



Commissioner for **Older People**
for Northern Ireland

CMA Care Homes Market Study

**Evidence from the
Commissioner for Older People
for Northern Ireland**

July 2017

1. Introduction

- 1.1. The Commissioner for Older People for Northern Ireland (COPNI) welcomes this market study into the care home market in the UK and hopes that it will provide clarity on some of the issues that is brought to the attention of his office on a regular basis.
- 1.2. The Commissioner is aware that the majority of people who enter nursing homes do so at a point of crisis in their lives. Family members are often provided with a list of nursing homes with current vacancies by the relevant Health and Social Care Trusts (HSCT) social worker (which can be limited if the older person has specific assessed care needs i.e. dementia) and therefore has little 'real' choice in the selection of a suitable placement.
- 1.3. The update paper produced by the CMA discusses the issue of those termed to be 'private funders' of care home places. However, in Northern Ireland, there are very few 'self-funding' placements within the sector. The majority of placements in Northern Ireland are through the five HSCTs, meaning that a social worker and/or care manager will be involved in the process.
- 1.4. In addressing the changing levels and types of need for older people in care homes and providing guidance on setting of fee rates, the Commissioner would welcome the suggestion in the update paper of establishing an independent body to 'plan and facilitate the development of appropriate capacity' across the UK.

2. Policy context

- 2.1. Northern Ireland, like the rest of the UK and Europe has an ageing population. People are living longer than ever before and according to the NI Statistics and Research Agency (NISRA), Northern Ireland has the fastest-growing population of any country within the UK. NISRA has projected that the number of adults aged 65 and over is to increase by 12.1%, between

2013 and 2018, and by 63.3% between 2013 and 2033. Between 2013 and 2018, the very elderly population (those aged 85 and over) is projected to increase by 22.2% and more than double between 2013 and 2033 from 1.8% to 4%.¹

2.2. Whilst increased longevity is a positive public health message, the consequences of living longer is that older people are living longer with complicated health and social care needs which means increased pressure on funding for care for older people. The introduction of the Transforming Your Care (TYC) public health strategic framework in 2011 represented a policy shift towards more use of community and home-based services so the need for hospital based interventions could be reduced. This means that people with increasingly complex co- morbidities like dementia, diabetes, cardiac diseases, pulmonary diseases etc. are supported to live in their homes with the help of primary and community care provision.

2.3. Health and Wellbeing 2026 - Delivering Together, recently published by the Department of Health, in response to the recommendations from the review led by Professor Rafael Bengoa, (who was tasked with ways of responding to the many challenges in Northern Ireland's Health and Social Care System) is also very relevant as a policy context. At the heart of Delivering Together is a call for partnership working, co-production and co-design with service users, patients, families and care providers.²

2.4. The current structure of adult social care stems from the system introduced in Great Britain in 1948. Unlike healthcare which is free in primary and secondary settings, in England, adult social care is fully means tested and social care services are resourced separately from the NHS with service commissioning and delivery being the responsibility of Local Authorities.

2.5. The position is distinctly different in Northern Ireland. Since 1973, an integrated structure of health and social care has been in place in Northern

¹ OFMDFM/NISRA - A Profile of Older People in Northern Ireland: Annual Update (2015)

² Duffy et al - Modernising Adult Social Care in Northern Ireland - KESS Policy Briefing (2017)

Ireland and currently five Health and Social Care Trusts have responsibility for hospital, community and social services. According to the ARK Programme³ (a research programme run by the Ulster University and Queen's University Belfast), the funding of social care has not kept pace with health care funding, nor has it increased in line with demographic changes resulting in greater demand for services.

2.6. It is clear that there has been a shifting of responsibility (and cost) between health care, social security and social care with substantive aspects of long term care now being categorised as social care rather than health care provision. This can be viewed as an attempt to limit the cost of health care due to certain key elements of social care being means tested. There has also been a significant shift towards individuals contributing towards their own care on the basis of a means test with successive governments suggesting that people needed to be encouraged to make provision for the cost of their long term care.

3. Market Competition

3.1. According to the Department of Health statistics, at 30th June 2016, 12,368 residential and nursing home care packages were in effect in Northern Ireland, which is an increase of 1% since 30th June 2015. Of the 12,368 care packages in effect, over two thirds (70%) were nursing home care packages and under one third (30%) were residential care packages. Over four fifths (81%) of care packages are provided from the 'Elderly Programme of Care'. This means that the majority of care packages were provided to people aged 65 and over.

3.2. In relation to the amount of beds available, there were more than twice as many nursing care beds available in Northern Ireland than residential places (10,692 compared to 5,180). Of the 5,180 residential places available, almost three in five (58%) were in independent residential homes while just over one

³ ARK – Attitudes to Social Care for Older People in Northern Ireland (2012)

in five were in the statutory residential homes and dual registered nursing homes (22% and 21%) respectively. Of the 10,692 nursing care beds available almost all (99.8%) were in the independent sector, 45% of which were in dual registered homes, and only a small proportion (0.2%) were in the statutory sector.⁴

3.3. The vast majority (90%) of residential and nursing home care packages were provided by the private sector. The voluntary and statutory sectors provided much smaller proportions of residential and nursing home care packages (6% and 4% respectively). However market competition is virtually non-existent in Northern Ireland due to the fact that only 5% of placements are privately arranged and all placements into care homes are facilitated by HSCTs.

3.4. The Regulation and Inspection Authority (RQIA) recorded that there were 15,897 nursing and residential places registered as of 12th May 2017. The DOH reported that as of 30th June 2016 there were 12,368 nursing and residential care packages in effect across the five HSCTs. This means that potentially, 3,529 nursing and residential care packages could be privately funded in Northern Ireland. However, the reality is that market competition is non-existent in Northern Ireland due to only approximately 5% of placements being privately arranged and the fact that all placements into care homes are facilitated by HSCTs based on a geographical remit/responsibility.

3.5. The Health and Social Care Board (HSCB) sets the regional tariff for care home (both residential and nursing) placements and that is used as a critical element of the cost which each HSCT commissions care at, leaving no room for competition between care providers. This creates a 'cost control' situation in Northern Ireland due to commissioning arrangements and the fact that demand for places in certain geographies outstrips supply.

⁴ Department of Health statistics on Community Care for Adults in Northern Ireland - <https://www.health-ni.gov.uk/sites/default/files/publications/health/cc-adults-ni-15-16.pdf>

4. Complaints/Fair Treatment

4.1. The CMA Care Homes Market Study update paper discusses the need to improve complaints and redress systems in order to make it easier for residents and their families or representatives to raise and escalate complaints. However, COPNI has become aware of instances where residents are threatened with or given notice of termination of contract due to a breakdown in relationships between care home representatives and resident representatives, therefore potentially making it more difficult to raise a complaint for fear of reprisals. Whilst some have been provided with 28 days' notice (as per their contract), the Commissioner is aware of instances where care home residents have been given only 24 hours' notice of eviction. The update paper discusses the issue of termination clause (point 5.28), stating that there are concerns that 'widely drafted termination clauses could be used unfairly by care homes in order to evict residents who have made complaints (alongside imposing other measures such as visitor restrictions or bans)'.

4.2. For many elderly residents the care home has become in a very real sense, their home. It may be in the same geographic area as they used to live, making it possible for friends and family in the community to visit them. It may have been their home for many years, so that they have friends (and in some instances family) in the same care home, who will be difficult if not impossible to replace in any move. As they have got older the importance of familiar surroundings and faces have become of fundamental importance to their quality of life, which is more acutely the case with the onset of dementia.

4.3. The particular concerns over 'evictions' arose not only from the perceived imbalance of power between a service provider on whom an elderly and infirm person may be wholly dependent for their health care and very quality of life, but because despite the fact that the nursing or care home may be their only home, their rights of tenure may not grant them the type of security they should have. If an older person is placed in a care home by a HSCT, the contract is between the care home and the HSCT. The older person does not

feature in the contract and therefore does not have their rights and interests protected. Furthermore, poor notification procedures may provide very inadequate warning of termination and/or transfer. Accordingly, the status of elderly residents whether as tenants or licensees and the significance for 'security of tenure', has become the focus of attention.

4.4. As of 12th May 2017, there were a total of 250 nursing homes in Northern Ireland and 194 residential care homes registered with the RQIA.⁵ There is no statistical data currently available in relation to the number of care home evictions in Northern Ireland. There is also unfortunately very little discussion about the issue. There does however appear to be more information available in relation to the situation in England. Indeed, the issue of termination of Care Home contracts was discussed in the recent 'State of Health Care and Adult Social Care in England 2015/2016 report'. The report highlighted:

*The number of contracts that providers are terminating early is concerning as this gives an indication of the fragility of the social care sector. Providers tell us that increasingly they are **making the decision to hand back contracts where they feel they cannot meet the fundamental standards of care** while maintaining profitability.*⁶

4.5. Media reports have additionally confirmed that this situation is leaving elderly vulnerable people at risk⁷; with some going as far to say that London's Care Home closure rate is "nearing crisis level".⁸ Professor Green from Care England suggested in a BBC interview that it would be "useful" if the CQC could keep track of eviction numbers, recognizing that there may be instances of appropriate transfers such as where the home can no longer

⁵ <https://www.rqia.org.uk/what-we-do/register/services-registered-with-rqia/>

⁶ www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf p45

⁷ www.theguardian.com/society/2016/oct/11/elderly-and-disabled-people-put-at-risk-by-care-homes-closures

⁸ www.bbc.co.uk/news/uk-england-london-38145000

provide the care required by a resident's particular needs.⁹

4.6. However, existing casework in COPNI has identified a management practice of concern whereby elderly people are being served with very little notice of the termination of their accommodation, or are being threatened with termination. Often the notice provided is only 28 days and in some instances it has been less. In all the cases brought to COPNI's attention, the service of notice has been prefaced by relationship issues with the elderly person's relative or a breakdown of the relationship between the family of the elderly person and the care home management. The stress and concern already felt by the family is then exacerbated by the need to find a new home when there are often waiting lists for the 'best' homes, additional top up fees required or simply not enough appropriate alternative homes in the vicinity.

4.7. The Commissioner is aware that it is different in other parts of the UK (with greater number of 'self-funding' care home residents than in Northern Ireland). The Commissioner suggests that there should be;

- i. An amendment to the regional contract between the HSCTs and private care home providers that would include provisions to deal with;
 - a. the type of tenure which a provider should grant to a resident;
 - b. circumstances in which a provider may terminate a contract;
 - c. definition of reasonable due cause;
 - d. requirement of the provider to automatically provide a copy of their complaints procedure to the relevant HSCT.
- ii. Mechanisms developed for the monitoring and review of complaints procedures in care homes.¹⁰

⁹ 'Care Quality Commission to publish rights guidance after care homes ban relatives from visiting', 2 November 2016,

¹⁰ Opinion: Review of Care Home Convictions

5. Top up payments

5.1. In Northern Ireland, each HSCT has a capped amount which they will pay for residential care based on an assessment of an individual's needs. If the home chosen by the person who requires the care charges more than this capped amount, the family member/next of kin is required to pay the difference in a top up payment as a third party payment.

5.2. More often than not, despite the offering of options, there is usually only one home that will meet an individual's needs or has immediate availability. Despite this, if that home still charges more than a HSCT's capped amount, a third party top up payment will still be applied/required.

5.3. The majority of residential homes in Northern Ireland charge a top up fee and this can range from £20 to £100 per week. When the person who requires the care is admitted a family member/representative is required to sign a contract to confirm they will meet the top up payment. The family member will often sign at a time of extreme stress without full knowledge of the ramifications of signing the contract.

5.4. The Commissioner would like to see more information provided to both residents and their families about this practice at the very start of the process through the assigned social worker or care manager to allow for better and more informed decisions to be made.

6. Making Informed Choices

6.1. In June 2015, COPNI published 'Modernising Adult Social Care in Northern Ireland' having commissioned Northern Ireland and international research from a team of academics from Queen's University, Leeds University and Penn State University (U.S.A.).

6.2. The primary aim of the original research was to compare the Northern Ireland legislative framework for adult social care (ASC) with other jurisdictions and

to offer options for legal reform to ASC provisions for older people in Northern Ireland. This was in recognition of the fact that the range of Northern Ireland's existing adult social care legislation dates back over forty years and is typified by disparate and outdated pieces of legislation which are disconnected and void of thematic coherency. The current legislation governing adult social care in Northern Ireland is provided through a myriad of laws dating back to 1978 where, in some instances, the language and terminology used is both outdated and oppressive.

6.3. As part of this research, one specific recommendation was to introduce a 'support visit' to all older people in Northern Ireland, which came directly from the research team's review of adult social care in Denmark where 'preventative visits' are an established aspect of care provision for older people. The system in Denmark is typified by older people (75+) receiving a visit twice per annum to determine their need for social care services. This type of visit could provide the opportunity to discuss future social care needs (including information about care homes). The introduction of this type of annual support visit to Northern Ireland would align both with meeting the expressed needs and wishes of older people as well as aligning with the requirements of current policies such as *Transforming Your Care* (2011) and *Delivering Together* (2016).¹¹

6.4. Following the completion of the research, COPNI completed an engagement programme through Age NI to "test" the recommendations against the real life experiences, concerns, and barriers identified by current users, carers and potential future users of adult social care. In total 58 older people, including current and potential future users of adult social care together with family members or carers, across a range of domiciliary, day care and group settings, participated in this engagement process.

¹¹ Duffy et al - Modernising Adult Social Care in Northern Ireland - KESS Policy Briefing (2017)

- 6.5. The view, strongly expressed by older people and their families and carers was that they did not know what they are entitled to under current law and policy in Northern Ireland. The focus on prevention through provision of a Support Visit was positively received. It was felt that this would enable older people to exercise choice and control rather than having to make life changing decisions at a time of crisis which so often is the case for many older people in their first encounter with the adult social care system.
- 6.6. Another way of helping older people and their families make informed choices about care homes is to introduce a ratings system (as is done in England through the CQC). By law, care home providers in England have to display the ratings CQC provide them with, somewhere that people who use their services can easily see them. In addition, they must also show their ratings on their website.
- 6.7. The introduction of a rating system in Northern Ireland would help to provide an indication of the standard of care delivered by a service for service users, relatives and these commissioning services. This would assist service users or relatives without the need to read and interpret lengthy inspection reports. Older people and their families should not have to do this in order to make difficult decisions on the selection of care services, often at a point of crisis. Instead, this type of system could offer an accessible overall rating and a qualitative description indicating the standard of care available. Inspection reports should continue to be publicly available and easily accessible.
- 6.8. A rating system would also allow service users and relatives to compare and contrast when choosing the service that they believe would best suit their needs. It is also expected that a rating system would encourage providers to increase standards and therefore continuously strive to provide the best quality care.¹² However to date there seems to be a reluctance from the DOH to introduce a rating system as is used in England.

¹² https://www.copni.org/media/1122/changing_the_culture_of_care_provision_in_northern_ireland_pdf.pdf

7. Continuing Health Care

7.1. The CMA Market Study update paper references the issue of Continuing Health Care and this is something that is raised with the COPNI office on an on-going basis. A lack of clarity and consistency has been highlighted to COPNI in respect of the provision of adult social care and support in Northern Ireland and particularly a confusion in relation to what constitutes “healthcare” (and is therefore free at the point of need under the NHS) as opposed to “social care” and other “support services” (which are means tested).

7.2. NHS CHC is a package of care arranged and funded solely by the NHS for a person aged over 18 years to meet physical or mental health needs that have arisen because of disability, accident or illness. Currently, eligibility in England currently places no limits on the settings in which the package can be delivered or the type of service delivery meaning it can be delivered:

- in your own home - in which case the NHS will fund an appropriate care package to meet your assessed health and personal care needs;
- or
- in a nursing home - in which case the NHS will contract with the home and pay for accommodation, board and meet ALL your assessed health AND personal care needs (i.e. all your health and social care costs). The rationale behind this is that if you were in hospital- all your medical/ healthcare and personal care needs would be paid for in full but the “continuing healthcare beds” which were originally ring - fenced in English hospitals have been phased out and an alternative setting was therefore required for these patients.

7.3. In England, the key requirement is for a person to be assessed as having a “*primary healthcare need*” in order for NHS CHC to be applicable.

7.4. In Northern Ireland, older people and their families have become aware of the position set out above and believe it to mean that in England, a person will not have to pay any nursing home fees if their loved one has been assessed

as having a “primary healthcare need”. COPNI, Age NI and NI Law Centre have been approached by families of older people asking when and how they may apply for NHS CHC in Northern Ireland.

7.5. It remains unclear whether and to what extent this exists in the same format in Northern Ireland. Until recently, the NI Direct website specifically referred to NHS CHC in its nursing home care fees section and Age NI published a report on this topic in 2014 entitled “The Denial of NHS Continuing Healthcare in Northern Ireland”.

7.6. It is unfortunately not just as simple as comparing “like for like” with the policy position in England. The legal significance of the differences identified below cannot be overemphasised.

Differences:

- Different enabling legislation.
- Structural differences; in NI we have an integrated system reflected in the joint/ integrated legislation and funding structures. In GB, the NHS and Local Councils are totally separate with different legal roles and funding capability.
- All social care is means tested with limits set by each Local Council in England. In NI, most domiciliary care (including personal care in your own home) is currently free (excludes, home help, community meals and day centre meals). Personal care in a care home is means tested in NI.
- Accommodation costs in NI are means tested and must be recouped where someone is assessed as able to pay/ contribute towards these costs. In England, if assessed as eligible for NHS CHC, the NHS will pay all your care costs including accommodation.

Similarities:

- Decision making tool.
- Guidance/ rationale.
- NHS Funded Nursing Care/ “Registered Nursing Care Contribution”- set weekly rate is similar to Nursing Care payment in NI.

7.7. In the last week (June 2017), the Department for Health launched a consultation on Continuing Health Care and COPNI will respond in due course. In order to provide clarity to those who need to access CHC, COPNI will ask for;

- Provision of up to date and clear guidance as to if and when CHC is applicable in Northern Ireland;
- Clarification of the definition of “primary healthcare” need;
- A specific assessment tool to be devised or the Northern Ireland Single Assessment Tool to be updated to deal with this issue clearly;
- Regional consistency.

8. Funding pressures - The ‘real’ cost of care

8.1. Unfortunately, it is not older people who are at the heart of the issue of care home evictions and CHC policy direction, but the issue is one of cost. The macro policy of ‘who pays for what’ needs to be addressed.

8.2. In 2013, the King’s Fund established the Commission on the Future of Health and Social Care in England, which in 2014 produced a report called “A new settlement for health and social care” considering how social care would be funded in the future. Considering the pressure the health system currently finds itself under coupled with the complex needs of an ageing population, this means additional funding, whether public or private, will be needed.

8.3. The report estimates that an additional £3 billion will be needed initially to make social care free for those regarded as having critical or substantial needs, raising to £5 billion by 2025 in England.¹³ As Northern Ireland is faced with the same pressures as England and the rest of the UK¹⁴, it too can

¹³ Commission on the Future of Health and Social Care in England (The King’s Fund) – A new settlement for health and social care (2014)

¹⁴ Appleby, J. - Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12 – 2014/15 (2011)

expect a £1billion funding gap in funding, highlighted by the then Department for Health, Social Services and Public Safety (DHSSPS - now titled the Department of Health) commissioned Appleby review from 2011.¹⁵

8.4. In 2011, the Dilnot Commission was established in GB to find a sustainable and fair way of funding adult social care and made the recommendation that the lifetime contribution care costs made by individuals would be capped at £72,000 and that the asset threshold for paying for residential care would rise to £100,000 from £23,250.¹⁶ These recommendations have been incorporated into the Care Act 2014 in GB, however the element of the legislation governing the cap on care costs is yet to be implemented.

8.5. In 2012, DHSSPS launched a consultation that looked at the future of adult care and support in Northern Ireland. The 'Who Cares?' document stated how "it is widely accepted that the adult care and support system in Northern Ireland is coming under increasing pressure for a number of reasons, including increased expectations, an ageing population and limited resources".¹⁷

8.6. The consultation document also explained that if the DHSSPS is to be in a position to respond to that challenge, it needs to find a fair, sustainable and efficient way to fund and provide care and support in the future, sharing responsibility with the individual, to ensure that those who need it have access to high quality, value for money care, at the right time and in the right place.¹⁸ Due to the pressures emerging year on year, the funding available for care and support in Northern Ireland is unlikely to increase to match the demand that will continue to grow.

8.7. A previous Minister for Health, Simon Hamilton MLA, announced in March 2016 his intention to establish a Commission to review adult care and

¹⁵ BBC News Website - <http://www.bbc.co.uk/news/uk-northern-ireland-12828603>

¹⁶ Dilnot Commission - Fairer Care Funding: The Report of the Commission on Funding of Care and Support (2011)

¹⁷ DHSSPS – Who Cares? The future of adult care and support in Northern Ireland (2012)

¹⁸ Ibid.

support. The Department of Health (DOH) website states how “the new three-person Commission on Adult Care and Support will be tasked with assessing the many challenges facing the care and support system, and producing a set of recommendations to reform the system and its funding structures to ensure its future sustainability”.¹⁹ The outcome from this panel was due to be published at the end of March 2017 and is still awaited.

8.8. Previous discussions between COPNI and DOH had already identified an absence of prioritisation of the necessary resources required to be able to commission an independent economic review of the provision of adult social care and support services. A commitment from the DOH to establish clarity on the cost of adult social care was not delivered under the last Programme for Government period nor is such a commitment contained within the draft Programme for Government which was recently consulted upon (prior to the dissolution of the NI Assembly).

8.9. Older people need and deserve clarity about what care is available and what they should expect to have to contribute towards their care needs. Inadequate research has been conducted in Northern Ireland to properly guide and support essential future planning of both healthcare and ASC needs of older people. Too often reviews consider one area in the absence of the other. There is a lack of transparency around decisions taken by Government and a confusing plethora of tariffs and rates charged for different services within HSCT boundaries and an inconsistent application of these services on a regional basis.

8.10. There has been no up to date assessment of the ‘real’ cost and resourcing of adult social care in recent years. In 2004, Professor John Appleby’s reviews (‘Health and Social Care Services in Northern Ireland’)²⁰ and a further review in 2011 (‘Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12 –

¹⁹ DHSSPS website - <https://www.dhsspsni.gov.uk/news/health-minister-establish-commission-reform-adult-care-and-support>

²⁰ Appleby, J. – Independent Review of Health and Social Care in Northern Ireland (2005)

2014/15') identified the funding gap that had developed and the productivity challenge then facing the health service in Northern Ireland. Specific guidance on modelling for tariffs for various care settings was not considered.²¹

8.11. There needs to be a robust health economics study undertaken at a Northern Ireland level to inform the development of a model that will allow for the adequate costing of care (in various settings, not only care homes) to take place. This will help people not only plan for their future social care needs but also for the commissioners of care to fully understand what measure they need to put into place to be able to meet demands, now and in the future.

9. Conclusion

9.1. The Commissioner notes that the update paper states that the CMA will not 'make a reference for a market investigation', however points out that often in profit making sectors where recommendations are made with no legislative requirement to implement change, it can be a very slow process with little impact for those who will need change the most – older people living in care homes and often without a voice.

9.2. However, the Commissioner would like to understand better why a market investigation is not likely to be undertaken and tentatively welcomes the commitment to monitor the implementation and impact of recommendations made with the potential for a market investigation if required.

²¹ Appleby, J. - Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12 – 2014/15 (2011)