responding to demand for nursing home placements in some areas at the time they are required. Demographic challenges include a significantly rising population of older people and increased demand for services as the prevalence of ill health and disability increase with age.

Care homes themselves report serious challenges both in terms of funding and workforce recruitment, retention and development. People are also being admitted with more complex needs.

What do we need to do to get to where we want to be in terms of services provided by care homes for older people?

In addition to the work in relation to fee setting and developing a sustainable workforce the following actions are priorities. They are among the recommendations that follow.

We need to develop and implement guidance in relation the process of admission to care homes. This will focus on enabling individuals and their families to make informed decisions and positive choices. This will also involve the avoidance of decision making about long term care whilst the individual is still receiving acute hospital care. It will also inform good practice concerning the transfer of care from hospitals or community settings into the care homes. This will also apply to those individuals who fund their own placements. This will help to avoid inappropriate admissions to care homes.

We need health board and local authority commissioning partners to work together with each care home provider to encourage the development of services that accurately reflect local needs including the needs of those who fund their own care. This may involve more providers moving to provide services that can respond to those individuals with more complex needs. Commissioners will need to explore how they can support and facilitate these changes.

Care home providers will be required to develop statements of purpose to describe those needs their service can address together with how they will be addressed. Commissioners will be developing their service specifications describing the requirements of the services they commission. Commissioners and providers need to work together to achieve the best fit between demand and service provision.

The role and contribution of nurses working in care homes requires further discussion. Their contribution requires both further clarification and acknowledgement.

We need to improve the quality of our management and financial information to help to shape provision so that it more accurately reflects need. The investment in the region of £369 million in the care home sector demands better management information.

Each regional partnership board will need to develop market position statements that provide sufficient information to existing and potential service providers of their commissioning intentions to inform the investment decisions of care home providers.

Health boards and their local authority partners are required to develop formal partnerships and pooled budgets for the integrated commissioning of services from care homes for older people by April 2018. The purpose of this measure is not simply a partnership agreement. The requirement is for health and social care commissioners to work together to influence and shape service provision to more accurately reflect demand.

Finally, the regulation and Inspection Act 2016 offers a more flexible approach to registration. Other guidance in relation to ‘Funded Nursing Care’ may also benefit from a review to encourage greater flexibility of provision.

N.B. The market Analysis provides a comprehensive analysis of placements at the time of the census and provides estimates of future demand in combining this information with population projects. 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.

The report examines management information requirements which will be taken forward as a separate work stream. To monitor demand Regional Partnership Boards will need to develop management information systems to provide timely information as a matter of routine.

Recommendations

Recommendation 1 The Care Homes Steering Group to commission the development of appropriate guidance in relation to both the decision-making processes concerning admission to care and to ensure that appropriate information is shared between the hospital and the care home to support effective transfers of care.

Recommendation 2 Regional partnerships should monitor:

- how many people are admitted to long term care directly from hospital?
- how many people are readmitted to hospital within a month of discharge?
- how many people have been admitted to long term care without any previous engagement from community health or social services
- If the numbers are significant regional partnerships may need to reconsider the case for step up / step down provision with effective reablement programs in care homes. Options such as shared lives should also be explored possibly alongside community reablement services.

Recommendation 3 Regional Partnership Boards through their partners should explore the contribution of respite care in care homes as part of their strategy for supporting families carers.

Recommendation 4 The Regional Partnership Boards should support the design of appropriate formal partnerships and pooled fund arrangements for the integrated commissioning of services from care homes. This will also require the design of appropriate commissioning arrangements.

Recommendation 5 Regional partnerships should ensure that there are integrated mechanisms in place between health boards and local authorities to meet with providers on regular basis for the purposes of maintaining and planning service development. Whether these mechanisms are regional, sub-regional or local are for the regional Partnership Board to decide.

The National Provider Forum and its representative bodies should encourage the full participation of providers in these forums.

Recommendation 6 As part of their approach to the integrated commissioning of services from care homes, health boards and local authorities should develop a profile of each home together with a strategy for working with each home.

Recommendation 7 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. The information from this analysis should inform this discussion.

Recommendation 8 Regional Partnership Boards should develop detailed Market Position statements for care homes which may include broader accommodation options for older people. These will need to reflect locality needs as well as regional and local authority level needs. They will also need to address the needs of self-funders.

Recommendation 9 The National Commissioning Board to work with Health & Social Care Commissioners, CSSIW, Care Home Providers and advocates / representatives of residents to develop model service specifications which enable us to provide a consistent description of the services required, the quality required and outcomes to be achieved. These will be aligned as closely as possible with the standards developed as part of the implementation of the Regulation and Inspection Act.

This work can also inform the work of a costs of care group being established by the Care Homes steering group.

Recommendation 10 Health and Social Care Commissioners should offer support to care home providers with the development of their statement of purpose to achieve an appropriate balance between demand and supply. The ultimate decision rests with the care home owner but presumably they want to locate their business where there is a healthy demand. Care home providers should also be engaged in the development of service specifications.

Recommendation 11 The statutory sector should maintain their own waiting lists for care homes.

Recommendation 12 Local authorities and health boards should ensure that potential self-funders enjoy equal access to information and advice to inform their decision making.

Further research is required on the needs and motivation of self-funders on seeking admission to care homes.

Recommendation 13 Steps to develop a more consistent interpretation of eligibility for CHC should be undertaken. This may involve the development of a national training regime together with a national arbitration / appeals mechanism.

Recommendation 14 Regional partnerships boards should continue to monitor the age profile of residents. The reasons for admitting anyone below the age of 65 to a care home for older people should be scrutinized.

Recommendation 15 Local authorities need to monitor the use made of third party payments together with the cost or size of the payment to ensure that they comply with the guidance issued in relation to the Social Services & Wellbeing Act 2014. It is important that local authorities understand the level of third party payments made in relation to each case. Those cases involving the highest fees (above £200 per week) should be subject to review.

Health boards will also need to monitor the use of any additional payments made to support NHS Continuing Health Care placements.

2. Executive Summary

2.1. Preface

The information from this study is included in three main documents. This working paper contains the main analysis to date. Such is the richness of the data that it can be subject to further analysis and colleagues in local authorities and health boards may wish to undertake further analysis. This working paper contains all the relevant tables from the pilot study in North Wales to demonstrate how the material can be used. The tables for the rest of Wales are included in annex 1. The same numbering used between the two reports – table 7 in this paper will mirrored by table 7A in the Annex. Finally, a separate paper on fees and the costs of third party payments has been developed and this will be forwarded to the 'Costs of Care Working Group' being established by Welsh Government.

Efforts have been made to keep the regions informed of the outcomes of the analysis with written briefings being provided. The data in these was provisional and will need to be checked against the figures in this document. Clearly we need to create a range of opportunities to discuss both the implications of the study and how we can build upon it to inform the development of future service provision.

This paper starts with an executive summary for those who simply want to understand the main implications of the study. Those who want to achieve a deeper understanding should read the full paper.

2.2. Introduction

This analysis will contribute to helping commissioners and providers to identify where we need to get to in terms of the range of services we need from care homes for older people across Wales. It will be for regional partnerships to take this forward with providers in their areas' hopefully where appropriate with the support of Welsh Government and the appropriate improvement agencies.

The analysis will help to inform the development of formal partnerships and pooled budgets required for the integrated commissioning of services from care homes for older people.

The analysis should also contribute to informing discussions concerning the development of market stability reports and an appropriate market oversight regime required under the Regulation and Inspection Act.

The number of placements recorded was nearly 18,000 which include 4877 placements of people funding their own care. There are 21,823 registered beds in care homes for older people in Wales at the time of the census dates used for this study. Some homes have closed since the time of the census. Health Boards and

local authorities spend approximately £369 million on placements in care homes for older people in Wales. This excludes client contributions, third party payments and the fees paid by those individuals who fund their own care. This is therefore a substantial market and contributes significantly both to the economy and employment in Wales.

At the time of the census we had 20 care homes in North Wales and 57 across Mid & South Wales with 20% plus vacancies. Some of these vacancies maybe technical vacancies in that they may include vacant beds in double rooms where there are no immediate plans to fill them. The vacancy rate in some homes is nevertheless a cause for concern.

The option of moving into a care home should be a positive choice for those individuals who need immediate access to care and support 24 hours a day and where such an option offers the most effective means of helping them to maximize their quality of life. Such positive choices will only be possible if we develop an appropriate range of care and support solutions / services throughout the continuum of care from the provision of information, advice and assistance through to the provision of long term care in a care home. This may also involve other forms of accessible accommodation. The development of the appropriate range of services and pathways will enable more people to be supported at home and will ensure the availability of good quality care homes for those who would benefit most from this more intensive form of care and support.

Individuals and their families will choose the option of a care home with a knowledge of all the service options, some of which they will already have been used, and the understanding that a care home placement offers the most effective means of maximizing the quality of their remaining years.

Given the contribution of family carers and the successful development of services within the community supporting people at home; care homes are having to respond to individuals, whose needs are often more complex and intensive than those of individuals entering homes 10 years ago. Care homes, therefore continue to make an essential contribution to the continuum of care for older people.

The aspiration is to secure good quality care and support provision from well managed care homes staffed with a skilled, knowledgeable and motivated workforce. A further requirement is to achieve a stable market. Sudden home closures are stressful for all concerned not least for the individual resident. The characteristics of a stable market as identified by the Care Quality Commission in England are as follows:

- Demand & Supply roughly in equilibrium with neither monopoly supply or monopoly of purchase.
- Price would be at a level to deliver the quality purchasers demand and to secure future investment

- Individuals would have good access to information and providers would be readily able to respond to consumer demand
- Regulatory or legislative change would be planned well in advance with ample warning to the supply side of the market.
- Providers would be able to access reliable information about the market to inform their planning/ investment.
- Entry & exit would occur but take place in orderly fashion.

The evidence from this study suggests that the market is not in a state of equilibrium and is not as stable as we would wish it to be. This paper identifies the steps required to make progress towards a more stable market.

The results from this study will inform the broader work program of the care home steering group.

2.3. Background

The Care Homes Steering Group was established to proactively address the challenges confronting the Care Homes Sector for Older People in Wales. As part of its work program it commissioned the National Commissioning Board to undertake a market analysis of the care homes for older people across Wales.

This study provides a snapshot of the demand and supply of placements for care homes for older people in Wales. The information was collected as part of a pilot study in North Wales and rolled out to other Welsh regions. The information was collected in relation to two census dates 15th May in North Wales and 1st August across the rest of Wales.

The 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 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.

This analysis is therefore reasonably comprehensive but as a snapshot it cannot provide data on trends. It also should be acknowledged that this was the first time much of this data has been collected and so there are some gaps and inevitably some errors. The main body of the report does contain recommendations on the requirements in terms of the data that should be collected as a matter of routine – information we should have at our finger tips if we want to maximize the influence of health and social care commissioners on the development of services. We should not have to rely on one off research exercises in the future. An

improvement in financial and management information will be vital if we wish to make optimum use of the £369 million plus referred to above.

A summary of the key issues is included below. They are covered in greater detail within the main body of the report.

2.4. Summary of Key Issues/Facts

1. Management of demand

The population of older people is rising significantly over the next 10 to 20 years and this will lead to an increasing demand for care and support services given that the prevalence of illness and disability increases with age. We need to cautious in attempting to project demand for care home placements based purely upon population projections and current use of care homes because demand as stated below will be influenced by a range of factors. However, we can say that if everything else stood still in terms of service development the changes in population could lead to the need for the potential demand of additional placements in care homes.

The tables below provide an illustration of potential demand. Table 1 includes projections for residential and nursing home places for 2020 and 2025. In relation to residential care the challenge appears at first glance to be more manageable given the number of present vacancies although we also must consider the needs of those funding their own placements – see table 2. Some homes have closed since the time of the census. It may well be that some of this demand is met by the development of more accessible forms of accommodation with immediate access to care and support. Such developments require planning and development.

The position in relation to nursing homes also looks challenging over the next decade. These are, of course, regional projections. The challenges in specific localities may be more acute.

N.B. The potential demand for nursing home placements looks particularly challenging for Cardiff and the Vale of Glamorgan for both the immediate (2020) and medium terms (2025). The figures in relation to nursing homes looks challenging for several regions in 2025. See table 1 below.

Table 1 Projections for potential additional placements given no other changes (e.g. in other service provision)						
	Residential Care Homes			**Nursing Homes**		
	Additional placement requirements			**Additional placement requirements**		
	2020	**2025**	**Vacancies 2016**	**2020**	**2025**	**Vacancies 2016**
North Wales	120	281	296	104	**246**	144
Powys	35	76	41	30	**63**	32
West Wales	66	150	227	46	105	110
Western Bay	70	169	199	78	**189**	93
Cardiff & Vale	51	129	169	**99**	**255**	75
Cwm Taf	34	83	105	32	**84**	21
Gwent	62	156	155	70	**175**	107
Total	438	1044	1192	459	**1117**	582

Table 6 attempts to estimate demand for nursing home placements for each local authority by dividing regional placements by population share of each local authority within the region.

Table 2 Self-Funder Projections for Additional Residential Care Placements		
	2020	2025
North Wales	65	152
Powys	21	46
West Wales	44	101
Western Bay	43	107
Cardiff & Vale	43	114
Cwm Taf	8	21
Gwent	33	82
Total	257	623

The triangulation of data within the regions (where the information is available) helps us to build up a picture of future requirements. If we combine information from vacancies, waiting lists, out of county placements due to lack of availability of services within the area, this begins to build a picture albeit a limited one, given the absence of trend data.

If we look at the data in relation to Anglesey, for example, there was only one vacant placement in a general nursing home available and none in nursing EMI homes at the time of the census in May. (see table 14). The waiting lists reported by providers indicates that there was one person waiting for a general nursing home placement, 30 waiting for nursing EMI placements and 58 on waiting lists for homes which have a dual registration. Anglesey have 7 general nursing home placements out of county because of no available provision within the county at the time required; 6 people are placed in residential EMI homes and 15 placed in Nursing EMI homes out of county because there was no available provision within the county at the time required. The Health Board made 21 placements in nursing EMI homes out of area because of no suitable local provision although it is not clear how many, if any originated from Anglesey. The timing of the requirements for such placements is an important factor. At the time of the census, for example, Anglesey had 9 vacant residential EMI beds. Choice of accommodation requirements will also be an important factor in that the individual or the family may not have liked a care home even the alternative meant moving out of county.

Whilst these figures are not precise and the use of categories of care requires further discussion the indications are that within Anglesey there is a need for more provision that can cater for older people with dementia and mental health problems. Trend data over a period would enable us to make more precise estimates.

Some caution also needs to be exercised in examining these figures in that areas with large numbers of surplus placements may still have localities where access to an appropriate care home placement may be short supply and may mean individuals moving some way from their original community. We need to consider the continuum of care available within localities as well as local authorities and health boards.

The report contains a more detailed discussion on the categories of care in operation but the most striking feature is the challenge of providing sufficient nursing home placements or placements for individuals with more complex needs. This looks particularly challenging for 2025. The projections would suggest a need to encourage more residential care providers to move towards supporting individuals with more intensive needs. Whether this requires the employment of nurses or enhanced support from community nursing services requires further discussion. Further discussion is also required in relation to what incentives we can use to encourage care home providers (existing or new) to change their provision to more accurately the needs of their community.

The development of early intervention and preventative services, together with other forms of accessible accommodation, will reduce demand for care home placements but the analysis demonstrates that there needs to be more effective planning between health and local authority commissioners and between

commissioners and providers to manage the challenge of surplus residential placements in some areas and investing in care homes capable of responding to the challenges of frailty, dementia and a wide range of health conditions in others. The alternative is that we continue to have to react to challenges concerning quality and closures resulting in disruption for residents and their families with all the worry and anxiety that goes with it.

The demand for places in care homes will be dependent upon a range of factors. These include among others:

- The growth of the population of older people because the prevalence of ill health and disability increases with age.
- The support available from family and friends
- The quality of support available to family/ carers is essential.
- Effective arrangements for assessment and care planning.
- The development of the range and quality of care and support services in the community together with alternative accessible forms of accommodation such as, for example, extra care housing.
- More effective treatment and support to individuals with long term conditions. This also involves treatment and support to help individuals manage problems in relation to continence.
- Development of technology enabled care to help individuals manage their own care and provide additional safeguards.
- The development of appropriate care pathways to ensure that individuals have access to rehabilitation and reablement will also have an impact. Decisions about long term care should never be made when an individual is acutely ill and should, whenever, possible be avoided whilst the individual is still in hospital.
- Whatever stage on the pathway of care and support the individual finds themselves he or she together with their family will need access to good quality advice and support on the options available.

If we are working to ensure that any decision to move into a care home involves a positive choice, we need to get the decision-making process right. This also have a positive impact upon managing demand. Because this study is based largely upon data, the Care Homes Steering Group approached the NHS Wales Delivery Unit with a request to build into its work program consideration of the decision-making process concerning admissions to long term care from hospital. The result is an extremely valuable report – 'Moving On? Review of the Decision-Making Process for Care Home Placement following Admission to Hospital in Wales – January 2017'. This highlights several serious concerns about such decision making. These include among others the timing and location of the assessment. If we fail to get such decision-making processes right, we are likely to inflate demand for care homes inappropriately let alone failing to enable individuals to make a positive

choice as described above. The added relevance of this report to the market analysis of care homes will become more evident when we look at the use of placements and opportunities for reablement.

Recommendation 1: The Care Homes Steering Group to commission the development of appropriate guidance in relation to both the decision-making processes concerning admission to care and to ensure that appropriate information is shared between the hospital and the care home to support effective transfers of care.

Opportunities for Assessment and Reablement in Care Homes.

The study examined capacity encompassing both long term and short term placements. The overwhelming majority of placements (97%) are for long term care. There are very few placements made for assessment/ reablement or for respite care. Some individuals may be medically fit to leave hospital but may not be ready to return home and benefit from a community reablement care and support package.

Recommendation 2: Regional partnerships should monitor:

- **how many people are admitted to long term care directly from hospital?**
- **how many people are readmitted to hospital within a month of discharge?**
- **how many people have been admitted to long term care without any previous engagement from community health or social services?**
- **If the numbers are significant regional partnerships may need to reconsider the case for step up / step down provision with effective reablement programs in care homes.**

In some areas, community hospitals may well be providing effective reablement or rehabilitation programs. We need to be confident about the quality of reablement services in every setting including community hospitals. The emphasis should be upon active reablement and not simply providing a bed. Services such as Shared Lives (formerly known as adult placement schemes) possibly in conjunction with community reablement could also contribute towards facilitating transfers of care. Reference is frequently made to step down from hospital facilities. The contribution of step up facilities to avoid hospital admission should also be explored. The availability of reablement services will promotes positive choice and helps to manage demand. There census reports very little use of placements for respite care.

Recommendation 3: Regional Partnership Boards through their partners should explore the contribution of respite care in care homes as part of their strategy for supporting families carers.

2. The interdependency between Health & Social Care Commissioners

Health Boards either pay for or contribute to the costs of 99 to 100% of nursing home placements in Wales with the local authority's contribution varying between 26% in Hywel Dda, 34% in North Wales, 44% in Gwent, 47% in Cardiff & Vale, 52% in Western Bay and 59% in Cwm Taf and Powys – 48% across Wales**.** Many placements are jointly funded between health boards and local authorities. In brief, local authorities and health boards are using the same providers. There is no such thing as a CHC nursing home or a local authority nursing home or a self-funders nursing home there are simply nursing homes. These are relatively fixed assets within communities and the challenge is for health boards and local authorities to work together to maximize their value to the continuum of care.

Although health boards rarely fund placements in residential care homes they do support residents through the provision of primary and community services. There is anecdotal evidence that the acuity / dependency levels of residents in these care homes is also increasing which will in turn make greater calls upon the NHS. If we want residential homes to cater for individuals with more complex needs they will require greater support from primary and community health services and further support if they can be persuaded to provide more intensive forms of care.

The inter-dependency of health and social care commissioners requires them to work together to develop a coherent approach to working with providers to develop and maintain an appropriate range of good quality care home provision. Health Boards and local authorities are required to develop formal partnership arrangements and pooled budgets for the integrated commissioning of services from care homes for older people by April 2018. By working together health boards and their local authority partners will have a better opportunity to shape service provision so that it reflects the needs of people requiring this form of care and support in their communities. It is important to emphasis that this measure designed to get local authority and health board partners to develop a common understanding of how they want to work with each care home to maximize its contribution to the continuum of care. Unilateral decisions by commissioners should be avoided because they impact upon their partner. This measure should also reduce unnecessary bureaucracy for providers and enable local authorities and health boards to streamline their commissioning and quality assurance functions.

Regional partnership boards decide for themselves whether or not they wish to establish a separate formal partnership and pooled fund arrangement for home care and reablement services or they may wish to add these to the arrangements being established for care homes over time which would contribute to the continuum of care in each locality.

The development of these arrangements, alongside effective assessment, pathways and commissioning practice is designed to improve outcomes for residents and their families and to facilitate the more effective use of resources by reducing duplication together with inappropriate bureaucracy.

Recommendation 4: The Regional Partnership Boards should support the design of appropriate formal partnerships and pooled fund arrangements for the integrated commissioning of services from care homes. This will also require the design of appropriate commissioning arrangements.

The National Commissioning Board will shortly be publishing a manual on integrated / collaborative commissioning. It has already shared a model partnership agreement at workshops within each region which was designed to identify the important steps required to develop a formal partnership agreement and pooled funds.

3. Partnership between Commissioners and Providers

The private/ independent sector provides a range of between 77 % of registered beds in Cwm Taf to 96% of registered beds in Powys. Overall across Wales the local authorities provide 10% of the registered beds; the third sector provides 3% and the independent sector provides 87%. If this was confined to nursing homes the proportion would be nearer 100%. There are four local authorities in Wales who no longer directly provide residential care. See tables 9 and 10 for North Wales and 9A and10A for the rest of Wales in Annex 1.

To put this into context the Betsi Cadwallader Health provides around 2,177 hospital beds (excluding maternity and pediatric) whilst funding or contributing to the funding of 1,794 placements in nursing homes. The ratio of private sector provision may be higher in other regions. This makes partnership working between the statutory and independent sectors essential. The National Commissioning Board has worked with the National Provider Forum to develop a Concordant to steer effective working relationships between them.

Recommendation 5: Regional partnerships should ensure that there are integrated mechanisms in place between health boards and local authorities to meet with providers on regular basis for the purposes of maintaining and planning service development. Whether these mechanisms are regional, sub-regional or local are for the regional Partnership Board to decide.

The National Provider Forum and its representative bodies should encourage the full participation of providers in these forums.

Recommendation 6: As part of their approach to the integrated commissioning of services from care homes, health boards and local authorities should develop a profile of each home together with a strategy for working with each home.

We know that care homes vary in the levels of dependency of the residents they are supporting. Care homes providing services to larger numbers of individuals with intense and or complex needs may need additional support. In some cases, care home owners may wish to retire and may need support to leave the market to help mitigate the impact on any disruption to care arrangements. Some homes may be in financial difficulties due to high numbers of vacancies. The development of a data base in relation to each home with appropriate information sharing protocols in place will facilitate service planning and quality assurance arrangements by scheduling and collecting information from contract compliance arrangements and the individual reviews of residents. The formal partnerships arrangements supported by appropriate information governance arrangements should enable the development of data base of publicly funded placements in each home which should inform this profile. It will also support the management of pooled funds.

4. The urgent need for improved management information to facilitate the effective management of resources.

Care homes in Wales are a multi-million £ business. Health Boards and local authorities directly fund around £369 million. This figure is estimated from the census. Health boards and local authorities can provide a more reliable figure. This figure excludes client contributions, third party fees and the fees paid by self-funders. To develop and commission services more effectively we need to improve our management information systems. We should not have to mount a research exercise to acquire information we should have at our finger tips and be collecting it as a matter of routine.

If health boards and local authorities are going to work together to maximize their influence over the development of care home services to respond to the needs of their populations, they will need to work with Welsh Government and care home providers to improve the quality of data available to inform decision making. The Population needs assessments should help to improve the information available to inform decision making.

This document includes recommendations (final chapter) on the information (and reports) that should be collected as a matter of routine to help partnership boards and their appropriate service and delivery management groups make informed decisions.

This should also include health and social care commissioners developing an integrated data base concerning the placements they fund in relation to each home. This can be undertaken as part of the development of their formal partnerships

This will require further discussion among stakeholders to reach agreement on consistent and robust management information and effective systems for its collection and analysis.

Recommendation 7: The Welsh Government to lead 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. The information from this analysis should inform this discussion.

5. Market Position Statements:

Whilst the regional partnerships will be working to maximize their influence over the development of services, care home providers also need good quality information on the commissioning intentions of the statutory sector and its analysis of the demand from individuals funding their own care; to inform their investment and any borrowing decisions. Market Position Statements are a means of providing this detailed information to providers. Population assessments may not provide sufficient detail concerning demand for care homes. Market Position Statements can be focused on care homes but can include wider accommodation options which will impact on demand for care home places. The development of such market position statements is also requirement under Part 9 of the Social services & Wellbeing Act 2014. Part 9 Guidance (S62) requires partners to agree an appropriate integrated market position statement and commissioning strategy. These will specify the outcomes required of care homes, including the range of services required.

Recommendation 8: Regional Partnership Boards should develop detailed market Position statements for care homes which may include broader accommodation options for older people. These will need to reflect locality needs as well as regional and local authority level needs. They will also need to address the needs of self-funders.

6. Shaping the services required: Clarifying service requirements to inform specifications and statements of purpose.

We need health board and local authority commissioning partners to work together with each care home provider to encourage the development of services that accurately reflect local needs. This may involve more providers moving to provide

services that can respond to those individuals with more complex needs. Commissioners will need to explore how they can support and facilitate these changes.

Care home providers will be required to develop statements of purpose to describe those needs their service can address together with how they will be addressed. Commissioners will be developing their service specifications describing the requirements of the services they commission. Commissioners and providers need to work together to achieve the best fit between demand and service provision.

Commissioners need to provide clarity about the services and the outcomes required from care homes. Given that we already have service specifications in place this requires explanation.

The following categories of care are widely used throughout Wales although they are not underpinned by legislation:

- Residential Homes
- Residential (elderly mentally ill – EMI) Homes
- General Nursing Homes
- Nursing (EMI) Homes

A description of each category is contained within the report.

These categories have been used for some time but it is not clear if they reflect current practice in terms of helping to steer people or professionals towards the most appropriate placement. This needs to be discussed in more detail with both commissioners and providers. There is some inconsistency in the pattern of distribution of placement categories throughout Wales and it is not clear how far they accurately reflect need (See tables 33 and 33A both within this document). There may also be inconsistency in the interpretation of these categories. The categories are used in some cases for helping to set fees. It proved difficult initially to get a written description of these categories. These categories are not part of registration requirements and the Regulation & Inspection Act will involve a more flexible approach to registration.

Another descriptor of care we have concerns eligibility for NHS Continuing Health Care in that it indicates some degree of complexity/ intensity of need. We have some homes in Wales with high numbers of residents eligible for CHC (86%) whilst others have 5% of residents eligible for CHC. The range can vary from 6% to 47% in Western Bay to 42% to 86% in Gwent. We may have the same specifications covering homes providing services to individuals with very different needs. We also know that care homes struggle to cope with some individuals with very intensive and complex needs and we need to develop and share good practice as to how they can respond more effectively to the needs of these residents.

The implementation of the Regulation and Inspection Act is likely to involve a much more flexible approach to the registration of care homes. Whilst commissioners should be basing or aligning their specifications on the standards developed to support the implementation of the Regulation and Inspection Act they will need to be clear concerning their expectations of services to be delivered by the provider and the standards required. A provider may meet the requirements of the regulator in terms of registration but may be offering a service which does not meet the requirements of the commissioner or the people requiring care and support.

One of the risks is that given the difficulties that some care homes experience in recruiting nurses, some may decide not to provide nursing care. These decisions are extremely unlikely to reflect the needs of older people and will only add to further places surplus to demand in residential care.

It will be important to get alignment between registration and commissioning standards to avoid unnecessary bureaucracy for providers. There are also important implications for policy in relation to “choice of accommodation” where there is a requirement to offer individuals choice between the same type of care home, i.e. individuals assessed as needing a placement in a nursing home cannot be offered a placement in a residential home.

Finally, assessments in relation to Funded Nursing Care require the involvement of a registered nurse and placements in nursing homes in relation to Funded Nursing Care and Continuing NHS Health Care require care homes to employ registered nurses 24/ 7 and yet there is a lack of transparent and accessible information describing the role and contribution of the nurse. Commissioners need to be clear about what services they require from care homes serving residents with different needs and they need to work with providers to influence the development of their statement of purpose which will determine their registration.

Recommendation 9: The National Commissioning Board to work with Health & Social Care Commissioners, CSSIW, Care Home Providers and advocates / representatives of residents to develop model service specifications which enable us to provide a consistent description of the services required, the quality required and outcomes to be achieved. These will be aligned as closely as possible with the standards developed as part of the implementation of the registration and Inspection Act.

This work can also inform the work of a costs of care group being established by the Care Homes steering group.

Recommendation 10: Health and Social Care Commissioners should offer support to care home providers with the development of their statement of purpose to achieve an appropriate balance between demand and supply. The ultimate decision rests with the care home owner but presumably they want to locate their business where there is a healthy demand.

7. Waiting Lists

Recommendation 11: The statutory sector should maintain their own waiting lists for care homes.

The information on waiting lists for care homes for this study was provided by care home providers. This may not be fully accurate because an individual may be on a waiting list for more than one home. The purpose of maintaining a waiting list in the statutory sector is to contribute to the development of a fair system for allocating placements. An older person, for example, may accept an interim placement and free up a hospital bed whilst waiting for a placement in their preferred choice of home to become vacant. When their preferred placement becomes available they should have the option of moving in advance to someone more recently assessed as needing such a placement. Individuals need to have some trust in the fairness of the system. The care home provider could, of course, ignore the statutory sector waiting list in favor of a self-funder who is prepared to pay a higher fee. The statutory sector can at least instill some fairness into the management of their placements they fund and may wish to discuss the effective operation of waiting lists with care home providers as part of the commissioning process. See tables 15, 16 for North Wales and 15A and 16A in Annex 1 for the rest of Wales

8. Self-Funders

Self-funders occupy a significant number of placements across Wales. The information on self-funders was largely provided by care home providers. There are 4877 people who fund their own care as reported by providers. Health reports report that there are 1121 people who fund their own care who also receive free nursing care and so there will be overlap between these figures.

Self-funders can occupy around 23% of registered beds across Wales. In terms of each region figures are as follows:

- Cardiff & Vale 35%
- Powys 27% Western Bay and Hywel Dda 26%
- North Wales 23%
- Gwent 16%
- Cwm Taf 9%
- Some homes have up to 50% of their places occupied by self-funders.

Recommendation 12: Local authorities and health boards should ensure that potential self-funders enjoy equal access to information and advice to inform their decision making. Further research required on the needs and motivation of self-funders on seeking admission to care homes.

9. Use of Care Homes: Rates of Placement:

The report captures information on the rates of placements per 1000 population of people aged 65 plus between local authorities and health boards. This information provides a crude benchmark. See Tables 27. The differential rates in respect of residents eligible for NHS continuing health care may be down to more effective pathways in some regions preventing an escalation of needs progressing to eligibility for CHC. Alternatively, it also be partially explained by inconsistent interpretation of the CHC Framework.

Regional Partnership Boards are invited to reflect upon these rates and explore their use of existing provision.

Recommendation 13: Steps to develop a more consistent interpretation of eligibility for CHC should be undertaken. This may involve the development of a national training regime together with a national arbitration / appeals mechanism.

10. Age of Residents

The age profile of residents is similar between regions. The average age at the start of the placement was recorded as 82. See tables 35 – 39. There were some variations – e.g. 85 in Monmouthshire.

There were 187 people admitted to care homes in North Wales below the age of 65. In the rest of Wales, 24 people were admitted below the age of 40; 54 being admitted between the ages of 40-49 and 521 between the ages of 50 to 64.

Recommendation 14: Regional partnerships boards should continue to monitor the age profile of residents. The reasons for admitting anyone below the age of 65 to a care home for older people should be scrutinized.

11. Length of Placement

This information may be slightly compromised in that some local authorities and health boards have recorded start of placement from the date they took some responsibility for funding the placement whereas the individual may have been in the place sometime beforehand.

The average length of placements from start of placement to census date for North Wales for each category of care are as follows:

Residential – 30 months; Residential EMI – 26months; General Nursing 22 months; Nursing EMI 22 months

There are variations across Wales: 39 months in Merthyr Tydfil for residential; 68 months in Neath Port Talbot for residential EMI; 42 months in Swansea for nursing

and 60 months in Blaenau Gwent for EMI. Partnerships may benefit from reviewing the circumstances of such long-term placements. The routine collection of data on length of placement terminating on death or transfer will be much more meaningful than an arbitrary census date. Anecdotally as we are supporting more people in the community people entering care homes are more frail both mentally and physically than would have been the case years ago. Consequently, they die sooner making the average length of placement much shorter which puts added pressure on homes having to get to know the preferences and outcomes of more and more new residents.

12. Third Party Payments

Across Wales we estimate that less than 10% of cases involve third party payments but we had no returns from 4 authorities. The rate (number of cases) of third party payments is above average in Flintshire, Swansea and Bridgend although the highest weekly third party contributions are reported in Gwynedd, Powys, Cardiff and Monmouthshire. See tables 42 and 43 in this paper for North Wales and 42A and 43A in Annex 1 for the rest of Wales.

Recommendation 15: Local authorities need to monitor the use made of third party payments together with the cost or size of the payment to ensure that they comply with the guidance issued in relation to the Social Services & wellbeing Act 2014. It is important that local authorities understand level of third party payments made in relation to each case. Those cases involving the highest fees (above £200 per week) should be subject to review. Health boards will also need to monitor the use of any additional payments made to support NHS Continuing Health Care placements.

For a wider discussion of these issues go to the main report.

3. Market Analysis of Care Homes for Older People in Wales

3.1. Introduction

Care homes in Wales and throughout the UK are experiencing serious challenges in terms of financial stability, recruitment of staff including nurses and registered managers, responding to higher levels of acuity and dependency among their residents (more complex health conditions) and not least the negative image of care homes.

The Care Home Steering Group was initially established to address serious operational pressures posed by the abrupt closure of several care homes. It very soon widened its brief to develop a broader vision for the future provision of these services. From the start, the Care Homes Steering Group adopted an integrated approach to looking at care home provision with representation from NHS and local authority commissioners, Providers, the Care & Social Services Inspectorate for Wales, the Care Council for Wales and many other partners. It divided its work into several work streams and one of these included a request to the National Commissioning Board (NCB) to undertake a market analysis of care homes for older people in Wales and this work is the subject of this report.

It would be more accurate to describe this study as a snapshot of demand and supply of care home placements in Wales. It has not analyzed the ownership or market share of provision in Wales. A separate exercise was undertaken by the Public Policy Institute for Wales which, commissioned the Institute of Public Care (Oxford Brookes University,) to examine ownership of care homes among other factors. This study found that there are significant variations in the care home market across Wales but overall there are fewer larger group providers compared to England and most homes are run by single providers. This study found The report – “The Care Home Market in Wales: Mapping the Sector” (October 2015) is available on the following link.

This analysis has been designed both as a one-off exercise to provide a picture of current demand and supply for care home places commissioned in Wales and to inform future data collection to ensure that such information is routinely available to regional partnership boards with no further need to mount one off research exercises. The PPI study referred to above noted that information gaps limit the ability of central and local government to anticipate potential problems in the care home market and to work with providers to secure future services. The routine gathering of information will also enable us to examine trends in demand and supply for the service.

This study provides a snapshot of the demand and supply of placements for care homes for older people in Wales. The information was collected as part of a pilot

study in North Wales on 16th May and rolled out to other Welsh regions on 1st August. The 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 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*. An analysis of this financial information will be included in a separate document and referred to the 'Costs of Care working Group' being established by Welsh Government.*

At an early stage it was decided to undertake a pilot exercise in North Wales. Given the size of the health board and the number of local authorities involved it was not the easiest region to pilot this project. The choice was governed by the fact that although there are challenges confronting the sector across Wales the difficulties in North Wales appear to be more acute.

The purposes of the pilot were also twofold in that in addition to building a picture of demand and supply the exercise was also designed to contribute to the development of a market position statement for care homes across North Wales. This work is already well underway. A number of workshops have been undertaken with providers where data from the analysis has been shared and with engagement of providers the Market Position statement is being drafted. A market position statement gives providers a range of information relevant to their business, particularly in relation to gaps in provision; and how it might develop. It should inform their investment decisions and borrowing requirements.

Following the provision of some background and contextual information the report describes the methodology before moving to the findings and a more detailed discussion of the key messages. This will include a description of the data which needs to be collected as a matter of routine to enable us to move from one off piece of expensive and time consuming research towards an up to date management information system to inform decision making and performance management. This will be important for partnership working. Effective partnerships and service integration require partners to be confident that the partnership arrangements are effective. Effective management information systems can serve to build confidence providing firm evidence that each partner is meeting their statutory responsibilities rather basing decisions on anecdotal information. This exercise has demonstrated the need for the development of an effective integrated management information system.

This report contains tables providing information relating to Wales.it also contains tables relating to the North Wales pilot for demonstrating how the information can

be analyzed. Most tables relating to the position across the rest of Wales are included in Annex 1. The main text will refer to the appropriate table in Annex 1.

Finally, it is important to note that this report should be bridging exercise. It is important that colleagues across the sectors scrutinize the data requirements and add or suggest amendments to ensure that our data collection systems in the future are sufficiently robust to inform service development. It will be for the regional partnership boards to scrutinize the local data and provide their own interpretation of it given their local knowledge and expertise. This study is partly designed to stimulate these discussions so that regional partnership boards working with their partners and develop an appropriate range of local solutions / services that respond to the needs and aspirations of the people in need of care and support.

3.2. Background and Context

How are services commissioned?

Services from care homes are commissioned in a number of ways. The most important point to make is that however these services are commissioned it is essential that the individual has the opportunity of having their needs assessed and are helped to identify the outcomes important to them. It is vital that the individual and his or her family are in a position to make informed decisions. Moving into a care home is a serious decision and may involve some sadness for the individual in moving from their home and in some cases their community. However, it should involve a positive choice in that it should offer the best means of maintaining and promoting the quality of life of those individuals in need of immediate access to care and support. Premature or inappropriate admissions should be avoided. They can have a negative impact upon the individual concerned, inflate demand and block beds for those more in need of them.

The Care home itself will also assess the needs of the potential resident to satisfy themselves and all concerned that they can meet the needs of the individual appropriately. This will apply whether the placement is funded by health or social services or funded by the individual themselves.

Most placements are funded by local authorities; jointly funded by local authorities and health boards or in the case of those eligible for continuing health NHS care, by health boards. Jointly funded placements will include placements in nursing homes funded by local authorities with the health board funding the ‘free nursing care element of the placement costs. Placements are also funded to respond to the needs of individuals with mental health problems under section 117 of the Mental Health Act. Section 117 aftercare is a legal duty that is placed on health and social services to provide after care services for individuals who have been detained under Section 3, Section 37, Section 47, Section 48 and Section 45A. It is the duty that comes in effect once the person has been discharged from the

hospital. The aim of Section 117 aftercare is to provide services to prevent further admissions to a hospital. Some of these placements are jointly funded whilst others are fully funded by the health board.

Where placements are funded by local authorities or health boards the needs of the individual will be assessed. This may involve a range of health and social care professionals who will work with the individual and their family/ carers to identify their needs, strengths and the outcomes important to them. This should provide an opportunity to explore all the appropriate options. The assessment should empower the individual to make an informed decision. NHS Funded Nursing Care will only be paid in respect of those people identified through an assessment confirming the need for care by a registered nurse. The assessment will normally be conducted by an appropriately trained nurse. NHS Funded Nursing Care is different from and not a substitute for Continuing NHS Care. Health boards (working closely with local authorities) need to ensure that there is alignment between NHS Funded Nursing Care and Continuing NHS Health Care arrangements. In carrying out an assessment, the first consideration should always be the extent to which the identified needs may meet the criteria for Continuing NHS Health Care.

Where the local authority is involved in making a placement it will undertake an assessment of the individual's financial circumstances to assess whether he or she should be making a financial contribution to the placement. This applies to placements in residential care homes and nursing homes funding by local authorities. With regard, to placements in nursing homes local health boards are required to fund the nursing care element of the care package (Funded nursing care). Where individuals are assessed as being eligible for NHS Continuing Health Care the costs of their placements are met by the local health board.

Some individuals will choose to enter a residential home and will fund their own fees. When their assets decline to threshold they can request financial support from a local authority. In these cases, the local authority will undertake an assessment of the individual's needs for care and support services and if there is an agreement that the placement in the care home offers the best option for providing the appropriate level of care and support the local authority will contribute to the costs of the placement. These situations can create dilemmas for local authorities. It may put them in a position where the assessment of the needs of the individual may conclude that they do not require care and support in a residential care placement but there may be no alternative. All individuals should have their needs for care and support assessed and all the options should be considered. Further research is required to explore the circumstances and motivation of self-funders (and their families) in choosing to move into a care home.

Some individuals whose needs have been assessed and a placement in a nursing home is determined to be the most effective option of responding to those needs may elect to pay their own fees but seek funding from health boards to fund the costs of nursing care (Funded Nursing Care).

In developing their area plans or market position statements or commissioning strategies it will be important for regional partnership boards to take account of the needs of those individuals who wish to fund their own care. Failure to do so will lead to a serious imbalance of provision. Self-funders may occupy over 30% of registered placements available in the area.

Choice of accommodation

The requirements in relation to “choice of accommodation” are important because they have an impact both in relation to the development of the market and in terms of transfers of care from hospital. Delays in choosing accommodation or waiting for a placement to become available are a significant source of delays involving transfers of care from hospital.

Whilst securing placements local authorities also have to offer a choice of accommodation to individuals whose needs and outcomes are assessed being most effectively met by placement in a care home with immediate access to 24hour care and support. Health boards are also expected to have local protocols on choice of accommodation.

Where a person’s needs are met by provision of accommodation in a care home, a local authority must provide for the person’s preferred choice of accommodation, subject to certain conditions. Determining the appropriate type of accommodation should be made with the person as part of the care and support planning process,

The local authority must ensure that the person has a genuine choice and must ensure that more than one option is available within its usual commissioning rate for a care home of the type a person has been assessed as requiring. However, a person must also be able to choose alternative options, including a more expensive home.

Where a local authority is to meet a person’s needs and that person’s needs have been assessed as requiring accommodation in a care home, the person must have the right to express a preference for a care home of their choosing provided that:

- The care home is suitable to meet the person’s assessed needs;
- To do so would not cost the local authority more than the amount it would usually expect to pay for accommodation of that type.; a place in the care home is available; and

- The provider of the care home is willing to enter into a contract with the local authority to provide the accommodation on the local authority's terms and conditions.

This choice must not be limited to those care homes or individual providers with which the local authority already contracts or operates; or those that are within that local authority's geographical boundary. It must be a genuine choice for the person across the appropriate care home accommodation available.

Additional Costs (Third Party Payments)

However, a person must also be able to choose alternative options, including a more expensive home. Where a home costs a local authority more than it would usually it would usually pay, a person must be able to be placed there if certain conditions are met and where a third party (or in certain circumstances the resident) is willing and able to pay the additional cost. However, an additional cost payment must always be optional and never as the result of a shortfall in the funding a local authority is providing to a care home to meet a person's assessed care needs. Local authorities must follow the Care and Support (Choice of Accommodation) (Wales) Regulations 2015 in connection with this type of arrangement and Annex C on choice of accommodation and additional cost payments.

In exercising choice, a local authority must ensure the care home accommodation for which a person expresses a preference is suitable to meet their assessed needs and identified well-being outcomes established as part of the care and support assessment process. In doing this, authorities must take account of any specific impairment or sensory needs a person has, so as to ensure the chosen accommodation has appropriate facilities or specialist services to meet these.

As part of the care and support assessment process, people can express a preference about the type of accommodation in which their needs are best being met (e.g. residential care or nursing home care). This process considers both the person's needs and preferences. Once the type of accommodation is agreed the choice of accommodation is between different care homes and different locations, not different types of residential settings. A person cannot exercise a right to a choice of accommodation by choosing another type of accommodation to that identified as appropriate to respond to their needs as identified in their assessment. Given that future registration requirements may become more flexible with the implementation of the Regulation & Inspection Act the descriptions of types of accommodation will be very important.

In all cases the local authority must have regard to the actual cost of good quality care in meeting a person's needs to ensure that the care home placement can genuinely meet their assessed needs. As such, a local authority must not set

arbitrary ceilings for particular types of accommodation that do not reflect the actual needs of the person being placed.

A person must not be asked to pay an additional cost towards the cost of providing the type of accommodation in a care home to meet their assessed needs. Where no suitable accommodation is available at its standard amount to meet a person's needs in full, the local authority must arrange a placement in a suitable more expensive setting and adjust its funding accordingly to ensure that needs are met. In such circumstances the local authority must not ask the person being placed or a third party to pay the additional cost.

Only where a person has chosen a care home that is genuinely more expensive than a local authority would usually pay for a care home placement of that type or, where a person has requested services or facilities that do not form part of their assessed needs, can additional cost be sought.

The National Framework for the implementation Continuing NHS Healthcare in Wales (June 2014) contains a section on Additional contributions from an individual who is eligible for CHC. The framework states: - "The NHS should never subsidize private care with public money and patients should never be charged for their NHS care or be allowed to pay for NHS care. The framework notes that there may be circumstances where individuals and /or their representatives may choose to access additional services or premium accommodation by making, and paying for separate arrangements themselves. The framework provides guidance in relation to additional personal contributions. Such arrangements should be monitored by local health boards.

The requirements concerning choice of accommodation are important both to the individual and their family but also because the individual can choose a home registered with the regulator even though the commissioner may not wish to contract with the home on grounds of quality or accessibility. This may impact upon the commissioner's ability to influence the shape of service provision.

Waiting List – choice of accommodation.

In general, a local authority must avoid a person being forced to wait for assessed needs to be met. However, in some cases a short wait may be unavoidable, particularly when a person has chosen a care home that is suitable but not immediately available. This may include putting in place temporary arrangements, taking account, the person's preferences and needs, and securing their agreement to these, including placing the person on the waiting list for their preferred choice of care home. Where a place subsequently becomes available at a person's chosen care home they must be offered this without delay where it is still appropriate. Many commissioners do not keep waiting lists and it is not clear how they maintain a record of responding to the individual's preference for moving to their preferred choice from an interim placement.

3.3. Challenges

The Care Homes sector faces significant challenges. The service is confronted by rising demand, serious workforce and financial pressures together with the challenges of responding to the needs and preferred outcomes of individuals who are more frail and have more complex needs than was previously the case. To some extent this is due to the success of family carers and all sectors in supporting individuals with increasingly complex needs within the community. It means that individuals seeking placements within care homes are now presenting with more complex needs.

The challenges in terms of demand are twofold. The first concerns the demographic challenge of a growing elderly population. The prevalence of ill health or disability increases with age. The demographic challenges are outlined below. The sector also faces other challenges in terms of providing alternatives to care provided within hospitals. There are pressures on both health and social services to avoid delayed transfers of care and the contribution of care homes will be explored later. We must also acknowledge that the number of hospital beds has declined over the past 10 to 15 years and this also implications for the sector both in terms of the demand in terms of numbers and the complexity of needs it is required to respond to.

The growing demographic challenge can be illustrated by reference to the Daffodil Care Needs projection system. The Daffodil Care needs projection system indicates significant changes in the population over the next 20 years. These projections pose serious challenges in terms of managing demand in both an efficient and equitable way. Demand for care homes is likely to increase unless alternative forms of accessible accommodation and care and support are available. The changes in terms of the growing population of older people are illustrated for Wales and for North Wales below.

Table 2 below demonstrates the changes in population in Wales between 2016 and 2030. Table 3 provides the estimate for the pilot area in North Wales.

Table 2 Wales Population Projections				
People Aged:	**2016**	**2020**	**2025**	**2030**
65-69	195,540	176,970	186,400	207,450
70-74	154,830	179,960	164,790	174,440
75- 79	116,570	132,020	159,990	147,640
80-84	85610	93,160	108,770	133,620
85+	84370	95,430	114,500	141,530
Total	**636,920**	**677,540 %+6.37**	**734,450 + 15.31%**	**804,680 +26.33%**

**% changes are all from 2016*

Table3 Betsi Cadwalladr Health Board				
People Aged:	**2016**	**2020**	**2025**	**2030**
65-69	48,100	42,140	43,770	48,860
70-74	38480	44,540	39,370	41,090
75-79	28,880	32,990	39,840	35,480
80-84	20,970	23,270	27,490	33,620
85+	21,350	24,070	29,100	36,310
Total	**157,780**	**167,010 +6%**	**179,570 +14%**	**195,360 +23.81%**

**% changes are all from 2015*

The demographic changes pose significantly larger challenges for specific areas. The County of Flintshire, for example, will see its population aged between 80-84 increase by 66% and its population aged 85 plus increase by 168% by 2035.

The value of the Daffodil system is that it helps us look into the future and challenges us to question what we want to achieve. If all factors, for example, remain constant (e.g. no significant changes in service development or medical interventions) these demographic changes would result demand for additional placements in care homes as illustrated below.

Placement projections based upon current practice and population projections

They are based upon placements today and populations projections assuming no change in practice or service provision. We want to change these scenarios through developing other accommodation and care and support options.

The projections in table 5 in relation to residential care look challenging for Flintshire, Wrexham, Powys, Neath Port Talbot, Bridgend and Caerphilly for 2025 and they look challenging for all areas when we add projections for placements for self-funders. The development of other accommodation and care and support services will change this scenario as will greater efforts to provide information to those funding their own care.

Table 5 Local authority placement projections (Residential Care)				
Local Authority	**Placements 2016**	**Additional Placements required 2020?**	**Vacancies 2016**	**Additional Placements required 2025?**
Anglesey	223	12	32	29
Gwynedd	358	12	33	31
Conwy	385	18	62	47
Denbighshire	279	17	101	39
Flintshire	352	26	19	**57**
Wrexham	426	35	49	**78**
Powys	406	35	41	**76**
Ceredigion	172	10	50	23
Pembroke	269	17	44	36
Carmarthenshire	562	39	133	91
Swansea	429	23	136	56
Neath Port Talbot	390	24	41	**57**
Bridgend	307	23	22	**56**
Cardiff	436	34	115	90
Vale of Glamorgan	187	17	54	39
Rhondda Cynon Taf	515	26	70	63
Merthyr Tydfil	117	8	35	20
Caerphilly	397	27	40	**66**
Blaenau Gwent	130	4	20	13
Torfaen	211	13	58	31
Monmouthshire	153	12	6	27
Newport	152	6	31	19

Table 2 Self-Funder Projections for Residential Care Placements Repeated from section 2		
	2020	2025
North Wales	65	152
Powys	21	46
West Wales	44	101
Western Bay	43	107
Cardiff & Vale	43	114
Cwm Taf	8	21
Gwent	33	82
Total	**257**	**623**

Table 1 Projections of additional placements required Repeated from section 2						
	Residential Care Homes			**Nursing Homes**		
	Additional placement requirements			**Additional placement requirements**		
	2020	**2025**	**Vacancies 2016**	**2020**	**2025**	**Vacancies 2016**
North Wales	120	281	296	104	**246**	144
Powys	35	76	41	30	**63**	32
West Wales	66	150	227	46	**105**	110
Western Bay	70	169	199	78	**189**	93
Cardiff & Vale	51	129	169	**99**	**255**	75
Cwm Taf	34	83	105	32	**84**	21
Gwent	62	156	155	70	175	107
Total	**438**	**1044**	**1192**	**459**	**1117**	**582**

The table below attempts to break the CHC and self-funder placements down to local authority estimates based upon each local authority's share of the region's population. This may be stretching statistical rules. Unfortunately, we cannot (in this exercise) trace residents eligible for these forms of help back to their local authority of origin. This is simply an estimate. The projected need for nursing home placements looks challenging for several areas in 2020 and for nearly all for 2025 when matched against vacancies reported at the time of the census.

Table 6 Estimated projections of nursing home placements required in each local authority area			
Placement Projections for Nursing Homes			
Local authority area based upon population share of placements funded by health board	**Additional Placements required 2020?**	**Vacancies reported 2016**	**Additional Placements required 2025?**
Anglesey	**11**	1	**25**
Gwynedd	17	35	**43**
Conwy	22	37	**53**
Denbighshire	14	22	**34**
Flintshire	22	35	**49**
Wrexham	**18**	14	**42**
Region	**104**	**144**	**246**
Powys	30	32	63
Region	**30**	**32**	**63**
Ceredigion	**11**	5	**24**
Pembroke	14	72	31
Carmarthenshire	21	33	**50**
Region	**46**	**110**	**105**
Swansea	36	70	**89**
Neath Port Talbot	**22**	14	**52**
Bridgend	**20**	9	**48**
Region	**78**	**93**	**189**
Cardiff	67	71	**175**
Vale of Glamorgan	**32**	4	**80**
Region	**99**	**75**	**255**
Merthyr Tydfil	**7**	3	**19**
Rhondda Cynon Taf	**25**	18	**65**
Region	**32**	**21**	**84**
Caerphlly	**21**	17	**50**
Blaenau Gwent	7	36	18
Torfaen	14	20	**34**
Monmouthshire	**15**	13	**33**
Newport	14	21	**40**
Region	**71**	**107**	**175**

The question arises as to on what scale we want to provide this model of care and in which locations do we need to work with partners to secure an appropriate range of provision.

Complexity of need

We have limited information to judge the complexity of needs care homes are having to respond to. One of the few descriptors concerns eligibility for NHS Continuing Health Care. The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need. The characteristics of need including nature, intensity, complexity and unpredictability; and their impact on the care required to manage them will determine whether an individual's primary need is a health need. These are described in more detail in 5.6.

Each of these characteristics may alone or in combination, demonstrate a primary health need because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and effects of the interaction of needs should be carefully considered. (Continuing NHS Healthcare: The National Framework for Implementation in Wales – June 2014).

In North Wales we have 11 homes operating with over 50% of residents eligible for CHC. The homes vary in size from 18 to 50 registered beds. The highest % of CHC residents in one home is 68% for a home registered for 34 placements and with 23 CHC residents. There are a further 9 care homes with 40% plus CHC residents. The relevance of this is that eligibility for CHC indicates the complex needs of the individual. In Gwent we have a home operating with 86% of its residents eligible for CHC.

We also have evidence from the current categories of care used. These are described in more detail later.

Workforce and Funding

Two major challenges facing care homes concern fees and workforce. The Care Homes Steering have two working groups established to address these issues. The Welsh Government has a working group in place in relation to addressing workforce challenges and is in the process of establishing a 'costs of care working group' to examine approaches to fee setting.

The relevance of these work streams to this exercise is that if we want commissioners to shape provision to more accurately reflect need we should consider how we can help providers to address serious workforce challenges. This would indicate the need for a more integrated approach to workforce development both between health and social care and between the sectors.

We will also need to consider the financial implications of incentivizing changes in provision.

3.4. Opportunities

The Integrated Commissioning of Services from Care Homes for Older people though Formal Partnerships & Pooled Funds

Part 9 of the Social Services and Wellbeing (Wales) Act 2014 requires that regional partnership boards develop formal partnerships and pooled funds to support the integrated commissioning of services from care homes for older people. This is a legal requirement and they should become operational no later than April 2018. The potential for developing such arrangements has been available since the introduction of the Health Act in 1999 as referenced by the guidance NHS Funded Nursing Care in Care Homes (WHC 2004/024) and NAFW 25/2004.

“It is a fundamental requirement of the guidance that LHBs work closely with key stakeholders, to maintain and or develop integrated and steam-lined arrangements for the commissioning, arrangement and provision of care in care homes”
“Implementation of the NHS Funded Nursing Care provides a genuine opportunity for establishing effective joint working arrangements. The particular opportunities for joint commissioning between Health and Social Services made available by the Health Act 1999, should help to minimize any potential disruption in care provision that changed funding requirements might generate”

“For the user there should be no boundaries in the provision of care, and this needs to be recognized in the development of integrated commissioning arrangements between local authorities and local health boards. The most straightforward approach will be for the local authority to continue to commission all aspects of care, including nursing care by a registered nurse, under the auspices of a Partnership Agreement.”

Regional partnership boards have complete freedom to develop formal partnerships and pooled budgets across any services they commission where such arrangements could improve outcomes for users /carers and make better use of resources.

The development of formal partnerships alongside effective commissioning practice will offer a coherent and integrated approach to working with providers to develop and maintain an appropriate range of services.

3.5. Regulation and Inspection of Social Care (Wales) Act 2016

The R&I Act requires local authorities to prepare and publish a local market stability report at such times as may be prescribed by regulations. The report will include an assessment of the sufficiency of provision of care and support in the local authority area. This report will be informed by the assessment and plan it has most recently published under sections 14 and 124(a) of the Social Services and Wellbeing (Wales) Act 2014. Hopefully this market analysis will prove helpful.

The R&I act also introduces a market oversight regime. Part of this regime may involve an assessment of the financial stability of the service provider's business of carrying on regulated services. Where Welsh Ministers in the light of such an assessment think that there is significant risk to the financial stability of a service provider's business, Welsh Ministers may:

- Require the service provider to develop a plan for how to mitigate or eliminate the risk, and
- Arrange for, or require the service provider to arrange for, a person with appropriate professional expertise to carry out an independent review of the business.

Welsh Ministers must inform the appropriate local authorities if they think the service provider becomes unable to provide the regulated service in question.

Welsh Ministers must by regulations specify criteria for determining whether the assessment of financial sustainability applies to a provider of regulated services. In specifying the criteria, Welsh Ministers must have regard to the following in particular: -

(a) The amount of care and support provided by the service provider
(b) The geographical concentration of a service user's business, and
(c) The extent to which a service provider specializes in the provision of particular types of regulated service.

Welsh Ministers are also required to prepare and publish a national market stability report at such times as may be prescribed. This report will include an assessment of the sufficiency of care and support provided in Wales during such time as may be prescribed. In preparing a market stability report Welsh Ministers must have regard to the most recent local market stability report published by each local authority.

4. Methodology

The purpose of the exercise was to provide a basic position statement describing current demand and supply of care home services across Wales. The exercise was also designed capture information on fees and third party contributions.

The exercise was designed to take account of every placement made in Care Homes for Older People in Wales together with every placement purchased by Welsh local authorities and health boards in care homes outside of Wales. The exercise does not encompass homes for younger adults and will therefore not take into account older people living in these homes. It will however capture the number of younger adults (aged below 65) living in care homes for older people.

The exercise does not include an analysis of ownership of care homes in Wales. A previous report 'The Care Home Market in Wales: Mapping the Sector (October 2015) requested by the then Minister was commissioned by the Public Policy Institute for Wales from the Institute of Public Care, Oxford Brookes University. We did not want to duplicate this work.

Although the exercise required limited information the results can be used to provide a wide range of useful information. Prior to the exercise starting several colleagues suggested that we could collect other useful information. We needed to balance these suggestions against what we thought would be deliverable. As it stands there are gaps in some of the limited information requested which demonstrates some of the shortcomings we need to address in the future. Despite considerable efforts some agencies, for example, were not able to provide all the information within the timescales required. This report lists suggestions for improving both the range of information collected and the means of keeping it up to date.

We asked local authorities and health boards to provide information all individual placements in relation to:

- Care home location – local authority
- Name of care home
- Nature of placement e.g. long term care, respite care, intermediate care step up / stepdown; intermediate care assessment.
- Category of care – residential, residential EMI, general nursing, nursing EMI
- Out of area placements
- Reasons for out of area placements
- Date of admission
- Length of stay at date of census
- Date of birth
- Age at date of census
- Age at the start of the placement

- Funding stream for placement
- Funding partners
- Existence of third party payments
- Weekly contributions from individual, local authority, health board, third party if known, and total cost of placement.

To avoid double counting we asked local authorities to provide the information on jointly funded placements. We asked local authorities to collect information directly from care home providers.

Information from providers included:

- Number of self-funders
- Number of individuals funded by health boards or local authorities outside of Wales
- Number of vacancies
- Number of people on waiting list.

We had a very high return from providers and we would like to take this opportunity to express our appreciation of their efforts. Similarly, we would like thank all the staff in health boards and local authorities for their contribution to this exercise.

Given the complexity of this exercise we started with a pilot study in North Wales. North Wales is perhaps the most challenging region simply in terms of its size and the large number of local authorities working in partnership with the health board. We chose North Wales because the pressures in terms of demand appeared to be more acute in North Wales. The Census date for North Wales was 15th May and 1st August for the rest of Wales.

Given our experience with the pilot study we did provide more detailed briefings for the other health boards and local authorities across Wales with two workshops. Some individuals also took opportunities to attend sessions with the data unit. Both staff from the NCB staff Data Unit also responded to questions by telephone and computer.

We also made a change to the data collected to separate section 117 placements (Placements made under Mental Health legislation for the other Welsh regions).

Once the returns were received the Data Unit also followed up to clarify information about specific cases.

Some areas were not able to provide all the information within the timescales required. Given the need to press on with the study and existing pressures within the regions we decided that there would be little benefit in continuing to chase for this information. We have enough information to specify requirements for the future

5. Findings and Key Messages:
5.1. The inter-dependency of Health and Social Services

In the pilot study it was found that the Health Board contributes to or funds in full 99% of all placements in care homes with nursing placements. Local authorities contribute to the funding of around 47% of placements in nursing homes across Wales.

It is therefore very important that neither health boards or local authorities make any unilateral decisions concerning what services they commission from specific care homes. If a health board decided, for example, to block contract for 6 placements for a specific purpose in a particular care home this will reduce the number of long placements in that home for the local authority to commission possibly in an area where there is a shortage of such placements and vice versa. Health boards and local authorities should work to reach agreement on the services to be commissioned (long term placements, step up / step down intermediate care placements, etc.) from each home and negotiate with the care home provider.

Both health boards and local authorities should be using their purchasing power to attempt to shape the market. They cannot manage the market in total because self- funders purchase a significant share of placements. The analysis did not request information from health boards or local authorities on total spend but if we look at the weekly costs pf placements North Wales alone are probably spending over £90 million per year which should buy some influence. The figure for Wales is around £369 million. Care homes are, of course, part of a continuum of care and should be developed as part of the whole systems approach described below.

“Developing whole- systems approaches to shaping the health and social care market is pivotal to ensuring that people can access the right care, at the right time, with greater co-ordination of planning and commissioning arrangements and budgets wherever possible”

“The purpose of market shaping is to stimulate a diverse range of appropriate services, both in terms of the type of services and the types of provider organisation, and to ensure that the market as a whole remains vibrant and sustainable”.

(Market Shaping Review IPC – Placed -based Market Shaping: Co-ordinating health and social care July 2016)

The development of formal partnerships and stronger integrated commissioning arrangements should assist. Regional partnership boards can build upon these arrangements for Care homes by adding home care and reablement services at a later date.

Information on the placements by funding stream for North Wales is included in table 7 below. See Table 7A Annex 1 for rest of Wales.

Table 7 Placements by funding stream									
	Local authority		**LA & FNC**		**CHC**		**Self funder & FNC**		**Total**
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	
Anglesey	223	79	58	21	-		-		281
Gwynedd	358	69	163	31	-		-		521
Conwy	385	72	153	28	-		-		538
Denbighshire	279	79	72	21	-		-		351
Flintshire	352	79	92	21	-		-		444
Wrexham	426	86	71	14	-		-		497
Health Board	0	0	0	0	883	75	302		1185
North Wales	2023	53	609	16	883	23	302		3817

Table 8 Placements made by funding organization							
Occupied by:							
	Self -funder		**Individuals placed by LA/LHB outside Wales**		**Individuals placed from inside Wales**		
	Number	%	Number	%	Number	%	Total
Anglesey	160	34	3	1	304	65	467
Gwnedd	268	28	36	4	646	68	1950
Conwy	303	30	10	1	704	69	1917
Denbighshire	258	31	32	4	535	65	825
Flintshire	193	28	20	3	485	69	698
Wrexham	208	23	26	3	658	74	892
North Wales	1390	29	127	3	3332	69	4849

The number of individuals placed from local authorities or health boards outside Wales at 127 compares with 434 placements made by North Wales out of area.

Charts 1 and 1A below provides an illustration of the significance of self- funders together with the relatively small number of placements made by public bodies outside Wales.

Occupied Beds by funding organization Chart 1.

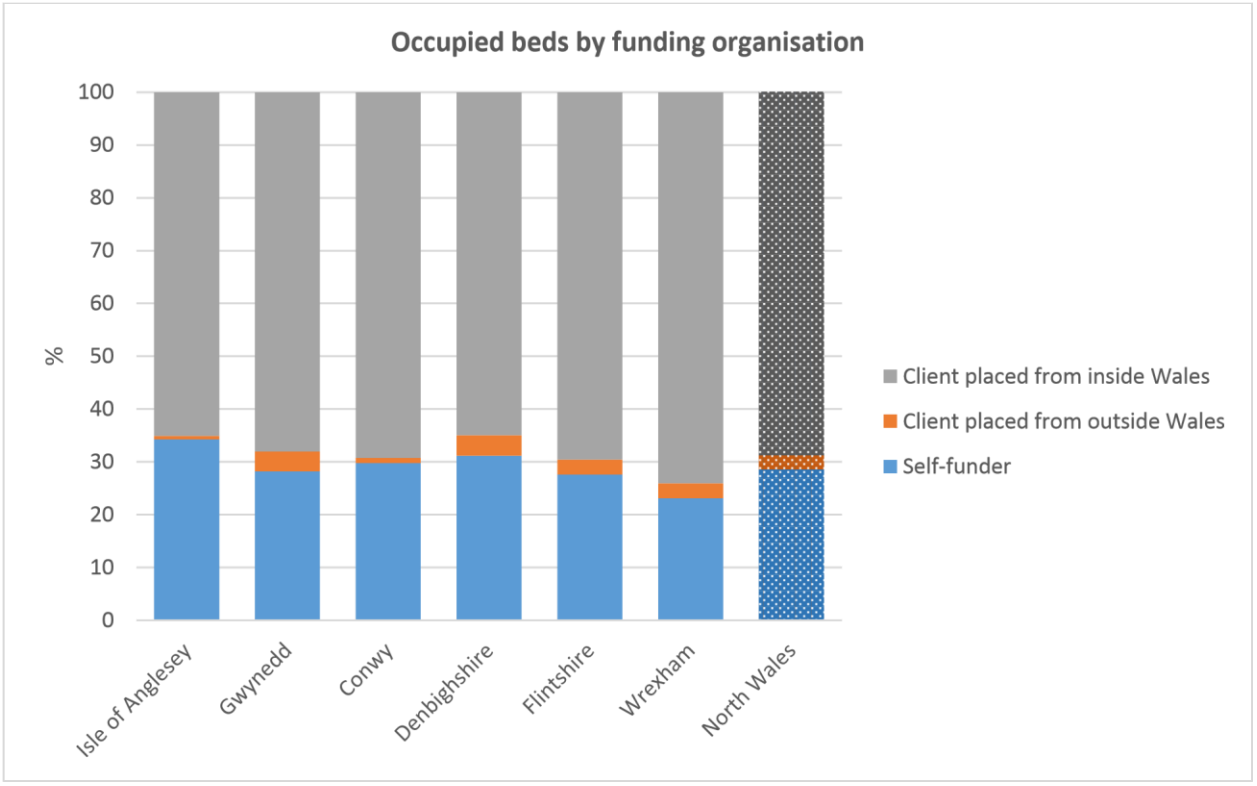


Chart 1A

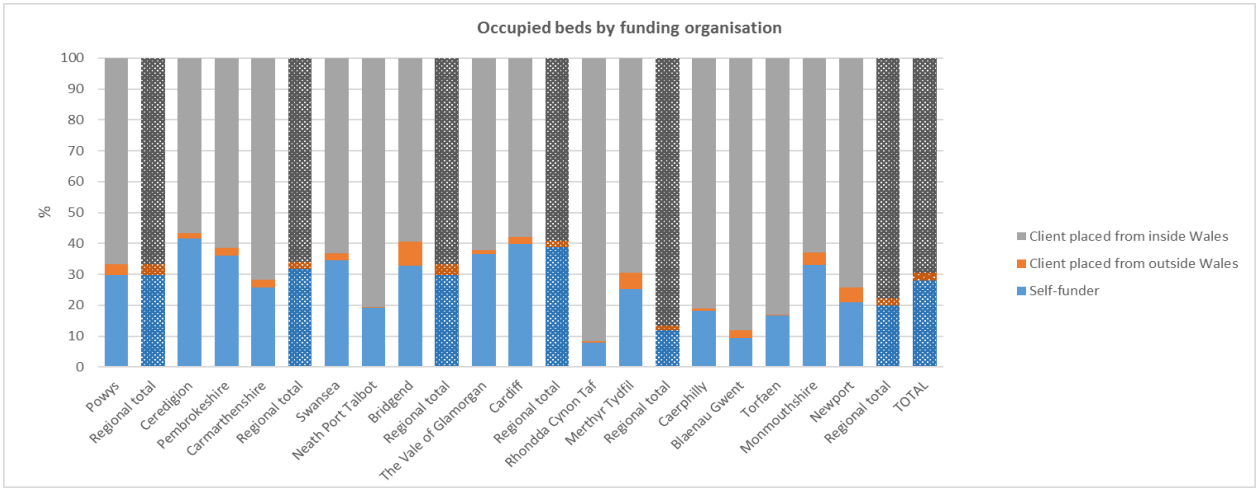


Chart 1A indicates the smaller proportion of placements occupied by self- funders in Blaenau Gwent and Rhondda Cynon Taf.

Chart 2 and 2A adds to the picture by adding the proportion of vacant registered beds.

Chart 2 Occupied Beds by funding organization

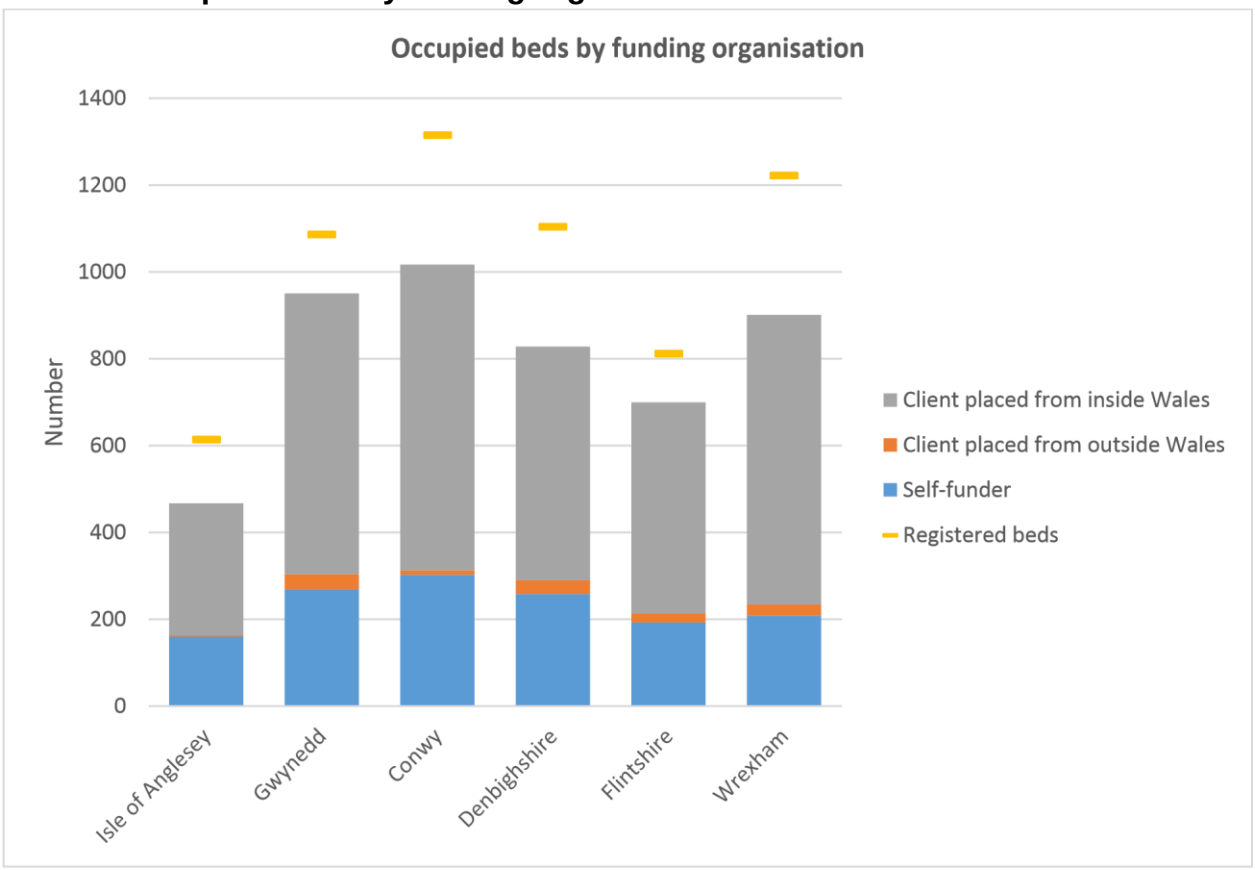


Chart 2A

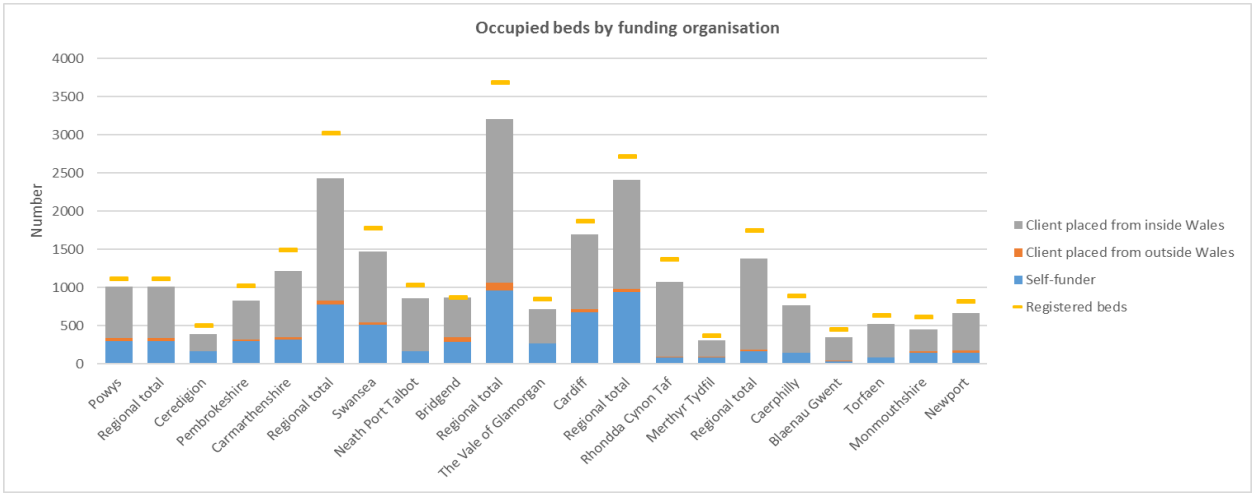


Chart 3 - Occupied Beds by funding organization (chart 3)

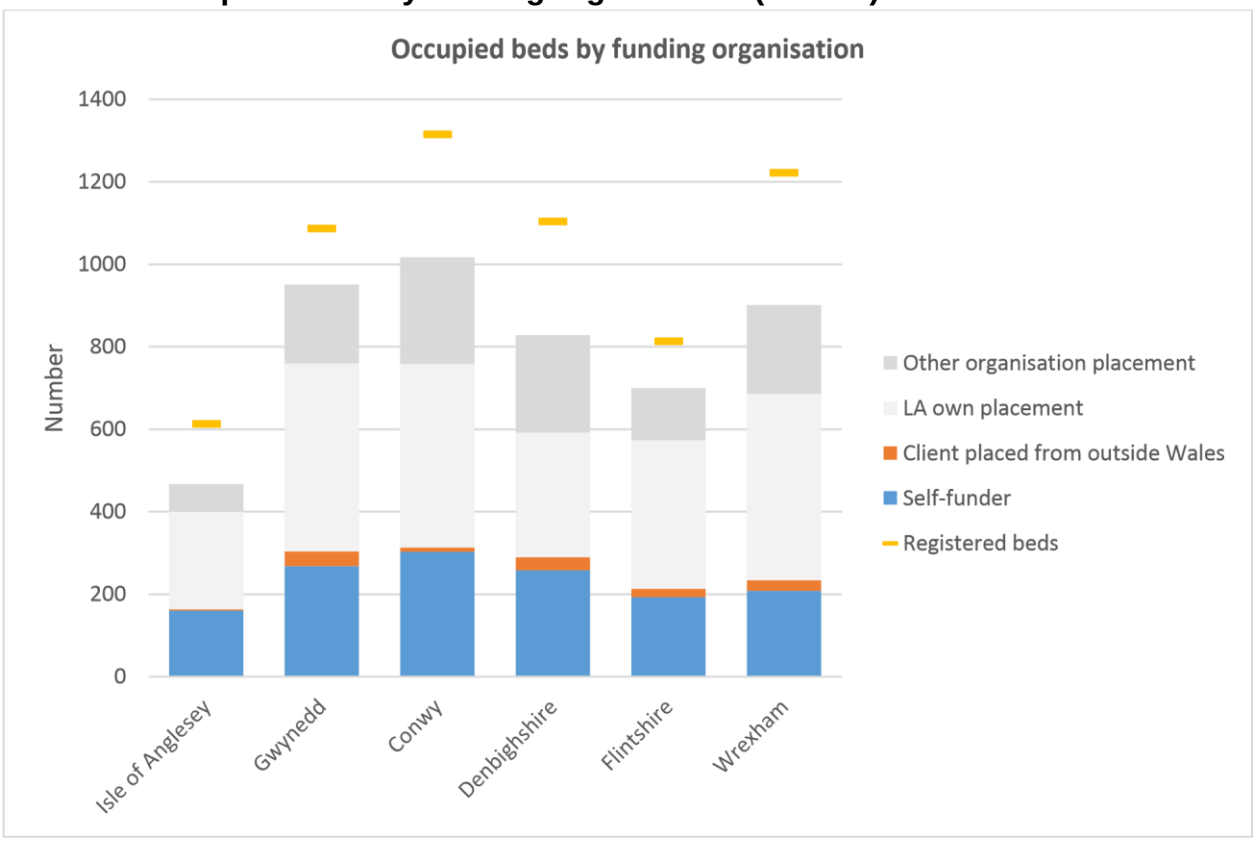
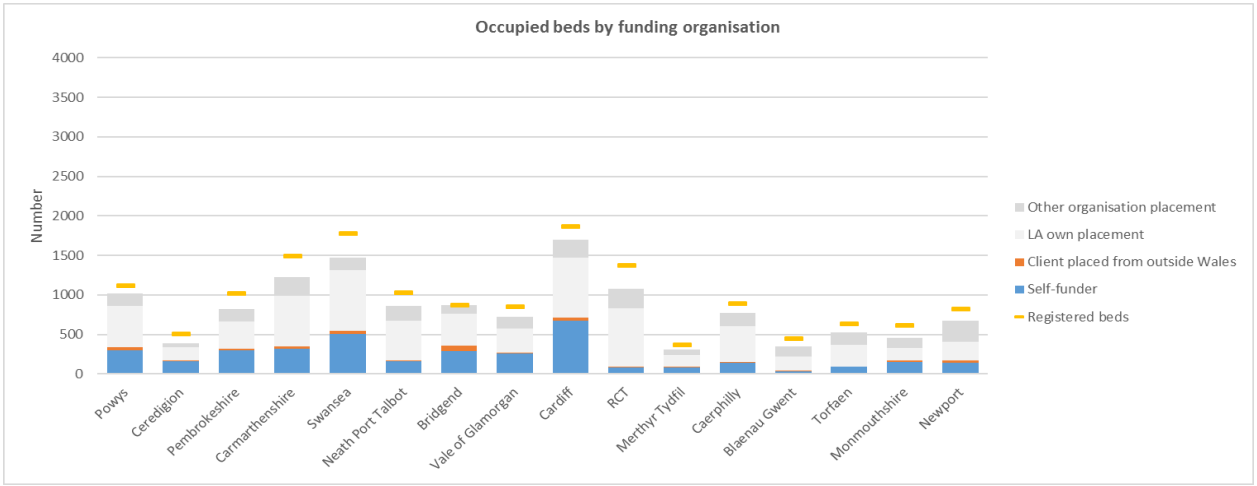


Chart 3A



5.2. Self- Funders

Self-funders occupy a significant number of placements across Wales. The information on self-funders was largely provided by care home providers. There are 4877 people who fund their own care as reported by providers. Health reports report that there are 1121 people who fund their own care who also receive free nursing care and so there will be overlap between these figures.

The number of placements funded by individuals purchasing their own care is very significant accounting for 1390 (23% of registered beds) or 29% of placements in North Wales. In North Wales:

- 82% of self-funders come from within LA area in North Wales.
- 6% come from another Welsh local authority
- 7% or 104 come from outside Wales
- There are a significant number of homes with over 50% of beds being occupied by self-funders. Anglesey has seven homes with over 50% selffunders. Most of these homes are small offering 8, 10, 16 placements whilst others cater for 22, 29, 29 and 42 total beds.
- Gwynedd has nine homes with over 50% of placements occupied by self-funders. – The size of homes by placements included :- 4,6,10, 11,13,23,23,32,35.
- Conwy has 12 homes with 50%plus self-funders the sizes of homes are 8,9,9,10,13,14,16,18,21,29,29 and 42
- Denbighshire has 9 homes with 50% plus self-funders – 9,12,17,17, 18,19, 22,26 and 32
- Flintshire 3 homes with 50% plus 23,27,31
- Wrexham 5 homes - 8,10,26,27,41

Self-funders can occupy around 23% of registered beds across Wales. In terms of each region figures are as follows:

- Cardiff & Vale 35%
- Powys 27% Western Bay and Hywel Dda 26%
- North Wales 23%
- Gwent 16%
- Cwm Taf 9%

- The regional partnership needs to ensure that all potential self- funders receive appropriate information and advice on all options available for care and support in the community.
- In order to manage demand effectively the health board and its local authority partners will need to ensure that every effort is made to ensure that potential self-funders have access to good quality information and

advice on all the care and support options available to inform their decisions. This may reduce demand but it will also impact upon the revenue of providers.

Recommendation

- Local authorities and health boards should ensure that potential self-funders enjoy equal access to information and advice to inform their decision making.
- Further research is required on the needs and motivation of self-funders on seeking admission to care homes.

5.3. Partnership between Commissioners and Providers

Overall across Wales the local authorities provide 10% of the registered beds; the third sector provides 3% and the private / independent sector provides 87%. If this was confined to nursing homes the proportion would move towards 100% in the private sector. There are four local authorities in Wales who no longer directly provide residential care. See Tables 9 and 10 for North Wales and 9A and 10A for the rest of Wales. The private sector provides between 77% of placements in Cwm Taf and 96% of placements in Powys.

To put this into context if we exclude paediatric (99) and maternity beds (93) the health board in North Wales provides 2177 beds (537community; 1416 major acute; 182 mental health; and 42 specialist). In comparison, the NHS funds or part funds 1794 beds in the care home sector in North Wales. This demonstrates the scale of activity undertaken by the care home sector on behalf of the NHS.

Tables 9 and 10 below and 9A and 10A in Annex 1 present no surprises in that it demonstrates the result of changes in provision by each sector:- local authority provision; third sector provision and independent/ private sector provision.

Eighty eight per cent of care homes (89) are provided by the independent/ private sector which in turn provide 5448 or 89% of placements in care homes for older people in North Wales. The third sector provides one care home with 31 placements and local authorities provide 24 or 12% of the care homes with 676 or 11% of the placements available in North Wales.

There is a significant difference in levels of local authority provision in North Wales with Gwynedd providing 11 care homes with a total of 318 placements: Anglesey providing 6 homes with a total of 162 placements; Flintshire providing 3 homes with a total of 92 placements; Denbighshire providing 3 homes with 77 placements; Conwy proving 1 care home with 27 places and Wrexham with no local authority care home provision.

The significance of these figures is that those local authorities that continue to provide care home provision directly there may be scope, if required, to explore a possible change of purpose to more accurately reflect demand within their communities. Barriers are likely to include difficulties with existing building design and meeting regulatory requirements.

Table 12 provides information on vacant beds by sector. There were a total of 71 vacancies in local authority care homes (27 in Gwynedd and 24 in Anglesey).

Recommendation

Regional partnerships should ensure that there are integrated mechanisms in place between health boards and local authorities to meet with providers on regular basis for the purposes of maintaining and planning service development. Whether these mechanisms are regional, sub-regional or local are for the regional Partnership Board to decide.

Table 9 Care Homes by Sector

	Local Authority	Voluntary / Third Sector	Independent / Private Sector	Total
Anglesey	6 (26%)	0	17 (74%)	23
Gwynedd	11 (31%)	0	25 (69%)	36
Conwy	1 (2%)	0	50 (98%)	51
Denbighshire	3 (8%)	1	36 (90%)	40
Flintshire	3 (12%)	0	23 (88%)	26
Wrexham	0	0	32 (100%)	32
North Wales	24 (12%)	1	183 (88%)	208

Table 10 Registered Beds by sector

Number and %share of places within each local authority area

	Local authority	Voluntary / third sector	Independent/ private sector	Total
Anglesey	162 (26%)	0	452 (74%)	614
Gwynedd	318 (29%)	0	769 (71%)	1087
Conwy	27 (2%)	0	1288 (98%)	1315
Denbighshire	77 (7%)	31 (3%)	996 (90%)	1104
Flintshire	92 (11%)	0	721 (89%)	813
Wrexham	0	0	1222 (100%)	1222
North Wales	676 (11%)	31 (1%)	5448 (89%)	6155

5.4 Analyzing Demand

Managing Demand for Care Home Placements: The contribution of short term placements: Discharge to assess: Interim placements.

Purpose of Placement

The analysis found that

- 3707 or 97% of placements were made for long term care
- 19 or 0.5% of placements were made for intermediate care / assessment
- 38 or 1% used for respite care (underestimate due to nature of census study.
- With regard to intermediate care / assessment Anglesey used 3 placements in residential care; Gwynedd used 7 and Flintshire used 8. Flintshire also used one placement for this purpose in res (EMI)

The figures were similar for the rest of Wales.

These figures illustrate the limited capacity of services used for the purposes of assessment and intermediate care services. Partnerships may judge that they have sufficient capacity to assess and support individuals in the community through their community reablement teams and that there is no need for such provision in care homes. It may also be the case that commissioners find it difficult to assess the capacity needed to provide these services in care homes, therefore limiting their capacity to block contract such services.

Commissioners need to establish and monitor on a regular basis the numbers of people admitted directly from acute settings and community hospital settings into long term care placements in care homes. Although unavoidable in some cases, due for example to severe stroke, it has long been accepted that it is not good practice to admit individuals into long term care homes directly from hospital. If there are significant numbers of individuals admitted directly from hospitals into long term care home placements, the partnership may wish to re- examine whether or not the commissioning of some intermediate care capacity in care homes would give individuals greater opportunities to recover perhaps before transitioning to a return home with community reablement support. In many cases surplus residential care beds could be utilised for this purpose subject to funding being available.

Hospital staff are not always aware of facilities available to support individuals within the community. If they are unaware of new service developments, there is a danger that they seek solutions through services they know of such as long term residential care. It is vital that all staff are aware of the full range of options when considering discharge.

Wherever possible individuals should be supported to return to their home for assessment. This should be the default pathway with alternative pathways for

people who cannot return straight home. These approaches fall within the definitions of discharge to assess – “where people who are clinically optimised (the point at which care and support can safely be continued in a non-acute setting) and do not require care services are provided with short term, funded support to be discharged to their own home or another community setting. Assessment for longer term care and support needs to be undertaken in the most appropriate setting and at the right time for the person”.

Community hospitals are not included within this analysis but if community hospitals have a clear remit to offer intermediate care services this may reduce the need to commission these services from care homes.

Community reablement services are now operating throughout Wales.

The Welsh Government is undertaking a benchmarking exercise in relation to intermediate care services. As part of this work it should consider drafting a specification to describe what a good intermediate care service looks like both in community hospitals, care homes and within the community.

The development of robust intermediate care facilities should improve outcomes for individuals and families by reducing inappropriate admissions to care homes and should also serve to facilitate transfers if care from hospital.

One note of caution is that the inputs must be appropriate. There is little point in securing a placement in a care home or community hospital and hoping for the best. There must be a program of reablement to support the individual to regain some level of independence or develop alternative means of supporting themselves. There should be a specification for this service. One variation of a reablement model could involve a ‘Shared Lives’ service. Shared Lives (formally known as adult placement schemes) is a regulated form of social care delivered by Shared Lives carers who are approved by a registered shared lives scheme. In Shared Lives, an approved individual or family includes an older person or disabled person in their family and community life. Shared Lives Carers are recruited and approved through a rigorous assessment process which is itself subject to a quality assurance by an independent panel. The schemes are a mixture of local authority and third sector provides and cover all local authorities in Wales. The schemes are regulated by CSSIW. Shared lives is also used to support people who have their own home, as day support, as breaks for unpaid family carers, as home from hospital care and as a stepping stone for someone who wants to get their own place.

Carers offering placements with ‘Shared Lives’ could be trained to offer some reablement support. Alternatively, community reablement services could be used to support individuals in short term placements with a ‘shared lives’ service where the carers could provide additional encouragement and support and link individuals with other community support services.

The regional partnership needs to determine its strategy for the use of discharge to assess or discharge to promote recovery / intermediate care and respite care. This should encompass the role of community hospitals. The commissioning of appropriate intermediate care placements should facilitate transfers of care.

With regard to respite care the number of placements at the time of the census were as follows:

	Residential Care	Residential EMI	General Nursing
Anglesey	1	0	0
Gwynedd	3	0	1
Conwy	3	0	0
Denbighshire	0	0	0
Flintshire	8	2	3
Wrexham	5	5	0
Health Board	0	0	7

These figures are likely to under estimate the amount of respite care being offered for two reasons. There are individuals / families who enjoy regular periods of respite care but were not using this service at the time of the census. Secondly the census date for North Wales was mid-May before the summer period. Subject to available funding surplus placements can be used for respite care.

Nature of Demand

Regional example plus commentary on other regions

Based upon the projections above illustrated in tables 5 and 6 we are not presently experiencing a serious shortfall in terms of the need for residential care. In fact, in some cases we have surplus cases. As other more accessible types of accessible accommodation services develop with care and support such as extra care housing the demand for traditional residential care is likely to fall. Given the fact that more and more people are being supported at home by the time that a care home placement becomes more suitable their needs are likely to be more intense and complex than those entering care homes some time ago. The figures would suggest that in terms of using categories of care involving residential care homes and nursing homes we may well experience difficulties in terms of having sufficient nursing home places available.

Using the data available, we can look at several factors which may give more direction to what we need to meet need. To work towards some judgements about changes required to achieve a more appropriate balance of provision we can look at a range of findings from the analysis. These include vacancies, waiting lists, out of county placements by category of care and the reasons for such placements. Both vacancies and waiting lists were identified by self- funders. Embargoes imposed because of ‘escalating concerns’ about the quality of care can also serve

to impact on supply of placements. This approach was adopted with the initial regional briefings discussed at regional commissioning groups.

If we look at the data in relation to Anglesey, for example, there was only one vacant placement in a general nursing home available and none in nursing EMI homes at the time of the census in May. (see table 14). The waiting lists reported by providers indicates that there was one person waiting for a general nursing home placement, 30 waiting for nursing EMI placements and 58 on waiting lists for homes which have a dual registration. Anglesey have 7 general nursing home placements out of county because of no available provision within the county at the time required; 6 people are placed in residential EMI homes and 15 placed in Nursing EMI homes out of county because there was no available provision within the county at the time required. The Health Board made 21 placements in nursing EMI homes out of area because of no suitable local provision although it is not clear how many, if any originated from Anglesey. The timing of the requirements for such placements is an important factor. At the time of the census, for example, Anglesey had 9 vacant residential EMI beds. Choice of accommodation requirements will also be an important factor in that the individual or the family may not have liked a care home even the alternative meant moving out of county.

In relation to vacancies one worrying finding is that in our pilot study of North Wales 20 homes were identified with 20% plus vacancies. Table 11 below provides an illustration. Table 11A in Annex 1 indicates that we have 57 homes with 20% plus vacancies operating in the rest of Wales. This is worrying because such a high vacancy rate must raise concerns about financial viability. One explanation is that some of these are technical vacancies in that they include registered beds but they may be registered beds in shared rooms where there is no intention to fill the vacancy. This is one area where we need to improve upon data collection. Nevertheless, the regional partnership boards will need to identify and work with providers with high vacancy rates.

Table 11
Note: Data on the number of vacant beds is not available for all care homes in Conwy and Wrexham

	Care Homes with vacancies		Care Homes with 20% + vacancies	
	Number	%	**Number**	%
Anglesey	10	43	1	4
Gwynedd	18	50	2	6
Conwy	29	59	5	10
Denbighshire	30	75	9	23
Flintshire	14	54	1	4
Wrexham	14	54	2	8
North wales	115	55	20	10

Table 12 Care Homes with vacancies by sector								
	Local authority		Voluntary / Third Sector		Independent / Private		Total	
	number	%	number	%	Number	%	Number	%
Anglesey	4	67	0		6	35	10	43
Gwynedd	8	73	0		10	40	18	50
Conwy	0	0	0		29	58	29	57
Denbighshire	3	100	1		26	72	30	75
Flintshire	2	67	0		12	52	14	54
Wrexham	0	-	0		14	44	14	44
North Wales	17	71	1		97	53	115	55

Table 13 Vacant Beds by sector Data on vacant beds is not available for all care homes				
Number of beds vacant and % share of vacant beds for each sector				
	Local Authority	Voluntary/ third sector	Independent / private sector	Total
Anglesey	24 (73%)	0	9 (27%)	33
Gwynedd	27 (40%)	0	41 (60%)	68
Conwy	0	0	99 (100%)	99
Denbighshire	14 (11%)	1 (1%)	108 (88%)	123
Flintshire	6 (14%)	0	38 (86%)	44
Wrexham	0	0	63 (100%)	63
North Wales	71 (17%)	1	358 (83%)	430

Vacant Beds by category of care

Table 14 provides information on the number and percentage of vacant beds for each category of care across each local authority area in North Wales. For residential beds we have 211 beds or 8% vacant. This may still allow a margin for choice. For the other categories of care this becomes more challenging. With regard to residential EMI provision we have 85 or 7% vacant beds. In Gwynedd (9); Conwy (8); and Wrexham (6) there are under 10 vacant beds available and in Flintshire there were only 2.

With regard to general nursing beds there were 80 or 5% vacancies with three counties having less than 5 or less vacancies. There was only one vacancy reported in Anglesey and 3 in Denbighshire.

With regard to Nursing EMI beds there were 54 or 8% vacancies. There were no vacancies reported in Anglesey or Wrexham. It would appear that there are pressures around the availability of both nursing care and dementia care.

This is borne out by examination of out of area placements.

Table 14 Vacant Beds by category of care
Data on vacant beds is not available for all care homes

	Residential Beds		Residential EMI		General Nursing Beds		Nursing EMI Beds	
	Number	%	Number	%	Number	%	Number	%
Anglesey	23	7	9	10	1	1	0	0
Gwynedd	23	5	10	9	28	7	7	5
Conwy	45	8	17	8	17	5	20	10
Denbighshire	79	14	22	11	5	3	17	11
Flintshire	14	5	5	2	15	6	10	23
Wrexham	27	6	22	6	14	6	0	0
North Wales	211	8	85	7	80	5	54	8

Figures for the rest of Wales are available in Table 14A Annex 1

Waiting Lists

The information on waiting lists was provided solely by the providers. They reported a total of 625 vacant beds across North Wales. These figures may not be totally reliable in that an individual can be on a waiting list of more than one home. See Table 15 below.

Table 15 – Waiting List information

Note: Waiting list data and data on the number of vacant beds is not available for all care homes.

	Number	
	People on waiting list	Vacant beds
Isle of Anglesey	120	33
Gwynedd	154	68
Conwy	159	99
Denbighshire	91	123
Flintshire	69	44
Wrexham	32	63
North Wales	**625**	**430**

See care home data

Waiting List by category of care

Table 16 and 16 A (Annex 1) provide information on waiting lists by categories of care as reported by *providers.* There are significant waiting lists in each local authority area for residential care but also significant levels of vacancies. A similar

picture emerges for other categories of care although with fewer vacancies. The main exceptions are for nursing homes and nursing homes EMI in particular.

The health board and local authorities should keep a waiting list for individuals they are required to fund together with the details of where they are waiting:- in hospital; in their own home; with relatives; in an interim placement until their preferred placement becomes available.

Waiting lists are theoretical in cases where a self-funder prepared to pay more than the public sector gets preference and consequently gets bumped up the list. The management of waiting lists requires further attention.

Table 16
Waiting list Information by home registration status (category of care)
We do not know category of care breakdown for one home in Wrexham

Number

	Residential	**Residential EMI**	**General Nursing**	**Nursing EMI**	**Dual Registration**	**Total**
Anglesey	31 (26%)	0	1 (1%)	30	58 (48%)	120
Gwynedd	37 (24%)	9 (6%)	26 (17%)	61	21 (14%)	154
Conwy	25 (16%)	37 (23%)	33 (21%)	32	32 (20%)	159
Denbighshire	21 (23%)	11 (12%)	0	6	53 (58%)	91
Flintshire	25 (36%)	10 (14%)	20 (29%)	0	14 (20%)	69
Wrexham	10 (31%)	8 (25%)	0	0	14 (44%)	32
North Wales	149 (24%)	75 (12%)	80 (13%)	129 (21%)	192 (31%)	625

Out of area placements

North Wales

- Total of 3398 (89%) placements made within area
- 434 (11%) made outside area
- 81% due to client choice and
- 19% made due to no appropriate provision available within area.
- Inappropriate provision – 71% Nursing EMI – 15% nursing
- Anglesey have 7 general nursing placements out of county because of no available provision within the county; 6 people placed in residential EMI provision and 15 people placed in Nursing EMI provision because there was no available provision within the county. The Health Board made 21 placements in nursing homes EMI out of area because of no suitable provision.
- Gwynedd and Conwy report a significant number of individuals where the reason for the out of county placement is unknown. The reasons for all out of area placements should be recorded.

Table 17 Placements by type of placement

	In area		Out of area		
	Number	%	Number	%	Total
Anglesey	237	84	44	16	281
Gwynedd	456	88	65	12	521
Conwy	446	83	92	17	538
Denbighshire	302	86	49	14	351
Flintshire	360	81	84	19	444
Wrexham	452	91	45	9	497
Health Board	1130	95	55	5	1185
North Wales	3383	89	434	11	3817

Table 18 Out of area placements

	Number	%
	Out of area	Out of area
Angelsey	44	16
Gwynedd	65	12
Conwy	92	17
Denbighshire	49	14
Flintshire	84	19
Wrexham	45	9
Health Board	55	5
North Wales	439	11

Table 19 Out of area placements by reason							
	Client Choice		No in area provision		Unknown		
	Number	%	Number	%	Number	%	Total
Anglesey	15	34	29	66	0	-	44
Gwynedd	0	-	0	-	65	100	0
Conwy	0	-	0	-	92		0
Denbighshire	48	98	1	2	0		49
Flintshire	84	100	0	0	0		84
Wrexham	45	100	0	0	0		45
Health Board	33	60	22	40	0		55
North Wales	225	81	52	19	157	36	277

Out of Area Placements by location

When we examine out of area placements by location the clear majority are made within county or health board boundary. Most placements made outside of these boundaries are made in neighbouring areas.

Table 19 (A) Out of area placements by location in North Wales								
	Angle.	Gwyn.	Con.	Denb.	Flint	Wrex.	Other Welsh LAs	Out side Wales
Anglesey	236	23	9	1	0	1	2	9
Gwynedd	5	456	17	6	0	2	4	31
Conwy	1	4	446	54	4	1	2	26
Denbighshire	0	0	14	302	8	10	0	17
Flintshire	1	0	2	27	360	32	0	22
Wrexham	0	0	1	17	11	452	0	16
Health Board	76	238	325	159	133	199	3	52
North Wales	319	721	814	566	516	697	11	173

Table 19 (B) Out of area placements by location Cardiff & Vale, Gwent & Cwm Taf (local authority placements)										
LA	**Card**	**Vale**	**Caer**	**BG**	**Torf**	**Mon**	**New**	**RCT**	**Merth**	**Other Welsh LAs**
Cardiff	763	42	13	2	1	-	10	13	2	8
Vale	14	303	1	-	1	1	-	1	1	26 (19 in Bridgend)
Caerphilly	2	2	456	12	7	1	19	9	6	4

Blaenau Gwent		1	7	175	3	3			1	3
Torfaen			1	15	284	12	12	1		
Monmouth.			1	12		163	5		1	7 (6 in Powys)
Newport	9	3	2	6	23	11	230	1		1
RCT	7	4	14					743	14	28 (inc. 17 in Bridgend & 5 in Powys).)
Merthyr Tydfil			7	1		1		29	140	4 (3 in Powys)

Table 19 (C) Western Bay, Powys and West Wales Out of Area Placements by location

	Swan.	NPT	Bridg.	Cer.	Pem.	Carm.	Powys	Other Welsh LAs
Swansea	766	12				26	6	1
NPT	17	507	10	1		5	34	2
Bridgend	1	22	404					8
Ceredigion		1		171	16	55	2	2
Pembroke				2	348	0		
Carmarthen	10	10		4	15	642	3	4
Powys	1	3	1	3	1	2	518	8 (5 in Monm.)

Table 19 (D) Out of Area placements by location made by health boards

	Powys	Hywel Dda	ABMU	Cardiff & Vale	Cwm Taf	ABHB
Powys	124	2	3	2		7
Hywel Dda	1	402				6
ABMU	10	24	627	5	1	1
Cardiff & Vale				633		10
Cwm Taf	14	1	3	22	213	7
ABHB	6	5		5	21	599

Table 20 Out of area placements by category of care									
	Residential		Residential EMI		General Nursing		Nursing EMI		Total
	Number	%	Number	%	Number	%	Number	%	
Anglesey	8	18	8	18	10	23	18	41	44
Gwynedd	37	57	8	12	9	14	11	17	65
Conwy	72	78	0	0	20	22	0	0	92
Denbighshire	13	27	14	29	7	14	15	31	49
Flintshire	19	23	31	37	7	8	27	32	84
Wrexham	18	40	13	29	6	13	8	18	45
Health Board	0	0	0	0	34	62	21	38	55
North Wales	167	38	74	17	93	21	100	23	434

Table 21 Out of area placements by category of care and reason - Residential								
	Client Choice		No in-area provision		Unknown		Total	
	Number	%	Number	%	Number	%	Number	%
Anglesey	7	88	1	13	0	0	8	100
Gwynedd	0	-	0	-	37	100	0	0
Conwy	0	-	0	-	72	100	0	0
Denbighshire	13	100	0	0	0	0	13	100
Flintshire	19	100	0	0	0	0	19	100
Wrexham	18	100	0	0	0	0	18	100
Health	0	-	0	-	0	-	0	-
North Wales	57	98	1	2	109	65	58	35

Table 22 Residential EMI								
	Client Choice		No in-area provision		Unknown		Total	
	Number	%	Number	%	Number	%	Number	%
Anglesey	2		6		0	0	8	100
Gwynedd	0		0		8	100	0	0
Conwy	0		0		0	-	0	-
Denbighshire	14		0		0	0	14	100
Flintshire	31		0		0	0	31	100
Wrexham	13		0		0	0	13	100
Health	0		0		0	-	0	-
North Wales	60		6		8	11	66	89

Table 23 General Nursing								
General Nursing	Client Choice		No in-area provision		Unknown		Total	
	Number	%	Number	%	Number	%	Number	%
Anglesey	3	30	7	70	0	0	10	100
Gwynedd	0	-	0	-	9	100	0	0
Conwy	0	-	0	-	20	100	0	0
Denbighshire	7	100	0	0	0	0	7	100
Flintshire	7	100	0	0	0	0	7	100
Wrexham	6	100	0	0	0	0	6	100
Health	33	97	1	3	0	0	34	100
North Wales	56	88	8	13	29	31	64	69

Table 24 Nursing EMI							
Nursing EMI	Client choice		No provision in area		Unknown		Total
	Number	%	Number	%	Number	%	
Anglesey	3	17	15	83	0		18
Gwynedd	0	-	0	-	11		0
Conwy	0	-	0	-	0		0
Denbighshire	14	93	1	7	0		15
Flintshire	27	100	0	0	0		27
Wrexham	8	100	0	0	0		8
Health Board	0	-	21	100	0		21
North Wales	52	58	37	42	11		89

Escalating Concerns Guidance

This statutory guidance addresses the management of escalating concerns in relation to individual care homes. Escalating concerns arise where there are accumulating issues relating to the operation of, or quality of care provided in, a registered care home providing services to adults.

Escalating concerns will warrant proactive or reactive intervention from those commissioning services, possibly from more than one or more commissioning agencies designed to improve the quality of services and where possible prevent what might be avoidable home closures.

Where there are such concerns a Development Action Plan (DAP) may be required where care management, contract monitoring and or other sources of information indicate a shortfall in the quality of service provided and statutory agencies want to see the service moving forward in specific areas of quality and

practice. A Corrective Action Plan (CAP) will be required where immediate action to ensure the safety of service users and or staff is needed. This would be indicated in a situation where a delay in taking preventative or remedial action could result in the need for enforcement action and cancellation of registration. The use of CAPs and DAPs do not replace notifications instituted by CSSIW.

Commissioners may also impose an embargo on placements. Embargos occur where a local authority or health board applies an embargo to a particular home, i.e. it chooses not to place new service users there for a specified reason. There must be a clearly evidenced rationale for the use of such embargos and commissioners will also be required to take appropriate steps to protect the wellbeing of existing residents.

Table 25 Care Homes with an Embargo in place

	Am embargo in place		**A CAP in place**		**A DAP in place**	
	Number	**%**	**Number**	**%**	**Number**	**%**
Anglesey	1	4	1	4	0	0
Gwynedd	1	3	0	0	0	0
Conwy	0	0	4	8	2	4
Denbighshire	5	13	5	13	5	13
Flintshire	2	8	2	8	0	0
Wrexham	2	6	2	6	1	3
North Wales	11	5	14	7	8	4

Table 26 Care Homes with embargos by category of care
Note: We do not know category of care breakdown for one home in Wrexham

	Residential		**Residential EMI**		**General Nursing**		**Nursing EMI**		**Dual Registration**		**Total**
Anglesey	0		0		0		0		1	100	1
Gwynedd	0		0		1		0		0	0	1
Conwy	0		0		0		0		0	-	0
Denbighshire	1		0		0		0		4	80	5
Flintshire	0		1		0		0		1	50	2
Wrexham	0		1		0		1		0	0	2
North Wales	1		2		1		1		6	55	11

At the time of the census there were 9 homes in Mid & South Wales with embargos in place.

Embargos may be necessary but they can have a negative impact upon providers and will, of course, limit the availability of placements.

5.5 Rates of Placement

The rate of placements in care homes for older people per 1000 population, aged 65 plus is outlined in the following table. The Figures for the North Wales authorities are at the top of the table.

The rates of placement funded by local authorities are slightly above the Welsh average with the exception of Flintshire. The variation between Flintshire and Wrexham is worth further exploration.

The rates of placement for LA/ FNC funded packages of care are all below the Welsh average. Once again Flintshire has a lower rate of placement than, for example, Gwynedd.

Whilst Wrexham has the highest rate of local authority placements per 1000 population of people aged 65+ it has the lowest rate of placements funded by LA/FNC.

Table 27 Local Authority

		LA/FNC	LA
1	Anglesey	3.27	12.60
2	Gwynedd	5.92	13.00
3	Conwy	4.88	12.29
4	Denbighshire	3.19	12.37
5	Flintshire	2.87	10.99
6	Wrexham	2.65	15.95
7	Powys	5.96	11.47
8	Ceredigion	4.87	9.63
9	Pembrokeshire	2.69	8.84
10	Carmarthenshire	3.13	13.03
11	Swansea	8.05	9.04
12	Neath Port Talbot	6.69	13.58
13	Bridgend	4.59	10.75
14	Vale of Glamorgan	6.07	7.01
15	Cardiff	8.55	8.6
16	RCT	6.80	11.44
17	Merthyr Tydfil	6.14	10.57
18	Blaenau Gwent	4.77	9.55

19	Torfaen	6.54	11.41
20	Caerphilly	3.69	11.64
21	Newport	5.54	5.85
22	Monmouthshire	3.85	6.85
	Wales	5	10.79

Rate of placement in care homes for older people funded by CHC or Section 117 wholly funded by health (11 placements117 placements funded 100% by Health Board).

Rate of CHC funded placements in ca re homes for older people per 1000 population aged 65 plus	
Betsi Cadwala	5.59
Powys	2.14
Hywel Dda	3.07
ABMU	3.39
Cardiff & Vale	3.27
Cwm Taf	4.40
Aneurin Bevan	5.73
Wales	4.31

This means that for every 1,000 older people aged 65 plus there are nearly 6 people eligible for NHS Continuing Health Care in placements funded by the Betsi Cadwaladwr Health Board. This is the highest rate in Wales but we do not fully understand what it means. Could it, for example, that Powys and Hywel Dda have more effective systems in place that prevent the needs of individuals escalating to the point when they become eligible for CHC and require a placement in a care home. This may be a valid explanation. It could be that each health board has different interpretations of the CHC Framework updated in in 2014. It could be that Betsi Cadwalladwr Health Board and Aneurin Bevan Health Board, have more generous interpretations of who is eligible for CHC. In any case the difference between nearly 6 people and just over 2 people per 1000 population of those people aged 65 plus is significant.

5.6. Shaping the services required: Clarifying service requirements to inform specifications and statements of purpose

We need health board and local authority commissioning partners to work together with each care home provider to encourage the development of services that accurately reflect local needs. This may involve more providers moving to provide services that can respond to those individuals with more complex needs. Commissioners will need to explore how they can support and facilitate these changes.

Care home providers will be required to develop statements of purpose to describe those needs their service can address together with how they will be addressed. Commissioners will be developing their service specifications describing the requirements of the services they commission. Commissioners and providers need to work together to achieve the best fit between demand and service provision.

Commissioners need to provide clarity about the services and the outcomes required from care homes. Given that we already have service specifications in place this requires explanation.

The following categories of care are widely used throughout Wales although they are not underpinned by legislation:

- Residential Homes
- Residential (elderly mentally ill – EMI) Homes
- General Nursing Homes
- Nursing (EMI) Homes.

These categories have been used for some time but it is not clear if they reflect current practice in terms of helping to steer people or professionals towards the most appropriate placement. This needs to be discussed in more detail with both commissioners and providers. There is some inconsistency in the pattern of distribution of placement categories throughout Wales and it is not clear how far they accurately reflect need (See tables 33 and 33A both within this document). There may also be inconsistency in the interpretation of these categories. The categories are used in some cases for helping to set fees. It proved difficult initially to get a written description of these categories. These categories are not part of registration requirements and the Regulation & Inspection Act will involve a more flexible approach to registration. These categories are described below.

Another descriptor of care we have concerns eligibility for NHS Continuing Health Care in that it indicates some degree of complexity/ intensity of need. This is discussed later.

The implementation of the Regulation and Inspection Act is likely to involve a much more flexible approach to the registration of care homes. Whilst commissioners should be basing or aligning their specifications on the standards developed to support the implementation of the Regulation and Inspection Act they will need to be clear concerning their expectations of services to be delivered by the provider and the standards required. A provider may meet the requirements of the regulator in terms of registration but may be offering a service which does not meet the requirements of the commissioner or the people requiring care and support.

One of the risks is that given the difficulties that some care homes experience in recruiting nurses, some may decide not to provide nursing care. These decisions

are extremely unlikely to reflect the needs of older people and will only add to further places surplus to demand in residential care.

It will be important to get alignment between registration and commissioning standards to avoid unnecessary bureaucracy for providers. There are also important implications for policy in relation to “choice of accommodation” where there is a requirement to offer individuals choice between the same type of care home, i.e. individuals assessed as needing a placement in a nursing home cannot be offered a placement in a residential home.

Finally, assessments in relation to Funded Nursing Care require the involvement of a registered nurse and placements in nursing homes in relation to Funded Nursing Care and Continuing NHS Health Care require care homes to employ registered nurses 24/ 7 and yet there is a lack of transparent and accessible information describing the role and contribution of the nurse. Commissioners need to be clear about what services they require from care homes serving residents with different needs and they need to work with providers to influence the development of their statement of purpose which will determine their registration.

Recommendation: The National Commissioning Board to work with Health & Social Care Commissioners, CSSIW, Care Home Providers and advocates / representatives of residents to develop model service specifications which enable us to provide a consistent description of the services required, the quality required and outcomes to be achieved. These will be aligned as closely as possible with the standards developed as part of the implementation of the registration and Inspection Act.

This work can also inform the work of a costs of care group being established by the Care Homes steering group.

Recommendation: Health and Social Care Commissioners should offer support to care home providers with the development of their statement of purpose to achieve an appropriate balance between demand and supply. The ultimate decision rests with the care home owner but presumably they want to locate their business where there is a healthy demand.

All care homes are registered with CSSIW and are regularly inspected.

Some care homes can provide a range of services and therefore could accommodate a change of care needs. An assessment will be carried out involving several professionals including social workers, doctors, nurses, hospital specialists and occupational therapists. The care home will also be required to undertake as assessment to ensure that they can meet the needs of the individual.

In homes providing nursing care, registered nurses are employed by the homes and available around the clock and supervise care delivery provided by a large workforce of care assistants. In care homes without nursing, registered nurses

from the community and primary care services visit to provide nursing care when required and, again will provide guidance and support to health assistants. These nurses may also be involved in supporting any specialist care for residents in care homes with nursing.

The categories of care widely in use are described below:

Residential Care

This type of care and support is for people who have assessed eligible needs that mean that the support needed is best provided in a care home environment with 24-hour support. People who live in residential care homes do not have any additional health needs requiring nursing support. Any support required from a qualified nurse should be provided by the community / district nursing service.

EMI Residential

This type of accommodation is for people having assessed eligible needs for residential care, but who are also living with a form of moderate dementia or other forms of mental illness. Care staff in residential care may have specialist training in dementia care and therefore individual needs in some circumstances, can be met in a residential care home rather than a specialized EMI residential home. The home may refer to a dedicated dementia community for an EMI (elderly and mentally infirm) residential placement.

Nursing

This type of accommodation is for people who have had an assessment of their needs for care and support. These people require more intensive physical support on a daily basis as well as funded nursing care. The homes in this category of care are expected to have a fully qualified nursing staff on duty and have dedicated nursing equipment, such as specialist beds and assisted bathrooms.

EMI Nursing

This type of accommodation is for people who have had an assessment of their needs for care and support and who require more physical support, as well as living with a form of dementia or other mental illness. This type of service is also expected to have a proportion of qualified nursing staff with specialist dementia training. This placement may be referred to by the home as an EMI (Elderly and mentally infirm) nursing placement.

An alternative and more detailed description is provided below:

Type of Residential Home		
Residential Care Home	Residential Care Home Very Dependent Elderly	Elderly Mentally Infirm (EMI) Residential Home
Help and assistance with: • Getting in / out of bed • Washing, bathing, dressing • Toileting/ use of pads/ normal catheter care • Having food cut up up / specially prepared/ prompting • A visual / audial impairment • Administration of Medication/ use of mask for oxygen or nebulizer • Mild confusion / memory loss • Support / reassurance	In addition to help and assistance specified in a residential home a person may require: • Assistance of two staff for walking / mobilizing/ toileting • Use of hoist for transfers and 1 or 2 staff members • Staff feeding the resident • Continued supervision by staff because of wandering /interference with others / or their personal possessions • Supervision / support at night because of awake for long periods • Assistance for long periods of time to complete tasks and require the help of 1 or 2 care staff.	A person should have an organic mental illness e.g. Alzheimer's or dementia or a functional illness such as depression. A person will possibly be: • Very forgetful of recent events • Forgets family names/ mixes them up • Personality change • Confused / disoriented/ gets easily lost/, gets angry / upset when pointed out to them • Neglectful of hygiene / eating • Very repetitive • Behaves inappropriately but is easily distracted • Unable to communicate appropriately / hold meaningful conversations
		• Behaviors exacerbated by darkness or patterns of light during day but coped with when anticipated without restraint.

Type of Nursing Home / Care		
Nursing Home	EMI Nursing Home	Continuing Health Care
A person requiring Nursing Care may require: • Basic nursing care as given to a chairfast / bedfast / or predominantly chairfast / bedfast person. • Unable to stand or weight bear, requiring assistance to stand / transfer / use of suitable hoisting equipment. • Assistance with continence e.g. enemas/ difficult catheter situs/ frequent urinary infections as a result of catheter care • Continuous monitoring / adjustment of medication requiring a trained nurse's judgement • Complicated regimes for communication/ medication • Skilled intervention to manage but their physical needs outweigh the confusion / behavioural problems and does not require	A person requiring this care may exhibit the following: • Restless behavior/ constant wandering • Unable to find way around • Little recognition of family/ friends/ everyday objects • Not responding appropriately and becoming angry / upset very quickly, not easily diverted • Can become aggressive towards staff/ residents, needs skillful intervention for prevention • Resistive to personal care requiring skillful handling to avoid anger • Easily disturbed day or night, not easily comforted • Hallucinations / delusions/ hearing voices they respond to Paraphrenia, fixed delusional ideas that require extra skilled staff • Behaviour constantly / severely affected by darkness resulting in	A person may qualify for this if there is: • Challenging behavior of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self and others. The risks are so serious that they require intervention from and access to an immediate specialist response at all times for safe care. • Completely immobile and the clinical condition is such that on movement or transfer there is a high risk of serious physical harm and where the positioning is critical • Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period due to complexities and to ensure nutrition / hydration for

psychiatric nursing skills	behaviour difficult to manage Physical disabilities where behaviour problems adversely impact upon other	example I.V. fluids, peritoneal feeding. • There is a need for expert and skilled intervention (usually as an inpatient). • Bowel management and skilled intervention is required on at least a daily basis to prevent life threatening / emergency situations • Unable to breath independently, requires invasive mechanical intervention • Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and or deteriorating condition. • **Or** unremitting and overwhelming pain despite all efforts to control pain effectively

The categories of care provide some description of the complexity of needs care homes are having to respond to. We do not know how consistently these descriptions are used or whether or not the services accurately reflect these needs.

Care Homes by Category of Care

Table 28 provides a breakdown of care homes by categories of care.

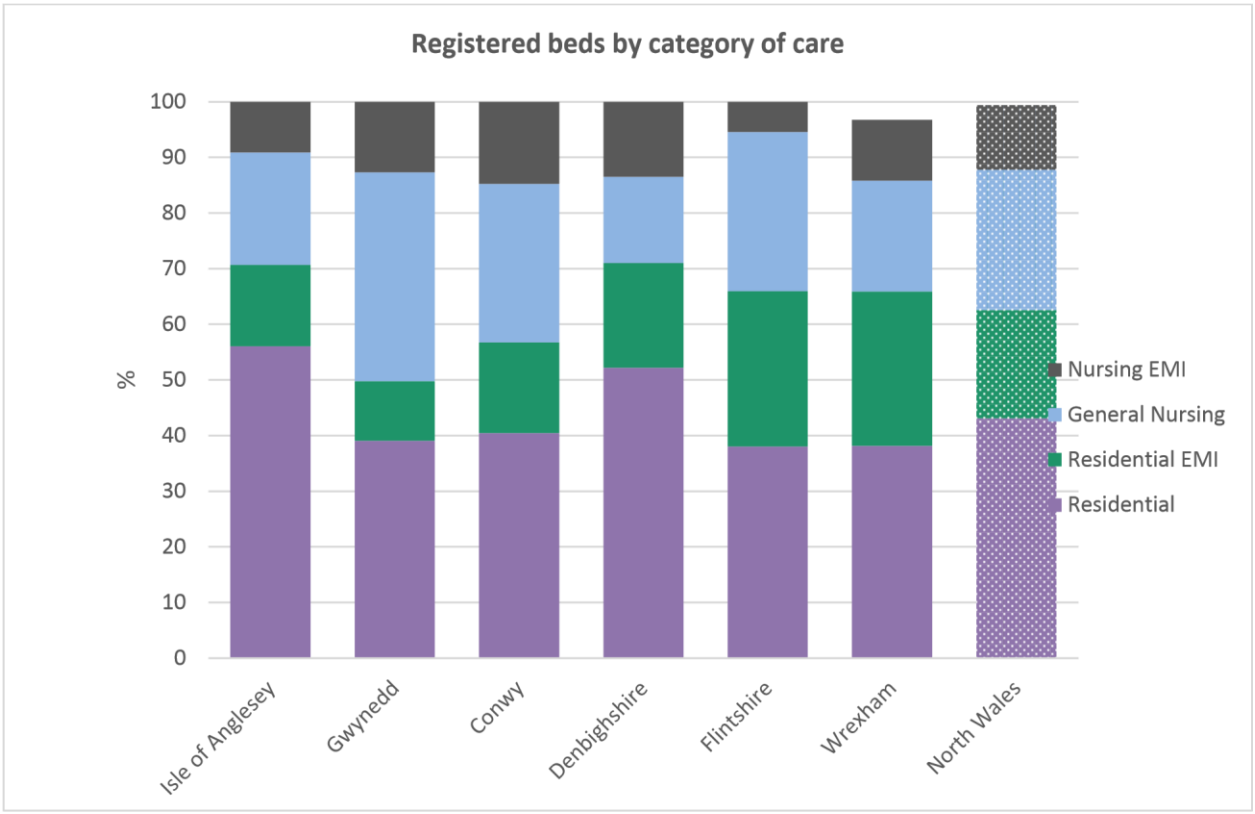
Note that the %'s reflect that category's share of placements located in that local authority. 11 residential homes in Anglesey, for example, accounts for 48% of the care homes in Anglesey.

Table 28 Number						
	Residential	Residential EMI	General Nursing	Nursing EMI	Dual Registration	Total
Anglesey	11 (48%)	1 (4%)	1 (4%)	1 (4%)	9 (39%)	23
Gwynedd	18 (50%)	3 (8%)	8 (22%)	2 (6%)	5 (14%)	36
Conwy	21 (41%)	8 (16%)	8 (16%)	7 (14%)	7 (14%)	51
Denbighshire	22 (55%)	5 (13%)	1 (3%)	4 (10%)	8 (20%)	40
Flintshire	8 (31%)	8 (31%)	2 (8%)	1 (4%)	7 (27%)	26
Wrexham	12 (39%)	6 (19%)	2 (6%)	2 (6%)	9 (29%)	31
North Wales	92 (44%)	31 (35%)	22 (11%)	17 (8%)	45 (22%)	207

Registered Beds by category of care

Note: we do not know category of care breakdown for one home in Wrexham.

Table 29 Number					
	Residential	Residential EMI	General Nursing	Nursing EMI	Total
Anglesey	344 (56%)	90 (15%)	124 (20%)	56 (9%)	100
Gwynedd	425 (39%)	116 (11%)	408 (38%)	138 (13%)	100
Conwy	532 (40%)	214 (16%)	375 (29%)	194 (15%)	100
Denbighshire	576 (52%)	208 (19%)	171 (15%)	149 (13%)	100
Flintshire	309 (38%)	227 (28%)	233 (29%)	44 (5%)	100
Wrexham	466 (38%)	339 (28%)	244 (20%)	133 (11%)	97
North Wales	2652(43%)	1194(28%)	1555 (25%)	714 (12%	99


Registered beds by category of care
100
90
80
70
60
50
40
30
20
10
0
%
Isle of Anglesey
Gwynedd
Conwy
Denbighshire
Flintshire
Wrexham
North Wales
Nursing EMI
General Nursing
Residential EMI
Residential

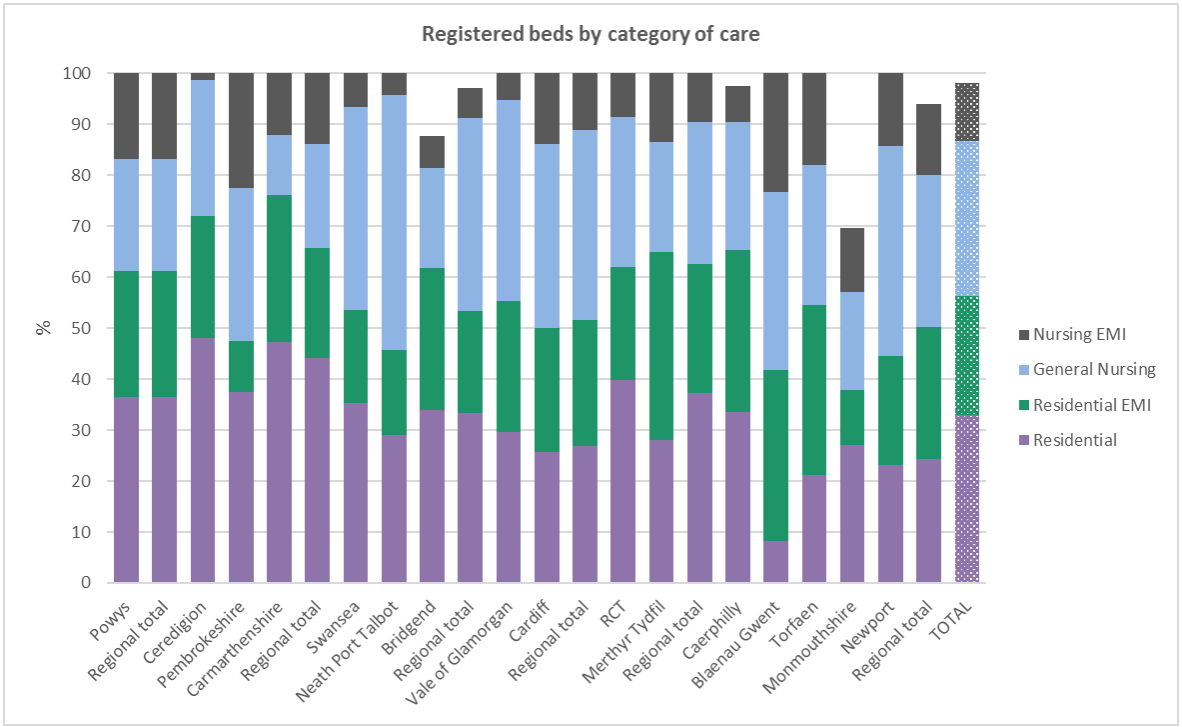

Registered beds by category of care
100
90
80
70
60
50
40
30
20
10
0
%
Powys
Regional total
Ceredigion
Pembrokeshire
Carmarthenshire
Regional total
Swansea
Neath Port Talbot
Bridgend
Regional total
Vale of Glamorgan
Cardiff
Regional total
RCT
Merthyr Tydfil
Regional total
Caerphilly
Blaenau Gwent
Torfaen
Monmouthshire
Newport
Regional total
TOTAL
Nursing EMI
General Nursing
Residential EMI
Residential

Table 30				
Information on Registered Beds and registered beds by category per 1000 older people aged 65 plus in brackets.				
	Residential care	Residential EMI	General Nursing	Nursing EMI
Anglesey	344 (19)	90 (5)	124 (7)	56 (3)
Gwynedd	425 (15)	116 (4)	138(5)	138 (5)
Conwy	532 (17)	214 (7)	375 (12)	194 (6)
Denbighshire	576 (26)	208 (9)	171 (8)	149 (7)
Flintshire	309 (10)	227 (7)	233 (7)	44 (44)
Wrexham	466 (17)	339 (13)	133 (5)	133 (5)
N.Wales	2652	1194	714	714

The number of registered beds by category per 1000 population aged 65 plus varies between authorities. Compare the rates of residential care beds between Flintshire and Denbighshire; the rates of Residential EMI beds between Gwynedd and Wrexham; the rates General Nursing Beds between Gwynedd, Wrexham and Conwy or the rates of Nursing EMI beds between Anglesey and Flintshire.

Placements by category of care

Table 31	**Residential**		**Residential EMI**		**General Nursing**		**Nursing EMI**		
	Number	%	Number	%	Number	%	Number	%	Total
Anglesey	165	59	58	21	33	12	25	9	281
Gwynedd	290	56	68	13	112	21	51	10	521
Conwy	344	64	41	8	113	21	40	7	538
Denbighshire	177	50	95	27	50	14	29	8	351
Flintshire	203	46	149	34	57	13	35	8	444
Wrexham	242	49	180	36	40	8	35	7	497
Health Board	2	0	1	0	746	63	436	37	1185
North Wales	1423	37	592	16	1151	30	651	17	3817

The use of various placements by category of care varies between areas. The % of residential EMI placements varies between 8% in Conwy to 36% in Wrexham and 34% in Flintshire. The % of residential placements varies between 46% in Flintshire and 64% in Conwy. The % of general nursing placements varies between 8% in Wrexham to to 21% in Gwynedd and Conwy.

Placements by nature and category of care – Long term placements					
Table 32 Number					
	Residential	**Residential EMI**	**General Nursing**	**Nursing EMI**	**Total**
Anglesey	141 (56%)	52 (21%)	33 (13%)	24 (10%)	250
Gwynedd	280 (55%)	68 (13%)	111 (22%)	51 (10%)	510
Conwy	319 (63%)	41 (8%)	110 (22%)	39 (8%)	509
Denbighshire	177 (50%)	95 (27%)	50 (14%)	29 (8%)	351
Flintshire	186 (44%)	144 (34%)	53 (13%)	35 (8%)	418
Wrexham	230 (48%)	173 (36%)	39 (8%)	35 (7%)	477
Health Board	2	1	737 (63%)	436 (37%)	1176
North Wales	1335 (36%)	574 (16%)	1133 (31%)	649 18%)	3691

Information on placements by category of care and by category per 1000 older people aged 65 plus (in brackets)				
Table 33				
	Residential Care	Residential EMI	General Nursing	Nursing EMI
Anglesey	165 (9)	58(3)	33 (2)	25 (1)
Gwynedd	290 (11)	68 (2)	112 (4)	51 (2)
Conwy	344 (11)	41 (1)	113 (4)	40 (1)
Denbighshire	177 (8)	95(4)	50 (2)	29 (1)
Flintshire	203 (6)	149 (5)	57 (2)	35 (1)
Wrexham	242 (9)	180 (7)	40 (1)	35 (1)
Health Board	2	1	746 (5)	436 (3)

Registered beds by category of Care

Categories of Care (see table) CHECK NUMBERS

The percentage of care homes operating in relation to each category of care is as follows:

Residential	**Residential EMI**	**General Nursing**	**Nursing EMI**	**Dual Registration**
44	**15**	**11**	**8**	**22**

Further analysis will need to be undertaken locally to determine the most appropriate balance of provision.

Anglesey, for example, appears to have above average provision of residential care (48%) but below average provision in relation to residential EMI (4%); general Nursing (4%) and nursing EMI (4%). This may well be compensated for by the above average provision of care homes with dual registration.

Per 10,000 population (aged 65 +)

Gwynedd appears to have slightly above average provision of residential care but below average provision of residential EMI. It has well above average provision of general nursing homes but a slightly lower than average provision of nursing EMI. It also has less than average provision of homes with dual registration.

Conwy has near average provision of residential and residential EMI places but above average provision for nursing and nursing EMI places. It has above average provision of care homes with dual registration.

Denbighshire has above average provision of residential care; average provision of Residential EMI; below average provision of general nursing but slightly above average provision for nursing EMI.

Flintshire has below average provision for residential care but significantly higher provision of residential EMI. It has slightly below average provision for general nursing and nursing EMI.

Wrexham has slightly below average provision of residential care; slightly above residential EMI; below average for general nursing and slightly below average for EMI. It has above average provision of homes with dual registration.

The above information demonstrates some sharp contrasts in in relation to different categories of care. This is evident by contrasting residential EMI provision between Anglesey, Gwynedd and Flintshire. The differences may be accommodated by those homes with dual registration. There may also be a genuine difference of need between communities. Alternatively it may be because there are different interpretations of categories of care. Individuals may also be fitted into the most appropriate placements available which may not match the category of care.

Table 33 (A) Placements by category of care per 1000 population (aged 65plus)				
LA placements	**Residential**	**Residential EMI**	**General nursing**	**Nursing EMI**
Powys	6.30	5.22	2.96	2.93
Ceredigion	5.04	4.92	2.68	1.84
Pembrokeshire	5.32	3.61	1.28	1.31
Carmarthenshire	8.30	4.87	1.92	1.06
Swansea	9.46	0.02 (1 placement))	7.04	0.86
Neath Port Talbot	13.65	0.17	6.41	0.39
Bridgend	13.30	9.26	8.08	1.54
Vale of Glamorgan	7.01	0	5.51	0.56
Cardiff	6.76	1.86	7.14	1.40
Rhondda Cynon Taf	6.29	5.15	6.09	0.71
Merthyr Tydfil	4.33	6.23	5.06	1.08
Caerphilly	5.72	5.95	2.93	0.73
Blaenau Gwent	2.94	6.69	3.67	1.02
Torfaen	4.86	6.59	5.24	1.24
Monmouthshire	3.98	2.95	2.59	1.16
Newport	3.81	2.42	4.23	0.92
Regions including Health Board Placements - Nursing Homes				
Powys			2.96	2.93
Hywel dda			4.34	3.32
ABMU			12.37	2.08
Cardiff & Vale			13.57	2.52
Cwm Taf			8.67	2.66
ABHB			6.08	4.25

Continuing NHS healthcare (CHC)

Another descriptor of the complexity of needs concerns eligibility for NHS Continuing Health Care. For those less familiar with NHS continuing care a description of the criteria may be helpful. The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need. The following characteristics of need and their impact on the care required to manage them will determine whether an individual's primary is a health need:

- **Nature**: This describes the particular characteristics of the individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type (quality) of interventions required to manage them.
- **Intensity**: This relates both to the extent (quantity) and severity (degree) of the needs and to meet them, including the need for sustained ongoing care (continuity).
- **Complexity**: This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.
- **Unpredictability:** This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of these characteristics may alone or in combination, demonstrate a primary health need because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and effects of the interaction of needs should be carefully considered. (Continuing NHS Healthcare: The National Framework for Implementation in Wales – June 2014).

In North Wales we have 11 homes operating with over 50% of residents eligible for CHC. The homes vary in size from 18 to 50 registered beds. The highest % of CHC residents in one home is 68% for a home registered for 34 placements and with 23 CHC residents. There are a further 9 care homes with 40% plus CHC residents. The relevance of this is that eligibility for CHC indicates the complex needs of the individual.

We have some homes in Wales with high numbers of residents eligible for CHC (86%) whilst others have 5% of residents eligible for CHC. The range can vary from 6% to 47% in Western Bay to 42% to 86% in Gwent. We may have the same specifications covering homes providing services to individuals with very different needs. We also know that care homes struggle to cope with some individuals with very intensive and complex needs and we need to develop and share good practice as to how they can respond more effectively to the needs of these residents.

Table 34 below contrasts the differences between homes who are responding to the needs of very different numbers of individuals eligible for NHS Continuing

Health Care. The contrast demonstrates that nursing homes are responding to very different levels of need. It is not clear if this is reflected in either the service specification or level of fees.

Table 34 CHC Placements			
Nursing Homes located in Caerphilly			
	Number of beds	Number CHC Placements	% CHC placements
1	75	39	52
2	34	16	47
Nursing Homes in Blaenau Gwent			
1	38		**53**
2	39	**18**	**46**
3	53	**22**	**42**
Nursing Homes located in Torfaen			
1	36	31	86
2	39	29	74
3	38	17	45
Nursing Homes in Monmouthshire			
1	32	20	63
2	24	10	42
Nursing Homes in Newport			
1	72	51	71
2	36	31	86
3	31	22	71
4	34	18	53
5	69	42	61
Nursing Homes in Swansea			
1	51	24	47
2	56	26	46
Rhondda Cynon Taf			
1	46	27	59
2	48	23	48
Nursing Homes in Merthyr			
1.	120	48	40
Nursing Homes in Cardiff			
1	40	25	63
2	108	45	42
Nursing Homes in Vale of Glamorgan			
1.	65	23	35
Nursing Homes in Powys			
1	56	25	45

This table shows a range of homes with higher numbers of CHC placements; the highest of 86% and 74% relating to homes in Newport sand Torfaen respectively. In contrast there are other homes with a much lower percentage of individuals eligible for CHC ranging from 4%,6%, 8%, 10%, 11%.

5.7. The role of the Nurse within Care Homes with Nursing

The discussions around this analysis and the future of the care home sector have often touched upon the role and contribution of nurses working in care homes. There are some residents in nursing homes who may not need immediate access to the care provided by a registered nurse 24 hours per day whilst there are others who need access to immediate clinical support and intervention that can only be provided by a nurse. We need to be very clear about how we define the contribution of nurses working in care homes. The R & I Act provides a more flexible approach to registration which means that commissioners must be clear about this in their contract specifications and providers will also need to be clear in their statements of purpose.

The Royal College of Nursing defines Nursing as: 'The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best quality of life, whatever, their disease or disability, until death'.

The purpose of nursing is to promote health, healing, growth and development, and to prevent disease, illness, injury, and disability. When people become, ill or disabled, the purpose of nursing is, in addition, to minimize distress and suffering, and to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of nursing is to maintain the best possible quality of life until its end.

Nursing interventions are concerned with empowering people, and helping them to achieve, maintain or recover independence. Nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they will lead the team, prescribing, delegating and supervising the work of others. (Defining Nursing – Royal College of Nurses – 2014)

Given the important contribution of nursing to care homes with nursing it is surprising that we have done little to understand the contribution of nursing. Spilsbury et al note that despite their important role, little is known about the nursing workforce employed in care homes. They are an overlooked professional group, with no defined career pathway and no specific training requirements for work in this setting (The nursing workforce in care homes has been trained to work in in hospital or a community setting rather than specifically for work in a care

home setting).” They go on to argue that “whilst the care home nurse’s role is broad and multifaceted, little is known about the characteristics of the care home registered nursing workforce, their employment or career trajectories and ambitions. Continuing professional development needs are recognized but there are challenges for care home nurses in being able to access learning opportunities and there are concerns of fewer opportunities than their NHS colleagues. As the health needs of care home residents become more complex, care home nurses require specialist knowledge to manage the care of these residents and to liaise with, and engage other health professionals in ensuring the needs of care home residents are met and to minimize ‘avoidable’ transitions to acute care.

(Supporting nursing in care homes: Project report for the RCN Foundation; Patient Care and Professional Development for Nursing Staff in Care Homes Nursing Homes: A Research Concultation Project – Karen Spilsbury, Barbara Hanratty and Dorothy McCaughan – Department of Health Sciences, University of York 2015.

Recent NICE guidance 2015 (cited above) highlights the importance of care homes employing nursing staff with the right knowledge, attitude and approach to ensure that staff are competent, appreciate the challenges of working in the sector and understand how to promote quality of care.

Spilsbury The Registered Nurse’s role and responsibilities include:

- Promoting person centred care (including personal choice and meaningful, purposeful activities
- Engaging with family members and providing appropriate support
- Managing acute illness and emergencies
- Preventing health problems
- Preventing adverse incidents and ensuring resident safety Monitoring resident’s condition (physical, mental, emotional & social wellbeing.
- Promoting self-care
- Managing long term conditions
- Maintaining an optimum environment for older people’s functioning and wellbeing
- Promoting mental health & wellbeing
- Managing complex medication regimes and therapies
- Clinical expertise in palliative and end of life care
- Supporting, supervising and leading the assistant workforce in care homes
- Ensuring timely referral of residents to primary and community health professionals
- Avoid unnecessary hospital admissions to emergency care
- Range of administrative, regulatory and management functions

It is therefore important for nurses in care homes to ensure they keep up to date with the management and treatment of conditions for residents in their care.

What aspects of the care home nurse's role could be undertaken by others to promote use of the nursing and support workforce to benefit resident care. How can the care home nurse's role be positively promoted to enhance understanding of the role?

Recommendation

The role and contribution of nurses working in care home requires greater clarification and appreciation.

5.8. Average Age of Residents

The average age at the start of the placement was recorded as 82 with no significant variation between areas. The figure recorded by Cwm Taf Health Board was 77. See table 35 below for North Wales and Table 35A in Annex 1 for rest of Wales.

Table 36 indicates that there were 187 admitted to care homes for older people below the age of 65. Table 36a in annex 1 provides more detail across the rest of Wales with 24 people admitted below the age of 40; 54 being admitted between the ages of 40 to 49 and 521 between the ages of 50 to 64. The figures for the younger group are a cause of concern and regional partnership boards need to understand the reasons for admitting younger adults into care homes for older people.

5.9. Average length of Placement

The average length of placement is recorded as 25 months or 2.1 years. The average length of stay varied between 20 months in Conwy to 33 months in Anglesey. See table 40 below. The health board recorded the average length of stay as being 19 months but this would include many people eligible for CHC and who therefore have more complex needs and conditions.

In terms of categories of care the average age upon admission was 83 for residential care; 82 for residential EMI care; 82 for Care homes with general nursing and 81 for nursing EMI provision. There was a greater variation on the average age on admission for people placed in nursing EMI care homes; ranging from 75 in Wrexham to 81 in Gwynedd. The average age of admission for the other areas was as follows: Anglesey – 79; Conwy – 80, Denbighshire 77, Flintshire 76 and the health board 81.

Caution needs to be exercised in any interpretation of these figures because the date of admission may vary from the date when an organisation accepted responsibility for funding the placement. We are aware, for example, that some

health boards have recorded date of accepting funding responsibility. We will need to tighten the definition for future use.

In terms of improving our data base for the future we need to record date of admission, date of departure, reason for departure (death or transfer to another home, return to family home, etc.) and change of circumstances in terms of funding responsibility for placement.

Table 35

Average age of clients

Further analysis

	At start of placement	At census date
Isle of Anglesey	82	85
Gwynedd	83	86
Conwy	82	84
Denbighshire	81	84
Flintshire	83	85
Wrexham	82	85
Betsi Cadwallader	81	83
North Wales	**82**	**84**

Table 36 Age of Clients at start of placement							
	<65		65-84		85+		Total
	Number	%	Number	%	Number	%	
Anglesey	17	6	131	47	133	47	281
Gwynedd	20	4	253	49	248	48	521
Conwy	39	7	252	47	247	46	538
Denbighshire	16	5	189	54	146	42	351
Flintshire	12	3	213	48	219	49	444
Wrexham	19	4	245	49	233	47	497
Health Board	64	5	590	50	531	45	1185
North Wales	187	5	1873	49	1757	46	3817

Table 37 Age of clients at census date							
	<65		65-84		85+		Total
	Number	%	Number	%	Number	%	
Anglesey	8	3	105	37	168	60	281
Gwynedd	8	2	192	37	321	62	521
Conwy	31	6	209	39	298	55	538
Denbighshire	0	0	163	46	188	54	351
Flintshire	8	2	179	40	257	58	444
Wrexham	8	2	191	38	298	60	497
Health Board	46	4	509	43	630	53	1185
North Wales	109	3	1548	41	2160	57	3817

Table 38 Average age at start of placement by category of care **Note:** We do not know category of care breakdown for one home in Wrexham				
	Residential	Residential EMI	General Nursing	Nursing EMI
Anglesey	83	81	84	79
Gwynedd	84	83	82	81
Conwy	82	83	82	80
Denbighshire	81	83	82	77
Flintshire	85	82	85	76
Wrexham	85	81	81	75
Health Board	94	83	82	81
North Wales	83	82	82	80

Table 39 Average Age at census date by category of care **Note:** We do not know category of care breakdown for one home in Wrexham				
	Residential	Residential EMI	General Nursing	Nursing EMI
Anglesey	86	83	87	81
Gwynedd	86	85	85	83
Conwy	84	84	83	82
Denbighshire	85	85	84	79
Flintshire	87	84	87	78
Wrexham	88	84	83	78
Health Board	94	83	84	83
North Wales	86	84	84	82

Table 40

	Months	Years
Isle of Anglesey	33	2.8
Gwynedd	31	2.6
Conwy	20	1.7
Denbighshire	36	3.0
Flintshire	23	1.9
Wrexham	30	2.5
Betsi Cadwallader	19	1.6
North Wales	**25**	**2.1**

Table 41 Average length of placement by category of care
Note: We do not know category of care breakdown for one home in Wrexham

	Residential	Residential EMI	General Nursing	Nursing EMI
Anglesey	38	25	35	18
Gwynedd	33	24	33	18
Conwy	21	18	17	23
Denbighshire	44	27	30	32
Flintshire	22	23	25	24
Wrexham	30	31	24	36
Health Board	7	1	19	20
North Wales	30	26	22	22

5.10 Third Party Payments in the pilot in North Wales

- 10% of cases involve third party payments
- 87% do not involve third party payments
- 4% don't know
- No return from one authority
- One authority has larger proportion of third party payments involving 41% of its placements and 58% of all third party placements in North Wales.
- One authority accounts for only 8% of placements involving third party payments but the average third party payment is much higher.
- Policy – uniform approach concerning financial assessment / contributions but variance in use of third party payments.

Table 42 Third Party Payments (No information from Wrexham)						
	Yes		**No**		**Don't Know**	
	Number	**%**	**Number**	**%**	**Number**	**%**
Anglesey	34	12	203	72	16	
Gwynedd	25	5	489	94	1	
Conwy	63	12	475	88	0	
Denbighshire	14	4	337	96	0	
Flintshire	184	41	189	43	16	
Health Board	0		1185	100	-	
North Wales	320	10	2878	87	4	

Across Wales we estimate that less than 10% of cases involve third party payments but we have no returns from 4 authorities. The rate (number of cases) of third party payments is above average in Flintshire, Swansea, and Bridgend although the highest third contributions are reported in Gwynedd, Powys, Cardiff and Monmouthshire. There is no evidence to suggest that such payments operate outside existing guidance. See tables 42 and 43 in this paper for North Wales and 42A and 43A in Annex 1 for the rest of Wales.

Recommendation

Local authorities need to monitor the use made of third party payments together with the cost or size of the payment to ensure that they comply with the guidance issued in relation to the Social Services and Wellbeing (Wales) Act 2014. It is important that local authorities understand the level of third party payments made in relation to each case. Those cases involving the highest fees (above £200 per week) should be subject to review.

Health boards will also need to monitor the use of any additional payments made to support NHS Continuing Health Care Placements.

Table 43 Placements with third party placements by category of care									
	Residential		**Residential EMI**		**General Nursing**		**Nursing EMI**		**Total**
	Number	%	Number	%	Number	%	Number	%	
Anglesey	6	18	5	15	16	47	7	21	34
Gwynedd	0	0	1	4	18	72	6	24	25
Conwy	52	83	1	2	4	6	6	10	63
Denbighshire	7	50	5	36	0	0	2	14	14
Flintshire	51	28	90	49	32	17	11	6	184
Wrexham	-	-	-	-	-	-	-	-	-
Health Board	-	-	-	-	-	-	-	-	-
North Wales	116	36	102	32	70	22	32	10	320

6. Future Data requirements both to facilitate the shaping of service provision and to provide oversight of care home provision (template for formal partnership reporting).

Data to be collected as a matter of routine

Care homes in Wales is a multi-million £ business. We need to develop more effective management and financial information systems to effectively commission and transform services. We should not have to mount a research exercise to acquire information we should have at our finger tips and be collecting as a matter of routine.

This project started by defining the information required to provide a reasonable analysis of demand and supply of placements provided by care homes for older people in Wales. It included information on placements made for older people by Welsh local authorities and health boards both in and outside of Wales.

The collection of this information has proved to be both time consuming and challenging in that much of it is not routinely gathered or reported upon. It has also proved challenging in that even keeping the information to a minimum the opportunities it presents for analysis are very broad. Whilst the design of the analysis was being discussed there were demands for it to capture a wider range of other information. This was rejected in that the analysis of the information collected has already proved to be very demanding. To have expanded the requirements further would have taken us beyond the limited resources available for this project. There is nevertheless a need to collect a broader range of information which will include information on the workforce.

There were some areas of information which some agencies could not provide within the timescale required. It would not have been profitable to keep chasing. The value of this exercise is that in addition to providing a basic analysis it helps to define the information we should be collecting as a matter of routine to support the development of provision by providing good intelligence both to commissioners and providers. We must remember that if we want providers to invest in new services they will require good quality information to make a business case for investment and borrowing.

The limitation of this analysis is that it is based on a one-off exercise so there is no trend data to indicate trends. The 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.

Trend analysis of care homes might also be useful if care reports were analyzed alongside the data in this work. This could highlight issues which affect care homes such as fee levels, numbers of beds, staffing levels and types of care offered. Analysis over a reasonable period could provide very useful insight into the sustainability of different care provider models.

This analysis provides 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 couple of 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.

This section builds on the original design of the analysis and makes further suggestions for routine data collection to inform decision making. The National Commissioning Board will need to work with stakeholders to refine these requirements and work with the data unit and others to design appropriate systems for collecting the data. Health boards and local authorities will already have financial reporting systems in place. Hopefully, all stakeholders will work towards agreeing the data required and its method of collection.

The formal partnerships for the integrated commissioning of services from care homes will need regular reports to give confidence to each partner that these arrangements are helping them to meet their statutory responsibilities more effectively. Partnerships need reliable information to build confidence. The reports/ data suggested will assist the development of these reporting arrangements.

Ideally health and social care commissioners with appropriate information governance arrangements in place can develop a data base in relation to those placements they fund in each home. The purpose of such a data base would include information relating to quality assurance requirements in terms of the planning and feedback from reviews of individual cases. Information on the type and duration of contracts should also be collected.

Further work is required to develop an appropriate range of outcomes measures.

Reports to Lead Commissioner (Leadership Group managing formal partnership and Pooled Budget) and available to Regional Partnership Board

Reports / Information	Rationale
Numbers of individuals admitted to care homes (broken down by category e.g. care home with 24 -hour nursing provision) during each month.	Both items of information provide an understanding of length of stay and turnover which puts additional pressure on care homes. They also help to build a picture of demand.
Numbers of individuals leaving long term placements to return home.	
Numbers admitted to long term placements direct from hospital	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.
Number of individuals admitted to care homes with no prior service intervention e.g. home care, reablement, step up step down provision.	Such cases would warrant further investigation, accepting exceptional circumstances referred to above. Why have the needs of the individual escalated to such an intensive form of care and support? What alternatives have been explored and are they available?

Reasons for admission to care home (Work to be undertaken to classify reasons)	Health Boards and local authorities should classify reasons for admission to care homes including individual choice to avoid inappropriate admissions. It may be that an improvement in community continence services, for example, would lead to fewer admissions. Such a classification should also capture information on the acuity/ dependency of individuals which will inform the profile of the home.
The % of residents who were rehospitalized within 30 days of admission to the care home And The % of residents who have an outpatient emergency department visit within 30 days of admission to the care home.	This may indicate that the care home is not properly assessing or taking care of residents who were admitted to the care home from hospital. It may indicate problems with the transfer of care from hospital e.g. incorrect information
Number of individuals transferring from residential care homes to nursing homes: • directly from residential care homes • indirectly from residential care homes via hospitals	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.
Numbers of individuals admitted to care homes for purposes of assessment, intermediate care or respite care.	This will demonstrate the options being used. The use of respite care will also provide some indication of how carers are being supported.

% of short stay residents who were successfully discharged home in the community from the care home And % of short stay residents who made an improvement in function.	This is an important outcome measure. Describes the number who were helped to gain more independence
Acuity/ Dependency of residents As above work will need to be undertaken on classifications	This will provide some measure of the total acuity levels being managed by the care home.
Length of placements	Some providers are reporting that as individuals are being supported in the community for longer they are more frail or dependent upon admission and there is a quicker turnover of placements. Length of placements are reducing which provide challenges for providers.
Age of individuals upon admission	If people are being placed into care homes at a younger age this could point to areas where improvements could be made. This information should offer useful insight as trend data develops. Significant changes might point to policy changes, as well as changed outcomes for older people.
Number of individuals on local authority / Health Board waiting lists	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.

Vacancies - Registered Beds which are vacant Vacant beds in shared rooms – some homes may have two registered beds in a shared room with one showing as a technical vacancy but where there is no intention to fill it.	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 may also be experiencing financial challenges.

Placements by location, out of area placements Reasons for out of county placements: • Individual choice. • No appropriate local provision broken down by category of care • Need for specialist provision	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.

Care homes with embargos, Development Action Plans or Corrective Action Plans.	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.

Number of placements taken up by self-funders	The statutory sector needs to be mindful to take account the needs of individuals who fund their own care when planning service provision. Just as local authorities and health boards strive to avoid inappropriate or premature admission to care homes for placements they fund they also need to strive to ensure that potential self-funders have access to goof information on the options for care and support available.
Number of self-funders who become eligible for local authority or health board financial support per quarter.	Trend data will help facilitate statutory partners with their financial planning.

Placements by funding stream Local authority Local authority @ Funded Nursing Care Self-Funder & FNC Continuing Health Care Joint funded 117 placements Health Funded 117 placements	This will be important to inform the contributions of the Health Board and Local authority partners to the Pooled budget(s). It will over time also demonstrate how demand is changing.
Contributions of each partner to the cost of the placement – local authority, health board, individual resident contribution and third party placement.	This will be important to inform the contributions of the Health Board and Local authority partners to the Pooled budget(s). This will maintain transparency both in terms of fees, expenditure and charges. It will facilitate the financial planning of the partnership.
Provision of Care by sector: Local authority; third sector and private sector	This demonstrates share of the market / provision by each sector.

Ownership of Care Homes	This will provide information on the share of the market in each local authority, health board region and for Wales of each provider and the exposure of local service provision to specific providers should any get into financial difficulties
Locality of Care Home including local authority and locality within authority including post code.	Distribution of care homes and populations would be very useful. Local authorities will often include a balance of sparsely populated communities and more densely populated communities This will be important because some localities may be poorly served by current provision involving individuals being placed a long way from their family and community.
% of long stay residents whose ability to move independently worsened or % of long stay residents who can maintain mobility	Loss of locomotion or mobility increases risks of hospitalization, pressure ulcers, circulatory problems, etc.
% of long stay residents who received an antianxiety or hypnotic medication	The use of such medication among older adults has been linked to
	adverse outcomes such as cognitive impairment, delirium, falls and fracture. The measure is intended to prompt nursing homes to re-examine their prescribing patterns to encourage practice in accordance with clinical guidelines.

Information on individual residents would need to include the following data to generate the reports above.

Data to be collected
Resident identifier
Date of birth
Age upon admission, discharge or death
Care home area (local authority location and possibly locality) and postcode.
Location of residence prior to admission (also prior to hospital admission if admitted from hospital)
Reason for admission

Services received either directly prior to admission or immediately prior to hospital admission if admitted from hospital
Change of circumstances e.g. individual becomes eligible for financial support or individual becomes eligible for NHS continuing health care, or individual discharge or death.
Change of circumstances – admission from residential care direct to care home with nursing or to care home with nursing through hospital
Nature of placement • Long term care • Short term reablement • Short term assessment • Short term respite
Location of placement – within local authority where individual ordinarily resident or out of county.
Category of placement out of county
Reason for Out of County Placement • Resident choice – to be nearer relatives • No appropriate local provision
Waiting list • In hospital waiting for placement • In interim placement waiting for preferred placement of choice.
Source of Funding for placement and weekly contribution from each partner • Self-funder • Local authority and resident contribution
• Health Board Contribution (FNC) • Health Board CHC placements • Section 117 placements • Third party payment

Care home providers also have a contribution in terms of providing data to help manage and develop the market. This will include:

- Vacancies – reported at least weekly
- Number of self-funders from local authority area
- Number of self-funders from outside region
- Number of placements funded by public bodies outside Wales

Number of self-funders and individuals to be fund by Health board and or local authority on the waiting list

Health boards and local authorities will already have systems in place to project spending commitments which can be adjusted month by month as circumstances change. The National Commissioning Board will arrange workshops with Commissioners to define and prioritize the management and financial information required. The result could be template for reports to the management group overseeing the formal partnership and pooled budget.

7. Conclusion

This analysis has generated a lot of valuable information in terms of the size, scale and nature of the sector. It has drawn on the data and information from the process of collecting the data to provide an analysis the challenges ahead together with providing some recommendations designed to getting all stakeholder on a path towards their resolution.

Colleagues in health boards, local authorities, care homes, the Data Unit and SSIA have all worked very hard to put this information together with all its limitations. If we are going to shape care home provision to reflect the needs of older people in need of immediate access to care and support, we will need to put in place adequate management information systems. This should be information we have at our finger tips on a day to day basis.