Older People and Domiciliary Care

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

NIA 45/07-08, 31 October 2007

TSO66666 CareOfElderly.indd 1 10/11/07 10:59:03 AM

Northern Ireland Audit Office

Report by the Comptroller and Auditor General for Northern Ireland

Older People and Domiciliary Care

NIA 45/07-08

BELFAST: The Stationery Office £5.00

TSO66666 CareOfElderly.indd 3 10/11/07 10:59:04 AM

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of that Order.

J M Dowdall CB
Comptroller and Auditor General

Northern Ireland Audit Office
31 October 2007

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office employing some 145 staff. He, and the Northern Ireland Audit Office are totally independent of Government. He certifies the accounts of all Government Departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU
Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: www.niauditoffice.gov.uk
© Northern Ireland Audit Office 2007

ABBREVIATIONS

CRT	Community Rehabilitation Team
DHSSPS	Department of Health, Social Services and Public Safety
HPSS	Health and Personal Social Services
NISCC	Northern Ireland Social Care Council
PSSRU	Personal Social Services Research Unit
RQIA	Regulation, Quality and Improvement Authority

	Page
EXECUTIVE SUMMARY	7
PART 1: Introduction	
Predicted rises in the older population place increasing demands and cost pressures on caring services	10
The aspiration of departmental policy is to enable older people to remain in their own homes	10
Scope of the examination	11
PART 2: The Pattern of Care for Older People	
Background	12
Spending on care for older people has increased by 24 per cent between 2002-03 and 2005-06	12
The percentage of older people cared for in their own homes has increased by 32 per cent since 1995-96, however, the balance with institutional care has risen by only 5 per cent and has remained relatively static over the past five years.	13
The balance of expenditure on the provision of domiciliary services and institutional care has remained stable in recent years	15
Expenditure on domiciliary provision is targeted at those older people with more intensive needs	16
The numbers waiting in hospital for domiciliary care packages are falling but many older people still wait for lengthy periods to have their needs met	18
The number of older people in the community waiting for care packages has dramatically reduced	19
Part 3: Promoting the Improvement of Care Services for Older People	
Prevention and rehabilitation services can break the cycle of unplanned admission to hospital and unnecessary moves into institutional care	21
A single needs-assessment tool can help older people to continue to live at home	23
Direct payments offer the potential for older people to have greater choice and control over the services they receive	24
Acute social care staff shortages continue to pose a threat to the aspirations of older people	25
Boards and Trusts need to develop a more strategic role in influencing the supply of domiciliary care services from the independent and voluntary sectors	26

TSO66666 CareOfElderly.indd 4 10/11/07 10:59:12 AM

	Page
Part 4: Providing Quality Domiciliary Care Services for Older People	
Introduction	29
In general, older people show a very high level of satisfaction with domiciliary care services	29
There is a need for greater flexibility in the provision of domiciliary care	30
There is scope to improve the reliability of domiciliary care services for older people	31
There is a perception of insufficient skill levels among some care workers	31
More can be done to help older people understand and be involved in the domiciliary care process	32
Users have identified a series of suggested changes to improve the quality of domiciliary care services	34
APPENDICES	
Appendix 1	
People First - Barriers to Progress	35
Appendix 2	
Elderly Delayed Discharges from Hospital: Awaiting a Community Care Package at 31 March 2006	37
Appendix 3	
Elderly People Living in the Community: Awaiting a Community Care Package at 31 March 2006	38
Appendix 4	
Personal Social Services: Development and Training Strategic Objectives	39
Appendix 5:	
Statutory versus Independent Domiciliary Spend 2002-03 to 2005-06	41
Appendix 6:	
Ipsos MORI Methodology for User Survey	43
NIAO Reports	54

TSO66666 CareOfElderly.indd 5 10/11/07 10:59:13 AM

TSO66666 CareOfElderly.indd 6 10/11/07 10:59:13 AM

EXECUTIVE SUMMARY

Background

1. In common with many countries across the world, the population of Northern Ireland is ageing. Over the coming years, the proportion of people of pensionable age will increase significantly. Despite the ageing process, however, most older people want to remain independent for as long as possible. Those who are old and frail or disabled can often continue to live in their own homes if appropriate support services are available, rather than moving into full time residential or nursing home care.

2. Current community care policy, which flows from the Department of Health, Social Services and Public Safety's (the Department) *People First* document published in 1990, stresses the importance of maintaining people in their own homes for as long as possible. Four Health and Social Services Boards (Boards) commission domiciliary care services for their resident populations from a range of providers, including Trusts and voluntary and private sector providers. The Department's current target in this regard is that, by 2010, 45 per cent of **all** people with care needs should have those needs met in their own homes. Latest figures indicate that 41 per cent of people are now having their care needs met at home.

3. In terms of older people, we found that the performance of the Boards and Trusts in providing domiciliary care for increasing numbers continues to improve. Between 1995-96 and 2005-06 the number of older people receiving care managed packages[1] at home

1 Care management is the process of tailoring services to individual needs. Assessment is an integral part of care management. It is a cyclical process, in which an older person's needs are assessed, services are delivered in response, and needs are re-assessed, leading to a changed service response. Care packages are provided in the form of places in nursing and residential homes as well as domiciliary care in a person's own home.

TSO66666 CareOfElderly.indd 7 10/11/07 10:59:21 AM

went up from 4,135 to 5,464 (Figure 3, paragraph 2.7), and an estimated 30,000 older people currently receive less complex interventions which help support them to live independently at home (paragraph 2.10). However, the proportion of care managed packages relative to institutional activity has remained static over the past five years (around 37 per cent) and the numbers receiving less complex services such as Home Help has fallen back, despite increases in the number of older people. This suggests a reduction in less complex support services.

4. At the same time, a significant proportion (60 per cent) of the £394 million spent by Trusts on personal social services for older people in 2005-06 still went to residential and nursing home care (paragraph 2.11). While nursing and residential care are generally more expensive than domiciliary care, a background paper for the Wanless Social Care Review[2] suggests that with a given budget and controlling for need, local authorities in England can substitute residential places with intensive home care packages at the same cost or slightly less. This implies that for some people, intensive home care is a feasible and cost-effective alternative.

5. We acknowledge that, while the Department's policy has been to ensure that as many people as possible receive care and support in their own homes, residential and nursing care will continue to have an important role to play in the spectrum of care for older people, particularly for older people with mental health problems. Moreover, we recognize that if a professional assessment concludes that an older person should be placed in institutional care, there is no alternative but to meet that requirement. On the other hand, domiciliary care can bring with it high risks to the safety of some older people and lead to social isolation if other public and private facilities are under developed. For example, accessible and affordable transport, comfortable housing and safe and accessible environments are all significant factors which can either enhance or undermine independence and inclusion. In addition, dealing with the stress of family carers who experience difficulty in coping is another issue which has to be addressed within a policy based on care at home.

2 *Social Care Needs and Outcomes: A background paper for the Wanless Social Care Review,* Wanless Review Team, July 2005, Kings Fund, London.

6. The Department's objective has been to modernise social care to meet the aspirations of older people and promote its policy of domiciliary care. In our view, while many aspects of social care have improved and continue to do so, modernisation has been gradual over the period since the implementation of *People First*. While welcome inroads have been made, the process of change and development is far from complete: there continues to be a relatively high dependence on institutional forms of care for older people; domiciliary care resources tend to be concentrated on those individuals with high-level needs (paragraphs 2.13-2.18); and there remains a constant level of unmet need among those waiting for domiciliary care (paragraphs 2.19-2.22).

7. The need to secure a more appropriate balance of care for older people in line with their aspirations, Departmental policy objectives and the prescription of services in ways that match need, remains a challenge. Therefore, in order to turn the Department's vision in *People First* into a reality, this report has benchmarked where services stand in relation to many of the issues that need to be addressed.

Prevention and rehabilitation (paragraphs 3.1 to 3.8)

8. One of the ways in which Trusts are making significant strides to improve domiciliary care services for older people is in introducing a range of preventive and rehabilitation services, which offer them the chance to improve their quality of life and ability to live independently and comfortably in their own homes. The Department issued strategic guidance to Trusts in January 2007 encouraging them to continue to take a proactive approach to developing such interventions, evaluating their cost-effectiveness and sharing good practice between each other.

Needs assessment (paragraphs 3.9 to 3.13)

9. We found that individual Trusts have robust assessment procedures in place based on maintaining the independence of older people. The introduction of a single needs-assessment tool for Northern Ireland is designed to gather the information necessary to plan care services for people with complex needs, bringing a greater degree of coherence, thereby enabling them to continue

TSO66666 CareOfElderly.indd 8 10/11/07 10:59:21 AM

living independently at home with appropriate home care support, or to make a decision regarding the need for nursing or residential care.

10. The Department told us that the development of the single needs assessment tool will not in itself result in better person-centred assessments. Its view is that the implementation plan and underlying processes will have greater significance and that the practice of staff will be underpinned by person-centred thinking. The effectiveness of the single needs-assessment tool, therefore, will depend on how it is implemented and the ability of those making the assessment to take a needs-led approach. The single assessment tool project is scheduled to complete in 2007-08 and should be rolled out across the health and personal social services (HPSS) in 2008-09, subject to the availability of resources.

Direct payments (paragraphs 3.14 to 3.17)

11. Direct payments offer the potential for older people to have greater choice and control over the services they receive. They will be able to choose who will help them and what sort of help will be provided, according to their preferences. Consumer choice like this can improve the self-determination and satisfaction of older people and increase the degree of independent living. The take-up of direct payments has historically been low, however, following a review and a subsequent training and awareness programme across the health and social care sector, an increase in the number of direct payments has been secured over the past three years. At 31 March 2007 there were a total of 660 care packages subject to direct payments, an increase of 210 over the previous year. The current target is 750 by 2008 and the Department told us that it fully expects to meet this figure. It is not clear what impact such a change will have on the balance of domiciliary and institutional care, however it does appear that to operate effectively, the system will need to rely on: good information on what is available; easy access to advice; and measures to ensure that the quality of provision does not deteriorate.

Staff recruitment and retention (paragraphs 3.18 to 3.21)

12. The domiciliary care sector faces serious staff recruitment and retention problems which have the potential to affect the range and quality of domiciliary care services Trusts are able to provide. To resolve this dilemma, the Department is currently developing a workforce plan. It is important that the issue of staff shortages is addressed as quickly as possible in order to ensure that sustainable, good quality domiciliary care is available for those older people wishing to remain in their own homes.

Private/voluntary sector provision (paragraphs 3.22 to 3.29)

13. Despite the aspiration of *People First* that the development of a flourishing independent sector alongside good quality public services should be encouraged, the majority of domiciliary care services continue to be provided directly by Trusts. Making domiciliary care a real alternative to institutional care means that Trusts must strive to meet the challenge of strategic commissioning with the independent sector, to ensure that the local market for care is encouraged and all existing resources are used to drive the development of domiciliary care services that genuinely meet the needs of older people.

Quality of service (Part 4)

14. While older people told us of their great appreciation of domiciliary care services in general, there are some areas where satisfaction is not as high as it could be. We heard some concerns about the flexibility, reliability and competency of care staff which can impose great strains and anxiety on the person who is reliant on that service. Moreover, others pointed to the need for better communication with older people and their involvement in the domiciliary care process. The key to a good quality domiciliary care service is the relationship between the person using the service and the person providing it. The Department requires Trusts to engage user and user representatives in the planning, design and evaluation of services. In order that local services address the needs of older people, Trusts need to ensure that this process influences the development and delivery of those services.

TSO66666 CareOfElderly.indd 9 10/11/07 10:59:22 AM

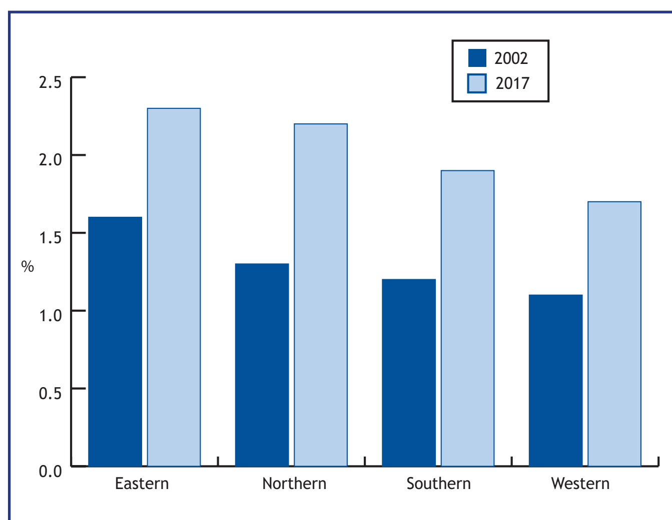
Part 1: Introduction

Predicted rises in the older population place increasing demands and cost pressures on caring services

1.1 The result of the 2001 Census showed that over the coming years the population of Northern Ireland will gradually become older. The number of people of pensionable age (60 plus for females and 65 plus for males) is projected to rise from 266,000 in 2002 to 350,000 by 2017, an increase of 32 per cent. Further analysis reveals even higher predicted rises in the very elderly population (aged 85 and over) from 24,000 to 37,000 over the same timeframe, an increase of 58 per cent. In addition, it is estimated that the number of people aged 65 and over will continue to rise after 2017, with a projection that by 2040 there will be twice as many as there are currently[3].

1.2 It is predicted that all four Boards will face a dramatic surge in the numbers of the very elderly in the coming years. Figure 1 shows that, over the period 2002 to 2017, this will range from a 44 per cent increase in the Eastern Board to a 69 per cent increase in the Northern Board.

Figure 1: Very elderly population of each Board as a percentage of the total Board population, 2002 and 2017



Source: NISRA

3 *2001 Census,* General Registrars Office Northern Ireland 2003.

1.3 Due to the fact that a greater number of elderly people live to an advanced age in Northern Ireland, many suffer illness, disability and become dependent on help from other people for their daily existence. This presents an increasing challenge for the development of current and future elderly care services. Moreover, the increasing proportion of the population over the age of 85 years of age means that the elderly are becoming more frail and dependent both in terms of functional and cognitive capacity, further increasing demand and cost pressures on caring services.

The aspiration of departmental policy is to enable older people to remain in their own homes

1.4 Current community care policy promotes independent living and, in the case of older people, a move away from over reliance on residential and nursing homes. This reflects the aspiration and preference of many older people to stay in their own homes and within their own communities[4]. One particular study records that as few as a fifth of people felt they had actively opted for residential care after having been presented with the choice of staying at home or going into care[5]. In 1990, the Department published *People First* which had as one of its key objectives:

"To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible."

1.5 While the Department is responsible for setting policy on elderly care, developing services and allocating funding, the four Boards currently plan and commission home care services for the older people in their areas. Domiciliary care for older people is defined as the provision of services in their own homes for people who, by reason of illness, infirmity or disability, are unable to provide for themselves without assistance or support. It can include a range of personal, nursing and domestic care services such as:

4 *Attitudes and aspirations of older people: a review of literature*, Boaz et al, 1999 London. Department of Social Security.
5 *Commissioning care services for older people in England: the view from care managers, users and carers*, T. Ware et al, Ageing and Society, 2003, volume 23, no.4, pp411-28.

TSO66666 CareOfElderly.indd 10 10/11/07 10:59:25 AM

- personal hygiene;
- continence management;
- problems of immobility;
- food and diet (assistance with eating);
- simple treatments (for example, assistance with medication, and dressings);
- personal assistance (for example, helping with dressing and getting in and out of bed);
- cleaning; and
- laundry.

Social Care Standards

1.6 The Health and Social Services (Quality, Improvement and Regulation) (Northern Ireland)) Order 2003 applied a statutory duty of quality on Boards and Trusts. In March 2006, the Department introduced a new set of standards[6] as part of a framework aimed at raising the quality of social care services provided in Northern Ireland. The standards will be inspected, regulated and monitored by the Regulation, Quality and Improvement Authority (RQIA).

Scope of the Examination

1.7 In 2000, concerns were raised by the Chief Inspector of Social Services about the availability, quality and appropriateness of community care services in Northern Ireland. As a result, the Department published a review of community care in April 2002[7] which, in assessing the objectives of *People First,* identified a number of barriers to progress in meeting the policy objective of ensuring that older people receive high-quality care services which enable them to live at home (see Appendix 1). The Department translated the recommendations of the review into an action plan centred on key projects, the majority of which have now been completed.

1.8 Against this background, Part 2 of our review will investigate, through financial and activity analyses and performance review, whether the *People First* policy of offering maximum opportunities for independent living to older people is being achieved. The policy elevated the notion of person-centred care from a desirable idea to a central value and mandatory practice within assessment. Part 3 will focus on the adequacy of measures taken by the Department, Boards and Trusts to support the development of domiciliary care services for older people to enable them to live at home. Clearly if domiciliary care services are perscribed in ways that do not meet the needs of older people, or if the services received are poor, value for money will not be achieved. Part 4 of the Report examines the users' perspective of quality issues surrounding the provision of domiciliary care. It is based on the results of a survey we commissioned from Ipsos MORI to elicit the views of service users about the services delivered.

1.9 To assist the study we obtained expert advice and comment from Mr Glenn Thompson CB, a consultant with wide experience in independent social care provision, and Dr Kevin McCoy, former Chief Inspector of the Social Services Inspectorate.

6 *The Quality Standards for Health and Social Care,* DHSSPS, March 2006.

7 *Review of Community Care: First Report,* DHSSPS April 2002.

TSO66666 CareOfElderly.indd 11 10/11/07 10:59:25 AM

Part 2: The Pattern of Care for Older People

Background

2.1 The Department's Elderly Programme of Care covers services required to meet needs that have developed as a consequence of ageing within the population of Northern Ireland. As part of this Programme, all *acute services* for older people are delivered by hospital Trusts, whilst *personal social services*, whether support at home (known as domiciliary care), residential and nursing home care, day care, home help or meals on wheels, are delivered through the collaboration of the Trusts, voluntary and private sector organisations. *Community services* for older people, covering such elements as district nursing, podiatry, occupational therapy, community care appliances and adaptations, are delivered mainly by the Trusts.

2.2 Care for older people is an area which also connects with other services in the community. For instance, the contribution that decent housing makes to independent living and to the provision of care and support in community settings is well recognized and understood. As a result, the Department works alongside the Northern Ireland Housing Executive in the provision of sheltered housing and to enable vulnerable older people to maintain their tenancies and live independently within their community. In addition, initiatives such as Healthy Cities, Health Action Zones and the Health Improvement Programme are providing new opportunities for the Department to work with the Northern Ireland Housing Executive in health improvement, planning and delivery. The key aim of all this work is to support people to live independently and safely in their own homes for as long as possible. The continuing expansion of flexible and responsive domiciliary care services is central to this.

Spending on care for older people has increased by 24 per cent between 2002-03 and 2005-06

2.3 The actual cost of the Elderly Programme of Care has risen from £474 million in 2002-03 to £587 million in 2005-06 (see Figure 2), an increase of 24 per cent, part of which relates to inflation[8]. The major part of this expenditure has been on personal social services, that is, nursing homes, residential homes and domiciliary care services.

Figure 2: Expenditure on the Elderly Programme of Care

Services	2002-03 £m	2003-04 £m	2004-05 £m	2005-06 £m	% Increase from 2002-03 to 2005-06
Hospital	104.0	107.5	115.1	118.4	13.9%
Community	56.0	62.5	66.0	74.1	32.3%
Personal Social Services	313.6	343.4	372.0	394.4	25.7%
Total	**473.6**	**513.4**	**553.1**	**586.9**	**23.9%**

Source: Department

8 The Department told us that it is widely accepted that health and social services inflation is higher than the general level of inflation in the economy. It is possible to adjust figures to remove the effects of general inflation but, as this would only remove part of the effect for health and social services, the figures have been left unadjusted.

TSO66666 CareOfElderly.indd 12 10/11/07 10:59:26 AM

2.4 As pointed out at paragraph 1.5, the desired outcome from *People First* was that the commissioning of care services would transform a care system which, in the early 1990s, was dominated by institutional care, to one which promoted independent living for the elderly, people with mental illness and physical disability. While the Department's overall target is that 40 per cent of community services support should be delivered to people in their own homes, there is no specific target set for older people. The 40 per cent target was achieved in 2005-06 and the Department is working to a new target of 45 per cent by 2010. Reaching the balance between institutional and non-institutional care services has been a key issue for the Department since the publication of *People First* more than fifteen years ago. If the intended shift in provision had been happening, it would most likely be reflected in increases in:

- domiciliary care activity; and
- the level of expenditure on domiciliary care provision.

The percentage of older people cared for in their own homes has increased by 32 per cent since 1995-96, however, the balance with institutional care has risen by only 5 per cent and has remained relatively static over the past five years.

2.5 In 2002, the Department's review of community care (see paragraph 1.7) concluded that "*there has been a decline in the ratio of people receiving care packages in their own home, compared to people receiving care in residential or nursing homes*". An effectiveness evaluation report[9] by the Department in the same year also refers to "*the stated policy of maintaining people in their own homes, in preference to residential care is not being delivered.*" In 2005 the Appleby Report[10] recorded that "*although only 38 per cent of care packages are currently delivered in a domiciliary setting, there appears to have been a downward trend over the past decade with 50 per cent of care packages in 1995 being delivered in a domiciliary setting*".

9 *Effectiveness Evaluation Report, Chapter 5 - Services for Older People,* DHSSPS November 2002.

10 *Independent Review of Health and Social Care Services in Northern Ireland*, Professor John Appleby (King's Fund): August 2005.

2.6 When we discussed these earlier findings with the Department, it told us that as a result of further investigation, the conclusion that domiciliary care had declined as a proportion of overall care packages for older people was based on incomplete data. It explained that those older people who were receiving institutional care prior to the introduction of *People First*, under what is known as "preserved rights", were excluded from the earlier calculations. Prior to 1993, a person who qualified for social security benefits and who wished to enter a private or voluntary sector residential home could do so with care fees being paid through the social security system. Since that time no older person has gone into institutional care under Social Security provisions.

2.7 Using all available data, Figure 3 provides an overview of the pattern of older people receiving care-managed packages since 1995-96. This shows that domiciliary care provision increased by 32 per cent over the period and that, as a percentage of all care packages for older people, the number of people cared for in their own homes increased by five per cent. This increase was achieved by March 2002 when remaining "preserved rights" cases were transferred from the Social Security Agency to the Department. Since that time, the balance between domiciliary care and institutional care has remained more or less constant.

TSO66666 CareOfElderly.indd 13 10/11/07 10:59:27 AM

Figure 3: Trends in the balance of care provision (institutional versus domiciliary care packages) for people aged 65 and over, at 31 March each year

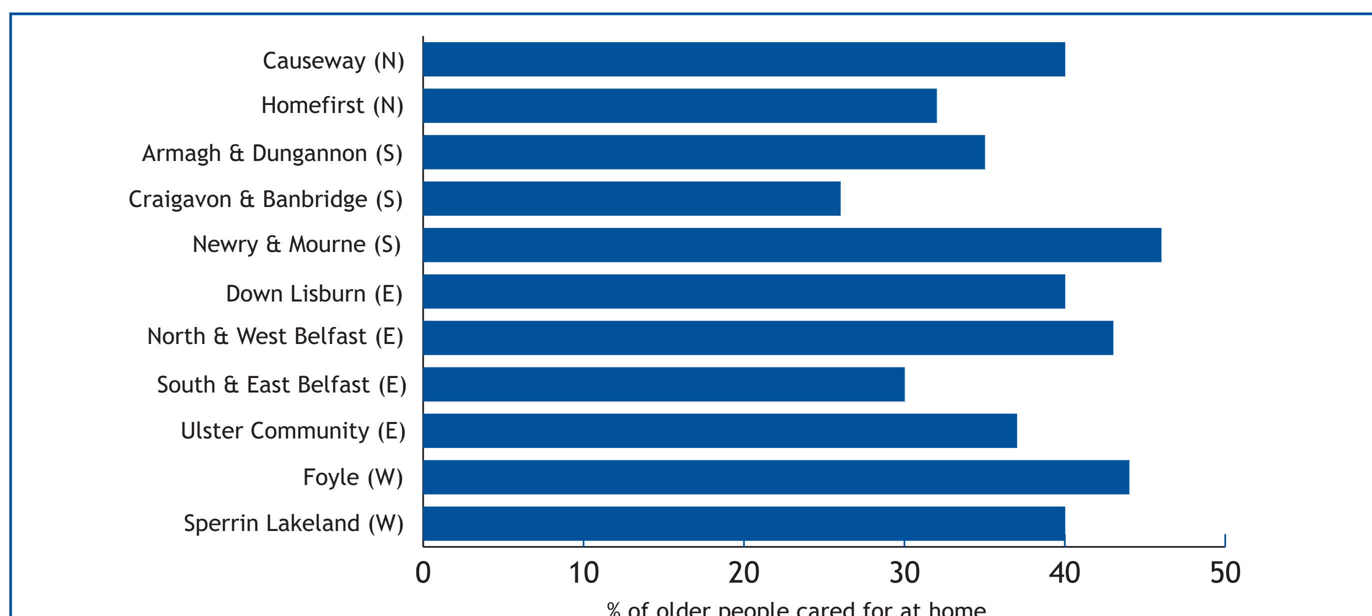
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Trend
Residential	3,216	3,133	3,139	3,158	3,099	3,296	2,959	3,124	3,151	3,076	3,031	-6%
Nursing	5,675	5,773	5,759	5,476	5,420	5,709	5,305	6,138	6,050	6,287	6,345	+12%
Total Institutional	8,891	8,906	8,898	8,634	8,519	9,005	8,264	9,262	9,201	9,363	9,376	+5%
Total Domiciliary	4,135	4,501	3,959	4,173	4,323	4,637	4,895	4,895	5,112	5,555	5,464	+32%
Total Packages	13,026	13,407	12,857	12,807	12,842	13,642	13,159	14,157	14,313	14,918	14,840	+14%
Domiciliary as a % of total	32	34	31	33	34	34	37	35	36	37	37	+5%

Source: Department

2.8 An analysis of data since April 2002 shows that the largest increase in care packages (20 per cent) has been in the nursing home sector, with residential care packages having only a marginal increase of two per cent. Over the same timescale, domiciliary care provision increased by 12 per cent. The Department told us this demonstrates that domiciliary care has been replacing residential care as the first choice for people with a particular level of need.

2.9 Figure 4 shows that there is also a substantial degree of difference across Trusts in the proportion of older people cared for at home. The Department pointed out that the age profile of older people within a Trust boundary and the level of deprivation will have an impact on the level of need and, therefore, the suitability of various care options

Figure 4: Proportion of older people receiving care packages who are cared for at home 2005-06



TSO66666 CareOfElderly.indd 14 10/11/07 10:59:28 AM

Figure 5: Overall domiciliary care services at 31 March each year

	2000	2001	2002	2003	2004	2005	2006	Trend
Care packages	4,323	4,637	4,895	4,895	5,112	5,555	5,464	+26.4%
Home Help	23,963	23,324	22,983	21,802	21,719	21,242	20,247	-15.5%
Meals Services	4,318	3,775	3,850	4,361	4,228	5,678	6,035	+39.8%
Statutory Day Care*	1,713	1,832	1,933	1,923	1,954	1,950	2,027	+18.3%

Source: Department

** people without a material handicap only*
Note: The figures in this Table cannot be added up because older people receiving a domiciliary care package may also be receiving home help, for example, as a component of that package. The management information available does not disaggregate such cases.

2.10 In addition to those older people who meet the eligibility criteria for access to a care managed package, around 30,000 other older people receive lower levels of intervention such as meals services and home help. Figure 5 provides a breakdown of these. It is interesting to note that the less-intensive help provided through home help has diminished significantly over the period.

The balance of expenditure on the provision of domiciliary services and institutional care has remained stable in recent years.

2.11 Figure 6 provides a breakdown of spending on different components of personal social services for older people. This shows that since 2002-03, the balance in expenditure between domiciliary and institutional care has remained fairly stable – 37 per cent and 63 per cent of overall expenditure respectively in 2005-06. Spending on domiciliary care packages alone, relative to institutional care has grown from 28 per cent to 32 per cent which broadly reflects the stability in relative activity levels shown in Figure 3 for the same period. Figure 7 shows that, as with activity volumes, overall spending on domiciliary care masks considerable variations across Trusts.

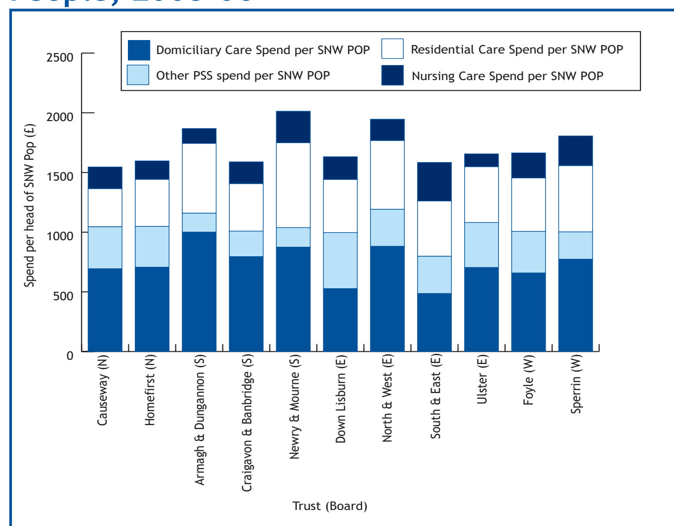
2.12 The difference in expenditure patterns shown in Figure 6 will be due to several factors including differing levels of deprivation and health across different areas. Among those aged 65 and over, for the same level of deprivation, the most complex needs are likely to be shown in the oldest age groups. The age profile within the 65+ age group can, therefore, impact on the appropriateness of various service options. The difference can also reflect local market conditions and commissioning strategies employed across Trusts and the priority given to different programmes.

Figure 6: Expenditure on Personal Social Services for Care of Older People

Categories	2002-03 £m	2003-04 £m	2004-05 £m	2005-06 £m
Residential Homes	66.6	66.6	70.5	73.7
Nursing Homes	131.9	143.8	153.0	164.7
Total Institutional Care	198.4	210.4	223.5	238.3
Supported and other accommodation	1.4	1.2	1.5	2.2
Day Care	11.2	11.6	11.9	13.1
Domiciliary Care services*	78.7	91.8	104.1	109.8
Social Workers	14.7	15.6	18.4	18.9
Meals delivered to clients' homes	2.2	3.2	3.0	3.1
Luncheon clubs	0.2	0.2	0.2	0.2
Total Domiciliary Care	108.4	123.6	139.0	147.3
Grants, Goods and Services	6.7	9.5	9.5	8.7
TOTAL	313.6	343.4	372.0	394.3
Domiciliary % of total	*35%*	*36%*	*37%*	*37%*
Institutional % of total	*63%*	*61%*	*60%*	*60%*

Source: Department
Note: Figures may not add due to rounding
* This includes direct payment cases (see paragraph 3.15)

Figure 7: Comparison of Trust Expenditure per head of SNW Population for Older People, 2005-06



Source: Department

*Note: In order to try and adjust, as far as possible, for differences in age profile and level of deprivation, a standardized needs weighting (snw) developed through resource allocation research has been applied by the Department to the main elements of personal social services expenditure.

Expenditure on domiciliary provision is targeted at those older people with more intensive needs

2.13 Figure 6 shows that expenditure on domiciliary care services, including home helps, has increased by 40 per cent in the four years from 2002-03 to 2005-06. Part of this rise reflects inflation which is widely accepted as being higher for health and social services than the general level in the economy (see footnote 8). Using data from Figure 3, over the same period the number of domiciliary care packages (the most intensive community services) has increased by only 12 per cent. This indicates that resources are increasingly being directed towards those with the most severe needs and greatest levels of dependency.

TSO66666 CareOfElderly.indd 16 10/11/07 10:59:32 AM

2.14 The high levels of spending on more complex services reflects one of the principles underpinning the approach to community care in *People First* that "services should concentrate on those with the greatest needs". This would indicate an intention to avoid the use of institutional care for those people, where intensive support can enable them to remain at home. The Department's review of community care in 2002 (see paragraph 1.7) highlighted this priority given to people with complex needs and reported that, among the stakeholders consulted, there was a view "*that targeting resources on those in most urgent need had led to a decline in support for less complex need, such as the traditional home help service, and that the vital role of these services in prevention should be recognised.*"

2.15 Research in Great Britain[11] has shown that domiciliary care can delay entry to an institutional setting by around six months, using care packages costing around £100 per week compared with £300-£400 per week in a care home placement. The recently published Wanless Report[12] in Great Britain concludes: "*The potential for helping vulnerable dependent people is justification for directing scarce and limited public funds to social care. But social care can also facilitate health care objectives and cost savings, such as reducing inappropriate hospital admissions and facilitating timely discharges to the community.*"

2.16 While the data at Figure 3 show that domiciliary care services are maintaining increasing numbers of older people in their own homes, the services which are available tend to be centred on people with needs at the top end of the care scale, not least to free up acute hospital beds. As a result, older people with lower levels of need receive less help. However, the pressure to speed up hospital discharge means there is also a risk that the levels of domiciliary support available will be insufficient to prevent many older people moving directly into residential care or nursing homes. The outcome, therefore, has been that services for older people with intensive needs are still substantially provided in a nursing or residential setting.

11 *Equality and Efficiency Policy in Community Care*, B. Davies, J L Fernandez and B Nomer, Aldershot: Ashgate, 2000.

12 *Securing good care for older people: taking a long-term view*, Wanless Social Care Review, London, King's Fund 2006.

2.17 We acknowledge the very real difficulties faced by Boards and Trusts when presented with complex need. We recognize that the professional assessment of older people will conclude that nursing home care is the most suitable setting for them in many instances. However, it is important that Boards and Trusts satisfy themselves that older people placed in residential or nursing home care are there appropriately, and that remaining resources for domiciliary care are used in the most effective way to promote and maintain independent living. The Department's policy and guidance[13] in this regard refers to the need to develop a continuum of care services, capable of responding to the full spectrum of need and ensuring that care interventions are made at the right time and in the appropriate setting.

2.18 While our data analysis has shown that advances have been made in translating the aspirations of *People First* into practice, further progress is needed to increase the reach of domiciliary care. In our view, the development of non-institutional care requires a balanced approach, not simply one focused on intensive care-managed packages. It will have to incorporate a view on how low-intensity services, including such elements as home-help, day care services, support accommodation, lunch clubs and meals-on-wheels are to be configured in the provision of domiciliary care services. Sustained reductions in permanent admissions to institutional care is one way in which savings could be released to finance increases across the range of domiciliary care services. It is also important that this approach is underpinned by clear performance indicators and regular reporting to monitor progress in achieving such outcomes. The percentage of older people being supported at home is an important indicator in this regard. The Department also told us that it is enhancing its monitoring system for domiciliary packages of care to ensure that less intensive packages are also recognised and recorded.

13 Circular HPSS (EPCC) 1/2007 "*Enhancing Primary and Community Care - Services Closer to Home*", January 2007.

2.19 Paragraph 2.16 highlighted how initiatives in place to improve the speed and coordination of hospital discharge can add to the concentration of domiciliary care services on older people with more intensive needs, potentially leaving the needs of those who require less intensive support, such as home help, unmet. The information does not exist to quantify the extent to which such need is unmet, however, it is clear that the current mix of service provision will serve some better than others. However, available data does show that, despite efforts to facilitate a smooth and timely transition to home, significant numbers of older people have to wait in hospital because of inadequate levels of domiciliary care support.

2.20 The Department's Public Service Agreement for 2006 set the targets that:

- Boards and Trusts should ensure that by 31 March 2006, 95 per cent of all people assessed as medically fit for discharge from hospital but who require community support to facilitate their discharge, should wait no longer than seven weeks for that support to be provided; and
- Boards and Trusts should ensure that by 31 March 2006, 85 per cent of all people assessed as requiring care in the community should wait no more than three months for the main components of that care to be put in place.

2.21 Performance against these targets has been mixed. No Board achieved the delayed discharge target, and of the eleven former Community Trusts in Northern Ireland, only three - Craigavon and Banbridge, Down Lisburn and Ulster Community - met the standard (see Appendix 2). Performance was equally poor on the care in the community target, with only the Southern Board and the Sperrin Lakeland Trust meeting it. The Boards and Trusts told us that the main reason for the delay was budget-limited resources, however they pointed out that waiting for an assessment of needs in hospital and the lack of available and appropriate care packages also caused problems.

2.22 The Department told us that it is addressing this issue through improved performance management arrangements focused on entirely new ministerial priorities for delayed discharge. Targets for simple discharge of 12 hours from being declared fit and for complex discharges of 50 per cent within 72 hours from being declared fit were substantially met at March 2007. For March 2008, these targets have been tightened to six hours for all simple discharges and 72 hours for all complex discharges. This has been matched by investment in new community-based intermediate care services designed to reduce avoidable admissions and facilitate prompt discharge.

The numbers waiting in hospital for domiciliary care packages are falling but many older people still wait for lengthy periods to have their needs met

2.23 The Appleby Report (see paragraph 2.5) recorded that since 2000, the number of delayed discharges from acute hospitals in Northern Ireland has remained around 350 to 400, tying up 4 per cent of all beds. In addition, the proportion of patients delayed in hospital by more than one month has remained at around 50 per cent of all delayed discharges.

2.24 Figure 8 shows the number of patients aged 65 and over experiencing a delayed discharge whilst waiting for a domiciliary care package. Whilst this indicates a general reduction in the numbers of delayed discharges, as at March 2006, they remained a particular problem in the Northern Board Trusts where almost half of the delays were more than 7 weeks (see Appendix 2). Of all the Trusts, Causeway had the highest number of delayed discharges at 31 March 2006 with 54 per cent delayed by more than seven weeks.

TSO66666 CareOfElderly.indd 18 10/17/07 8:25:33 AM

Figure 8: Delayed Discharge from Hospital – patients aged 65 and over awaiting a care package as at 31 March each year

	2004	2005	2006
Domiciliary care	128	87	104
Institutional care	246	185	149
Not specified	34	37	27
TOTAL	408	309	280
% waiting > 3 weeks	59%	64%	48%
% waiting > 2 months	25%	30%	19%

Source: Department

By contrast, Craigavon and Banbridge Trust had none, due to its operation of an enhanced intermediate care scheme (see paragraph 3.6). We asked the Department if it could explain this variation and we were told that there has been a public recognition by the Northern Health and Social Services Board that its balance of investment between hospital and community based services was wrong. The Board now has a comprehensive programme of reform and modernisation in place to address this. The key components of this reform include the expansion of intermediate care services to bridge the interface between community and hospital, and the development of a case management approach for people with long term health conditions that make them susceptible to unplanned hospital admissions.

2.25 The Department told us that the drive to reduce delayed discharges is part of a major programme of care reform through which it aims to improve patient care at every stage in the pathway. It acknowledged that not only is it clinically inappropriate for patients who have been declared medically fit to remain in an acute hospital, the problem of delayed discharges also impacts on waiting times in Accident and Emergency departments and on the timely provision of elective care.

2.26 Targets have been set that, by March 2008, all complex discharges from an acute setting will take place within 72 hours of the patient being declared medically fit and all other discharges will take place within six hours of the patient being pronounced medically fit. A number of other key actions have been identified which Trusts must put in place to reduce delays in discharge, while the wider healthcare reform agenda is currently being extended to give greater focus to delays associated with the hospital and community interface. This will include a set of performance standards in relation to the expansion of intermediate care and assessment, and community based rehabilitation services.

2.27 The Department told us that it monitors performance against these targets on a weekly basis as part of its management information system. This system allows delays for patients currently waiting for discharge to be monitored and, for those patients who have been discharged, how long they were delayed prior to discharge and the principal reason for any delay.

The number of older people in the community waiting for care packages has dramatically reduced

2.28 Figure 9 shows that by 30 September 2006, the number of people in the community waiting for a community care package had fallen to 190 from 767 at the end of March 2004. Around half of these had been waiting 12 or more weeks. Waiting lists have been highest in the Causeway Trust, with the major proportion of clients waiting over 12 weeks (see Appendix 3).

TSO66666 CareOfElderly.indd 19 10/11/07 10:59:34 AM

Figure 9: Persons Living in the Community and Waiting for Care Packages

	31 March 2004	31 March 2005	31 March 2006	30 September 2006
Domiciliary care	503	688	399	98
Institutional care	216	175	84	23
Not specified	48	56	55	69
TOTAL	767	919	538	190
% waiting < 12 weeks	33%	31%	40%	53%
% waiting > 12 weeks	67%	69%	60%	47%

Source: Department

Conclusion

2.29 The picture emerging from this review of the pattern of care for older people is one of gradual improvement in the reach of domiciliary care packages. However, in terms of a shift away from institutional care, progress has been static in recent years due to the continuing pressure of increasing nursing home placements. At the same time, while more older people are now receiving domiciliary care packages, the tighter targeting of support means that a higher proportion of domiciliary care is absorbed by those with higher-level needs. In terms of those waiting for care packages in both hospital and the community, the numbers have reduced over the last three years, however, it remains particularly important that those older people still waiting receive the care they require as quickly as possible, both to minimize their anxiety and to start their treatment.

2.30 While we acknowledge the progress that has been achieved over recent years, we consider that there is still a pressing agenda of change required to further ensure that services are driven by what really matters most to older people. New processes are emerging which embrace a wider range of alternatives aimed at increasing the independence of older people and to enable them to remain in their own homes. There have been some real success stories and Part 3 of the Report explores the further potential which exists for moving towards this transformation.

TSO66666 CareOfElderly.indd 20 10/11/07 10:59:35 AM

Part 3: Promoting the Improvement of Care Services for Older People

Prevention and rehabilitation services can break the cycle of unplanned admission to hospital and unnecessary moves into institutional care

3.1 Paragraph 2.14 records the view, expressed during the Department's review of community care services in 2002, that the large amounts of resources absorbed by those with complex needs reduces the number of older people Trusts can provide with supportive care. Positive action aimed at improving the independence of older people, or ensuring that people do not develop complex needs prematurely, can potentially improve well-being and independence, as well as being cost-effective. The development of preventive and rehabilitation services for older people, therefore, can be useful in averting crises which may lead to their admission to hospital or the risk that residential or nursing home care becomes the only sensible option.

3.2 The Boards have been developing forward strategies for older people and have submitted plans to the Department for the expansion of intermediate care aimed at implementing a range of integrated services to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge and maximise independent living. In this context, we found a number of examples of new and innovative practice in the area of intermediate care in Northern Ireland. In January 2007 the Department issued strategic guidance to the Health Boards and Trusts on the enhancement of primary and community services in general and in March 2007, it issued specific guidance on the expansion of intermediate care.

3.3 The development of services to improve mobility and safety in the home is an important part of crisis prevention. In this regard, the Department's *Home Accident Prevention Strategy* published in 2004 includes a target to reduce by 25 per cent the number of older people admitted to hospital as a result of falls, by 2009. Increasing use of preventive services will require additional funding in the short-term but such services hold the promise of being cost effective in the long-term by delaying the need for more intensive and costly services. Evidence from Great Britain shows that falls among older people cost health and social care services around £1 billion in 1999.[14]

14 *Incidence and costs of unintentional falls in older people in the UK*, Scuffham P, Chaplin S, Legood R, Journal of Epidemiology of Community Health, vol 57, pp 740–44, 2003.

3.4 Intermittent respite care provided by Trusts in an institutional setting can also be a valuable preventive measure in avoiding the breakdown of care arrangements at home for family and friends who provide long-term care. Similarly the provision of short-term "step-up" care in an institutional setting to assist individuals to regain abilities that may have declined can also enable a return to their own home.

3.5 Preventive services are an important part of the vision for domiciliary care for older people as they can help to maintain someone's independence for as long as possible. We acknowledge that the Department, Boards and Trusts face hard choices in how to allocate sufficient resources to those in greatest need, while identifying and supporting those for whom a small amount of service might sustain the ordinary fabric of life. A more comprehensive approach to improving the health and wellbeing of older people needs to take a broad view of prevention. This will involve building on and expanding cost effective prevention and rehabilitation initiatives and mixing these with high-level targeted intervention. The Department's *Modernising Services*[15] initiative has given impetus to these changes but concerted action is needed across Trusts and between the health and social care elements of the health service if the desired outcomes are to be achieved.

3.6 Intermediate care initiatives come into play at the interface between health and social care. What the different models involved have in common is the movement of an older person from an acute hospital setting to a secondary setting for a specific period of time. Like preventive schemes, investment in effective rehabilitation support can also make a positive difference to people's lives by helping to maintain and improve the quality of their lives and sustain independent living. There are a number of examples of good practice in rehabilitation schemes across Northern Ireland. For example: Homefirst Community Rehabilitation and Stroke Service provided a service to 877 discharged patients during 2005 and prevented admission to care of 346 people; North and West Belfast Trust's use of Rapid Response Nursing, which provides a community-based alternative to hospital care, made 1,028 patient contacts in 2004-05; and Foyle Health and Social Services Trust's Supported Early Discharge scheme saved 1,131 bed days

15 *Developing Better Services: Modernising Services and Reforming Structures*, DHSSPS, June 2002.

TSO66666 CareOfElderly.indd 21 10/11/07 10:59:35 AM

in an 18 month period. The case example outlined below provides further detail on the type of innovative practice being developed.

Community Rehabilitation Team (CRT): Sperrin Lakeland Trust

Main objectives of the Team

To enable patients to be discharged earlier from hospital by offering a short-term six weeks rehabilitation service; to prevent hospital admission with short term rehabilitation; to promote patients independence at home; and the introduction of Falls Prevention Strategies.

CRT adopted the principles of collaborative working

Whole system approach
User experiences a seamless service
Single assessment process
One set of Professional notes
One set of client held notes
One set of patient outcomes
Genuine multidisciplinary working
Reduces duplication
Challenging professional boundaries
Maximise independent living

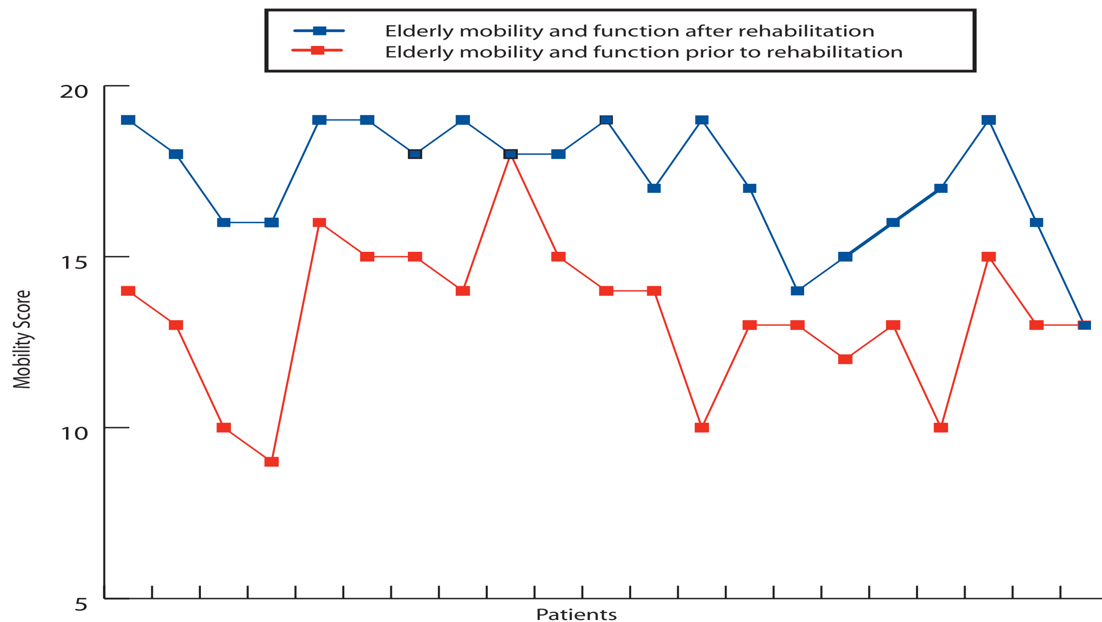
A number of examples demonstrate the benefits of the approach of CRT

1) One of the exercises undertaken by CRT demonstrates the benefits of its approach to a programme of 6-8 weeks rehabilitation. The table below shows the cost of CRT involvement in the cases of six older people against what it would have been, had social work teams continued to review the situation on a regular three month and six month basis, which would have been normal practice.

Patient	Care prior to CRT	Care hours initiated by CRT	Total cost of CRT six weeks £	Care after 6-8 weeks CRT involvement	Cost of Social Work intervention after 3 months £	Cost of Social Work intervention after 6 months £
1	0	3.50	133.00	0	342	683
2	0	3.75	544.25	0	1,341	2,682
3	0	7.00	250.43	0	553	1,105
4	0	1.50	47.55	0	119	237
5	0	12.00	588.00	0	1,170	2,340
6	0	10.50	408.93	0	829	1,658

The advantages of CRT involvement are depicted in the graph below. CRT believe that, as a result of their involvement in 36 cases, they have saved between £16,888 and £43,788 over a six month period.

TSO66666 CareOfElderly.indd 22 10/11/07 10:59:36 AM



2) Four patients who were admitted for long term admission were successfully rehabilitated at home by CRT at a cost of £405.35 per week. Social work involvement would have cost £1,621 per week for 26 weeks. This meant £42,156 savings in 6 months.

3) Ten patients were prevented from going into nursing homes for short term respite periods of two weeks. This saved the Trust £6,000 over 6 months (i.e. £300 per week X 10 X 2 = £6,000).

4) Probably most notably, the Team saved around £138,000 over six months as a result of saving 347 bed days.

3.7 The evidence suggests that the domiciliary care needs of many older people have been enhanced by proactive support to assist their recovery and recuperation. However, the scope and range of provision varies across the Trusts, reflecting the largely ad-hoc nature of its development. As opportunities for rehabilitation expand, it is important, in shaping the future development of intermediate care provision, that the cost-effectiveness of different schemes is evaluated. We acknowledge that in 2005 the Department issued guidance calling for concerted efforts to assess the relative effectiveness of different schemes. In December 2006, the Department published a report by PricewaterhouseCoopers on the relative cost-effectiveness of different approaches to intermediate care, following which it issued guidance on the strategic expansion of intermediate care services across Northern Ireland (see paragraph 3.2). In addition, it has supported the establishment of the Northern Ireland Forum for Intermediate Care to support the regional development of intermediate care and the sharing of good practice.

3.8 Clearly, the Boards and Trusts cannot divest themselves of existing commitments to those older people who require intensive levels of support in order to invest in more intermediate forms of care. Achieving a shift towards more preventive and rehabilitative provision presents a challenge which needs to be carefully planned and will take time.

A single needs-assessment tool can help older people to continue to live at home

3.9 The assessment of need is crucial to the efficient and effective management of domiciliary care services and to providing the most equitable and appropriate care to meet a person's needs. If the process is not soundly based, an older person's needs may not be correctly met, possibly increasing their chances of entering residential or nursing home care or allowing their condition to deteriorate to the point where this becomes the only feasible alternative.

TSO66666 CareOfElderly.indd 23 10/11/07 10:59:37 AM

3.10 Guidance issued by the Department in 1993[16] requires the Boards "…to assess the care needs of any person who appears to them to be in need of community care services and to decide, in the light of that assessment, whether they should provide, or arrange for, the provision of any services." It is up to the Board or Trust, having regard to all the relevant factors, including professional standards, to determine what type of assessment a person requires and to arrange for the assessment. All Trusts are required to have robust assessment procedures and criteria, which are agreed with their Boards.

3.11 Current policy in health and social care emphasizes the importance of a comprehensive assessment of people's needs in order to adequately determine and deliver the most appropriate care and services. However, in 2002, the Departmental review of community care concluded that the lack of a shared understanding of what assessment meant had led to differences in needs assessment and the eligibility criteria used in different Trusts, which mitigated against equality of service provision throughout the health and social services sector.

3.12 The Department concluded that the wide range of different models in operation in other parts of the United Kingdom did not necessarily represent an improvement on existing arrangements in Northern Ireland. As a result it obtained Ministerial agreement that Northern Ireland's unique integrated system of health and social care merited a locally developed approach. Following this, a contract was awarded to the University of Ulster to develop a single comprehensive assessment process, including a single tool for assessing older people's needs for health and social care. The Department told us that this will be developed during 2007-08 and, subject to the availability of resources, it will be rolled out across Northern Ireland in 2008-09.

3.13 Existing evidence had suggested that many older people experience a wide range of assessment approaches by a variety of different health and social care professionals. These multiple and often disconnected assessments, not all of which are validated, may fail to capture a complete picture of the older person and their care needs. Older people, their carers and those who advocate on their behalf have for a long-time called for a less bureaucratic, better co-ordinated and managed approach to the assessment of care needs, service delivery and review. In the interim, we note that the Southern and Western Boards reviewed their needs assessment and access to domiciliary care criteria in 2005. As a result, they provided their Trusts with standard assessment and eligibility criteria based on "*Fair Access to Care Services*"[17], in order to target those older people in greatest need.

3.14 Individual Boards and Trusts have developed their own assessment processes and we acknowledge that there is movement to a position where they will have only one process, underpinned by a single tool for the whole of Northern Ireland. This will be unique in the United Kingdom. Despite this, we consider that progress in developing the single assessment tool has not been as timely as it could have been, given that People First was introduced over 13 years ago and that health and social services are structurally integrated in Northern Ireland. We welcome the "person-centred" nature of the single assessment tool and we acknowledge that it should help to ensure that, where the older person wishes it, suitable domiciliary care provision can be offered. However, in our view, the absence of a single needs assessment tool means there is a potential risk that existing variability in approach may mean that the domiciliary care needs of older people are not fully identified and they may not get access to the support services they require.

Direct Payments offer the potential for older people to have greater choice and control over the services they receive

3.15 Direct Payments are cash payments made in lieu of social service provision to individuals who have been assessed as needing services. They were introduced in Northern Ireland for adults of working age in 1996. They can currently be used to pay for personal assistants, or to purchase goods or services. A common choice is to use the money to pay for care from close relatives and friends who do not live in the same household. To date, older people have made only minimal use of Direct Payments. At the end of March 2007, 3.3 per cent of all those aged 65 and

16 *People First, Care Management: Guidance on Assessment and the Provision of Community Care*, Department of Health and Social Services, 1993.

17 *Fair Access to Care Services*, Department of Health (England), May 2002.

TSO66666 CareOfElderly.indd 24 10/11/07 10:59:38 AM

over receiving domiciliary care were in receipt of Direct Payments.

3.16 Direct Payments are designed to enable more people with care needs to stay at home as long as possible, by mobilising or sustaining the contribution made by informal carers. The greater consumer choice provided by Direct Payments is seen as leading to an improvement in the self-determination and satisfaction of older people and to an increase in the degree of independent living even among those dependent on long-term care.

3.17 While Direct Payments increase choice and independence, they are not without potential risks. For instance, safeguarding the quality of provision is likely to be a challenge, as it will be difficult to assess the relative quality of provision if people are more willing to trade off improved autonomy against reductions in the quality of domiciliary care. Nor is it clear whether Direct Payments provide services more cheaply than if a Trust had commissioned them. If a Direct Payment is regarded as more efficient simply because the administrative function of organising care is passed on to the person using the services or their families, its status as an efficiency saving is questionable. Moreover, to the extent that some informal caring is shifted in status to paid caring, there will be an increase in public funding without any commensurate increase in benefit.

3.18 In our view, the extent to which Direct Payments are able to facilitate the ultimate goal of shifting the balance of care for older people towards a domiciliary setting requires careful monitoring. At the same time, a marked shift in approach and culture will be needed to realise the Department's objective that more older individuals should be funded to purchase their own care via Direct Payments. This may require enthusiasm on the part of those involved in the management of care for older people to actively promote Direct Payments as an option, so that opportunities to use them as a means of extending choice and independence are not missed. The Department told us that it has targeted resources directly at addressing this problem by ensuring that health and social services bodies engage directly with those community organizations working in support of vulnerable people who wish to avail of Direct Payments.

Acute social care staff shortages continue to pose a threat to the aspirations of older people

3.19 In general, the social services are very labour intensive so the availability and quality of staff is a key aspect of achieving any rebalancing of provision between institutional and domiciliary care. It is important in examining the domiciliary care workforce, however, to recognise that in addition to those that are in paid employment to provide a care function or service, there are many more who provide care to a friend or family member on an unpaid basis, although some may receive a carer's allowance. In the 2001 Census, around 185,000 people (11 per cent of the population) reported providing unpaid care to family members, friends, neighbours or others.

3.20 An estimated 11,774 people are in paid employment in the provision of domiciliary care – 7,524 are employed by the Trusts and 4,250 are employed by the private or voluntary sector. According to the *Review of Social Care* in 2002 (see paragraph 1.7), recruitment and retention of social care staff was a difficult and complex issue which affected all grades within the social services, particularly among those carrying out assessment, treatment and rehabilitation.

3.21 Discussions with the Boards and Trusts indicated that it is increasingly difficult to recruit and retain workers in social care when other employers pay more and ask for less. This situation is compounded in that the Appleby Review (paragraph 2.5) reported that independent and voluntary providers also have difficulty in recruiting sufficient numbers of staff because of the higher salaries and greater certainty of employment offered by statutory providers. The use of "spot contracting" by Trusts (see Figure 9 at paragraph 3.25) hinders the ability of private and voluntary providers to predict requirements from week to week. Consequently, this lack of job security is reflected in the conditions imposed upon staff, such as no guaranteed hours, and thus no stable income or employment. The requirements of the new regulatory regime (see paragraph 1.6) – such as standards relating to staff training, quality assurance systems and robust administrative arrangements – may also pose significant challenges to some of the smaller and inexperienced independent providers.

TSO66666 CareOfElderly.indd 25 10/11/07 10:59:38 AM

3.22 Given the link between an expected increase in demand for care in the future and the aim of providing more of this care in people's own homes, there is a need for the Department to examine closely the potential impact the supply of care workers will have on this relationship. If there is insufficient capacity in the care workforce, efforts to help more people live in their own homes will falter. In the absence of long-term recruitment and retention data it is difficult to draw any definite conclusions, however, following a recent workforce review[18], the Department issued a development and training strategy for the personal social services.[19] This identified a number of strategic priorities (see Appendix 4) to support the development of the personal social services workforce to enable it to respond effectively to current and emerging demands.

Boards and Trusts need to develop a more strategic role in influencing the supply of domiciliary care services from the independent and voluntary sectors

3.23 Changing the balance of care from institutional to domiciliary services in order to meet the needs of older people also means working closely with all providers - in-house, private and voluntary sectors - as they will all play an important part in developing innovative services. Under the Review of Public Administration, direct rule Ministers had decided to create a new Health and Social Services Authority to come into existence from April 2008 in place of the existing four Health and Social Service Boards and seven primary-care led Local Commissioning Groups which were envisaged as local offices of the new Authority. While these decisions are being considered further by the Minister, a clear commissioning strategy will need to be developed based on a good understanding of both the expectations and preferences of older people and the dynamics of the local care market.

3.24 One of the core objectives of *People First* is promoting the development of a flourishing independent sector alongside good quality public services. However, we found that there had been no dramatic shift in Trusts' involvement in the provision of care services. Overall, we found that Trusts were directly responsible for 65 per cent of the £110 million spent on domiciliary care provision, however, there were variations across individual Trusts in the source of provision: for example, Down Lisburn commissions 52 per cent of its provision from the independent sector while Causeway has a completely in-house service (see Appendix 5). The situation in Northern Ireland contrasts with that in England, where the ratio of in-house to private and independent provision is reversed[20].

3.25 Results of a survey published in 2002 by the Northern Ireland Social Care Council[21] showed that there were 92 independent providers of domiciliary care services, split almost evenly between the private and voluntary sectors. The survey also found that 15 per cent of these providers had only begun to operate a service within four years of the survey. Given the dominance of their direct role in provision, however, many Trusts have limited involvement in commissioning services from these providers. Despite this, in 2005-06 Trusts spent £38 million on the purchase of domiciliary care services from the private and independent sectors using a range of contractual arrangements for the delivery of different types of service or package of care (Figure 9).

Figure 9: Different contract types used by Trusts

Block: these contracts are for the provision of a particular type of service. For instance, Newry and Mourne Trust has set up a block contract, running for a number of years with one provider, which is specifically targeted at tackling delayed discharges. Such contracts are stable, easily administered and the volumes procured can provide value for money. On the down side, however, they tend by their nature to be inflexible.

Cost and Volume: Homefirst uses this type of contract where the cost of providing a service decreases with the level of provision. The benefit of this is that costs are known at the outset and the contract can deal better with unpredictable demand by being more flexible. The disadvantages are that costs can be higher than a block contract and setting the contract up can be long and complex.

18 *Workforce Planning Review - Social Services Staff Groups*, DHSSPS, 2006.

19 *Personal Social Services: Development and Training Strategy 2006-2016*, DHSSPS, September 2006.

20 *Who Cares Now? An Updated Profile of the Independent Sector Home Care Workforce in England* McClimont B, Grove K, Carshalton Beeches: UKHCA, 2004.

21 *Independent Home Care Provision in Northern Ireland: Workforce and Training Issues*, Northern Ireland Social Care Council, February 2002.

TSO66666 CareOfElderly.indd 26 10/11/07 10:59:39 AM

Cost per case: This type of contract is quite common across the Trusts. Under this arrangement, a provider agrees to provide a service for a fixed price irrespective of the volume involved. The advantages and disadvantages of this type of contract are in the main similar to those associated with cost and volume contracts. While there is also no pressure to provide what may be an unnecessary level of service just to keep costs down, the ad hoc nature of the service can discourage providers from investing in services.

Spot: South and East Belfast Trust makes use of this type of contract to purchase services on an individual basis. The attraction of this contract is that it is tailored, quick, competitive and avoids waste. However, it gives little incentive to providers. It hampers their ability to plan ahead and leads to insecurity, since they have no guaranteed business. Monitoring can also be difficult due to the number of individual contracts in place.

3.26 The Department told us it recognises that, since the Review of Public Administration, there is potential for more effective and efficient arrangements for the provision of a range of common services, including the procurement of health and social care services through the use of a Shared Services Organisation. To that end, in Autumn 2007 the Department plans to launch a major consultation in order to assist in the development of a policy on the best future arrangements for the provision of business and other common services to the health and social care system.

3.27 Given the advantages and disadvantages of the different contract types, it is essential that Trusts consider carefully all the available options, to ensure that their approach to commissioning services for older people leads to the procurement of sustainable provision that meets people's needs and provides value for money. In our view, this requires regular review of how services are commissioned and the types of contract employed. The Department told us that the planned structures following the Review of Public Administration will further consolidate commissioning based objectively on quality and value for money. The Department also told us that the HPSS has made significant investment in domiciliary care over the last number of years and has successfully engaged with the Independent Health and Care Providers organisation.

3.28 The Department's 2002 Review noted the concerns of the independent sector: that it has not been fully involved as an equal partner in the development of community care; that its relationship with the statutory sector had become quite strained; and that contract prices for basic levels of community care needed to be agreed. The Review also noted the view held in the independent sector, that the contract culture had significantly damaged relationships and has resulted in less partnership working and joint planning.

3.29 Although the Department told us that health and social services bodies had engaged successfully with independent home care providers through the Regional Community Care Finance Forum and the Chief Executive's Forum, we found that morale amongst independent providers was very low. This was often attributed to what they regarded as the harsh competitive environment in which they operated and failure by Trusts to engage constructively with home care providers in their localities. For example, the Independent Health and Care Providers (IHCP) organisation[22] told us that a "fair rate for care" is essential if independent providers are to be able to continue delivering relevant and good quality services which meet the needs of older people.

3.30 Recently, too, the Appleby Review expressed a concern that the public (statutory) sector was "crowding out" the independent sector in providing domicilary care. For example, although independent and voluntary providers are able to tender for contracts to deliver domiciliary care packages, they have difficulty in recruiting sufficient numbers of staff because of the higher salaries and greater certainty of employment offered by statutory providers. Therefore, even when independent provision may be preferable in terms of service and cost, the contract may be lost due to staff shortages.

3.31 One of the responses by the Department to the findings of its 2002 Review was to commission research to identify the true economic cost of independent community care provision, both institutional and

22 IHCP is a non-profit making organisation representing private, voluntary, charitable and church affiliated providers of health and social care. Its members provide nursing and residential homes, housing with care schemes and domiciliary care. Services are provided for older people, for vunerable adults, including those with learning disabilities or mental health problems, and for those people with other special needs.

TSO66666 CareOfElderly.indd 27 10/11/07 10:59:40 AM

domiciliary. PriceWaterhouseCoopers reported in March 2005[23] and we note that the Department has been assessing the long-term implications of their findings and recommendations. It has established a health and social services working group to engage with the independent sector about a comprehensive regional rate structure for independent sector residential home, nursing home and domiciliary care provision. This process should make explicit all the elements that need to be considered and promote an open discussion between commissioners and providers, particularly in relation to the rate of returns and the level of risk. The Department told us that since the publication of the PriceWaterhouseCoopers Report, it has invested an additional £24.5 million above the rate of inflation in uplifts to independent sector care rates.

3.32 Under *People First*, Boards and Trusts have a duty to develop the local social care market so that it is responsive to the needs of local communities and local conditions. Trusting and inclusive partnerships are a necessary condition towards developing the appropriate range and configuration of services for older people. We recognise that such partnerships have not been easily developed and require investment in their own right. It is important that all stakeholders have a clear understanding of both the synergies and the differences which drive the commissioning and purchasing process. In particular, the Trusts as commissioners need to be aware of the key business drivers which affect the ability of independent providers to remain within, or exit, the marketplace.

3.33 Purchasing services from a variety of providers should allow Trusts to offer a wider range of services than they can offer themselves. Therefore, taking a more active role in influencing the supply of domiciliary care services will help to strengthen the strategic commissioning role of Trusts and help to meet the challenge of developing and securing an appropriate range of services that can help to maintain older people in their own homes. We acknowledge the Department's commitment that the health and social services will continue to promote the independent sector, either to replace and reduce dependency on institutional care or, where it represents better value for money, to replace in-house services. It will also continue to audit and benchmark in-house services to this effect.

23 *DHSSPS: Research Project to Identify the True Economic Cost in Northern Ireland of Independent: Residential and Nursing Elderly Care Home Sector Provision; and Domiciliary Care Provision*, PriceWaterhouseCoopers, March 2005

Part 4: Providing Quality Domiciliary Care Services for Older People

Introduction

4.1 It is important to users of domiciliary care that services are provided in such a way that helps them remain as independent as possible, are tailored to their own individual needs and are of a consistently good quality. Clearly, the user perspective is fundamental to defining and measuring the quality of domiciliary care services. In order to explore the experiences of older people who are in receipt of a domiciliary care package, we commissioned Ipsos MORI to survey the views of 255 users, selected from across the Trusts, about the general quality of service they received. The survey covered issues such as timing, flexibility, reliability and the attitude of home care staff providing the service. Appendix 6 describes the methodology used by Ipsos MORI and the questionnaire used in the survey is included at Appendix 7.

4.2 During May 2006, the Department published the results of a survey[24] it carried out of carers of older people. We have drawn on its report where we consider it has relevance to our own survey findings.

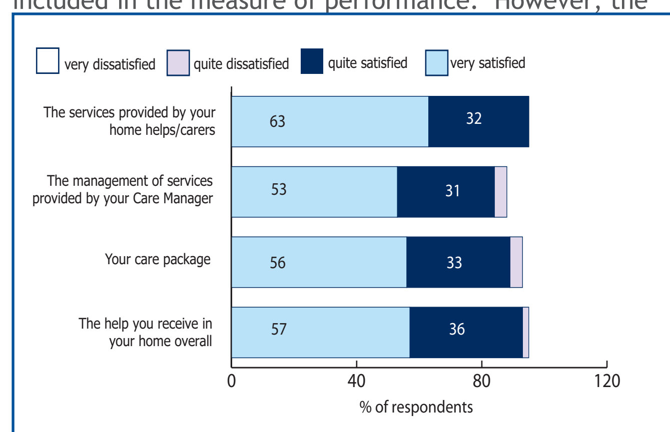
In general, older people show a very high level of satisfaction with domiciliary care services

> *"I just couldn't do without them. They are great, marvellous and I couldn't rate them all highly enough."*
>
> *"I like the different people. I don't get out much so it is good to get the variety."*
>
> *"You get used to them."*
>
> Survey respondents

4.3 When asked how satisfied they were with various aspects of the service they received, the vast majority of those surveyed reported that they were either 'quite' or 'very satisfied' with each element (Figure 10). In particular, 63 per cent of respondents were very satisfied with the services provided by home carers. This is broadly in line with the findings of a survey carried out in England in 2004 by the Personal Social Services Research Unit (PSSRU)[25] where 60 per cent of respondents expressed equivalent levels of satisfaction in response to a similar question. It is interesting to note that the carers surveyed by the Department (paragraph 4.2) took a slightly less favourable view, with only 49 per cent indicating that they were "very satisfied" with the services received by the person cared for.

Figure 10: Satisfaction with Services Received

4.4 As Figure 10 shows, there is little reporting of low quality services, particularly when "quite" satisfied is included in the measure of performance. However, the survey found that over one in five respondents (22 per cent) had made a complaint about their domiciliary care services in the past, a level which is also reflected in the Department's survey of carers (21 per cent having made a complaint). Moreover, occurrences of low satisfaction are expressed alongside the high level of overall satisfaction when individual aspects of service quality are examined, such as visits never being missed, punctuality and older people having confidence in their care workers. These provide a sharper insight into those areas of service where further improvement is possible. The rest of this part of the report looks at the detail of the feedback provided by the survey, points up strengths and good practice and highlights key areas of difficulty. Where relevant, the findings of our survey are compared with those of similar surveys carried out by PSSRU in England (paragraph 4.1) and Audit Scotland[26]. In addition, the findings of a



24 *Survey of carers of older people in Northern Ireland,* Department of Health, Social Services and Public Safety, May 2006.

25 *Performance and quality: user experiences of home care services,* A. Netten et al, Personal Social Services Research Unit, Discussion Paper 2104/3, April 2004.

26 *Homing in on care. A review of home care services for older people,* Audit Scotland, November 2001.

recent joint review[27] of care for older people in England (the "Living Well" review) undertaken by the Healthcare Commission, the Commission for Social Care Inspection and the Audit Commission will also be referred to where these have relevance for our survey.

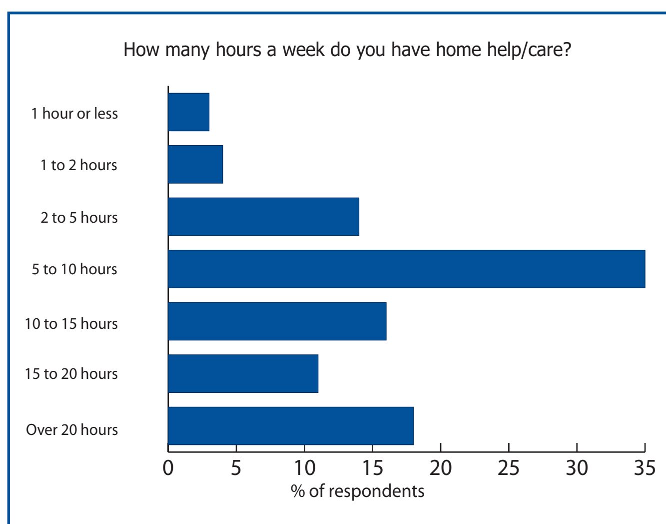
There is a need for greater flexibility in the provision of domiciliary care

> *"Maybe just a little more time given to the carers so they don't have to rush."*
>
> *"I would like them to come earlier to get me out of bed. My daughter has to do that as my first visit is not early enough."*
>
> *"Carers coming in too late in the morning. Wasn't dressed today until 11.00am but up since 8 o'clock. Home help doesn't arrive until 10.00am or 11.00am to serve breakfast."*
>
> Survey respondents

4.5 Figure 11 shows that about 80 per cent of those receiving domiciliary care packages receive over 5 hours of assistance per week, with almost a half dependent on more than 10 hours. This equates broadly with the findings of our data collection exercise on domiciliary care packages in effect at 31 March 2006, where we found that 69 per cent comprised over 8 hours of assistance per week (see paragraph 2.8).

27 *Living Well in Later Life: a review of progress against the National Service Framework for older people*, Healthcare Commission, March 2006.

Figure 11: Amount of Assistance received



Source: Ipsos MORI

4.6 The survey found the vast majority of those who receive care packages (97 per cent) are satisfied with the days on which they receive the services. However, 12 per cent of the survey respondents were dissatisfied with the times that their home carers visited. This is almost exactly the same proportion (11 per cent) of service users who told PSSRU in England that care workers always or usually came at times that did not suit them. The Audit Scotland survey found that almost 30 per cent of service users said they did not have enough choice over the times that they received home care.

4.7 In addition to the dissatisfaction expressed about the times care workers visited, 20 per cent of respondents felt they did not receive enough visits from their care workers. In England, the PSSRU survey found that this was around 10 per cent. In the Department's survey of carers, 14 per cent of respondents expressed dissatisfaction with the amount of services received by those they cared for. Moreover, in Northern Ireland, 16 per cent of those in receipt of care packages reported that their carers 'sometimes' or 'never' had time to carry out the tasks agreed in their care plan, while 21 per cent indicated that their carers left before they should, albeit after their tasks had been completed. The survey in Scotland records that only six per cent of care workers left before they should. On the other hand, a quarter of respondents in our survey reported that their carers had to stay longer in order to complete their tasks, which is line with findings from the survey in Scotland.

TSO66666 CareOfElderly.indd 30 10/11/07 10:59:43 AM

4.8 These findings raise questions over the extent to which home carers are allocated the appropriate time to undertake the tasks allocated to them, and the impact that this has on both the home carers and the quality of service that they are able to provide to users.

There is scope to improve the reliability of domiciliary care services for older people

4.9 The majority of the older people surveyed reported that they received a 'good' and 'reliable' service all of the time (82 per cent and 80 per cent respectively), broadly similar to the findings of the Audit Scotland survey. This means that approximately one in five consider that the care they receive is not 'good' or 'reliable' some of the time. However, only 62 per cent of respondents reported that they were always satisfied with the services they received when their usual carers were not available. Indeed 6 per cent said that they were 'not satisfied' in this regard. While these figures compare well against those found in the Audit Scotland survey (41 per cent are always satisfied), there is potential to increase levels of satisfaction further.

4.10 The reliability of domiciliary care services is important in enhancing the independence of those receiving them. If users have to wait for carers who fail to turn up or arrive late, then their ability to retain control over their daily lives will be compromised. Over a third (35 per cent) of those surveyed reported that their home carers did not turn up for an expected visit on one or more occasions in the last year. Fourteen per cent reported being let down on three or more occasions. In our view these figures are concerning, given the nature of the personal and domestic tasks that respondents depend upon, particularly since 46 per cent of them lived alone and 20 per cent indicated that they were not sure who to contact if their carer failed to show up.

4.11 The "Living Well" review in England (see paragraph 4.4) also found that appreciation from older people for the services they received was often tempered by concerns about care workers being rushed, the shortness and timing of visits and reliability associated with care workers rushing between visits and turning up late.

4.12 Increasingly, domiciliary care packages are focused on those with complex needs, which means that older people require more help with personal care. For instance, our survey recorded that 80 per cent of respondents received help with dressing and 76 per cent required assistance with washing. Intensive domiciliary provision of this nature can be time-consuming and places pressure on available resources. However, the demand for additional and more flexible domiciliary care services indicates that older people regard such provision as important in assisting them to lead more independent lives. We consider it important that the Department and the Trusts take steps to consider the shortcomings identified by our survey: to ensure that packages are as flexible as possible in terms of the times at which care is provided and reliable and comprehensive enough to ensure that opportunities to further improve outcomes for older people are not lost.

There is a perception of insufficient skill levels among some care workers

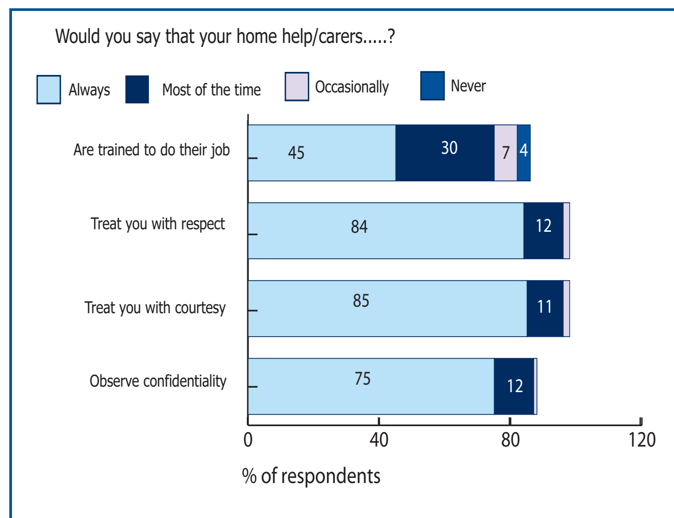
"<Client> can't swallow and he has to be kept upright and I have told the carers that but they don't listen. They say they can't keep him upright when they are changing him or working with him but it can be done because I do it when I am working with him. I put 2 pillows behind him".

Survey respondent

4.13 In line with findings elsewhere in the United Kingdom, the majority (96 per cent) of those interviewed considered that their home carers treated them with respect and courtesy always or most of the time (see Figure 12), a finding borne out also by the experience of carers (99 per cent). Despite this level of satisfaction, however, respondents were much less positive about the training of home care workers, with less than half (45 per cent) expressing the view that their home carers were 'always' trained to do their job; the converse being that 55 per cent believed at least some of their care was being delivered by carers who were not adequately trained.

TSO66666 CareOfElderly.indd 31 10/11/07 10:59:44 AM

Figure 12: Views of home carers



Source: Ipsos MORI

4.14 The survey of independent sector home care provision carried out in 2002 (see paragraph 3.25) concluded that although providers at that time were positive about the benefits of training and there were comprehensive training programmes in place for a number of providers, many organisations lacked the capacity to offer the training required of a workforce that has provided and continues to provide increasingly demanding and skilled care.

4.15 Person-centred care for older people may be jeopardized in a system where care workers lack adequate and proper training. In this regard we acknowledge that the Department has now put in place a development and training strategy (see paragraph 3.21) aimed at ensuring that care workers receive adequate and proper training. Having evidence that care workers are trained in their job will become even more crucial given the planned introduction of registration with the Northern Ireland Social Care Council (NISCC) and the regulation of services by the Regulation and Quality Improvement Authority (see paragraph 1.6). The Department anticipates that induction training will be a requirement for re-registration.

More can be done to help older people understand and be involved in the domiciliary care process

4.16 Older people need to be aware of why they are getting services, what services they are to receive, when they should be expected and what they are aiming to do. Providing this information, preferably both in verbal and written forms through copies of assessments and care plans, is essential to help older people (and their informal carers) understand the process, challenge if they feel it is wrong and ensure that services are delivered as planned. Responses to the survey, however, showed that one third of respondents considered that they did not have enough information on the services available. Only around half of those interviewed said that they had a copy of their assessment of need or a written care plan. A similar view was expressed by carers responding to the Department's survey, with 55 per cent of carers stating they had a copy of a care plan.

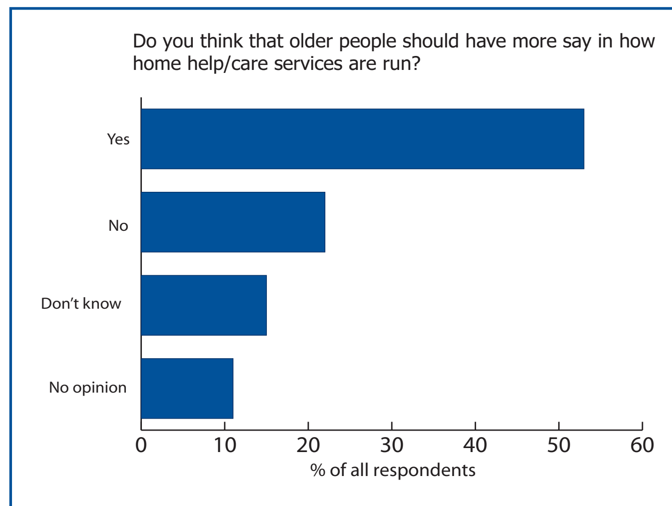
> 4.17 Trusts are already required to provide a copy of care plans to users and carers. Therefore, any instances where this requirement is not fulfilled will need to be addressed through ongoing professional training and awareness.

4.18 In order to make domiciliary care services more user-responsive, Trusts need to have effective processes in place for consulting with older people. While the survey indicates that users are generally content with the level of communication they have with care management teams, some misgivings were expressed: a third reported that they did not have enough information about the range of home care services that can be provided; around 20 per cent of those interviewed believed that their views had not been taken into account when the decision was made about services they would receive; and in terms of visits from Trusts to discuss requirements, seven per cent of respondents reported that they had not been visited in the last 12 months and 13 per cent could not recall whether or not they had been visited over this time. Perhaps an even more telling commentary on the involvement of users in domiciliary care provision is provided in Figure 13 which shows that over half those surveyed believed that users did not have a great enough say in how domiciliary care services are run. In the Department's survey of carers, 25 per cent of respondents indicated that they were never

TSO66666 CareOfElderly.indd 32 10/11/07 10:59:45 AM

asked what they thought about the services received by the people they cared for and 13 per cent informed the survey that they were never involved in deciding services.

Figure 13: Improving home care services



Source: Ipsos MORI

4.19 The philosophy of care places the user perspective at the heart of service delivery and the ability of individuals to articulate their own needs is the key to realizing this philosophy. As a result, we consider that Trusts need to review how they consult with older people when deciding on the care package they intend to provide to meet their needs. It is clearly important that, as part of the assessment process and setting up the package of care, effective use is made of the views, knowledge and preferences of older people, to ensure that the considerations of users play a key part in clarifying what and how services are provided.

> 4.20 If services are to be as user-focused as possible and improve the effectiveness of service delivery, Trust managers need to have an informed view of what users want from them. The most common ways of obtaining user views are through user and carer forums and/or a user survey similar to the one which we commissioned Ipsos MORI to conduct on our behalf for this review. However, we found none of the Trusts, Boards or the Department undertook any work of this nature. In view of this, we recommend that, in the drive towards better quality domiciliary care services, the development of methods to elicit users' views on a regular basis should be a priority.

4.21 While surveys should be an integral part of the management of domiciliary care services, they are only one element in the process of maintaining standards. Equally important will be the role of the new Regulation and Quality Improvement Authority (see paragraph 1.6) which, as part of its functions, will conduct inspections of domiciliary care services relative to a set of new minimum care standards issued by the Department in March 2006 (see paragraph 1.6). These provide an explicit statement of the (minimum) quality that is required. In our view, this regulatory structure needs to become embedded in the domiciliary care workforce, to drive quality improvements and ensure innovative and timely services for older people.

4.22 The Department told us that it plans to issue guidance to strengthen the involvement of people in plans and decisions about their care or treatment, as well as involving people in plans and decisions about service provision. This guidance, "Strengthening Personal and Public Involvement in the Health and Social Services", expected to issue in Autumn 2007, is based on a set of core values and guiding principles and provides a framework for good practice in involving people at all levels in health and social care. It supplements the Quality Standards for Health and Social Care which were published in March 2006. There are three key premises which underpin the guidance. They are that:

- people in receipt of services should be actively involved in decisions affecting their lives and should fully contribute to any planning, decisions and feedback about their own care or treatment;
- the wider public has a legitimate entitlement to have opportunities to influence health and social care services, policy and priorities; and
- private and public involvement is part of everyday practice within health and social care and should lead to improvements in an individual's personal experience of the service and the overall quality and safety of service provision.

4.23 Statutory requirements to consult and involve people are already enshrined in Equality[28] and Disability[29] legislation. The proposed new statutory duty of public involvement and consultation in the draft Health and Social Services (Reform) (Northern Ireland) Order 2007

28 Section 75 of the Northern Ireland Act 1998.
29 Section 49A Disability Discrimination Act 1995 (as amended by the Disability Discrimination (Northern Ireland) Order 2006).

(draft Reform Order) will place a new requirement on all health and social care organizations which should also improve Trust activity in this area.

4.24 Standards are also being developed by the Department to improve the experiences of service users. These standards, "Domiciliary Care Agency Standards", expected to issue during 2007-08, will set out the behaviours and attitudes expected of staff towards those with whom they work. This includes listening to and taking account of the views of service users about the type of services they want and their views about the quality of service they receive.

Users have identified a series of suggested changes to improve the quality of domiciliary care services

4.25 Domiciliary care is the mainstay for many older people living at home and a large majority of those surveyed expressed their appreciation of the services and staff involved. However, at the same time, domiciliary care remained a source of anxiety for a significant minority of older people, particularly when staffing was inconsistent or unreliable. As a result, the experiences of these users showed that domiciliary care services often fall short of the quality they would have expected. The following areas were highlighted by users as meriting specific attention and we recommend that the Department and the Trusts consider how they might be improved:

- *Improved communication:* Trusts need to ensure that service users have sufficient opportunities to provide feedback and to be consulted on service developments, and that there are clearly understood and responsive ways for users to register comments and complaints.
- *Continuity and Timeliness of Care:* Services that are unreliable or lack continuity in staffing fail to give users the confidence and practical assistance they need to continue living independently. Instances where care staff fail to turn up or where there is inadequate holiday cover may be reflective of strains in the relationships between staff recruitment and wages, as well as inadequacies in monitoring. Nevertheless, to avoid unnecessary institutional outcomes, Trusts need to progress solutions to ensure the delivery of an acceptable quality of service.
- *Monitoring and Review:* There were indications from the survey that the adjustment of care packages through case review was poor. However, the needs of users cannot be assumed to remain static. Efficient review systems are essential to ensure that needs continue to be met adequately and to prevent over-provision, should users' circumstances improve. Besides wasting resources, over-provision brings serious risk of creating dependence. Under-provision, on the other hand, may leave eligible individuals with needs at risk. Improved reviewing, therefore, has the potential to produce substantial gains.
- *Better trained staff:* The emphasis within the domiciliary care sector is on the need for high quality, user-centred care delivered by a well-trained workforce. Commissioners, providers and regulatory bodies will need to build upon the potential in the sector by enhancing the capacity of the workforce to deliver these services.

TSO66666 CareOfElderly.indd 34 10/11/07 10:59:47 AM

Appendix 1

(paragraph 1.7)

PEOPLE FIRST - Barriers to Progress

The Hospital/Community Interface

- Much could be done to improve integrated patterns of working across hospital/community interfaces.

Better Practice

- The service is severely inhibited by the failure to share good practice among Trusts;
- There is a need to promote and implement schemes which are not simply crisis interventions but are rehabilitative and preventative , making it possible to maintain people in their own homes for longer; and
- The valuable role of carers is not fully recognised.

Resourcing Community Care

- There is a trend to rely on nursing home provision rather than domiciliary care.

Multi-Disciplinary and Multi-Agency Working

- There is insufficient integrated team working within the system and a need to ensure a better skills mix in community care provision.

Medicines Management

- Medicine related problems are frequently encountered in the delivery of community care, with a need for effective medicine management strategies forming an integral part of community care provision.

Structure and Systems

- Existing communication systems between and within Trusts need rationalising and simplifying, with the development of new systems which can readily pool and exchange information; and
- A more accurate way of recording unmet need needs to be developed.

Care Management Processes

- Assessment systems are not offering appropriate choice. They may be creating perverse incentives leading to inappropriate long-term solutions, resulting in too much focus on residential and nursing homes;
- Assessments and services are targeted at those with most complex needs while those with less complex needs are often left without a service; and
- The present system of service delivery has led to inequity.

TSO66666 CareOfElderly.indd 35 10/11/07 10:59:48 AM

Budgets

- There is an ever increasing call on finite resources. Community care budgets need ring-fenced or protected.

Strategic Planning and Direction

- A strategic vision for community care is needed with a clear understanding of current provision, its trends, projections and resources. All gaps, deficiencies, and duplications need to be identified to develop such a strategy, with a firm understanding of the service's priorities and the implications for funding of the expected growth in services.

User involvement

- Not enough is known about what older people want. They are often not given enough information to make informed choices.

TSO66666 CareOfElderly.indd 36 10/11/07 10:59:48 AM

Appendix 2

(paragraph 2.24)

Elderly Delayed Discharges from Hospital: awaiting a community care package at 31 March 2006

Board/Trust	Total number of delayed discharges	Total waiting ≤ 7 weeks	Percentage of total waiting ≤ 7 weeks (PFA* Target:95%)
Northern:	**102**	**57**	**56%**
Causeway	*26*	*12*	46%
Homefirst	*76*	*45*	59%
Southern:	**17**	**14**	**82%:**
Armagh & Dungannon	*12*	*10*	83%
Craigavon & Banbridge	*0*	*0*	100%
Newry & Mourne	*5*	*4*	80%
Eastern:	**151**	**138**	**91%**
Down Lisburn	*28*	*27*	96%
North & West Belfast	*41*	*35*	85%
South & East Belfast	*52*	*47*	90%
Ulster Community	*30*	*29*	97%
Western:	**10**	**8**	**80%**
Foyle	*8*	*7*	88%
Sperrin Lakeland	*2*	*1*	50%
TOTAL	**280**	**217**	**78%**

Source: Trust DD1 returns and Board Monitoring Reports

* Priorities for Action

TSO66666 CareOfElderly.indd 37 10/11/07 10:59:49 AM

Appendix 3

(paragraph 2.28)

Elderly Persons Living in the Community: awaiting a community care package at 31 March 2006

Trust / Board	Total Number of Elderly People Waiting	Total Waiting ≤ 12 weeks	% Waiting ≤12 weeks
North & West Belfast	48	19	39.6%
South & East Belfast	6	2	33.3%
Ulster Community	21	14	66.7%
Down Lisburn	13	8	61.5%
Eastern Board	**88**	**43**	**48.9%**
Causeway	32	10	31.3%
Homefirst	37	20	54.1%
Northern Board	**69**	**30**	**43.5%**
Armagh & Dungannon	4	4	100.0%
Craigavon & Banbridge	0	0	-
Newry & Mourne	3	2	66.7%
Southern Board	**7**	**6**	**85.7%**
Foyle	20	15	75.0%
Sperrin Lakeland	6	6	100.0%
Western Board	**26**	**21**	**80.8%**
Northern Ireland	**190**	**100**	**52.6%**

Source: DHSSPS CC5b return

TSO66666 CareOfElderly.indd 38 10/11/07 10:59:49 AM

Appendix 4

(paragraph 3.22)

Personal Social Services: Development and Training Strategic Objectives

1. Leadership and Management

1.1 **By 2010**, appropriate leadership and managerial skills training programmes will be available for leaders and managers of social services at all levels.

1.2 **By 2016**, all senior, middle and first line managers will have undertaken appropriate leadership and managerial skills training within 2 years of appointment to post.

2. Safety and Accountability

2.1 **From 2009**, all new social work registrants and re-registrants will be working towards or hold relevant accredited training or qualifications appropriate to job role and associated with continuing registration.

2.2 **By 2016**, all new social care registrants and re-registrants will be required to be working towards or hold relevant part or whole NVQs appropriate to job role and associated with continuing registration.

3. Flexibility and Skill

3.1 **By 2008**, comprehensive information will be available on the range of appropriate training opportunities from access routes to specialist training programmes for social services staff at all levels across Northern Ireland. This will be updated annually with an action plan and timescales for the development of new learning and training initiatives.

3.2 **By 2011**, systems will be in place to produce reliable regional information on the qualification profile of the social services workforce across all sectors.

4. Motivation and Confidence

4.1 **By 2010**, career structures in social work and social care will be linked to agreed accredited training and/or qualifications linked to continuing registration.

4.2 **By 2016**, all social services staff, including managers, will have ongoing, planned access to learning and development opportunities, that reflect the different stages of their career, changing service needs and any mandatory requirements, including registration requirements.

TSO66666 CareOfElderly.indd 39 10/11/07 10:59:50 AM

5. Working in Partnership

5.1 **By 2008**, there is evidence that the design, delivery and quality assurance of National Occupational Standards and professional social work training are informed by service user and carer perspectives.

5.2 **By 2010**, shared accredited learning opportunities for social services across the statutory, voluntary and private sectors will be available in each Trust area with an action plan for further development.

5.3 **By 2010**, a range of shared learning and training initiatives will be in place with other key sectors, including health, justice, education and housing, with an action plan for further development.

6. Continuous Learning and Development

6.1 **By 2008**,all social services employees will have an annual performance appraisal with their employer, and a personal development plan.

6.2 **By 2010**, all social care providers will, as part of social care governance, have arrangements in place to support the organisation's development as a learning organisation and an action plan to meet further identified development.

7. Delivering the Strategy

7.1 **By 2008**, commissioning responsibility and associated resources for PSS training will have transferred to the Regional Authority.

7.2 **By 2009**, the resources required to continue to deliver the strategic targets from 2010-2016 will have been identified and submitted to the Department to inform the 2010 comprehensive spending review.

TSO66666 CareOfElderly.indd 40 10/11/07 10:59:50 AM

Appendix 5

(paragraph 3.24)

Total Spend on Domiciliary Care Packages 2002-03 to 2005-06

Board / Trust	2002-03 Total £m	2003-04 Total £m	2004-05 Total £m	2005-06 Total £m
Northern:				
Causeway	4.5	4.5	4.8	4.6
Homefirst	13.3	14.0	15.4	16.9
Southern:				
Armagh & Dungannon	6.2	6.6	7.5	8.0
Craigavon & Banbridge	4.4	4.7	6.0	6.3
Newry & Mourne	5.2	5.9	7.4	7.3
Eastern:				
Down Lisburn	7.3	8.7	9.6	9.5
North & West Belfast	9.8	11.2	12.7	13.3
South & East Belfast	9.2	13.6	15.5	15.9
Ulster Community	6.7	8.3	10.0	11.0
Western:				
Foyle	5.0	5.9	6.3	7.8
Sperrin Lakeland	7.1	8.3	9.0	9.3
TOTAL:	78.7	91.8	104.1	109.8

Note: figures may not add due to rounding

Source: DHSSPS Strategic Financial Analysis Unit, on the basis of TFR returns from individual Trusts

TSO66666 CareOfElderly.indd 41 10/11/07 10:59:51 AM

Appendix 5
(continued)

Domiciliary Care - Independent* as a % of Total

Board / Trust	2002-03	2003-04	2004-05	2005-06
Northern:				
Causeway	4.6%	-	-	-
Homefirst	13.2%	8.2%	10.6%	13.7%
Southern:				
Armagh & Dungannon	34.8%	30.6%	32.3%	35.5%
Craigavon & Banbridge	26.6%	23.7%	22.2%	21.1%
Newry & Mourne	39.2%	42.4%	42.4%	41.5%
Eastern:				
Down Lisburn	42.5%	47.5%	50.6%	52.2%
North & West Belfast	31.2%	32.5%	35.4%	36.5%
South & East Belfast	0.0%	32.5%	32.2%	36.9%
Ulster Community	34.5%	41.8%	44.1%	46.0%
Western:				
Foyle	22.9%	22.9%	24.7%	25.1%
Sperrin Lakeland	52.8%	54.3%	52.4%	50.1%
TOTAL:	26.3%	30.8%	33.7%	35.0%

*Includes direct payments (see paragraph 3.15)

TSO66666 CareOfElderly.indd 42 10/11/07 10:59:51 AM

Appendix 6

(paragraph 4.1)

Ipsos MORI Methodology for User Survey

Summary of approach

In designing our approach to this study we were very aware of the vulnerability of the target group and the potential concerns that they and their carers might have about being approached to take part in an interview. Therefore, at each stage of the research, steps were taken to ensure that respondents and their carers were assured of the validity of the project, and that they felt comfortable taking part. We endeavoured to conduct the research in a sensitive way by:

- Writing to potential respondents to introduce the study prior to interviewing;
- Telephoning potential respondents to request participation and arrange a suitable time to visit;
- Sending a letter confirming the time and date of the interview, should their carer wish to be present;
- Encouraging a relative/carer to be present at the time of the interview;
- Making a home visit in order to conduct the interview; and
- Leaving a letter with the respondent thanking them for participating and which they could show to their carer (if they were not present) to allay any concerns.

A named contact from NIAO was also made available in case potential respondents or their carers had any concerns about the research.

Sampling

According to DHSSPS statistics, approximately 4,800 people were in receipt of domiciliary care packages across 11 Community Trusts in Northern Ireland at 31 March 2004[30]. The following table details the number of reported domiciliary care packages in each Trust.

Provider	Number of Domiciliary Care Packages at 31 March 2004
Armagh & Dungannon HSS Trust	349
Causeway HSS Trust	492
Craigavon & Banbridge Community HSS Trust	247
Down Lisburn HSS Trust	534
Foyle HSS Trust	379
Homefirst Community HSS Trust	361
Newry & Mourne HSS Trust	331
North & West Belfast HSS Trust	676
South & East Belfast HSS Trust	387
Sperrin Lakeland HSS Trust	436
Ulster Community & Hospitals HSS Trust	623
Total	**4,815**

30 p51, Community Statistics, 1 April 03 – 31 March 04, http://www.dhsspsni.gov.uk/comstats_04.pdf

TSO66666 CareOfElderly.indd 43 10/11/07 10:59:52 AM

The first step in relation to sampling involved NIAO contacting each of the Trusts and asking them to supply initially the postcodes of all older people in their area receiving a domiciliary care package, along a with unique identifying number which could be used to trace back to the original contact details once the sample selection had taken place.

The second step, using the information provided, was to identify the number of interviews required in each Trust area to ensure proportional representation by number of clients in receipt of domiciliary care packages.

Using a clustered random sampling approach we then randomly selected three postcode areas in each Trust area at which interviews would be conducted. From these areas, we randomly selected a sample of clients of 2.5 times[31] the target number of interviews. The Trusts were then approached by NIAO to provide contact details for those selected for interview.

A number of issues arose during the sampling stage. Firstly, two Trusts were unable to provide easily a list of the full postcodes for those in receipt of domiciliary care packages. However, we worked with them to identify a suitable solution and to minimise the burden of identifying potential contacts.

Secondly, when the Trusts provided the full list of potential respondents we identified a number of differences between the numbers published at March 2004 and the number of contacts supplied. Where the differences were significant this was highlighted to NIAO, who raised the issue with the relevant Trusts. In some cases the Trusts had included contacts outside the criteria for the study – once identified this was rectified. In other cases the numbers detailed in the published data were identified as being inaccurate.

Issues over the accuracy of numbers continued to be identified when the Trusts came to draw the sample of contacts for the survey, with some Trusts revising the numbers that they had for people in receipt of domiciliary care packages. This impacted to some extent on the sampling procedures, as it meant that the number of interviews that had been identified to take place in each Trust area had to be revised to ensure proportional representation. One exception to this was in relation to Homefirst Trust, where an additional 366 cases were identified. In this case we decided to proceed with the stratification based on the originally identified numbers for that Trust. This was because using the new numbers would have meant interviewing a disproportionately large number of clients in that Trust area when compared with the other Trusts. However, contacts for the additional cases were included in the sample selection process.

The following table details the numbers of older people in receipt of domiciliary care packages, as provided by the Trusts, and the target and achieved number of interviews in each Trust area.

31 It was estimated that, allowing for inaccurate data, deaths, moves to other care settings and refusals, we would require 2.5 times the number of contacts in order to achieve the required number of interviews. As this type of survey has not been conducted previously, we took the precaution of drawing a reserve sample in case our assumptions about response rates were inaccurate.

TSO66666 CareOfElderly.indd 44 10/11/07 10:59:52 AM

Provider	Number of Domiciliary Care packages at 31 March 2004	Number in receipt of Domiciliary Care package as identified by Trusts at time of study	Percentage	Target number of interviews	Number of interviews conducted
Armagh & Dungannon HSS Trust	349	323	7%	18	18
Causeway HSS Trust	492	445	10%	24	27
Craigavon & Banbridge Community HSS Trust	247	258	6%	14	13
Down Lisburn HSS Trust	534	423	9%	23	23
Foyle HSS Trust	379	451	10%	25	25
Homefirst Community HSS Trust	361	426*	9%	23	23
Newry & Mourne HSS Trust	331	212	5%	12	12
North & West Belfast HSS Trust	676	688	15%	38	38
South & East Belfast HSS Trust	387	330	7%	18	18
Sperrin Lakeland HSS Trust	436	396	9%	22	23
Ulster Community & Hospitals HSS Trust	623	613	13%	34	35
Total	***4,815***	***4565***	***100%***	***251***	***255***

* This later increased to 792 when additional cases were identified.

Questionnaire design

The basis for the questionnaire for this study was one used previously by Audit Scotland. It was reviewed to ensure that it was appropriate to the Northern Ireland context and a number of additional questions added. DHSSPS were consulted on the content of the questionnaire and the terminology used. The final agreed questionnaire is included at Appendix 7.

Survey implementation

As mentioned previously we were very aware that conducting a survey among older people could potentially cause them and their carers concern, particularly as there were a number of well publicised burglaries at older people's homes around the time that the interviews were being conducted. Therefore, through our approach, we aimed to provide them with reassurance about the validity of this study, so as to encourage them to participate.

TSO66666 CareOfElderly.indd 45 10/11/07 10:59:53 AM

As a first step the Trusts sent out a letter on behalf of NIAO to the selected contacts, informing them of the study and requesting their participation. A number of older people or their carers contacted either their Trust or NIAO to say that they did not wish to participate. The Trusts updated their database of contacts with this information prior to providing NIAO and subsequently Ipsos MORI with a list of those who had not opted out of the survey. A number of Trusts contacted each of those selected for interview and asked them if they were willing to participate in the study (opt in) rather than letting them opt out. In some of these cases we found that lower numbers were willing to participate in the survey, and therefore raised concerns with NIAO as to the potential bias that this approach could potentially introduce. However, this had to be balanced with the concern that the Trusts expressed about wanting to ensure that their clients were comfortable with participating and, indeed, checking the accuracy of the data that they held on their clients.

Once we obtained the contact information from the Trusts our interviewing team contacted each respondent by telephone to set up an appropriate time for interview. Respondents were informed that a relative or friend would be welcome during the interview, should they want this. This action was taken so as to make clients feel more confident about participating in the survey. We discouraged respondents from having home helps or other Trust carers present at the time of interview, owing to the conflict of interest that this represents. A letter confirming the appointment was sent to respondents as appropriate.

Our interviewers attended each respondent's home at the arranged time to conduct the interview. During this stage of the research our interviewers again reassured the respondent of the validity of the research and provided a letter thanking them for taking part and detailing who they or their carer should contact if they had any further questions.

Wherever possible the interview was conducted with the respondent. If it was apparent that the respondent needed assistance with the interview, we looked to the relative or friend to provide this help. This was recorded on the questionnaire.

All interviewers are trained to the standards set out by the Interviewer Quality Control Scheme (IQCS). Being part of this accreditation programme means that our interviewers are accompanied on a regular basis and a proportion of their interviews are back checked to ensure that they are accurate and comply with the Market Research Code of Conduct.

Data processing and analysis

The data from the questionnaires was entered into a computer for analysis and a set of cross tabulations produced detailing the responses to each question.

TSO66666 CareOfElderly.indd 46 10/11/07 10:59:54 AM

Appendix 7

(paragraph 4.1)

NI Audit Office

Survey of People Receiving Home Care Packages

February 2006

Good morning/afternoon. My names is …. from MORI Ireland. We are conducting some research on behalf of the Northern Ireland Audit Office regarding opinions of the services provided by home care workers. That is, the people who come into your home, from your local Health and Social Services Trust, to help you with day to day tasks.

You may remember that we discussed this on the telephone?/ Your carer may have told you that I would be here.

Show ID, give letter to respondent explaining study, and ensure that they are happy to participate.

Question		Response	Code
Q.1	Record gender?	Male	1
		Female	2
Q.2	**What was your age last birthday?**		
	RECORD EXACT AND CODE:		
		65 to 74 years	1
		75 to 84 years	2
		85 years +	3
Q.3	Do you live…? **SINGLE CODE**	On your own	1
		With your spouse	2
		With your son/daughter	3
		With your spouse and son/daughter	4
		With other relatives	5
		With others	6
Q.4	Do you live in sheltered housing? Eg Fold, Clanmil etc	Yes	1
		No	2
Q.5	Do you receive Attendance Allowance	Yes	1
		No	2
		Don't know	3
Q.6	How long have you had services at home from the Health and Social Services Trust? That is, someone who comes into your home to help with day to day tasks such as personal care, domestic tasks or other household responsibilities **SINGLE CODE**	Less than 6 months	1
		6 months to 1 year	2
		1.1 to 2 years	3
		2.1 to 5 years	4
		5.1 to 10 years	5
		More than 10 years	6

Q.7 Which of the following things do your home help/ home carers help you with?
CODE ALL THAT APPLY
PROBE FOR ANY OTHERS

Domestic tasks		Personal care		Household responsibilities	
Housework	1	Dressing	6	Accompany you on a shopping trip	13
Shopping	2	Washing	7	Accompany you to bank or post office	14
Cooking meals	3	Bathing	8	Help you to visit family or friends	15
Washing clothes	4	Toilet needs	9	Help you to attend social events	16
Pension/paying bills	5	Getting in or out of bed	10	Help you to attend church	17
Other - specify		Assisting with medication	11	Help with hobbies or past times	18
		Assisting with feeding	12	Other - specify	
		Other - specify			

Q.8 What are the THREE most important things that home help/home carers help you with?
PLEASE LIST

TSO66666 CareOfElderly.indd 48 10/11/07 10:59:55 AM

Q.9 How many hours **a week** do you have home help/ home care?
SINGLE CODE
Please add together all the time spent by home helps/home carers etc.

1 hour or less	1
1 to 2 hours	2
2.1 to 5 hours	3
5.1 to 10 hours	4
10.1 to 15 hours	5
15.1 to 20 hours	6
Over 20 hours	7

Q.10 On what days do you have home help/home care?
CODE ALL THAT APPLY

Monday	1
Tuesday	2
Wednesday	3
Thursday	4
Friday	5
Saturday	6
Sunday	7

Q.11 At what times do you have home help/ home care?
CODE ALL THAT APPLY

During the day (7am to 7pm)	1
In the evening (7pm to 10pm)	2
At night (10pm to 7am)	3

Q.12a How many different home helps/ home carers usually visit you in a week?

Q.12b Is this an acceptable number?
SINGLE CODE

Yes	1
No	2

Q.12c Why do you say this?
PROBE FULLY

Q.13 Is there anything that you would like help with that your home carers do not do?
PLEASE LIST

Q.14 Do you use any of the following services IN ADDITION TO your HSS home care/ home help services?
CODE ALL THAT APPLY

Meals on wheels	1
Community alarm	2
Lunch club	3
Respite care	4
Laundry	5
Shopping delivery	6
Day care	7
Other - specify	8

Q.15a In general, do you think the home help/home care you receive through your HSS Trust is **good…**
SINGLE CODE

All of the time	1
Some of the time	2
None of the time	3

Q.15b In general, do you think the home help/home care you receive through your HSS Trust is **reliable…**
SINGLE CODE

All of the time	1
Some of the time	2
None of the time	3

Q.16 How satisfied are you with the service you receive when your **usual** home help/carer(s) is (are) **not** available?
SINGLE CODE

Always satisfied	1
Usually satisfied	2
Not satisfied	3

Q.17 Are you satisfied with…

a The **days** on which you have home help/home care
SINGLE CODE

Yes	1
No	2

b The **times** at which you have home help/ home care
SINGLE CODE

Yes	1
No	2

TSO66666 CareOfElderly.indd 50 10/11/07 10:59:57 AM

Q.18 Do you think you have been given any choice in…

a The **days** on which you have home help/home care
SINGLE CODE

Yes	1
No	2

b The **times** at which you have home help/ home care
SINGLE CODE

Yes	1
No	2

c The things your home help/home carer helps you care
SINGLE CODE

Yes	1
No	2

Q.19 What do you think is the most important quality that a home help/home carer should have?
PLEASE DETAIL

Q.20 For each statement ask
Would you say that your…
SINGLE CODE ON EACH ROW

		Always	Most of the time	Occasionally	Never	Don't know
a	…home carers/ home help are trained to do their job	1	2	3	4	5
b	…home carers/ home help treat you with respect	1	2	3	4	5
c	…home carers/ home help treat you with courtesy	1	2	3	4	5
d	…home carers/ home help observe confidentiality	1	2	3	4	5

TSO66666 CareOfElderly.indd 51 10/11/07 10:59:58 AM

Q.21a	In general, when they visit, do your home help/home carers...? **SINGLE CODE**	Stay for the time agreed	1
		Stay longer as needed to do the work	2
		Leave before they should and before the work is completed	3
		Leave before they should but after the work is completed	4
Q.21b	How often do your home helps/ home carers have time to carry out the tasks agreed on your care plan?	Never	1
		Sometimes	2
		Often	3
		Always	4
Q.22	On how many occasions, if any, in the last year have you expected your carer/ home help to visit but they did not turn up? **SINGLE CODE**	None	1
		One	2
		Two	3
		Three	4
		Four to five	5
		Six to ten	6
		More often	7
Q.23	Do you think your views were taken into account in deciding what help you get from home care/ home help? **SINGLE CODE**	Yes	1
		No	2
		Don't know	3
Q.24	Do you have as many visits from your home carer/ home help as you feel you need? **SINGLE CODE**	Yes	1
		No, I need a few more	2
		No, I need a lot more	3
		No, I have too many	4
Q.25	Do you have a Care Manager? **SINGLE CODE**	Yes	1
		No	2
		Don't know	3
Q.26	Do you have a copy of the ASSESSMENT of your need for home care/ home help services? **SINGLE CODE**	Yes	1
		No	2
		Don't know	3
Q.27	Do you have a written CARE PLAN or CARE TIMETABLE? **SINGLE CODE**	Yes	1
		No	2
		Don't know	3

Q.28	How long is it since anyone from the Trust discussed with you (or the person responsible for your affairs) the help you need? Eg your care manager, social worker etc **SINGLE CODE**	Within the last month	1
		1 to 3 months ago	2
		3.1 to 6 months ago	3
		6.1 to 12 months ago	4
		More than a year ago	5
		Don't know	6
Q.29	Do you think you have good enough information about the range of home care services that can be provided? **SINGLE CODE**	Yes	1
		No	2
Q.30	Do you pay any charges for your home care services? **SINGLE CODE**	Yes	1
		No	2

IF YES, GO TO Q.31
IF N0, GO TO Q.33

Q.31	Is this a private arrangement that you have made or was it arranged by your Trust/Care manager? **SINGLE CODE**	Private arrangement	1
		Arranged by Trust/Care Manager	2
		Both	3
Q.32a	Have you had any problems with the billing for your home care charges? **SINGLE CODE**	Yes	1
		No	2

Q.32b Please say what the problems are
PLEASE DETAIL

ASK ALL

Q.33	If your home carer/ home help did not arrive when you were expecting a visit, would you know who to contact? **SINGLE CODE**	Yes	1
		No	2

NIAO Reports

Title	HC/NIA No.	Date Published
2007		
Internal Fraud in Ordnance Survey of Northern Ireland	HC 187	15 March 2007
The Upgrade of the Belfast to Bangor Railway Line	HC 343	22 March 2007
Outpatients: Missed Appointments and Cancelled Clinics	HC 404	19 April 2007
Absenteeism in Northern Ireland Councils 2005-06	-	30 March 2007
Good Governance - Effective Relationships between Departments and their Arms Length Bodies	HC 469	4 May 2007
Job Evaluation in the Education and Library Boards	NIA 60	29 June 2007
The Exercise by Local Government Auditors and their Functions	-	29 June 2007
Financial Auditing and Reporting: 2003-04 and 2004-05	NIA 66	6 July 2007
Financial Auditing and Reporting: 2005-06	NIA 65	6 July 2007
Northern Ireland's Road Safety Strategy	NIA 1	4 September 2007
Transfer of Surplus Land in the PFI Education Pathfinder Projects	NIA21/07-08	11 September 2007

Printed in the UK for The Northern Ireland Audit Office
PC2090 10/07

TSO66666 CareOfElderly.indd 54 10/11/07 11:00:00 AM

TSO66666 CareOfElderly.indd 55 10/11/07 11:00:00 AM

Published by TSO (The Stationery Office) and available from:

Online
www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders / General enquiries: 0870 600 5522
Fax orders: 0870 600 5533
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
E-mail book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588
The Parliamentary Bookshop
12 Bridge Street, Parliament Square
London SW1A 2JX
Telephone orders / General enquiries 020 7219 3890
Fax orders 020 7219 3866
Email bookshop@parliament.uk
Internet bookshop.parliament.uk

TSO@Blackwell and other Accredited Agents