Audit of NHS Continuing and Long Term Care in Wales

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Executive Summary

Introduction

This Project is an audit of current provision and costs of NHS long term and continuing health care in Wales. The term NHS Continuing care as used here means fully funded care for people who do not require care in an NHS acute hospital but who still require a high degree of ongoing health care (House of Commons Health Committee 2005), this may include patients who are in some instances treated as inpatients in NHS beds but also those treated outside hospital. This report uses the term 'NHS long term and continuing care' to describe patents who fall into the categories covered by the report. There is a tendency to assume that NHS long term and continuing care means only care of older people however, not all of this kind of care is delivered to older people. People of all ages, including children and younger adults with severe physical and mental health problems or who have learning disabilities may need such care, however, the nature of long term and continuing health care means that it is mostly provided to older people.

Background

Estimates suggest that about one in two women and one in three men who reach retirement age will need some form of long-term care in their late old age (Hancock et al., 2006). The number of dependent older people in Wales is projected to increase by 70% between 2001-2031 (Comas-Herrera et al., 2005) this will have considerable cost implications in Wales.

As the population ages the question of who should fund care continues to provoke debate. Care, when provided by the NHS is free at point of use, when provided by local authorities, is means tested. Whether a person receives long term care from the NHS or instead enters the means tested social care system depends on whether they meet eligibility requirements. NHS continuing care eligibility criteria were designed to identify and provide free care only to those who had a high level of need for ongoing health care, as distinct from supportive help with the daily activities of personal care. The majority of elderly people are not eligible for NHS continuing care funding.

Eligibility is currently established with reference to criteria issued by the Welsh Assembly Government which relate to the complexity, intensity and unpredictability of a patient's health care needs, individual Local Health Boards are required to develop local policies and eligibility criteria within this general framework (Welsh Assembly Government 2004)

While the Assembly have offered guidance for local Health Boards there are no national criteria in England or Wales; in the absence of legislative definitions some people have sought clarifications through case law. Two significant cases; Coughlan 1999 and Grogan 2006 have aided the development of the legal framework and caused further discussion about who is entitled to fully funded care.

Methods

This project took place in two phases, first in depth case studies were carried out at a sample of sites across Wales; the case studies were followed up by an email survey of all Local Health Boards in order to gather standard data to estimate total cost and numbers of patients. The case studies offered the opportunity to explore and compare key issues in some depth across a number of Local Health Boards (LHBs), they were chosen to represent a mix of urban and rural, affluent and more disadvantaged as well as to represent all areas of Wales. The case studies were followed up by an email survey which collected comparative data from all LHBs and aimed to produce a national map of provision.

Results

Case Studies

The case studies highlighted a number of issues which were of concern to the LHBs; these included; the additional workload that the assessment process places, as well as the difficulty interpreting the eligibility criteria, especially where a multidisciplinary team need to reach a consensus. A further major issue for the LHBs is the consequences of the Grogan judgement and the impact that it will have on costs, as yet, these have not been assessed, additionally the fact that the boundary between health and social care is blurred and this may impact on patients and their care..

Survey

The total number of people covered by NHS Long term and continuing care at the time of the survey was 4,129; with a total spend for the NHS in Wales of £114.6 million from an overall NHS Wales budget of about 4.4 billion (3%). Almost four fifths of spending (79.0%) was allocated to four categories of patient; mentally ill, learning disability, nursing home care and the elderly mentally ill, these accounted for two thirds (68%) of patients. Two other categories include significant numbers of patients, children with complex needs (11.6%) and nursing care at home (7.9%). The overall spend per person in the population in Wales was £42.36.

Discussion

As the welsh population ages NHS long term and continuing health care will increasingly become an issue for the health service. The bureaucratic workload of eligibility is a significant demand for multi-disciplinary teams and difficulties in achieving a consensus within the team can result from different interpretations and professional backgrounds with the potential for cost shifting from one agency to another. Across agencies, access to information was also an issue, particularly the availability of information from NHS trusts on patients occupying an NHS bed for which continuing care is an appropriate option.

The case studies indicate that Local Health Boards identified the need for a consistent approach in determining eligibility and managing care, with clarification provided by the Welsh Assembly Government also taking into account changes that result from case law that may have an impact on the expenditure of LHBs. Other factors which may also have an impact on expenditure is the changing demography of Wales, with significant projected increases in the numbers of over 85s and increases also in the number of highly dependent older people. The increasing cost of nursing home care and the cost of out of area placements put additional pressure on LHBs.

Additionally, significant costs can result from individual cases where complex needs are involved, for example children or adults with disabilities. The high proportion of mental health cases and learning disability cases recorded was somewhat unexpected and indicates that, although this issue tends to be conflated with care of older people, the whole population should be considered in developing policy on this issue.

Summary of Recommendations

Guidance and Training

Increased coordination and strengthening of the current eligibility guidance on long term care by the Welsh Assembly Government would be of value to Local Health Boards. Also, it would be beneficial for all members of the multidisciplinary teams to receive coordinated training in the assessment process to address inequities across geographical and disciplinary boundaries.

Sharing of Information

The improvement of access of information by Local Health Boards from NHS trusts would improve planning and management of long term care. The Assembly, Trusts, LHBs and Social Services would benefit from regular and complete access to information about long term care patients accommodated in NHS beds, including personal and assessment details. Further work between the stakeholder groups should be undertaken to agree a minimum data set for monitoring of long term and continuing health care.

Financial Implications

A small number of very expensive cases, for example rehabilitation cases, may put a severe and unpredictable burden on LHB budgets. There may be a case for sharing the risk of such cases through some sort of collective exceptional budget, perhaps a ring-fenced top slicing by the Assembly or in some other way, with contributions by all LHBs.

While finance is an important issue in the context of long term care, it is important that, at local and national level, care reflects the needs of patients rather than the financial envelope available. Long term care needs to be seen in the context of broad trends in healthcare provision. While reductions in

acute sector beds and the closure or re-provision of community hospitals may have implications for patients in continuing care, their needs should be protected.

Need for further research

The Assembly could consider commissioning a thorough study of the likely impact of the Grogan and Coughlan cases on long term and continuing care in Wales. The review might also consider allocation of resources between health and social care and the potential of pooling of budgets.

Further work could be undertaken to understand the operation of the assessment process. It is beyond the scope of this piece of work to investigate the process in detail, but we have indications of anomalies and inequities which require further investigation.

1.0 Background

This report represents an audit of current data and management practice in long term and continuing health care across Local Health Boards (LHBs) in Wales. It is an attempt to derive a baseline for assessing changes in the cost to the NHS of long term and continuing health care, especially in view of recent legislative and legal changes in the field. It will also try to estimate the number of people currently receiving such care from the NHS. Finally, it will establish the current management arrangements across Wales and seek to identify a minimum dataset to enable monitoring of future demand and service provision. We are grateful to everyone who has taken part in the audit, particularly those in the local health boards used as case studies in the early phase of the research.

The term, NHS continuing care, as used here means fully-funded care for people who do not *require* care in an NHS acute hospital, but whom nevertheless require a high degree of ongoing health care (House of Commons Health Committee, 2005). For the purposes of this study, we include those patients who are in some instances treated as inpatients in NHS beds, but in other geographical areas might be treated outside of hospital. The report uses the term *"NHS long term and continuing care"* to describe patients who fall into the categories covered by the report.

1.1 Demography

There is a tendency to assume that NHS long term and continuing care means only care of older people, however not all of this kind of care is delivered to older people. The Welsh Assembly's guidance (Welsh Assembly Government, 2004) recognises that people of all ages, including children and younger adults with severe physical or mental health problems or who have learning disabilities, may need such care. However the nature of long term and continuing health care means that it is mostly provided to older people.

Estimates suggest that about one in two women and one in three men who reach retirement age will need some form of long-term care in their late old age (Hancock et al., 2006). According to the Welsh Assembly Government, the number of people over retirement age in Wales will increase by 11 per cent over the next 20 years to more than 650,000. Over the same period, the number of people over 85 will grow to 82,000, more than a third higher than today.

Continuing and long term care has considerable cost implications for the NHS in Wales. A report from the Personal Social Services Research Unit at the LSE (Comas-Herrera et al., 2005) commissioned by the Welsh Assembly Government projected the number of dependent older people in Wales to increase by 70 per cent by 2030 over 2001 levels. A recent Joseph Rowntree Trust Report found that, assuming no change in dependency levels, real terms spending on long term care in the UK will need to rise by more than 300 per cent to keep pace with demographic change over the next 50 years.

1.2 Policy Context

Continuing and long term care can be seen as encompassing a number of categories of health care. For the purposes of this report, we regard continuing and long term care as including:

- the provision of long term care in hospital (including beds which may be called continuing care, but may also be identified in other ways);
- the provision of continuing NHS health care in care homes;
- the provision of continuing NHS health care in a person's own home;
- NHS Funded Nursing care in care homes.

The funding of this care as the population ages is an issue which continues to provoke debate. The debate often centres on whom, whether the individual or the state, should fund this care. Care provided by the NHS is delivered free at point of use while care provided by local authorities is means tested.

One important report identified evidence of widespread dissatisfaction with the current means-tested funding arrangements (Wanless, 2006). Disagreement over the respective responsibilities of the NHS and social services for long term care is nothing new, and reflects the blurring of boundaries between the two services. In recent years, it has been argued that this is indicative of the health service's retreat from the provision of long term care and the transfer of responsibilities to social services, and thereby to patients and their families (Henwood and Waddington, 2005).

In the sixties and seventies, many people who were no longer able to take care of themselves in their own homes, but who did not need the high level of care provided in acute hospitals, were cared for in NHS long-stay wards and community hospitals. An emerging consensus at the time was that care at home was preferable to care 'in a home' and that entry to hospital or other institution represented an increased level of dependency (MacDonald et al, 1996). As this became formal policy, the closure of many long-stay wards for older people, people with mental health problems and people with learning disabilities meant that growing numbers of them were cared for in residential or nursing homes, or in their own home.

The health service today does not provide help with domestic tasks, such as shopping and preparing meals or assistance with personal care tasks, such as dressing and bathing (Comas-Herrera et al., 2004). Most of this care for older people and others who live at home is provided by informal carers with additional input from social care agencies (Pickard et al, 2000).

Formal services are provided by a range of agencies including local authority social services, community health services and independent sector residential and nursing homes and home care services (Comas-Herrera et al., 2004). Much of the care arranged and paid for through local authorities is supplied by independent sector providers. People may also arrange and pay privately for their own residential or home care without involving a local authority (Hancock et al., 2006)

Whether a person receives long term care from the NHS or instead enters the means-tested social care system depends on whether they meet eligibility requirements. Eligibility for NHS long term and continuing care funding is currently established with reference to criteria originally introduced by the Department of Health in 1995. NHS continuing care eligibility criteria were designed to identify and provide free care only to those who had a high level of need for ongoing health care, as distinct from supportive help with the daily activities of personal care, such as washing, dressing and eating. The majority of elderly people being cared for on a long term basis in residential or nursing homes, or by carers in their own homes, are not eligible for NHS continuing care funding.

If a person is eligible for NHS continuing care, the entire costs will be met by the health service. However if a patient is not eligible for NHS continuing care but requires long-term residential care, the 'hotel' costs, for board and lodging, and 'personal care', will be funded either by local authorities or by the resident themselves, or by a combination of the two.

In Wales, detailed eligibility guidelines are issued by the Welsh Assembly Government. The criteria relate to the complexity, intensity or unpredictability of a patient's health care needs and any requirement for the regular supervision of a consultant, specialist nurse or other member of the NHS multidisciplinary team. Individual Local Health Boards are required to develop local policies and eligibility criteria for NHS long term and continuing care funding within this general framework (Welsh Assembly Government, 2004).

The Guidance issued in 2004 asked that Local Health Boards (LHBs) take responsibility for planning the implementation of the guidance framework and that they issue local guidelines for use in their locality. In doing so, they were required to work closely with NHS Trusts, Local Authorities and other local agencies to ensure the effective management of NHS long term and continuing care; and that staff are trained to undertake multidisciplinary assessments of potential patients; and that long term and continuing care is considered in needs assessment and service development (Welsh Assembly Government, 2004).

Those deemed not eligible for NHS funded care through the assessment, but still in need of help with daily tasks, accommodation or other locally authority provided services may be required to contribute to the cost (Welsh Assembly Government, 2004; 2006). In practice, the boundary between the two services remains unclear and has shifted over time (Henwood, 2004), so that the long term care responsibilities of the NHS have tended to contract substantially, and people who in the past would have been cared for in NHS long stay wards are now often accommodated in care homes. This means that responsibility for funding long term care has to a major extent shifted from the NHS to local authorities and individual patients and their families.

Concerns about the apparent unfairness of the system which saw people having to fund all or part of the costs of their care which they believed they

would receive from the NHS, were an important part of the background to the establishment of the Royal Commission on Long Term Care in 1997. The Commission reported in 1999 and recommended that all nursing care and personal care should be provided free of charge (and funded through taxation), while people should be means-tested for the living and housing cost components of their residential accommodation.

Central Government did not accept the principal recommendation on removing personal care costs from means-testing, but did address some anomalies which meant that people accommodated in nursing homes were asked to pay for care which they would receive free of charge in any other setting. In Scotland, the Parliament took an early policy decision to provide personal (though not hotel) care free (Bell et al, 2006)

Designed for Life identifies the challenge of re-designing health care according to the evidence and developing the evidence where it is absent. There are currently no reliable figures for overall spending on NHS continuing care or numbers of people involved. As care may take place in a number of settings, including in people's own homes, NHS facilities and care homes, the task of estimating the total resources used, the number of people currently in receipt of NHS long term and continuing care or indeed assessing unmet need for care is very challenging. This research attempts to begin to fill that gap by gathering and standardizing data from Local Health Boards who are responsible for ensuring the appropriate provision of NHS long term and continuing care in Wales.

The needs of patients receiving long term and continuing care are not always fixed, but change and fluctuate over time. This means that the source of funding for their care may also change. Patients may be the responsibility of local health boards, local authorities or the Health Commission Wales (HCW), depending on their current needs. HCW has been established to provide a specialist commissioning body to secure tertiary and other highly specialised services throughout Wales on behalf of the population and to support LHBs in their own commissioning of specialist services. Examples of HCW commissioned services are cardiac services, specialist cancer care and the Welsh Ambulance and blood services.

1.3 Legal Developments and Challenges

The legal framework separates the "social care" which local councils provide and which is means-tested, and the "health care" provided by the NHS, free to the user whatever the setting (Henwood, 2004). In practice the distinction between the two can be difficult to make. The Care Standards Act 2000 tried to address the blurring of boundaries by abolishing the statutory distinction between nursing homes and residential homes; retaining some requirements for care homes providing nursing; and bringing them within a social care regulatory regime. While this was seen as a step forward, there remained uncertainty about eligibility for funded care.

While the Assembly has offered guidance for local health boards, there are no

national criteria in England or Wales and in the absence of legislative definitions, some people have sought clarifications through case law. Two very significant cases have aided the development of the legal framework, one in 1999 (the Coughlan case) and more recently the Grogan case (January 2006). Both cases have caused further discussion about who is entitled to fully funded care.

The Coughlan judgment (1999) and the subsequent Health Service Ombudsman for England's reports in 2003 and 2004, criticized health organizations for using overly restrictive criteria and led to new guidance and a framework for implementation. Guidelines for assessment of eligibility were developed in Wales by the Assembly Government and issued in 2004. The guidance contained criteria for eligibility to be implemented locally. Local Health Boards produced local plans for implementing this guidance in 2005.

The judgment stated that if the patient's need for medical or nursing care was "incidental to" or "ancillary to" their need for accommodation in a care home then their care could be the responsibility of the local council, and means-tested. But if it that was not the case and the patient's primary need was a health need, then all their care was the responsibility of the NHS, and had to be provided free. Thus Coughlan effectively reviewed and re-drew the line between health and social care.

A further important decision in the case of Maureen Grogan v Bexley NHS Care Trust was given in early 2006. This case forced health administrations and local authorities in England and Wales to further clarify the eligibility criteria for NHS care (Welsh Assembly Government, 2006). The Grogan case concerned a woman who had been assessed as not qualifying for NHS continuing health care; she challenged the ruling on the basis that the assessment was flawed because it was based on criteria that were themselves flawed.

The judgment examined the confusion that arises between nursing definitions, particularly for higher levels of care, and the definition of eligibility for NHS funded care. The judge acknowledged an *"understandable confusion and dissatisfaction"* of others (including the Health Select Committee and the Health Service Ombudsman) that the definitions appeared to set a *higher* threshold of needs than would qualify a person for NHS continuing care. So that some people who would be eligible for care in one situation could be denied care in another.

Legal advice, including the criticism by the judge in the Grogan case, shed light on the inadequacy of current advice to the NHS and local authorities on the application of current guidance and eligibility criteria. Interim guidance was issued by the Welsh Assembly in October 2006. This guidance and the frameworks will be subject to review in 2007. Research suggests that there remains considerable variation in the interpretation of eligibility criteria between local health organizations (Vindlacheruvu and Luxton, 2006), while other authors have questioned whether assessments are designed to facilitate proper care or control costs (Morrissey et al., 2006).

Under further guidance from the Department of Health (2006) and the Welsh Assembly Government (2006), amplified the focus on the 'primary health need'. Where such need can be established, the patient should be seen as eligible for NHS funded care.

1.4 Background to the Research

In 2006, the Welsh Assembly Government commissioned this project from the All Wales Alliance for Research & Development in Health and Social Care (AWARD) under the contract for policy relevant research managed by the Wales Office for Research & Development (WORD).

After initial discussions, a protocol was agreed between the Policy Lead at the Welsh Assembly Government and AWARD to undertake the research. The research, which is described in more detail in the next section aimed to establish a baseline dataset through which the Assembly could monitor provision of and spending on NHS long term and continuing care. It would also establish how services were being managed in LHBs, identify key issues and recommend appropriate data for monitoring.

2.0 Project Description

This project is an audit of current provision and costs of NHS long term and continuing care in Wales. Additionally, the researchers used qualitative case study and survey methods to explore the management and costs of long term and continuing care at local level and provide policy advice to the Welsh Assembly Government.

Discussions with the Welsh Assembly Government and a brief review of the literature and policy documents provided the researchers with an overview of the main policy issues in this area. The design of the research developed from this knowledge. It was decided that a mixed approach, beginning with case study research to identify the most important local issues and moving on to survey all LHBs in order to collect the data would generate the most appropriate information.

2.1 Project Aims

- To identify processes currently employed in managing NHS long term and continuing care
- To establish current numbers of patients in receipt of NHS long term and continuing care across Wales
- To estimate the current cost of providing long term and continuing care to different patient groups.
- To identify appropriate data for monitoring NHS long term and continuing care across Wales.
- To identify other key issues in this policy area from the perspective of LHBs.

2.2 Approach and Methods

This project took place in two phases. Phase 1 was in the form of in-depth case study work at a sample of sites across Wales. The case studies were followed by an email survey of all local health boards to gather standard data required to estimate total cost and numbers of patients. The questionnaire used in the telephone survey was informed by the information gathered at the case study sites and by consultations with policy colleagues at the Welsh Assembly.

All Local Health Boards were informed of the research by a letter from the Welsh Assembly Government directed to that individual who has responsibility for NHS long term and continuing care. Identified contacts were used to make initial contact for the case studies and subsequently to address the questionnaires.

After the questionnaires were distributed, it emerged that much of the data requested had already been collected, sometimes using slightly different categories, while some other parts of the data were not available to LHB staff.

It was pragmatically agreed that to minimize the workload on staff, we would

access data previously collected and use the questionnaire as a check on the accuracy of this data, requesting only a minimum of additional material.

2.3 Case Studies

Case studies were appropriate for this project as they offered the opportunity to explore and compare key issues in some depth across a number of LHBs before gathering data from all. Thus the combination of case studies and an all-Wales survey provided the research design most likely to achieve the aims of the project. The case studies were chosen to include a mix of urban and rural areas, a mix of affluent and more disadvantaged areas and to encompass all parts of Wales.

After an initial analysis of socio-economic determinants, four local health boards were chosen in discussion with the Assembly policy lead as case study sites.

The four Local Health Boards chosen were:

- Bridgend LHB
- Cardiff LHB
- Conwy LHB
- Torfaen LHB

Each of the four local health boards was contacted with a request for information and suggestions of possible interview subjects.

Interviews were arranged and conducted, using a topic guide designed by the researchers. Audio recordings of the interviews were transcribed for analysis and themes were identified independently by members of the research team.

The aim of this stage of the work was to establish how NHS long term and continuing care is managed in Wales, to establish who was involved in the provision of care and to identify appropriate data for collection. Issues for discussion included; management arrangements, existing mechanisms for collecting data, adequacy of current provision and potential for future data collection. Interviewees were also asked to identify key issues at a national and local level. The interview topic guide is included as an appendix to this report (Appendix 1).

Case study dossiers were compiled for each selected site. These included interview transcripts, documentary evidence and data. Together with an analytical summary drawing the studies together, the dossiers are summarized in this report.

2.4 Email Survey

The aim of the survey phase was to collect comparative data from all LHBs and to produce a national map of provision and management arrangements.

AWARD researchers made an initial contact with the named individual at each LHB by email and sent a data collection questionnaire (Appendix 2) which included the data already available. LHBs were requested to return the questionnaire, adding additional information, annotating and checking the data.

After the initial contact, it emerged that much of the data requested had already been compiled by Directors of Nursing. This was made available to the researchers, who altered the form to reflect this, entering the data to the form before re-distribution and requesting that LHB contacts validate and annotate the data.

Some additional questions were asked about management structures and respondents were also asked to identify key issues.

The data gathered by the AWARD researchers was entered into a spreadsheet for analysis.

3.0 Results

3.1 Case Studies

Four case studies were undertaken by the researchers. They consisted of interviews, documentary analysis and analysis of data gathered from LHBs in all parts of Wales. Case studies were selected with the assistance of the Welsh Assembly Policy lead to include LHBs with differing experiences of NHS long term and continuing health care.

3.1.1 Bridgend Local Health Board

Bridgend Local Health Board serves a population of around 129,000 people within a geographical boundary which is coterminous with that of Bridgend County Borough Council (BCBC), with whom it shares statutory responsibility for the implementation of the Health, Social Care and Well-Being Strategy.

Bro Morgannwg NHS Trust is the principal provider of health care to the local population. The Trust manages a comprehensive range of integrated hospital and community services for a resident population of around 300,000 people living in the County Boroughs of Neath Port Talbot, Bridgend and the western Vale of Glamorgan. Annual income is around £300 million, it is responsible for twelve hospitals with over 1,400 beds and for more than 29 community premises.

Following the publication of the 2004 Guidance (Welsh Assembly Government, 2004) a **Regional Joint Implementation Plan for Continuing NHS Health Care** was developed through a partnership which included the following agencies**:**

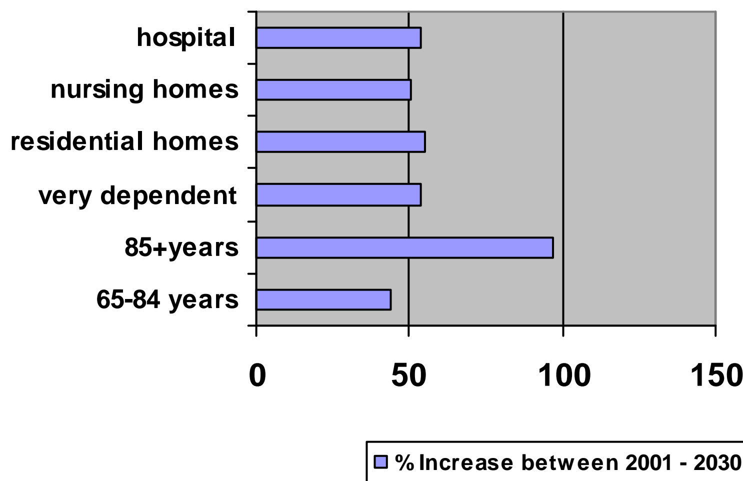
- Bridgend LHB and Bridgend County Borough Council
- Carmarthenshire LHB and Carmarthenshire County Council
- Ceredigion LHB and Ceredigion County Council
- Neath Port Talbot LHB and Neath Port Talbot County Borough Council
- Pembrokeshire LHB and Pembrokeshire County Council
- Powys LHB and Powys County Council
- Swansea LHB and City and County of Swansea

This Plan provides the framework and local eligibility criteria within the wider area of mid and West Wales. Within the Regional plan, the LHB manages continuing care through its Nursing Directorate, with a senior nurse for continuing care taking day to day responsibility. For in-patients, assessments are managed by the NHS Trust, whereas in the community, the multidisciplinary team is in operation.

Coma-Herrera et al. (2005) estimates that the numbers of older people are projected to grow very substantially, in particular between 2020 and 2031, the extent to which these older people are dependent will be the crucial determinant of the future needs for services. The estimates for Bridgend

are for a 44.13% increase of the 65-85 age groups and a 96.65% increase in those aged over 85 between 2001 and 2031. Further, it is estimated that the numbers of very dependent older people will increase by 53.54% and the numbers of people in residential homes will increase by 55.16%, in nursing homes by 50.42% and in hospital by 53.53%.

Figure 1



(Coma-Herrera et al. 2005)
For managers of the Bridgend service, a key issue is health care assessments, which are a burden for district nurses. The additional workload for district nurses to support the assessment process for long term continuing care patients is substantial and there are knock on impacts on other patients.

In the past, district nurses provided all care but as a result of the division between health needs and social care needs the skill mix of district nurses has changed. As continuing care policy and practice develops district nurses are now expected to carry out a wider range of duties but it is felt that they no longer have the relevant skill mix required.

Terminally ill patients who meet the criteria for continuing health care often do not go through continuing NHS healthcare assessment, consequently, there are some patients who are continuing health care but are not recognised as such within the statistics.

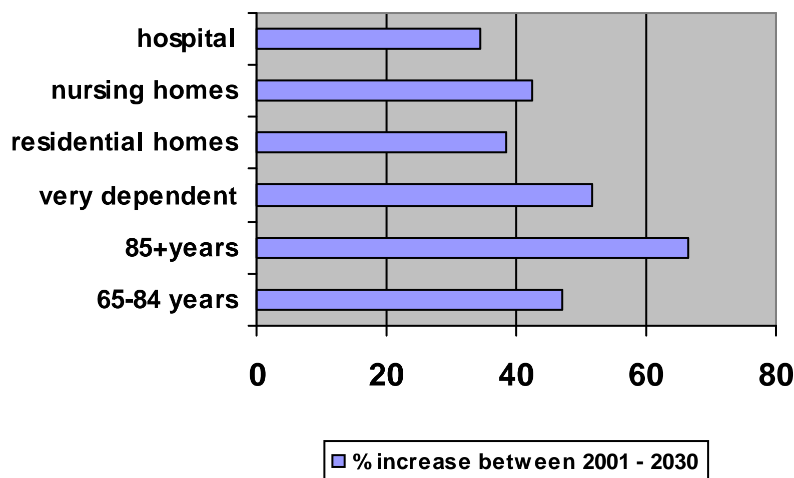
3.1.2. Cardiff Local Health Board

Cardiff is Wales' capital and its largest city. The population of 319,000 is somewhat younger than Wales as a whole, perhaps reflecting the large student population. Cardiff Local Health Board works closely with the Cardiff and the Vales NHS Trust to secure health services for the local population. Cardiff and the Vale is the largest NHS Trust in Wales and one of the largest in the UK, it provides day to day health services to a population of around 500,000 people living in Cardiff and the Vale of Glamorgan.

Patients also attend from across Wales for a range of specialist services, for which the Trust is regarded as a centre of excellence, including paediatric, renal, cardiac, neurological services and bone marrow transplantation.

Coma-Herrera et al. (2005) produced projections of the impact of demographic pressures on demand for long term care services. In Cardiff between 2001-2030 the numbers of people within the 65-85 age groups will increase by 47.14% and those in the 85 and over age group will increase by 66.42%. The numbers of very dependent older people will increase by 51.81%. The numbers of people in residential home is estimated to increase by 38.60%, nursing home by 42.42% and hospital by 34.57%.

Figure 2



(Coma-Herrera et al. 2005)

It was acknowledged that Cardiff, because of its capital city status, may have different requirements regarding continuing care than other parts of Wales. Firstly, the average costs of nursing home placements are more expensive in Cardiff by approximately £100-200. Also, because of the tertiary specialist hospital it is possible that people relocate to this are because they are receiving specialist care through the tertiary hospital. Cardiff has a prison population as well as a high homeless population, these populations often

have a higher level of mental illness, substance misuse and physical health needs.

Children with very complex needs are living longer, meet continuing health care and want to live at home. Also, an increase in adults ventilated at home who previously would have remained in an in-patient hospital setting, the expectation now is that people should be cared for within their own home or within their own family. Also there have been strategic changes around mental health and learning disabilities and where these individuals should receive their care.

A further issue raised was that the eligibility criteria are difficult to interpret and may be interpreted differently depending on which organisation was using them. Often assessments for continuing health care have to include opinions from a multi disciplinary team who have to reach a consensus, different interpretations of the eligibility criteria may make it difficult for this to happen. There is a financial incentive for local authorities to have somebody considered continuing health care because then the responsibility for the health care package shifts across organisations.

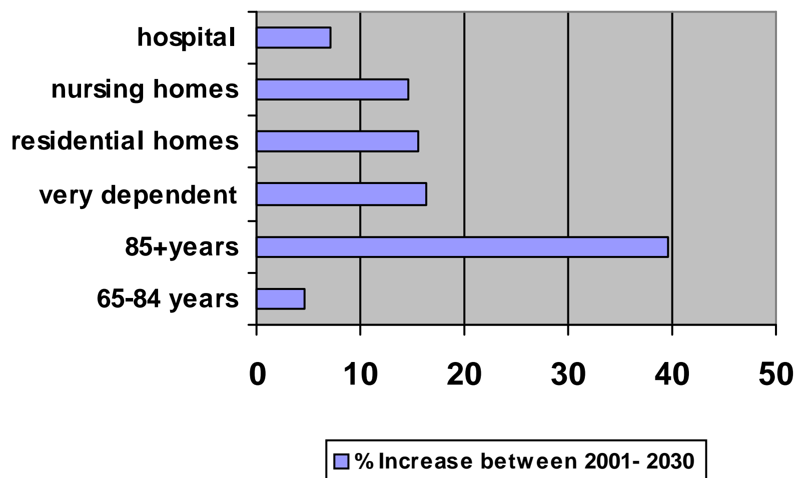
A recurrent issue was the ‘artificial’ divide between health and social care and the consequent division of funding as well as division of responsibility between separate organisations and the impact that this has on patients and their care. There is also a financial incentive for a patient to be deemed continuing NHS health care and this has led to challenges to decisions on eligibility from individuals and their families, this applies both to current decisions but also retrospectively.

3.1.3 Conwy Local Health Board

Conwy has the highest proportion of older people of any local health board in Wales. The overall population of 111,500 includes almost 13,000 over 75 year olds. Coma Herrera (2005) produced projections of the impact of demographic change on demand for long term care services. In Conwy, between 2001 and 2030, the number of people within the 65-85 age group will increase by only 4.62%, but the number of people in the over 85 age group will rise by 39.64%. The number of very dependent older people will increase over the same period by 16.31% and the number in residential homes is estimated to be 15.64% higher, nursing homes will accommodate 14.62% more people and hospitals 7.04% more.

Figure 3

Conwy - Projected percentage increase in numbers between 2001-2030



(Coma-Herrera et al. 2005)
Conwy works closely with its neighbouring LHBs, NHS Trusts and local authorities on a joint approach to continuing NHS care. The six local health boards, together with the six local authorities and three NHS Trusts in North Wales collaborate on issues of NHS long term and continuing care, meeting regularly to decide on eligibility and policy. A group, the “North Wales Continuing Health Care Implementation Board” meets regularly to discuss matters of common concern. An example of this cooperation is in the response to the Grogan judgement, where the Board discussed and agreed the need for amendments to eligibility criteria. These have since been drafted and included in an interim revision to the implementation plan issued on February 1, 2007.

The North Wales authorities have adopted an approach through which the multidisciplinary team first considers eligibility for continuing health care, before considering eligibility for funded nursing care and/or health and social care for those found not to meet the eligibility criteria.

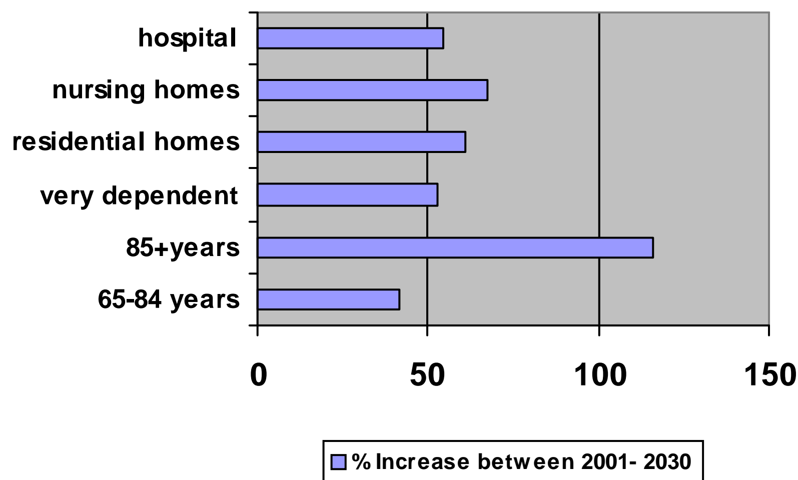
3.1.4 Torfaen Local Health Board

Located in South East Wales, bordering the Brecon Beacons, Torfaen is an LHB which serves a population of 90,000. The LHB works very closely with four other Health Boards and local authorities on continuing and long term NHS Care. The origin of this collaboration is a pre-existing agreement between the Gwent Health Authority and Gwent NHS Trust that the Trust would manage continuing NHS care on their behalf. From April 2007, this agreement ends, but the five LHBs will continue to cooperate on the commissioning of long term and continuing NHS care, working with their local authorities and Gwent NHS Trust, the main provider. The cost of continuing and long term NHS care is currently in the region of £22 million per year.

Coma Herrera (2005) produced projections of the impact of demographic change on long term care services. In Torfaen, between 2001 and 2030, the 65-85 age group will increase by 41.54% and the over 85s by 116.13%. The number of very dependent older people will rise by 52.74%. Residential homes will need to accommodate 61.10% more people, nursing homes 67.13% more and hospitals 54.36% more.

Figure 4

Torfaen - Projected percentage increase in numbers between 2001-2030



There are a number of current issues raised in the case study and further issues that are seen as important for the future. Among current issues is the level of training for staff. Although managers view individuals as able to undertake assessments adequately, there is a question about whether different professional staff is offering assessments to the same standard across disciplinary and geographical lines. The Coughlan and Grogan cases introduce more complexity into the situation and make a check-list form of assessment more difficult.

A second issue raised was the level of commitment of the members of the multi-disciplinary team. There were questions of whether there was the same level of commitment to ensuring that the needs of Long term care patients was in evidence in all staff. One view expressed was that GPs were unlikely to initiate an assessment, while district nurses may also be reluctant and that in mental health, there were significantly different views taken of the eligibility process.

In Torfaen, there are a number of developments on the horizon that are likely to have an impact on long term and continuing NHS care in the Gwent area. One is the *Gwent Clinical Futures* public consultation and discussion which is looking at the strategic development of healthcare for the Gwent community in the long term. Clinical futures proposes a major refocus from acute to community led services and a reduction in hospital beds by some 700, accompanied by the development of a three level model of care with more comprehensive primary care supported by local community hospitals in each of the local authorities and a new specialist and critical care centre.

The decline in bed numbers makes community-based long term and continuing NHS care essential, with primary care staff then occupying an important place in the process.

The second issue is the changing relationship with the Gwent NHS Trust. For several years, long term and continuing care commissioning has been handed over to the NHS Trust, who have also managed the process. Their approach has been to hand over the process to the individual medical directorates, so that mental health and learning disabilities services have been separated from services for older people or children. This has created some problems for the assessment process, as patients in (for example) mental health will be assessed differently than those in nursing homes.

From April 2007, Torfaen LHB took over responsibility for commissioning the service from the Trust, working with the other LHBs in the Gwent area. This can be seen as an opportunity to re-assess those patients involved and ensure that their needs are properly met and yielding potential for cost reductions.

A major issue for the LHBs is the consequences of the Grogan judgement. Estimates are not available, but individuals suggested that as a result, the cost of long term care would rise significantly as the NHS is forced to take over care for those who have fallen in the “gap” between social and health care.

Note:

Comparisons of projected percentage increase in numbers for the case study sites are provided in Appendix 5

3.2 Audit of Continuing Care Data

3.2.1 Response to the Survey

Although responses were slow in coming, with one reminder, 16 LHBs had submitted data. Further reminders succeeded in securing data from the remaining LHBs although the Vale of Glamorgan were unable to disaggregate cost data. They are therefore excluded from some of the analyses although their total figures are included. The data collected from the questionnaire are included as tables in Appendix 3.

3.2.2 Management of Continuing Health Care

Long term and continuing health care is recognized across Wales as a crucial issue. The commissioning of care is managed predominantly within each Local Health Board by a dedicated team, usually under the management of the Nurse Director. The team is often made up of nursing professionals together with administrative and financial support.

Most if not all LHBs work closely with their neighbours and local authorities to develop coherent policies. Within the Gwent area five Local Health Boards have formed a consortium (consisting of Blaenau Gwent, Torfaen, Monmouthshire, Newport and Caerphilly). The process is overseen by a complex care team based in Torfaen LHB; this team has the dual role of supporting the assessment process, undertaken by multi disciplinary teams, as well as putting together the package of care following the completion of the assessment.

In other areas, similar arrangements apply, with policy groups including representatives of NHS Trusts, local authorities and LHBs establishing wide area agreements or partnership arrangements to deal with commissioning, eligibility and assessment issues.

Most LHBs have recognised the need for action as a result of judicial decisions related to NHS long term and continuing care. Their responses highlight three main areas; firstly, that guidance was being reviewed or redrawn in light of the recent legal decisions. Secondly there were potential financial implications, recognised by LHBs and in varying stages of being quantified. Thirdly, it was recognised by LHBs that as a consequence of recent developments there would be an increase in workloads for the continuing health care teams, with increasing numbers of requests for assessments including retrospective assessments; it was recognised that this would impact upon resources.

3.2.3 Numbers of Patients and Cost of Long Term and Continuing Care

The total number of people covered by NHS long term and continuing care at the time of the survey was 4,129. The total spends for the NHS in Wales was £114.6 million, from an overall NHS Wales budget of about £ 4.4 billion (3%).

Almost four fifths of spending (79.0%) went on four categories of patient: mentally ill, learning disability, nursing home care and elderly mentally ill. These also accounted for two thirds (68%) of all patients. Two other categories include significant numbers of patients: children with complex needs (11.6%) and nursing care at home (7.9%), but the proportions of the overall spend for these were small: nursing care at home consuming 5.57% of the budget and children with complex needs 5.49%.

One third of the spending went on mental health (33.4%), however in some authorities; this included elderly mentally ill people. If these two groups are combined for all LHBs, they make up 46.0% of the spend and 26.8% of people. If the two categories mentioned are separated, the largest number of people in individual categories was in the learning disabilities group (21.0%) and in nursing homes (20.7%).

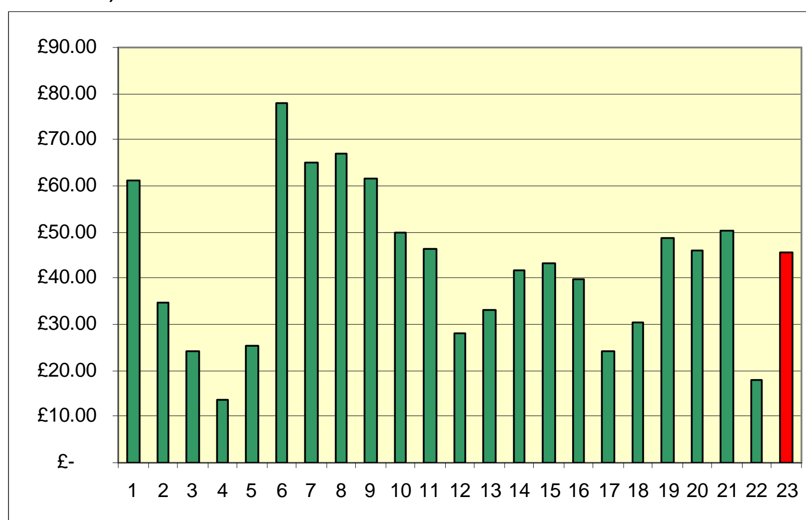
The highest spending authorities are Carmarthenshire (£13.87 million), Swansea (£10.98 million) and Cardiff (£8.09 million). At the low end of the scale were Merthyr (£1.53 million), Caerphilly (£2.34 million) and Blaenau Gwent (£2.36 million). However a better picture of spending is one that takes into account the overall population served.

The overall spend per person in the population in Wales was £42.36, but this varied by LHB from £13,79 in Caerphilly to £77.88 in Carmarthenshire. Figure 1, below shows the cost per person for each LHB, with the Wales figure to the right for comparison.

Key to Local Health Boards

1	Anglesey	12	Merthyr Tydfil
2	Blaenau Gwent	13	Monmouthshire
3	Bridgend	14	Neath Port Talbot
4	Caerphilly	15	Newport
5	Cardiff	16	Pembrokeshire
6	Carmarthenshire	17	Powys
7	Ceredigion	18	Rhondda Cynon Taf
8	Conwy	19	Swansea
9	Denbighshire	20	Torfaen
10	Flintshire	21	Vale of Glamorgan
11	Gwynedd	22	Wrexham
		23	All Wales

Figure 5: Long term and continuing care cost per person in population (2001 Census)



Nb: Key to LHBs on page 18

3.2.4 Cost per Case

The mean spend per case served across Wales was £27,155.46 although the spend per case varied at a local health board level from a high of £71,255.20 in Monmouthshire to a low of £16,817.30 in Newport. By category, the highest average cost per case was in rehabilitation (£72,253.65), although this figure is raised by one local health board that were spending more than £1million on only 4 cases, whereas most LHBs were currently not funding any patients. Of the four major patient categories, mental health (including EMI) had the highest cost per case at £51,907.04) although for those authorities where it was possible to identify younger mentally ill people, the cost per case was somewhat higher at £61,207.08.

Costs for mental health care tended to be higher everywhere, but they also show the greatest variation, exceeding £100,000 per case in five LHBs (Figure 6). Both Learning Disabilities (Figure 7) and Nursing home care (Figure 8) showed more consistency across LHBs. In no LHB was the cost per case for Nursing Home care greater than £50,000, while this was the case for Learning Disability care only in Newport (£108,148.08 per case) and in neighbouring Monmouthshire (£57,579 per case).

Figures 6-8 show cost per case for the major contributors to the total long term and continuing care workload and spend. Figure 9 compares the three major categories,

Figure 6: Cost per case, mental health by Local Health Board

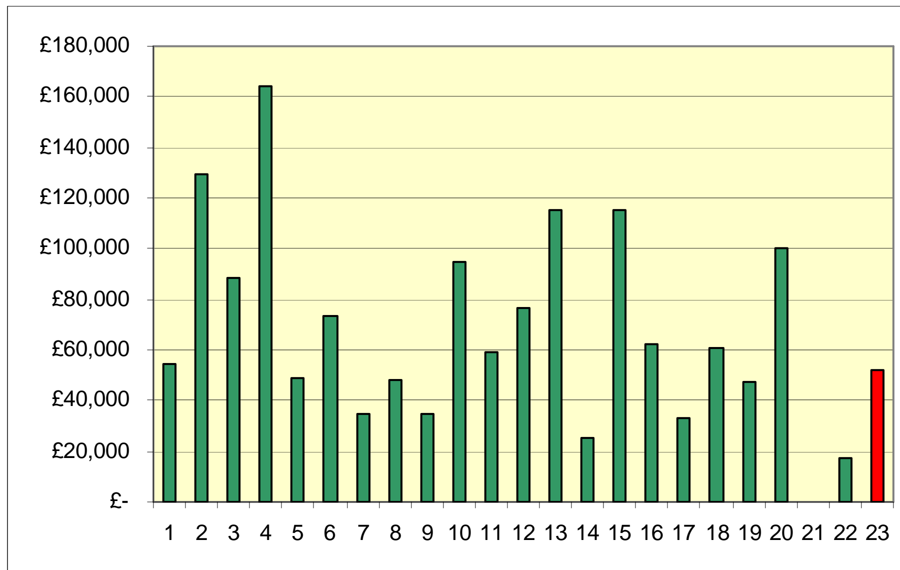


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Figure 7: Cost per case, Learning Disabilities by Local Health Board

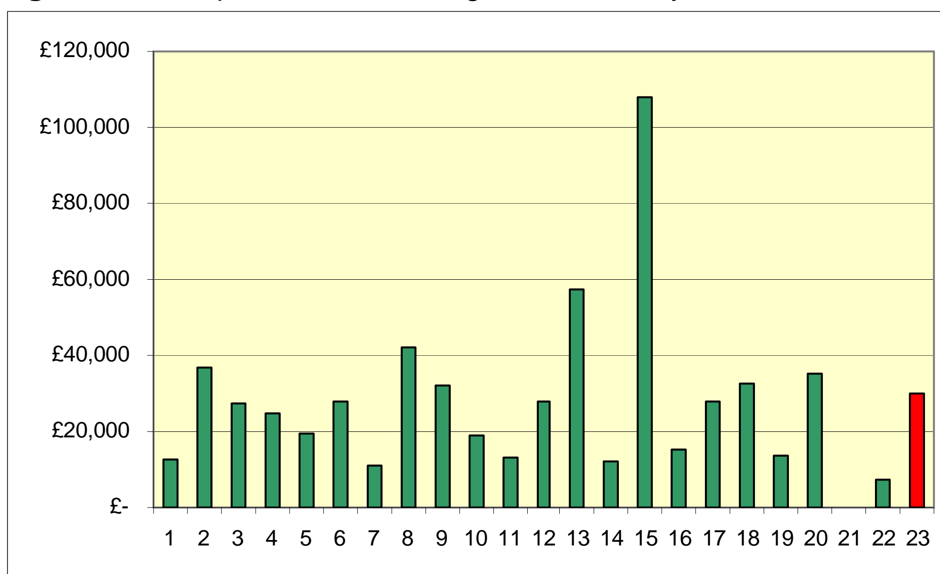

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Figure 8: Cost per case for Nursing Homes by Local Heath Board

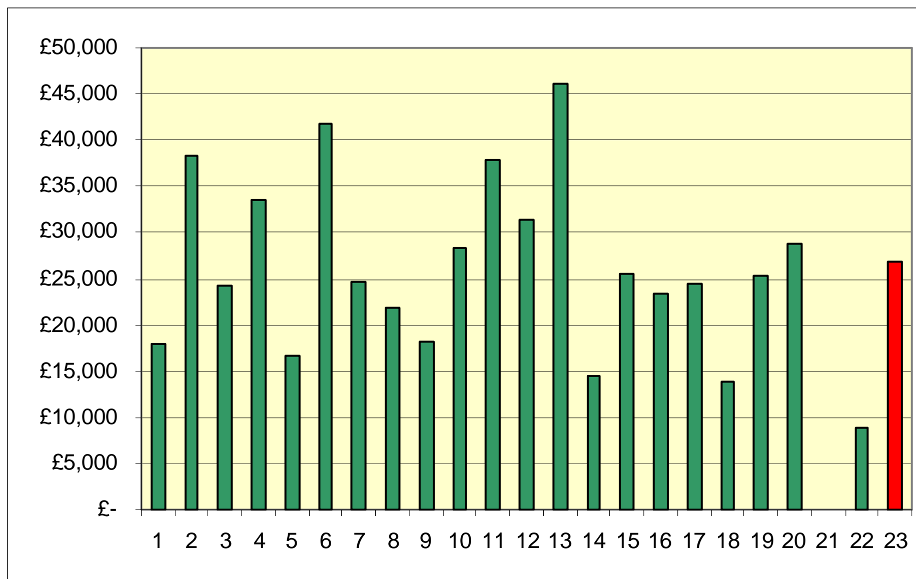

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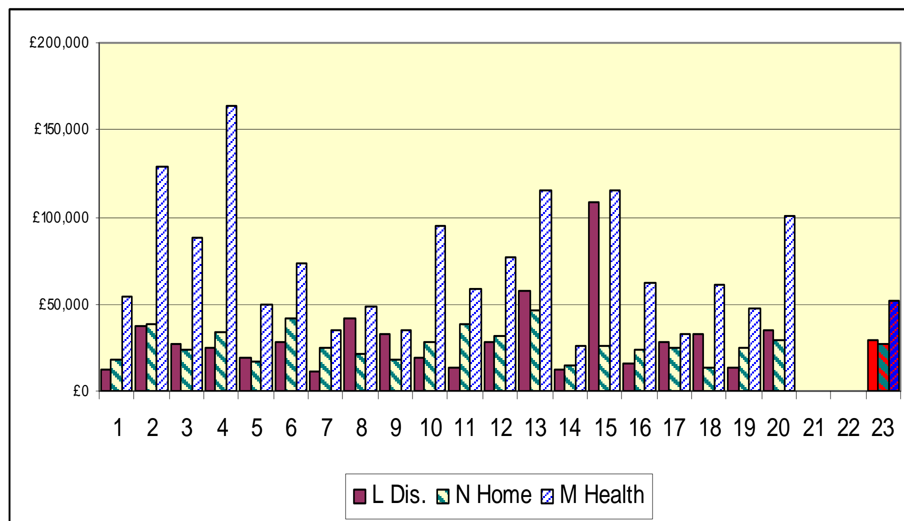
Figure 9: Cost per case comparison of three NHS long term and continuing care categories



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Full details for cost per case for all categories and all LHBs are found in Appendix 3.

3.2.5 Key Issues for Local Health Boards

Many LHBs noted the increase in applications, both current and retrospective, and the resultant pressure placed upon the system and resources. Other issues raised by Local Heath Boards have been listed below:

- The need for children's criteria. Children with complex needs consume a comparatively small part of the overall budget, but individual cases may run into many thousands over many years. There is concern that this is an unpredictable part of the spend.

- Concern about rising fees of nursing homes, which are above the continuing health care fee paid. This was a specific issue for some LHBs who have seen recent increases in fees, putting pressure on budgets.

- The significant impact on community nursing and therapy services which, without an increase in resources come under additional pressure as a result of continuing health care.

- Lack of clear guidance on the issue of contribution by patient if it is the patient's choice to go into a more expensive home. This and other concerns about the contemporary legal framework are of general concern.

- There are currently many unresolved cases before the appeals process or the courts.

- It was felt by some that a common core of training for multidisciplinary teams would improve confidence in assessments.

- The reluctance of some professional groups to fully participate. GP's are reluctant to participate in assessment and decision making largely because of the impact upon their core contractual work and thus the impact upon their practice income. They also express concern that they are under undue pressure from families because of the close relationships they have.

- There is little clarity about on-going clinical responsibility for patients who are placed out of area. This creates potential risks, concerning who should take responsibility and local clinical teams are often reluctant to do so.

- The Health Commission Wales has responsibility for a certain number of patients; however there appears no clinical foundation or consistency in the transfer of responsibility.

- There can be tensions in the working relationship between the LHB and the Local Authority in the interpretation of guidance. The need for real partnership can be compromised by the potential for cost shifting.

4.0 Discussion

4.1 Broad health policy trends

As the Welsh population ages, NHS long term and continuing health care will become an increasing problem for the health service. The estimates from the Joseph Rowntree Foundation (JRF, 2003) and Personal Social Services Research Unit (Comas-Herrera, 2004) indicate a potentially unsustainable increase in the necessary funding.

NHS long term and continuing care should also be seen in the context of other policy development processes that affect the health service in Wales. For example, in Gwent, there is a Clinical Futures project which proposes a major re-configuration of acute health care in the area. This may mean that the focus of care switches from acute services to those provided closer to where people live, either through primary care or in lower tech community hospital facilities. It will mean a dramatic reduction in acute bed numbers (estimated at 700) making supporting people in the community or care homes crucial to securing their care in old age.

While there are some local conditions, we found that across Wales there is a consistent approach to management of long term and continuing care. The rule appears to be that local authorities and health services are working closely together on the issue and have often made strategic agreements over wide areas, recognising shared needs. While we have not been able to examine the operation of these agreements in detail, it appears that the cooperation has in most cases been genuine and continues.

Cardiff is to an extent, a special case. Although the Cardiff population is currently younger than the average for Wales, there will still be a significant increase in population of those older adults requiring access to NHS long term and continuing care over the next 20-30 years. In addition, as the site of Wales's main tertiary care provision, some people may re-locate to the area to be close to treatment services.

The bureaucratic workload of eligibility is a significant demand for multi-disciplinary teams and inevitably has an impact on patient care. This workload seems to be born primarily by nurses in local health boards, with less input from general practitioners or social services teams than might be ideal. Difficulties in achieving a consensus within the team can result from different interpretations and professional backgrounds. The potential for cost shifting from one agency to another is enormous; the incentives are there in terms of stretched budgets for both health and social care sectors which may influence the outcome of assessments, while the only available recourse for the patient and her family is the arduous appeals process or ultimately the courts. The potential of pooled budgets, as is already happening in the shared commissioning of the Gwent LHBs should be explored.

The role of Health Commission Wales is currently minor in this area but could be expanded as was suggested by some respondents. The Commission

already deals with complex groups of patients, but this role could also take in very costly individual cases which can be disastrous for individual LHB budgets.

4.2 Assessment issues

The case studies indicate that local health boards identify the need for a consistent approach in determining eligibility and managing care. They have already taken major steps towards this goal by working closely together and creating area partnerships involving local health boards, local authorities and NHS Trusts. In Gwent, this amounts to merging LHB commissioning efforts completely, whereas in West Wales and North Wales, shared planning, wide area agreements, continuing contact and discussion lead to shared approaches and policies. In West Wales for example, seven LHBs and seven local authorities have produced a joint implementation plan designed to guarantee, equitable treatment. A similar agreement exists in North Wales. However LHBs continue to seek clarification from the Welsh Assembly Government on approaches to eligibility and nation-wide coordination of responses to case law changes that may have significant impacts on their expenditure. The true extent of this pressure on budgets remains to be seen, but it is a common concern of local health boards and there may be a role for the Assembly in modelling its likely impact over the coming years.

4.3 Unpredictable costs

While much attention has been directed to the effects of the Grogan and Coughlan judgments which redefine responsibilities in long term and continuing care, this is not the only cost pressure for local health boards.

Increasing costs as a result of demographic change are likely to be a significant problem. Coma-Herrera (2005) projects increases in the number of over 85s in Valleys communities of more than 100% over the next thirty years, with dramatic increases also in highly dependent older people. While this is not currently the largest group involved in continuing care, the increasing numbers will see it become so in the future.

There are also increasing costs in nursing home care and in the cost of out-of area placements which put additional pressure on LHBs both in terms of costs and the need to monitor provision. Where cases such as the complex needs of children or adults with disabilities are considered, LHB budgets may suffer dramatic impacts from individual cases and this urgently needs consideration at a national level.

4.4 Information Flows

Access to information on NHS Long Term and continuing care has proved confusing and inconsistent. Both Welsh Assembly Government and LHB colleagues have had problems in putting together what seems to be crucial information for the management of large budgets.

The most striking omission is the availability of information from NHS Trusts on patients occupying an NHS bed for which continuing care is an appropriate option. Although we did not survey NHS Trusts directly, previous work from the Directors of Nursing and provided to us has attempted to gather such data. It only partly succeeded in providing an All Wales picture. From what data is available, it appears that there are few commissioned beds in NHS Trusts, with the exception of in Cardiff, where a large number of elderly mentally ill places are commissioned.

This does not mean that NHS beds are not being used for continuing care patients however. Many people who would in other places be accommodated at home or in care homes remain in NHS beds as there are delays in the progress of patients through the system. These so called 'delayed transfers of care' occur when patients who are ready cannot move on for one or more of many reasons. Data is gathered monthly by Statistics Wales (Statistics Wales, 2007) and a one-month snapshot is included in the appendices to this report (Appendix 4). We also attempted to gather this data by questionnaire; however this was not successful, producing an inconsistent and limited response. Further research on delayed transfers of care is now being undertaken by the University of Glamorgan.

Through the Directors of Nursing, we were able to gather the data required to assess long term and continuing care by care group. This too was initially to have been collected through the questionnaire, however since in most cases it was already available; we asked only that LHBs validate the figures. The apparent lack of communication between Welsh Assembly and LHB colleagues is unfortunate but future cooperation should lead to improved availability of data for sharing and planning.

An aim of the project was to establish a minimum data set for monitoring NHS long term and continuing care in Wales. We feel that we have only partly achieved this goal, particularly in estimates of the number of NHS Continuing care beds. This is due to the fact that data is held by Trusts for inpatient beds and appears not available to LHBs. We do feel that it is proper that the Welsh Assembly Government work closely with the Directors of Nursing to take this forward and that NHS Trusts be asked to contribute, particularly to estimating the cost of continuing care in NHS beds.

4.5 Data Collected

The variation in cost per case and in overall spend is difficult to explain with reference to eligibility criteria, management process or demography. In general, rural LHBs tend to have higher levels of spend per person in the population, but not per patient. There may be some explanation in the implementation of the assessment process, but this would require further investigation. In any case, it would be unwise to draw conclusions from a single year's data.

The high proportion of mental health cases and learning disability cases

recorded was somewhat unexpected as the issue of continuing health care tends to be conflated with care of older people. The data show that this is an error and that the whole population should be considered in developing policy on this issue.

5.0 Recommendations

The Assembly could consider commissioning a thorough study of the likely impact of the Grogan and Coughlan cases on long term and continuing care in Wales. The review might also consider allocation of resources between health and social care and the potential of pooling of budgets.

Further work could be undertaken to understand the operation of the assessment process. It is beyond the scope of this piece of work to investigate the process in detail, but we have indications of anomalies and inequities which require further investigation.

A small number of very expensive cases, for example rehabilitation cases, may put a severe and unpredictable burden on LHB budgets. There may be a case for sharing the risk of such cases through some sort of collective exceptional budget, perhaps a ring-fenced top slicing by the Assembly or in some other way contributed to by all LHBs.

It would be beneficial for all members of the multidisciplinary teams to receive coordinated training in the assessment process to address inequities across geographical and disciplinary boundaries.

Increased coordination and strengthening of the current Assembly eligibility guidance on Long term care would be of value to Local Health Boards.

The improvement of access of information from NHS trusts by Local Health Boards could improve planning and management of Long term care. The Assembly, Trusts, LHBs and Social Services would benefit from regular and complete access to information about long term care patients accommodated in NHS beds, including personal and assessment details. Further work between the stakeholder groups should be undertaken to agree a minimum data set for monitoring of long term and continuing health care.

While finance is an important issue in the context of long term care, it is important that, at local and national level care reflects the needs of patients, rather than the financial envelope available. Long term care needs to be seen in the context of broad trends in healthcare provision; while reductions in acute sector beds and the closure or re-provision of community hospitals may carry an implication for patients in continuing care, their needs should be protected.

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Appendix 1

Topic Guide for Case Study Interviews

1. Interviewee's involvement

- Can you tell me what your position is in the LHB and describe how you are involved in NHS Long term and continuing Care.

2. Management of NHS LT & CC

- In your LHB, how (and by whom) is NHS long term and continuing care managed?

- Apart from the LHB, which other organisations are involved in management of NHS Long term and continuing care?

    - What is their role and how are they involved?

- What is the overarching strategy for continuing and long term care?

    - Can you indicate any relevant policy documents?

3. Eligibility/Assessment

- How are individual patients who may be eligible for NHS long term and continuing care identified?

- By what possible routes/pathways do patients enter long term/continuing care?

- How do you ensure equity of service for patients with differing conditions/needs

- How important is training for staff whose role it is to assess patients for NHS funding of long term and continuing care?

- How do you ensure this training/knowledge is implemented consistently by professionals involved in assessment?

4. Other issues

- Are there any current issues/problems that you think should be considered by the Assembly in NHS LT & CC?

5. Further contacts

Appendix 2

NHS Long Term and Continuing Health Care Questionnaire
SAMPLE
Local Health Board

We have been commissioned by the Welsh Assembly Government to gather data on current numbers of patients and NHS expenditure on long term and continuing health care. Following case study work in four LHBs and discussions with Welsh Assembly Government colleagues, we now would like to ask for your contribution to the study.

The data provided will be available to the Assembly, however comments or other materials received will remain confidential. No names or personal identifiers will be used in reporting on comments made.

Please complete the questionnaire and return it by email by (June 23rd). If this deadline is problematic or you have any other questions, please contact us as soon as possible by telephone or email: Michael Shepherd (shepherdm@cardiff.ac.uk) or Samia Addis (addiss@cardiff.ac.uk). Phone number: 02920 870098.

Person Completing the form:

Phone number/email (we may wish to contact you for further information).

Please complete the tables attached, adding any additional notes you think suitable. We would value your comments on the data, particularly any data that is not available.

Please add any further comments you may have.

Data for SAMPLE LHB

Where possible, data has been entered from sources previously received. Please complete any blank cells and/or update those where more recent data may be available.

1. Continuing health care in NHS beds and delayed transfers of care

	NHS in-patient care Designated CHC beds
Number of beds	
Total Expenditure	

	Number of patients delayed in hospital over 60 days
Non mental health	
Mental Health	

2. In your Local Health Board, how is NHS long term and continuing care managed and who is involved?

3. Has the LHB considered the likely effects of recent legal decisions in NHS continuing and long term care?

4. Are there other important issues?

Additional Information – please add explanatory notes as necessary
SAMPLE LHB

Continuing Care Comparative Data – By client group

	Total current clients funded	**Number of joint funded clients**	**Full-Year Expenditure 2006/07 (Projected or actual)**	**Comment**
Mental Health				
Learning disability				
Inpatient in Nursing Home				
Inpatient in EMI nursing home				
Palliative Care at home (nursing)				
Palliative care at home (personal care)				
Palliative in nursing home				
Children – complex needs				
Rehab/recovery (including physio)				
Nursing care at home				
Respite				

Thanks for your help

APPENDIX 3: Data Tables

1. NHS in patient care: designated Continuing Health Care Beds: Data submitted was incomplete, but the table shows returns as submitted.

Local Health Board	*Beds*	*Cost*	*Notes*
Anglesey	0		
Blaenau Gwent	0		
Bridgend	-		
Caerphilly	0		
Cardiff	155	n/a	Costs not available, bed number approx. About 110 EMI (Cardiff & Vale Trust)
Carmarthenshire	0		
Ceredigion	10	£450	Cost is per week (commissioned in last 6 months
Conwy	0		
Denbighshire	0		
Flintshire	0		
Gwynedd	0		
Merthyr Tydfil	24	£698,007	EMI Beds, direct costs shown
Monmouthshire	0		
Neath Port Talbot	18	£777,616	From Wanless monies
Newport	0		
Pembrokeshire	1	£6,000	Cost is per week (agency nursing)
Powys	0		
Rhondda Cynon Taff	-		
Swansea	0		
Torfaen	0		
Vale of Glamorgan	-		
Wrexham	0		

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Additional data provided by Hazel Reese, Powys LHB

Previous data collection by NHS Trust found that Cardiff & Vale had 110 EMI beds and approx 55 general nursing beds designated as continuing health care.

Ceredigion & Mid-Wales Trust has 10 palliative care beds (as noted these are commissioned by Ceredigion LHB.

2. Delayed Transfers of Care: This data is taken from Statistics Wales website, rather than from the data submitted by the LHBs which varied in terms of completeness and date.

A delayed transfer of care is experienced by a hospital inpatient, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. The Assembly recognize 45 possible reasons why delay might occur.

Local Health Board	*All*	*Mental Health*	*All Other*
Anglesey	7	4	3
Blaenau Gwent	10	2	8
Bridgend	13	3	10
Caerphilly	57	7	50
Cardiff	137	57	80
Carmarthenshire	49	11	38
Ceredigion	3	0	3
Conwy	2	0	2
Denbighshire	6	0	6
Flintshire	15	1	14
Gwynedd	12	2	10
Merthyr Tydfil	14	7	7
Monmouthshire	14	4	10
Neath Port Talbot	34	9	25
Newport	19	4	15
Pembrokeshire	4	1	3
Powys	37	10	27
Rhondda Cynon Taff	37	11	26
Swansea	64	14	50
Torfaen	50	3	47
Vale of Glamorgan	40	11	29
Wrexham	13	1	12
All Wales	637	162	475

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Source: Statistics Wales, Data for May 2007.
http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx

3. Patient Numbers: NHS funded Data are as confirmed by Local Health Boards.

Local Health Board	*Mental health*	*Learn. Disab.*	*Nursing Home*	*EMI Nursing Home*	*Palliative Care at home (nursing)*	*Palliative Care at home (personal)*	*Palliative Care Nursing home*	*Children with complex needs*	*Rehab/ recovery inc Physio*	*Nursing Care at home*	*Respite*	*Total All patient categories*
Anglesey	13	21	62	18	1	0	7	21	0	9	0	152
Blaenau Gwent	12	6	3	0	3	0	0	0	3	12	0	39
Bridgend	15	13	16	3	2	0	4	4	4	4	0	65
Caerphilly	5	9	2	0	2	0	1	0	8	12	1	40
Carmarthenshire	38	81	44	101	23	0	19	21	7	27	14	375
Cardiff	52	32	29	2	0	2	2	16	5	7	2	149
Ceredigion	22	37	33	45	9	0	4	7	1	27	9	194
Conwy	28	21	53	44	0	0	15	17	0	28	5	211
Denbighshire	32	10	65	49	0	5	28	42	6	5	7	249
Flintshire	19	47	47	12	6	0	2	53	5	10	1	202
Gwynedd	17	21	56	18	2	0	0	18	3	8	0	143
Merthyr Tydfil	10	2	8	2	0	0	0	8	2	1	0	33
Monmouthshire	15	5	3	0	0	0	1	0	5	5	1	35
Neath Port Talbot	16	21	113	37	11	0	5	23	25	11	5	267
Newport	24	12	10	0	10	0	7	0	16	10	0	89
Pembrokeshire	15	35	22	21	6	0	4	9	2	9	9	132
Powys	18	20	33	76	11	7	9	19	5	6	8	212
Rhondda Cynon Taf	53	12	65	19	0	0	5	8	0	26	14	202
Swansea	88	53	134	0	4	0	10	14	30	0	29	362
Torfaen	20	12	12	0	5	0	4	0	4	12	0	69
Vale of Glamorgan	5	10	60	25	4	0	3	10	0	11	13	141
Wrexham	27	27	54	30	11	0	5	22	4	4	2	186
Total All LHBs	544	507	924	502	110	14	135	312	135	244	120	3547

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4. Patient Numbers: Joint Funded. Data are as submitted by Local Health Boards.

Local Health Board	*Mental health*	*Learn. Disab.*	*Nursing Home*	*EMI Nursing Home*	*Palliative Care at home (nursing)*	*Palliative Care at home (personal)*	*Palliative Care Nursing home*	*Children with complex needs*	*Rehab/ recovery inc Physio*	*Nursing Care at home*	*Respite*	*Total All patient categories*
Anglesey	0	21	2	0	0	0	0	9	0	7	0	39
Blaenau Gwent	0	5	0	0	0	0	0	0	0	0	0	5
Bridgend	3	8	0	0	0	0	0	4	0	0	0	15
Caerphilly	0	9	0	0	0	0	0	0	0	0	0	9
Carmarthenshire	14	74	4	2	0	0	0	18	0	7	1	120
Cardiff	19	14	2	0	0	0	0	12	0	0	0	47
Ceredigion	16	35	0	0	0	0	0	0	0	0	0	51
Conwy	15	15	0	2	0	0	0	15	0	12	1	60
Denbighshire	10	6	3	1	0	3	0	25	2	4	4	58
Flintshire	4	41	1	0	0	0	0	36	2	0	1	85
Gwynedd	6	21	0	0	0	0	0	5	3	0	0	35
Merthyr Tydfil	2	2	0	0	0	0	0	7	0	1	0	12
Monmouthshire	2	4	0	0	0	0	0	0	0	0	0	6
Neath Port Talbot	6	21	0	0	10	0	0	23	3	6	0	69
Newport	7	3	2	0	1	0	0	0	2	60	0	75
Pembrokeshire	9	35	5	0	0	0	0	9	1	5	1	65
Powys	10	16	0	1	3	2	0	17	5	3	5	62
Rhondda Cynon Taf	9	10	0	0	0	0	0	1	0	2	2	24
Swansea	2	53	0	0	0	0	0	0	0	0	0	55
Torfaen	10	5	2	0	0	0	0	0	0	0	0	17
Vale of Glamorgan	2	5	0	0	0	0	0	7	0	0	9	23
Wrexham	3	21	0	0	0	0	0	22	0	4	4	54
Total All LHBs	149	424	21	6	14	5	0	210	18	111	28	986

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5. Costs: Data are as submitted by Local Health Boards. Vale of Glamorgan were unable to disaggregate the cost data, however total figures are included.

Local Health Board	*Mental health*	*Learn. Disab.*	*Nursing Home*	*EMI Nursing Home*	*Palliative Care at home (nursing)*	*Palliative Care at home (personal)*	*Palliative Care Nursing home*	*Children with complex needs*	*Rehab/recovery inc Physio*	*Nursing Care at home*	*Respite*	*Total All patient categories*
Anglesey	£1,174,017	£533,065	£1,154,889	£518,797	£3,183	£0	£16,500	£232,828	£0	£591,828	£0	£4,225,107
Blaenau Gwent	£1,550,027	£406,571	£114,952	£0	£0	£0	£0	£0	£289,148	£0	£0	£2,360,698
Bridgend	£1,524,349	£575,692	£388,499	£69,680	£44,684	£0	£97,892	£256,610	£114,888	£71,107	£0	£3,143,401
Caerphilly	£819,988	£444,757	£66,941	£0	£0	£0	£21,330	£0	£909,870	£0	£83,982	£2,346,868
Carmarthenshire	£4,474,051	£2,980,167	£799,139	£2,374,701	£533,686		£0	£589,025	£308,798	£1,715,573	£96,837	£13,871,977
Cardiff	£3,877,786	£1,289,260	£1,295,266	£89,231	£0	£1,500	£119,403	£670,260	£36,508	£705,832	£9,630	£8,094,676
Ceredigion	£1,152,471	£798,012	£814,256	£1,157,842	£156,123	£0	£46,250	£389,752	£24,152	£452,123	£89,241	£5,080,222
Conwy	£1,281,429	£1,520,567	£1,162,304	£2,179,062	£0	£0	£516,834	£109,059	£0	£627,254	£84,128	£7,480,637
Denbighshire	£1,588,970	£515,395	£1,232,775	£1,227,397	£0	£40,513	£145,826	£862,550	£170,855	£85,289	£36,791	£5,906,361
Flintshire	£2,490,161	£1,654,032	£1,357,049	£437,401	£88,268	£0	£158,183	£762,440	£53,257	£469,203	£16,356	£7,486,350
Gwynedd	£1,151,436	£558,432	£2,123,995	£910,453	£16,357	£0	£0	£167,260	£129,838	£401,711	£0	£5,459,482
Merthyr Tydfil	£871,595	£111,984	£250,300	£44,816	£0	£0	£0	£230,365	£5,037	£20,014	£0	£1,534,111
Monmouthshire	£1,729,592	£518,211	£138,471	£0	£0	£0	£28,599	£0	£422,608	£0	£83,982	£2,921,463
Neath Port Talbot	£676,000	£507,728	£1,644,421	£674,432	£23,528	£0	£29,843	£718,295	£1,141,540	£222,806	£29,827	£5,668,420
Newport	£2,765,755	£1,622,221	£307,348	£0	£0	£0	£155,343	£0	£1,165,164	£0	£0	£6,015,831
Pembrokeshire	£1,696,317	£1,080,945	£630,833	£548,612	£52,636	£0	£47,721	£930,523	£11,100	£186,350	£38,798	£5,223,835
Powys	£1,092,913	£1,013,647	£804,952	£2,016,055	£31,617	£10,846	£176,281	£249,446	£31,022	£138,180	£29,228	£5,594,187
Rhondda Cynon Taf	£3,907,496	£717,378	£900,479	£461,187	£0	£0	£93,474	£79,403	£0	£692,678	£182,134	£7,034,229
Swansea	£2,367,217	£1,430,977	£3,392,287	£1,830,444	£414,103	£0	£647,407	£44,286	£244,693	£0	£611,338	£10,982,752
Torfaen	£2,005,871	£601,716	£404,444	£0	£0	£0	£106,399	£0	£1,029,797	£0	£0	£4,148,227
Vale of Glam.						**LHB unable to disaggregate figures to categories shown**						£6,173,000
Wrexham	£528,539	£ 351,293	£ 473,413	£ 686,788	£ 84,968	£0	£ 155,580	£ 25,837	£ 17,000	£13,523	£6,925	£ 2,343,866
Total All LHBs	£38,725,980	£19,232,050	£19,457,013	£15,226,898	£1,449,153	£52,859	£2,562,865	£6,317,939	£6,105,275	£6,393,371	£1,399,197	£116,922,700

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Appendix 4 –
Comparison of case study sites projected percentage increase in numbers.

Figure 10 - Comparison of projected percentage increase of numbers in the 65-84 age group in the case study areas between 2001-2030 (Coma-Herrera et al. 2005).

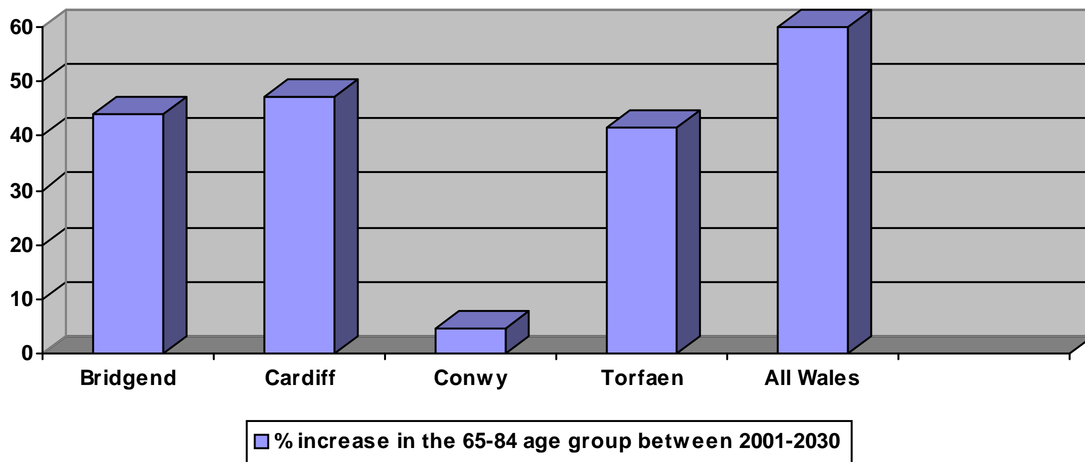

Figure 11 – Comparison of projected percentage increase of numbers in the 85+ age group in the case study areas between 2001 - 2030 (Coma-Herrera et al 2005).

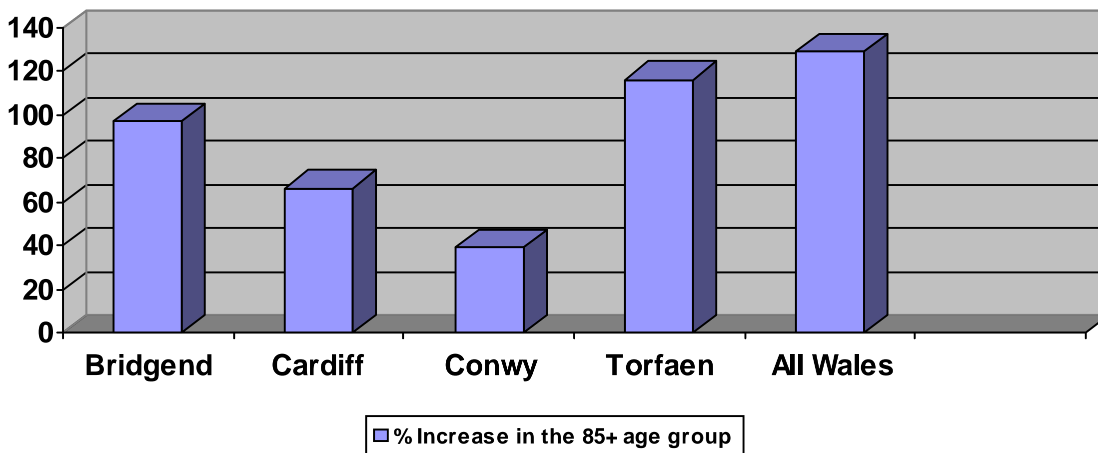

Figure 12 – Comparison of projected percentage increase of numbers of very dependent older people in the case study areas between 2001 – 2030 (Coma-Herrera et al 2005)

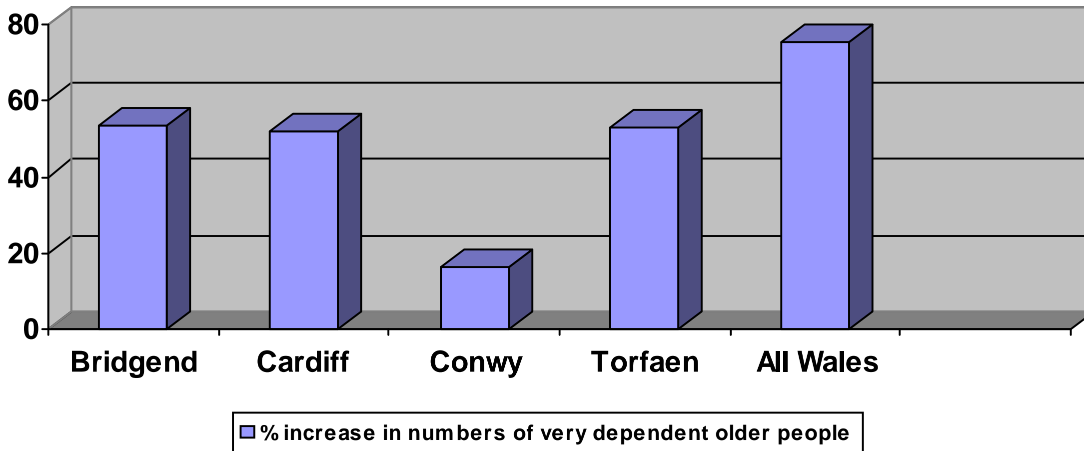

Figure 13 – Comparison of projected percentage increase of numbers of people in residential homes in the case study areas between 2001-2030 (Coma-Herrera et al 2005)

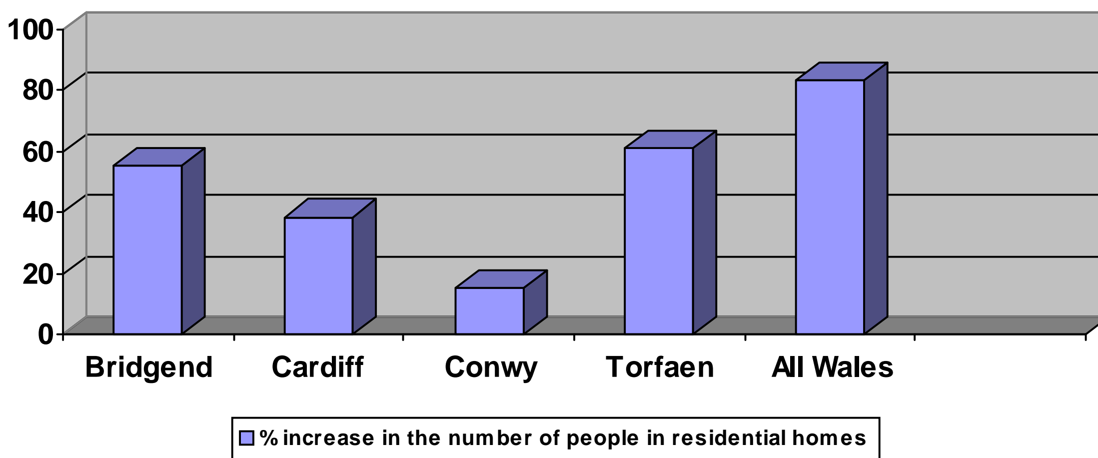

Figure 14 – Comparison of projected percentage increase of numbers of people in nursing homes in the case study areas between 2001-2030 (Coma-Herrera et al 2005).

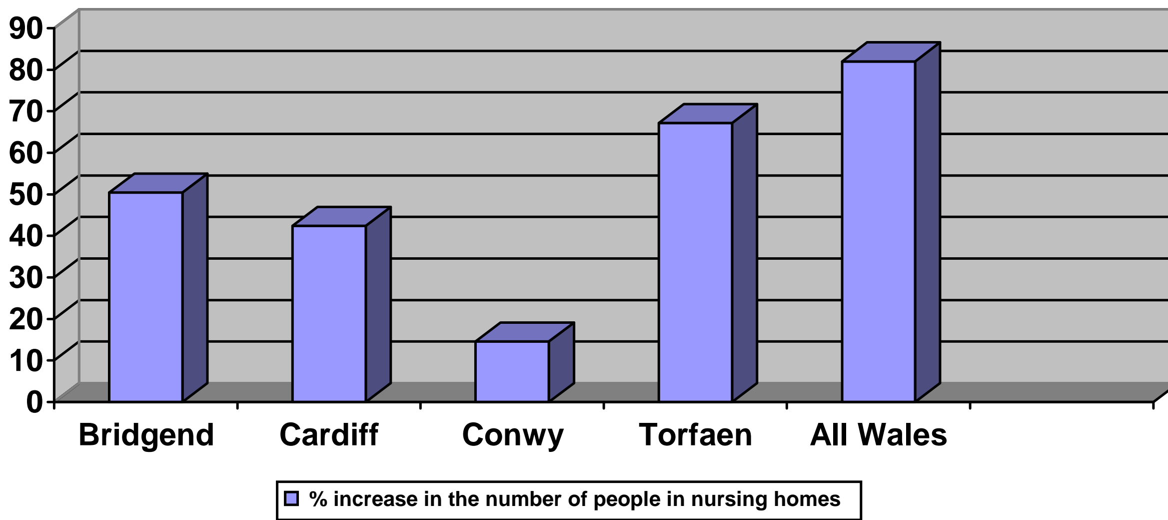

Figure 15 – Comparison of projected percentage increase of numbers of people in hospital in the case study areas between 2001-2030 (Coma-Herrera et al 2005).