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CARE PACKAGES

This Research Paper describes in detail the policy, practice and statistics of domiciliary care, particularly for older people, in Northern Ireland and also covers more briefly similar information for England, Scotland and the Republic of Ireland. The paper closes with a selection of concluding comments on progress in this area of care.

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KEY MESSAGES

Key Comments

Although the social security system is uniform throughout the UK, the care system with which it closely interacts is subject to significant regional variation, as England, Scotland, Wales and Northern Ireland can each determine their own policies, resourcing arrangements (including level of charges and co-payments) and eligibility criteria for social care.

It appears, in Northern Ireland, that there has still not been a significant shift away from institutional care for older people as in ratio terms the proportion of those receiving care in residential or nursing homes still exceeds those receiving a domiciliary care package.

There is also concern that in recent years, across the UK, there has been a shift away from low and moderate levels of care provision with qualifying criteria being tightened and domiciliary care resources focused on those with high levels of need to the exclusion of those with less intensive care needs.

The NIAO noted that the picture that emerged from its review of domiciliary care in Northern Ireland is one of gradual improvement in the reach of domiciliary care packages. However, progress, in terms of a shift away from institutional care, has been static in recent years due to the continuing pressure of increasing nursing home placements.

Key Points

In Northern Ireland - Health and Social Care Trusts carry out care management assessments and when domiciliary care is identified as the best form of care the HSC Trust organises the delivery of this care either by a statutory provider (operated by HSC Trusts) or by contracting an independent provider (voluntary or private sector).

Statistics show that over 80% of people in receipt of a home-help service in Northern Ireland are in the Elderly Care Programme of Care.

With regard to policy, *People First* (1990) is the DHSSPS vision for community care with six core objectives, including the development of domiciliary care services.

An analysis of balance of care by the Northern Ireland Audit Office indicates that resources are increasingly being directed towards those with the most severe needs and levels of dependency.

Care management and the assessment of individuals have been described as central to the implementation of *People First*. In February 2009, the Health Minister launched the Northern Ireland Single Assessment Tool (NISAT) designed to capture the information required for holistic and person-centred assessment of the older person.

Domiciliary Care Providers are required to register with the Regulation and Quality Improvement Authority (RQIA) and are inspected annually based on a set on minimum standards developed by the DHSSPS. There are 260 offices of homecare/domiciliary care organisations registered with the RQIA.

In England - The majority of people in England in receipt of home care receive it through local social services, which assess need for help according to certain eligibility criteria.

Most Councils with Adult Social Services Responsibilities (CASSR) contract out the supply of home care services to the independent sector, which now provides over three quarters of public funded home care.

Providers in England are regulated against standards. From April 1st 2009 this regulation was taken over by the Care Quality Commission which replaced the Commission for Social Care Inspection.

The Department of Health in England has made self-directed support a key focus for the development of health and social care services since the mid-1990s. The latest direction is 'Personal Budgets', devised based on the experience of direct payments and individual budgets.

The long term future of community care is under consideration and in July 2009, HM Government published the green paper *Shaping the Future of Care Together* with its proposals for reforming the care and support system for adults in England and a 'National Care Service'.

In Scotland - Local authorities in Scotland have a duty for undertaking community care assessment and are then responsible for developing packages of care, planning services and commissioning services.

The local authority will use their own services, those of the private sector and those of the voluntary sector. Individuals have the right to request self-directed support (direct payments) to enable them to pay for their own care from an agency or to employ a home care worker.

In Scotland personal care provided by a local authority, defined as anything done for an individual of a personal nature, is free to those over 65 years of age since the Community Care and Health (Scotland) Act 2002.

In the Republic of Ireland - the Home Care Support Scheme (also known as the Home Care Support Package), is an administrative scheme that evolved from a series of pilots over the past five years or so.

The scheme is at a relatively early stage and is not yet a national scheme. The main priority is older people living in the community or those who are in-patients in acute hospitals at risk of admission to long term care.

SUMMARY

Older people are the biggest single group of users of community social care services, particularly those living alone. This paper has therefore focused on care services for older people, with particular emphasis on domiciliary or home care. In Northern Ireland community home care services are referred to as domiciliary care services, which the DHSSPS defines as "*the range of services put in place to support an individual in their own home*.[1]

The Northern Ireland Executive PSA targets for the DHSSPS are under PSA 18, Objective 1 (promote independent living and a reduction in avoidable admissions to hospital)[2] and include the target - by March 2010, 45% of people with assessed community care needs to be supported at home.

Health and Social Care Trusts in Northern Ireland carry out care management assessments to identify a person's needs and determine the best form of care to meet those needs. When domiciliary care is identified as the best form of care the HSC Trust organises the delivery of this care either by a statutory provider (operated by HSC Trusts) or by contracting an independent provider (may be voluntary or private sector) to do so.[3]

In Northern Ireland, with regard to policy, *People First* (1990) is the DHSSPS vision for community care with six core objectives, including the development of domiciliary care services. In 2008, the Public Accounts Committee expressed the view that there had been a failure to develop sufficient capacity in the domiciliary care sector. In response, the DHSSPS noted that "*the aspirations of the [People First] policy remained valid but accepted that some of its aims had not been achieved*"[4]. The DHSSPS also noted that, in developing domiciliary care, it was working against a background trend of rising need for long term care.[5]

Subsequently, in 2002, the DHSSPS published the *Review of Community Care – First Report*, including Project 1 – *Enabling people to live in their own homes* was to build upon the examples of good practice found and examine how people can be maintained in their own homes or other community setting.

With regard to spending, Age Concern Help the Aged NI recently noted that Personal Social Services (PSS), under the Elderly Programme of Care, experienced only a 4.7% increase in terms of planned expenditure and activity from 2007/08 to 2008/09. This compared to larger increases on PSS spending in other areas, for example, family and childcare (9.2%) and mental health (19.1%)[6]. It concluded that this

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[1] Domiciliary Care Services for Adults in Northern Ireland (2008), NISRA, 7th May 2008, page 2

[2] Building a Better Future, Northern Ireland Executive, Programme for Government 2008-2011, Annex One, PSA Framework

[3] Survey of Domiciliary Care Providers Northern Ireland 2008, DHSSPS, NISRA, (September 2009), page 3

[4] Report into Older People and Domiciliary Care, Public Accounts Committee, Northern Ireland Assembly, February 2008, paragraph 10

[5] Report into Older People and Domiciliary Care, Public Accounts Committee, Northern Ireland Assembly, February 2008, paragraph 12

[6] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Government Spending

spending is insufficient to meet the PSS needs of the ageing population of Northern Ireland.[7]

Section 3.2 of the main paper includes 4 tables of statistics on NI Statistics (2008 and 2009) on Residential, Nursing Home and Domiciliary Care Packages. The figures show that over 80% (17,252) of people in receipt of a home-help service in Northern Ireland are in the Elderly Care POC.[8] Between 2008 and 2009 the number of clients receiving domiciliary care services from the statutory sector decreased by 10% and the number receiving independent domiciliary care services increased by 8%.

Section 3.3 of the main paper deals with Trends in Care Provision in NI. An analysis of balance of care data since April 2002 to 2006 by the Northern Ireland Audit Office shows that the largest increase in care packages for those aged 65 and over (20%) has been in the nursing home sector, with residential care packages having only a marginal increase of two percent. Over the same timescale domiciliary care provision increased by 12%.

Figures from the NIAO show that the expenditure on domiciliary care services increased by 40% in the four years from 2002-03 (£108.4m) to 2005-06 (£147.3m), however over the same four years the number of domiciliary care packages had increased by only 12%. The NIAO concluded that this indicated that resources are increasingly being directed towards those with the most severe needs and levels of dependency.

With regard to the Regulation of Domiciliary Care Providers and Minimum Standards - all domiciliary care providers are required to register with the Regulation and Quality Improvement Authority (RQIA). There are currently 260 offices of homecare/domiciliary care organisations registered with the RQIA.[9] The DHSSPS has developed minimum standards for domiciliary care agencies. There are 15 main standards, the detail of which can be found in the 2008 DHSSPS publication *Domiciliary Care Agencies Minimum Standards.*[10]

Experiences of Domiciliary Care Providers and Service Users in Northern Ireland are highlighted in sections 3.4 and 3.5 of the main paper which refers to a 2008 survey of domiciliary care providers registered with the RQIA and conducted by the DHSSPS seeking to assess domiciliary care providers in the context of regulations and minimum standards that the DHSSPS introduced and with regard to service users, the NIAO commissioned Ipsos MORI to survey the experiences of 225 older people, selected from across the Trusts in Northern Ireland who are in receipt of a domiciliary care package, about the general quality of the care they received.

Section 3.6 of the paper covers a ranges of other related matters including; assessments and the Single Assessment Tool (on 11th February 2009, The Health Minister, Michael McGimpsey, launched a new tool for assessing the health and social care needs of older people in Northern Ireland); delayed discharges, rehabilitative and intermediate care; and information around paying for domiciliary care, including direct payments.

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[7] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[8] DHSSPS Adult Community Statistics 1st April 2008 – 31st March 2009, Community Information Branch, NISRA, Key Points, Elderly Care POC, page 31
[9] Personal Communication, RQIA, Communications Manager, 5th March 2010
[10] Domiciliary Care Agencies Minimum Standards, DHSSPS, July 2008

Section 4 of the paper describes the main 'home care' policy and practice from England, Scotland and the Republic of Ireland.

In England the majority of people in receipt of home care receive it through local social services, which assess need for help according to certain eligibility criteria. Most Councils with Adult Social Services Responsibilities (CASSR) contract out the supply of home care services to the independent sector, which now provides over three quarters of public funded home care. Providers in England are regulated against standards and from April 1st 2009 this regulation was taken over by the Care Quality Commission which replaced the Commission for Social Care Inspection.[11]

The Department of Health has made self-directed support a key focus for the development of health and social care services since the mid-1990s and in the social care context the personalisation agenda is outlined in the NHS, HM Government publication *Putting People First: A shared vision and commitment to the transformation of Adult Social Care (Dec 2007)*. Direct Payments were first introduced in England in 1996 and in 2007-08 Individual budgets were first trialled in 13 English local authorities and are a way of combining funds from different statutory sources. The latest direction is 'Personal Budgets', one of the ambitions of *Putting People First*, devised based on the experience of direct payments and individual budgets.

In July 2009, HM Government published the green paper *Shaping the Future of Care Together* with its proposals for reforming the care and support system for adults in England. It is beyond the scope of the paper to go into detail regarding the proposed reforms, however a short summary of the three proposed funding models that the Government believes could meet its criteria for a National Care Service are included.

With regard to Home Care Statistics for England the information is found in tables 9 and 10 of the paper.

In Scotland, the basis of recent community care stems from the policy document *'Modernising Community Care: An Action Plan'* (1998) which was published by The Scottish Office in 1998. Currently local authorities in Scotland have a duty for first undertaking community care assessment for those people presenting to them and asking for one, and is then responsible for developing packages of care, planning services and commissioning services. In doing so, the local authority will use their own services, those of the private sector and those of the voluntary sector.[12] Individuals have the right to request self-directed support (direct payments) to enable them to pay for their own care from an agency or to employ a home care worker.

In Scotland personal care provided by a local authority is free to those over 65 years of age since the Community Care and Health (Scotland) Act 2002. Personal Care is defined as anything done for an individual of a personal nature.

The Scottish Commissioner for the Regulation of Care is the national regulator of care services and inspects care at home and housing support providers according to certain standards. In its most recent report on the quality of care services, it found

[11] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 4
[12] Payne, J. (2007), Community Care in Scotland, SPICe briefing 07/29

that people who receive care at home often express a high level of satisfaction with the service.[13]

Statistics for 'Home Care' in Scotland are found in section 4.2.2 of the paper (tables 11 and 12).

In the Republic of Ireland the range of services provided to support those who could continue to live independently as an alternative to residential care is being expanded by the Health Service Executive. Part of this expansion is the Home Care Support Scheme (also known as the Home Care Support Package), which is an administrative scheme that evolved from a series of pilots over the past five years or so. The scheme appears to be at a relatively early stage as it is not yet a national scheme. The main priority is older people living in the community or those who are in-patients in acute hospitals at risk of admission to long term care but it is also available to younger chronically sick people and others who could continue to live at home provided they had adequate supports.[14]

Concluding comments include the concern expressed by 'Age Concern Help the Aged NI'[15] that it has still to witness a significant shift away from institutional care for older people and also commenting that policy directed towards providing care in the home will not lead to improved outcomes for older people if taken in isolation, therefore it must "*be viewed as sitting closely with policies relating to housing, community safety and transport, to name a few*".[16] The NIAO noted that the picture that emerged from its review of domiciliary care in NI 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*"[17].

[13] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 6
[14] Home Care Packages, Department of Health and Children, Republic of Ireland, www.dohc.ie/public/information/health_services_for_older_people/home_care_packages_for_carers.html, Who is the Home Care Support Scheme aimed at?
[15] These charities have now merged to become Age NI
[16] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[17] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, page 20

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1. Context

Individuals may need to avail of community care services during their lifetime for a variety of reasons including age, disability, physical or mental illness. As older people are the biggest single group of users of community health and social care services and research has identified that older people living alone are more likely to use social care services[18], this briefing will focus on care services for older people, with particular emphasis on domiciliary or home care. Older people may have a range of support needs "*ranging from assistance with basic tasks of daily living (such as shopping or housework) through to a need for intensive care and support on a routine basis in their own homes or in a care setting*"[19].

People First (1990) is the Department of Health, Social Services and Public Safety's (DHSSPS) vision for community care in Northern Ireland with six core objectives, including the development of domiciliary care services to enable more people to continue to live in their own homes. Some eighteen years later, the DHSSPS told the Public Accounts Committee (PAC) that "*the aspirations of the policy remained valid but accepted that some of its aims had not been achieved*"[20]. The PAC was of the view that there had been a failure to develop sufficient capacity in the domiciliary care sector to support the objectives of *People First* and that the challenge for the DHSSPS is to shift the balance of care towards the delivery of domiciliary care. The DHSSPS noted that it was working against a background trend of rising need for long term care and despite that was "*working against that trend and maintaining a good performance*" in relation to domiciliary care, pointing to a 32% increase in domiciliary care provision over ten years.[21]

The current DHSSPS targets regarding the delivery of community care needs are highlighted in *Priorities for Action 2009-2010* (March 2009) under 'Priority 4: ensuring fully integrated care and support in the community'. The related Northern Ireland Executive PSA targets for the DHSSPS are as follows under PSA 18 (Deliver High Quality Health and Social Services), Objective 1 (promote independent living and a reduction in avoidable admissions to hospital)[22]:

- Target: by March 2010, 45% of people with assessed community care needs supported at home;
- Target: from April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks;
- Target: from April 2008, 95% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will be discharged from hospital within six hours of being declared medically fit.

[18] Meeting Care Needs in the Community, Help the Aged Policy Statement 2007, page 2
[19] Meeting Care Needs in the Community, Help the Aged Policy Statement 2007, page 2
[20] Report into Older People and Domiciliary Care, Public Accounts Committee, Northern Ireland Assembly, February 2008, paragraph 10
[21] Report into Older People and Domiciliary Care, Public Accounts Committee, Northern Ireland Assembly, February 2008, paragraph 12
[22] Building a Better Future, Northern Ireland Executive, Programme for Government 2008-2011, Annex One, PSA Framework

2. Introduction

Community Care services in the UK are care services that are arranged or provided by a local authority or social services department, mainly to adults who have care needs. Such care services or packages of care can include a place in a care home or services provided to allow individuals to remain living independently in their own homes, such as home care services, home helps, adaptations to the home, meals, and recreational and occupational activities. Home care services generally mean "*help with personal tasks, for example, bathing and washing, getting up and going to bed, shopping and managing finances…someone coming to your home at agreed times…two or three times a day or even 24-hour care where necessary*".[23]

In Northern Ireland these home care services are referred to as domiciliary care, often referred to as the traditional home help services, which the DHSSPS defines as "*the range of services put in place to support an individual in their own home. Services may include routine household tasks within or outside the home, personal care of the client, and shopping. It excludes services such as day care, meals services, transport and equipment*".[24] It is also described as "*the personal care and the associated domestic services that are necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home*"[25]. A full list of the duties appropriate to the home help service can be found in the DHSSPS Circular HSS (SS) 1/80[26]

The NISRA statistical bulletin describes Domiciliary Care Services as including the three key elements of (i) provision must be in or centred on the client's own home, (ii) include some definite manual activity and/or social emotional support, and (iii) must be wholly or partly funded by the Social Services Department and includes[27]:

- Traditional Home help services, including home help services provided by the voluntary sector which were commissioned by HSC Trusts;
- Overnight, Live-in and 24-hour services;
- Services which assist the client to function as independently as possible, for example, routine household tasks within or outside the home, personal care of the client; and shopping;
- Home care provided in sheltered or supported housing; although this does not include care provided as part of the sheltered housing package, such as services provided by the warden or sheltered housing staff

Health and Social Care (HSC) Trusts in Northern Ireland carry out care management assessments to identify a person's needs and determine the best form of care to meet those needs. When domiciliary care is identified as the best form of care the HSC Trust organises the delivery of this care either by a statutory provider (operated by HSC Trusts) or by contracting an independent provider (may be voluntary or private sector) to do so.[28] During one survey week in September 2008 an estimated

[23] Citizens Advice Bureau, Advice Guide - Community Care, www.adviceguide.org.uk/nireland/your_family/family/community_care.htm

[24] Domiciliary Care Services for Adults in Northern Ireland (2008), NISRA, 7th May 2008, page 2

[25] Survey of Domiciliary Care Providers Northern Ireland 2008, DHSSPS, NISRA, (September 2009), page 3

[26] http://www.dhsspsni.gov.uk/home_help_circular_-_2009_-_pdf.pdf

[27] Survey of Domiciliary Care Providers Northern Ireland 2008, DHSSPS, NISRA, (September 2009), Technical Notes, page 10

[28] Survey of Domiciliary Care Providers Northern Ireland 2008, DHSSPS, NISRA, (September 2009), page 3

23,553 persons were in receipt of publicly funded domiciliary care services and around 78% of service users were aged 65 and over (see section 3.2 for further statistics).[29] The five HSC Trusts are the dominant purchasers of domiciliary care in Northern Ireland and providers rely heavily on these Trusts to purchase their services.[30] In February 2009 the Health Minister, Michael McGimpsey, launched the Northern Ireland Single Assessment Tool (NISAT) to underpin the assessment process for the health and social care needs of older people in Northern Ireland (see section 3.6.1).[31]

3. Care Packages in Northern Ireland – Policy and Practice

3.1 Community Care Policy in Northern Ireland

Current community care policy flows from the DHSSPS *People First* document published in 1990 which stressed the importance of maintaining people in their own homes for as long as possible. The aim of the policy was to move away from the arrangements for public funding, which up until that point had contained a built-in bias towards residential and nursing home care, rather than services for people at home.[32] The Department noted at that time "*people were still being inappropriately admitted to hospitals, residential care homes and nursing homes; people who have successfully completed rehabilitation and resettlement programmes are having to stay in hospital; domiciliary care services are uneven and sometimes poorly targeted; and packages of care are not being tailored appropriately to meet individuals' needs*".[33]

The policy paper *People First* identified ways of addressing these deficiencies and proposed changes in the way community care was delivered and funded in Northern Ireland, including[34]:

- Boards would be expected to assess individuals' needs more systematically, tailoring care packages more precisely to meet need within available resources;
- Boards would be expected to make full use of the independent sector;
- A new funding structure was proposed for those seeking public support for residential and nursing home care ("*ending unlimited central funding for elderly and disabled people who need placement in residential or nursing homes*"[35]); and
- Boards would be expected to establish registration and inspection units, at arm's length from the management of their own services, to monitor standards in statutory and independent sector care homes.

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[29] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 7
[30] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 7
[31] DHSSPS Press Release, 11 February 2009
[32] People First, Community Care in Northern Ireland for the 1990s, DHSS, 1990, paragraph 1.9
[33] People First, Community Care in Northern Ireland for the 1990s, DHSS, 1990, paragraph 2.39
[34] People First, Community Care in Northern Ireland for the 1990s, DHSS, 1990, paragraph 1.15
[35] Tonks, A. (1994), Community Care in Northern Ireland: a promising start, *British Medical Journal*, **308**, 839-842

In 2002, the DHSSPS published the *Review of Community Care – First Report*. In the report the Project Board set out a framework for the future work programme of the community care review incorporating projects relating to the objects of the *People First* policy paper. Of particular relevance here is *Project 1 – Enabling people to live in their own homes*. It was proposed that this project would build upon the examples of good practice found and examine how people can be maintained in their own homes or other community setting. The project was to comprise 3 elements[36]:

- An examination of a range of rehabilitation methods to determine whether it is an appropriate and cost effective approach to addressing need, focusing upon best practice schemes in Northern Ireland, Republic of Ireland, England, Scotland, Wales and further afield;
- A review to examining the range of preventative services and other innovative approaches to meeting the needs of the community before they become dependent on care management services; and
- A review to identify the scope for developing a range of services in the community/service user's home which would previously be provided in an acute hospital setting, including an examination of existing schemes and schemes from further afield.

Age Concern Help the Aged NI noted that Personal Social Services (PSS) under the Elderly Programme of Care experienced the lowest percentage increase in terms of planned expenditure and activity from 2007/08 to 2008/09 (4.7% increase) compared to increases on PSS spending in family and childcare (9.2%), physical and sensory disability (9.5%), learning disability (13.2%) and mental health (19.1%).[37] **They concluded that this spending is insufficient to meet the PSS needs of the ageing population of Northern Ireland and has resulted in "*qualifying criteria being tightened*" leading to "*the present scenario where services are being withdrawn from older people with low and moderate needs*".[38]**

3.2 NI STATISTICS (2008 AND 2009) ON RESIDENTIAL, NURSING HOME AND DOMICILIARY CARE PACKAGES

Within the Elderly Care POC, at 31st March 2009, there were 9,485 elderly people benefiting from residential care (31%) or nursing home care (69%) packages. This represents approximately 79% of the total nursing home care and residential care packages for all age groups in Northern Ireland. Over 80% (17,252) people in receipt of a home-help service were in the Elderly Care POC.[39] The statistics in Table 1 below are extracted from Tables 2.2, 2.3 and 2.4 of the DHSSPS Adult Community Statistics publication[40]:

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[36] Review of Community Care, First Report, DHSSPS, April 2002, pages 71 -72
[37] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Government Spending
[38] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[39] DHSSPS Adult Community Statistics 1st April 2008 – 31st March 2009, Community Information Branch, NISRA, Key Points, Elderly Care POC, page 31
[40] Tables 2.2, 2.3, 2.4 - DHSSPS Adult Community Statistics 1st April 2008 – 31st March 2009, Community Information Branch, NISRA, Key Points, Elderly Care POC, pages 33-35

Table 1 – Persons Aged 65 and over – Care Packages in Effect at 31st March 2009; No. of Clients Receiving Home-Help Service; and No. of Clients Receiving Meals Service

TRUST	Residential and Nursing Home Care Packages – Total All Sectors (Statutory, Voluntary and Private)			Home-Help Service – No. of Clients	Meals Service – No. of Clients
	Residential Care	Nursing Home Care	Total		
Belfast	790	1464	2254	5282	1231
Northern	710	1552	2262	3180	992
South Eastern	693	1368	2061	2382	635
Southern	312	1244	1556	3286	649
Western	401	951	1352	3122	1060
NI Total	2906	6579	9485	17252	4567

Table 2 below outlines the number of clients (all ages) receiving domiciliary care services from the statutory sector, the independent sector or from both sectors during the survey week 20th-26th September 2009 and the survey week 21st –27th September 2008. During the survey week in 2009 HSC Trusts provided domiciliary care for 23,377 clients in Northern Ireland, similar to the number in 2008. Of this total 15,882 received services from the statutory sector and 10,590 from the independent sector. Between 2008 and 2009 the number of clients receiving domiciliary care services from the statutory sector decreased by 10% and the number receiving independent domiciliary care services increased by 8%.

Table 2: Number of Clients Receiving Domiciliary Care Services, by Sector and HSC Trust (2008-2009)[41]

TRUST	Statutory		Independent		Clients Receiving Domiciliary Care from both Sectors		Clients Receiving Domiciliary Care (excludes double counting)	
	2008	***2009***	***2008***	***2009***	***2008***	***2009***	***2008***	***2009***
Belfast	5393	4883	2166	2579	1262	1248	6297	6214
Northern	3709	3453	927	1030	493(E)	431	4636	4052
South Eastern	2344	1728	2459	2696	525	516	4278	3908
Southern	3299	3183	1686	1545	300	266	4685	4462
Western	2861	2635	2565	2740	1769	634	3657	4741
NI Total	17606	15882	9803	10590	4349	3095	23553	23377

(E) = Estimated based on the proportionate split for 2009

Table 3 below shows the number of clients receiving intensive domiciliary care services during the survey weeks in 2008 and 2009. Intensive service is defined as

[41] Information extracted directly from Domiciliary Care Services for Adults in Northern Ireland (2009), DHSSPS, NISRA, 25th February 2010, Table 5 page 10

those receiving six or more visits and more than 10 hours during the survey week. During the survey week in 2009, 6630 clients received intensive domiciliary care services, accounting for 28% of all clients but 7% less than the number in 2008. The number of clients receiving intensive services from the statutory sector fell by 18% with the most significant decrease being in the Belfast HSC Trust which fell by 39% from the survey week in 2008.

Table 3: Number of Clients Receiving Intensive Domiciliary Care Services, by Sector and HSC Trust (2008-2009)[42]

TRUST	Statutory		Independent		Total No. of Clients Receiving Intensive Domiciliary Care	
	2008	***2009***	***2008***	***2009***	***2008***	***2009***
Belfast	820	498	1081	1289	1755	1787
Northern	986 (E)	913	231(E)	214	1217	1127
South Eastern	292	181	990	1081	1239	1207
Southern	766	755	842	718	1603	1453
Western	371	298	572	448	1310	1056
NI Total	3235	2645	3716	3750	7124	6630

(E) = Estimated based on the proportionate split for 2009

Table 4 below outlines the client groups receiving intensive domiciliary care and indicates that in 2009 85% of such clients were aged 65 and over, with 15% of clients aged 18-64. Across HSC Trusts the proportion of clients aged 65 and over receiving intensive domiciliary care services ranged from 80% in the South Eastern HSC Trust to 87% in the Belfast and Western HSC Trusts.

[42] Information extracted directly from Domiciliary Care Services for Adults in Northern Ireland (2009), DHSSPS, NISRA, 25th February 2010, Table 6 page 11

Table 4: Clients Receiving Intensive Domiciliary Care Services, by Client Group (2008-2009)[43]

Client Group	2008		2009	
	Number	% of Total Clients	Number	% of Total Clients
Aged 18-64	1120	16%	1011	15%
Clients with a Physical Disability	815	11%	660	10%
Clients with a Learning Disability	233	3%	217	3%
Clients with Mental Health Needs	49	1%	123	2%
Clients with No Material Handicap	23	0%	11	0%
Aged 65 and Over	6004	84%	5619	85%
Total Clients	7124	100%	6630	100%

NB: 0 values represent a percentage less than 0.5
Components may not add to totals due to rounding

Other information regarding service intensity[44]:

- During the survey week in 2009, 66% of all clients receiving domiciliary care received 6 or more visits, the same as the proportion in 2008;
- Between 2008 and 2009, the proportion of clients receiving less than 5 hours of domiciliary care increased from 43% in 2008 to 49% in 2009;
- During the survey week, almost 15% of all clients receiving domiciliary care in the Southern HSC Trust received more than 20 hours, compared with 5% in the Western HSC Trust;
- Over 50% of all clients in the Belfast and Western HSC Trusts received less than 5 hours domiciliary care during the survey week (56% and 55% respectively) compared with 42% and 41% in the Southern and South Eastern HSC Trusts respectively.

3.3 Trends in Care Provision in Northern Ireland

Table 5 below shows trends in the balance of care provision for those aged 65 and over. An analysis of this data since April 2002 by the Northern Ireland Audit Office (NIAO) shows that the largest increase in care packages for those aged 65 and over (20%) has been in the nursing home sector, with residential care packages having only a marginal increase of two percent. Over the same timescale domiciliary care provision increased by 12%.

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[43] Information extracted directly from Domiciliary Care Services for Adults in Northern Ireland (2009), DHSSPS, NISRA, 25th February 2010, Table 7 page 12
[44] Domiciliary Care Services for Adults in Northern Ireland (2009), DHSSPS, NISRA, 25th February 2010, page 13

Table 5: Trends in the Balance of Care Provision (Institutional versus Domiciliary Care Packages) for People Aged 65 and Over, at 31 March Each Year[45]

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Trend
Residential	3216	3133	3139	3158	3099	3296	2959	3124	3151	3076	3031	-6%
Nursing	5675	5773	5759	5476	5420	5709	5305	6138	6050	6287	6345	+12%
Total Institutional	8891	8906	8898	8634	8519	9005	8264	9262	9201	9363	9376	+5%
Total Domiciliary	4135	4501	3959	4173	4323	4637	4895	4895	5112	5555	5464	+32%
Total Packages	13026	13407	12857	12807	12842	13642	13159	14157	14313	14918	14840	+14%
Domiciliary as a % of Total	32	34	31	33	34	34	37	35	36	37	37	+5%

In addition to those older people who meet the criteria for access to a care managed package, other older people receive lower levels of intervention such as meals service and home-help (see Table 1 above). Table 6 below shows a breakdown of these services as compiled by the NIAO. The figures in this table cannot be totalled because older people receiving a domiciliary care package may also be receiving home-help, for example, as a component of that package.

Table 6: Trends in Overall Domiciliary Care Services at 31st March Each Year

	2000	2001	2002	2003	2004	2005	2006	Trend
Domiciliary Care Packages	4323	4637	4895	4895	5112	5555	5464	+26.4%
Home Help	23963	23324	22983	21802	21719	21242	20247	+15.5%
Meals Services	4318	3775	3850	4361	4228	5678	6035	+39.8%
Statutory Day Care	1713	1832	1933	1923	1954	1950	2027	+18.3%

Figures from the NIAO 2007 report show that the expenditure on domiciliary care services increased by 40% in the four years from £108.4m in 2002-03 to £147.3m in 2005-06. Using the NIAO data found in Table 5 above, over the same four years the number of domiciliary care packages (the most intensive community services), has increased by only 12%. The NIAO report concluded that this indicated that resources are increasingly being directed towards those with the most severe needs and levels of dependency, "*the high levels of spending on more complex services reflects one of the principles underpinning… People First that 'services should concentrate on those with the greatest needs*".[46]

Regarding this trend the NIAO concluded,

[45] Information extracted directly from Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, Figure 3, page 14
[46] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, pages 16 and 17

> "*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…a balance 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*".[47]

In support of this conclusion the Public Accounts Committee noted its concern that "*failure to address relatively lesser needs may result in a missed opportunity to prevent future crises or deterioration in independence. Minor interventions such as the provision of meals on wheels or day centre access can assist in preventing, or at least delaying, admission to hospital and/or residential nursing home*".[48]

3.4 Regulation of Domiciliary Care Providers and Minimum Standards

The Health and Personal Social Services (Quality, Improvement and Regulation) (2003 Order) (Commencement No.4 and Transitional Provisions) Order (Northern Ireland 2007 brought into effect the requirement for all domiciliary care providers to register with the Regulation and Quality Improvement Authority (RQIA). All such organisations (statutory, voluntary and private) were to have applied to be registered with the RQIA by 29th April 2008. Part III provides for the registration and inspection of establishments and agencies, including domiciliary care agencies, by the RQIA. It also provides powers to make regulations governing the conduct of establishments and agencies.

There are currently 260 offices of homecare/domiciliary care organisations registered with the RQIA.[49] Domiciliary Care Agencies are subject to one inspection per year as per The Domiciliary Care Agencies Regulations (Northern Ireland) 2007, which came into force on 30th April 2007. Some of the specifics of the Regulations are as follows:[50] Regulation 5, provides that each agency must prepare a statement of purpose in relation to the matters set out in Schedule 1 and a service user's guide to the agency (regulation 6); Regulations 8 to 12 make provision about the fitness of the persons carrying on and managing an agency; and Regulations 13 to 30 make provision in relation to the conduct of agencies, in particular about the quality of services to be provided by an agency.

Article 38 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 gave power to the DHSSPS to publish minimum standards that the RQIA must take into account in the regulation of establishments and agencies. The DHSSPS has developed minimum standards for domiciliary care agencies. There are 15 main standards, the detail of which can be

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[47] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, page 17
[48] Report into Older People and Domiciliary Care, Public Accounts Committee, Northern Ireland Assembly, February 2008, paragraph 18
[49] Personal Communication, RQIA, Communications Manager, 5th March 2010
[50] The Domiciliary Care Agencies Regulations (Northern Ireland) 2007, Explanatory Notes http://www.opsi.gov.uk/sr/sr2007/nisr_20070235_en_5#Legislation-ExNote

found in the 2008 DHSSPS publication *Domiciliary Care Agencies Minimum Standards.*[51]

3.5 Experiences of Domiciliary Care Providers and Service Users in Northern Ireland

3.5.1 Domiciliary Care Providers

In 2008 a postal survey of domiciliary care providers registered with the RQIA was conducted by the DHSSPS seeking to assess domiciliary care providers in the context of regulations and minimum standards that the DHSSPS introduced (see sections 3.4.1 and 3.4.2 above). Results of the survey are based on the response received from 154 providers (75% of the eligible sample) of domiciliary care. Of the 154, 45% came from the voluntary sector, 27% from the statutory sector and 28% from the private sector. The key results of the survey are as follows[52]:

- General Information about providers
  In total domiciliary care was provided to around 23,028 clients of which about 18,142 were aged 65 and over. 64% of service users were provided with domiciliary care on six or more occasions and 65% received more than 5 hours domiciliary care in the 7 days prior to the survey;

- Client groups provided with care
  Care was provided to people with mental health problems, with learning difficulties, with sensory disabilities and with other physical disabilities in the 12 months prior to the survey. Three of these four client groups were provided with domiciliary care by over three fifths of providers: people with mental health problems (66%), people with learning difficulties (65%) and people with other physical disabilities (62%). Nearly two fifths (38%) of providers said they provided domiciliary care for people with sensory disabilities. Almost all (99%) providers reported providing domiciliary care to at least one of these client groups;

- Prospective Service Users
  Nearly half (48%) of the providers said a member of staff had visited all new service users in their own homes in advance of service provision commencing in the 12 months prior to the survey. A further 31% said this had happened for some new service users. However, 21% said this had not happened. 70% of providers said they told service users the names of new domiciliary care workers before their first home visit in all cases. Less than one in ten (8%) said they did not do this.

- Written Care Plans
  Nearly four fifths (78%) of providers said all their service users had care plans, 18% said most of their service users had care plans, 4% said some of them had and 1% said none of them had. The majority (89%) of providers with care plans said they specified what services would be provided for the service user in all their care plans and 72% specified when the care plans would be reviewed;

[51] Domiciliary Care Agencies Minimum Standards, DHSSPS, July 2008
[52] Key points directly extracted from Survey of Domiciliary Care Providers in Northern Ireland 2008, DHSSPS, NISRA, 2nd Sept. 2009, pages 2-3

- SERVICE USERS' INVOLVEMENT
  Almost all (95%) providers said they had, in the 12 months prior to the survey, sought the views of their service users or their representatives about the domiciliary care services they receive, 72% of providers said they had made changes in response to these views and 28% said they had not;

- POLICIES AND PROCEDURES
  Approximately one in three providers (31%) with a formal complaints procedure said they included an outline of the role of the RQIA in the procedure and a similar number (33%) said their complaints procedure was available in an appropriate form for a person who is blind or whose vision is impaired;

- STAFF, TRAINING AND DEVELOPMENT
  Just over a third (37%) of providers said they had their own occupational health services. A similar number (33%) said they arranged for staff to access external occupational health services. The other 30% said they did not provide their domiciliary care workers with any access to occupational health services; and

- RECORDING AND REPORTING
  Nearly all providers (94%) said they had, in the 12 months prior to the survey, checked whether domiciliary care workers were providing the number of hours of domiciliary care they had been contracted to.

It appears that domiciliary care providers reported performing better in some areas than in others,

> "*almost all said they had formal procedures in place to be followed when service users' or their representatives made complaints about their care (99%), when abuse towards a service user was reported (100%), and, where applicable, when domiciliary care workers were handling money (98%) and medicines (99%) for service users. High proportions also said they sought feedback on their services from service users (95%), formally appraised their staff (94%) and provided all their staff with job descriptions (97%) and all their new staff with induction training (96%)*". However, "*only a small proportion of providers said they had informed service users about the RQIA (31%) or asked independent bodies to collect service users' views on their services (19%), informed prospective service users how to access inspection reports (24%) or made their complaints procedure available in a suitable format for service users who are blind or who have impaired vision (33%)*".[53]

Results indicate there may be areas in which there are differences in the quality of domiciliary care delivered by voluntary, statutory and private providers. These differences are listed in Appendix 1. **The majority of voluntary (84%) and statutory (59%) providers were small and the majority (62%) of private providers were large. It is, therefore, feasible that some of the differences between the sectors may be explained by the differences displayed between small and large providers** (see Appendix 2 for details).

[53] Survey of Domiciliary Care Providers in Northern Ireland 2008, DHSSPS, NISRA, 2nd Sept. 2009, Conclusions, page 30-31

3.5.2 Domiciliary Care Service Users

The NIAO commissioned Ipsos MORI to survey the experiences of 225 older people, selected from across the Trusts in Northern Ireland who are in receipt of a domiciliary care package, about the general quality of the care they received. The following issues from that survey are taken from the NIAO report, *Older People and Domiciliary Care*.[54]

With regard to general satisfaction, 22% of the 225 people had made a complaint about their domiciliary care services in the past; however occurrences of low satisfaction sat alongside high levels of overall satisfaction when individual service elements were examined. One of the key issues was flexibility of provision with 97% being content with the days on which services were received but 12% being dissatisfied with the times that home carers visited. 20% of respondents felt they did not receive enough visits in total and 16% reported that their care workers 'sometimes' or 'never' had time to carry out the tasks agreed in their care plan. However, in comparison, 21% indicated that their care workers stayed longer than allocated to complete tasks.

The following areas were highlighted by service users as needing special attention[55]:

- Improved communication to ensure users have sufficient opportunity for feedback and to be consulted on service development, and appropriate ways for users to register complaint and comment;
- Continuity and Timeliness of Care – Services that fail to deliver reliably or with continuity impact on the user's ability to continue to live independently;
- Monitoring and Review – The survey indicated that adjustment of care packages through case review was poor – this can lead to either under or over-provision of services, leaving users at risk or creating dependence; and
- Better Trained Staff – the survey emphasised the need for a high quality, user-centred care delivered by a well-trained workforce.

3.6 Other Related Matters

3.6.1 Assessments and the Single Assessment Tool

In 1991 a supplement to *People First*, the DHSSPS Community Care Policy (see section 3.1) entitled *Care Management: guidance on assessment and the provision of community care* was issued by the DHSSPS. This guidance pointed to the need for Trusts, as from April 1993, to assess the care needs of any person who appears 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. The guidance described care management and the assessment of individual need as being the cornerstone of the delivery of quality care and central to the implementation of *People First*.[56]

On 11th February 2009, The Health Minister, Michael McGimpsey, launched a new tool for assessing the health and social care needs of older people in Northern

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[54] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, paragraphs 4.6 – 4.18

[55] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, paragraph 4.25

[56] Citizens Advice Bureau, On-line Advice Finder, Community care: Assessments NI, 08.34.04.07

Ireland. The Northern Ireland Single Assessment Tool (NISAT) is the first of its kind in the UK as although other regions of the UK have developed such single assessment process, they have used 'off-the-shelf' tools, whereas NISAT is tailor-made for Northern Ireland to underpin the assessment process. NISAT is designed to capture the information required for holistic, person-centred assessment of the older person and "*will focus on a person's abilities and strengths rather than their disabilities. It will also reduce the stress by many older people who are frustrated when faced by a stream of well meaning professionals all wanting to ask them the same questions*".[57]

The NISAT has seven components as follows[58]:
1. Contact Screening – on first contact with Health and Social Care carried out by any Health and Social Care professional or support staff;
2. Core Assessment – performed when needs are not clear-cut; requests for further assessment is made and a more holistic picture covering all aspects is required. This Core Assessment can be carried out by any health and social care professional;
3. Complex Assessment – this is carried out by Care managers or those co-ordinating complex needs when intensive long or short-term support is needed, co-ordination is required and a change of domicile is recommended;
4. Carer's Assessment – A standardised Carer's Assessment has also been developed to use in conjunction with the NISAR or as a stand-alone document;
5. Specialist Referral – This can be done by any Health and Social Care Professional and is for use when need for specialist referral is triggered;
6. Specialist Summary – This is done by any specialist practitioner and is used when specialist recommendations are needed;
7. GP and Medical Practitioner Report – Done by any medical practitioner and is used for medical information and where referral to other specialists is required through a GP.

Further details on each of these components can be found on the DHSSPS website.[59] It is envisaged that NISAT will be introduced into practice by June 2010. To implement the project the DHSSPS gave funding for 5 Trust Implementation Officers and all are in post.[60] In 2011 the RQIA will be carrying out a review of the impact of the implementation of the NISAT.[61]

3.6.2 Delayed Discharges, Rehabilitative and Intermediate Care

For certain patients in hospital a domiciliary care package must be agreed and available before the person can return home. As HSC Trusts are under pressure to speed up hospital discharge, the absence of such a care package can mean admission to a nursing or residential home. As mentioned already in Section 1 of this paper the current DHSSPS targets are as follows:

- Target: from April 2008, 95% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will be discharged from hospital within six hours of being declared medically fit.

[57] Single Assessment Tool (NISAT) DHSSPS Press Release, 11th February 2009
[58] NISAT News, volume 1(1), September 2009, www.dhssps.gov.uk/nisat_news_-_oct.09.pdf
[59] www.dhssps.gov.uk/ec-northern-ireland-single-assessment-tool-and-guidance
[60] NISAT News, volume 1(1), September 2009, www.dhssps.gov.uk/nisat_news_-_oct.09.pdf
[61] Personal Communication with Communications Manager of the RQIA, 17th February 2010

Table 7 below shows the number of patients aged 65 and over experiencing a delayed discharge whilst waiting for a domiciliary care package in 2004, 2005 and 2006.

Table 7: Delayed Discharge from Hospital – patients aged 65 and over awaiting a care package as at 31 March each year[62]

	2004	2005	2006
Domiciliary Care	128	87	104
Institutional Care	246	185	149
Not Specified	34	37	27
TOTAL	*408*	*309*	*280*
% waiting more than 3 weeks	59%	64%	48%
% waiting more than 2 months	25%	30%	19%

The NIAO noted a general decrease in the number of delayed discharges but that the issue still remained a problem as at March 2006, particularly in the Northern Board Trusts where almost half the delays (44%) were for more than 7 weeks and of all the Trusts at that time Causeway had the highest number of delayed discharges with 54% delayed by more than 7 weeks. By contrast, Craigavon and Banbridge Trust at that time had no delayed discharges due to its policy of an enhanced intermediate care scheme. The DHSSPS advised the NIAO that, at that time, the Northern Board acknowledged that its balance of investment between hospital and community based services was wrong and that it was putting place a programme of reform to address these issues.[63]

Intermediate care schemes can assist timely discharge of older people from an acute setting and "*come into play at the interface between health and social care…the movement of an older person from an acute hospital setting for a specific period of time*". In addition to intermediate care facilities, rehabilitative support provided to older people can help to sustain independent living, 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; and Foyle HSS Trust's Supported Early Discharge scheme saved 1,131 bed days in an 18 month period.[64] The NIAO highlighted that "*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 varies across the Trusts…achieving a shift towards more preventative and rehabilitative provision presents a challenge which needs to be carefully planned and will take time*".[65]

A Review of UK literature of 21 studies on delayed hospital discharges and older people identified a combination of factors contributing to delayed discharges. These included delays in care assessments/funding or the availability of care home

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[62] Information extracted directly from Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, Figure 8, page 19
[63] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, paragraph 2.24, page 19
[64] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, paragraph 3.6, page 21
[65] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, paragraph 3.7-3.8

placements as well as internal hospital factors including timing of ward rounds by consultants, delays in obtaining take-home medication and delays in transport home. The main area reported in terms of service provision was the need for more rehabilitation services[66].

Table 8 below shows that the number of people in the community waiting for a community care package had fallen from 767 at end March 2004 to 190 at end of September 2006.

Table 8: Persons Living in the Community and Waiting for Care Packages[67]

	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 less than 12 weeks	33%	31%	40%	53%
% waiting more than 12 weeks	67%	69%	60%	47%

The NIAO highlighted that half of those waiting in the community had been waiting 12 or more weeks and that waiting lists at 30 September 2006 were highest in the Causeway Trust, with the majority of clients waiting over 12 weeks.

3.6.3 PAYING FOR DOMICILIARY CARE

The financial assessment of a person's ability to pay for home care services should be made after a needs assessment has been carried out and after the HSC Trust has decided whether or not to provide any services and ability to pay should not influence the decision on whether to provide services.[68] A client may also be receiving health services which are provided free and there should only be charges for the social services provided. The HSC Trust can charge for home care services although it is not obliged to do so and there is no national scale of charges, although any charges should follow any Departmental guidance.

The assessment of charges for the home-help service in Northern Ireland are found in the DHSSPS Circular HSS (SS) 1/80 (as revised in April 2007). In the assessment of the charge, account will be taken of the income of the person in need and his or her spouse or civil partner in accordance with a set of provisions, including the treatment of Capital Resources. The provisions also include income that it is to be wholly disregarded – attendance allowance, disability living allowance, independent living fund payments and any child element of child tax credits. The service is

[66] Glasby, J et. al. (2006), All dressed up but nowhere to go? Delayed hospital discharges and older people, *Journal of Health Services Research and Policy*, **11**(1), 52-58
[67] Information extracted directly from Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, Figure 9, page 20
[68] Community Care: Assessments NI, Citizens Advice Bureau, Advicefinder 08.34.04.07, paragraph 40

provided free of charge to persons assessed in need aged 75 or over and those in receipt of income support or Family Credit. Full details on the calculation of contributions from the client towards the home help service are found in DHSSPS Circular HSS (SS) 1/80[69].

In Northern Ireland a Trust has a duty to provide direct payments to allow people with an assessed need for community services to choose who provides these services. People with an assessed need will include a disabled person, an older person, a carer, or parent of a disabled child. A person using a direct payment has to arrange the services they require, however an individual can choose not to accept a direct payment and have the services arranged by the Trust. Local organisations, for example, The Centre for Independent Living offer support for people in receipt of direct payments. A person can employ anyone who is eligible to work in the UK, usually with the exception of close relatives living in the same household, however in exceptional circumstances where the Trust considers that it is in the best interests of the person being cared for, direct payments can be allowed for relatives living in the same house.[70]

4. Community Care/Domiciliary Care in Other Jurisdictions

4.1 ENGLAND

4.1.1 CURRENT POLICY AND PRACTICE

In 1999 the Royal Commission on Long Term Care recommended that the best method of pooling the financial risk of long-term care was that the costs of personal care services for older people should be met by the state from general taxation, but that board and lodging fees paid in care homes and the practical help people received in their own home should continue to be means-tested. The principle behind this was adopted in Scotland in 2002 but not in England.[71] The majority of people in England in receipt of home care receive it through local social services, which assess need for help according to certain eligibility criteria. Most Councils with Adult Social Services Responsibilities (CASSR) contract out the supply of home care services to the independent sector, which now provides over three quarters of public funded home care. Providers in England are regulated against standards and from April 1st 2009 this regulation was taken over by the Care Quality Commission which replaced the Commission for Social Care Inspection.[72]

The rules that determine the charges made for care provided in an individual's own home are set by local councils in England but must comply with the Fairer Charging guidelines published by the Department of Health in 2003. However, there is a big variation in funding systems as a small number of councils provide free services, most use a means-test to determine user charges and others charge a flat rate. A service user with assets above £22,250 (2008/09) is usually asked to pay the full cost of the care plan. NHS nursing care is provided free in one's own home and since 2001 the NHS has contributed to the cost of registered nursing care for care home

[69] http://www.dhsspsni.gov.uk/home_help_circular_-_2009_-_pdf.pdf
[70] Community Care: Assessments NI, Citizens Advice Bureau, Advicefinder 08.34.04.07, paragraph 40a-40g
[71] Poole, T. Funding Adult Social Care in England, The King's Fund, March 2009, The Path to Reform
[72] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 4

residents. Separately from social care, the UK disability-related benefits (Attendance Allowance and Disability Living Allowance) have national eligibility rules and are not means-tested.[73]

With regard to provision of services for certain groups leaving hospital the non means-tested services of *NHS Continuing Care* are used in England. To be eligible for *Continuing Care*, care needs must be complex, substantial and have arisen as the result of disability, accident or illness.[74] Following assessment there are a number of possible options included to meet continuing needs including support at home with a care package of health and social care, sheltered housing, a care home with or without nursing care, admission for NHS continuing (long term) care or care in a rehabilitation centre. *Continuing Care* can include both health and social care. If an individual meets their strategic health authority's criteria for NHS Continuing Care, the NHS will pay for all the care needs.[75]

The Department of Health has made self-directed support a key focus for the development of health and social care services since the mid-1990s. In the social care context the personalisation agenda of the Adult Social Care System is outlined in the NHS, HM Government publication *Putting People First: A shared vision and commitment to the transformation of Adult Social Care (Dec 2007)*, with the aim of "*ensuring older people, people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life and the equality of independent living*".[76] The key elements of this personalised Adult Social Care System are[77]:

- Local authority leadership with partnership working with local NHS, other statutory agencies, third and private sector providers, users and carers to create a new, high quality care system;
- Agreed and shared outcomes which should ensure people, irrespective of illness or disability are supported to among other things, live independently, exercise maximum control over their own life, participate as active and equal citizens, retain maximum dignity and respect;
- System-wide transformation including:
    - Commissioning which incentivises and stimulates quality provision;
    - A common assessment process of individual social care needs with greater emphasis on self-assessment;
    - Person-centred planning and self-directed support to become mainstream and define individually tailored support packages;
    - Personal budgets for everyone eligible for publicly funded adult social care (other than emergency provision); and
    - Increased utilisation of Direct Payments.

Direct Payments, mentioned in the list above, were first introduced in 1996 and are when individuals are given money in lieu of social care services which they are then

[73] Poole, T. Funding Adult Social Care in England, The King's Fund, March 2009, How is social care funded?

[74] NHS Choices, What is the National Framework for NHS Continuing Healthcare?, www.nhs.uk/chq/Pages/2392.aspx?CategoryID=68&SubCategoryID=155

[75] Directgov, Disabled People, Support after leaving hospital, http://www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/Hospitals/DG_4000456

[76] Putting People First: A shared vision and commitment to the transformation of Adult Social Care, Dec. 2007, HM Government, NHS, Section 2 Values

[77] Putting People First: A shared vision and commitment to the transformation of Adult Social Care, Dec. 2007, HM Government, NHS, Section 3 A Personalised Adult Social Care System

able to spend on the support they feel they most need. Individuals can arrange their own care through and agency or employ a personal assistant.[78]

In 2007-08 Individual budgets were first trialled in 13 English local authorities and are a way of combining funds from different statutory sources such as council social care funds, Supporting People funding, Independent Living Fund and Disabled Facilities Grant. The Budget collects together the various income streams into a budget to allow the individual to spend the total amount on the support they feel they most need. Direct Payments and Individual Budgets have not been popular with older people; however there are examples of good practice which have led to increasing the number of users. For example, Kent County Council provides the 'direct payment' pre-loaded onto a Visa card and the money can then be spent on services chosen by the client and paid for over the telephone, online or by withdrawing cash.[79]

Personal Budgets, one of the ambitions of *Putting People First*, have been devised based on the experience of direct payments and individual budgets and can be taken by service users in a variety of ways:

- As a notional allocation of funding – a transparent amount of money, where the individual can exercise control over how it is spent;
- As a Direct Payment (these are also used in Northern Ireland and Scotland); or
- As a mixture of the two.

Personal budgets can be deployed in a number of ways, by an individual, by a care manager, by a Trust, as an indirect payment to a third party or held by a service provider. People can use their budgets to access a wide range of services, including traditional social care, as long as the service meets agreed outcomes and is legal.[80]

The Social Care Institute for Excellence concludes[81],

> "*The value of personal budgets is widely recognised, alongside the need for the support, advocacy and brokerage service infrastructure, including user-led organisations…Emerging findings from the UK are reflecting what the international research suggests: that there is no single personal budget scheme blueprint suitable for all adults needing social care support. They are one approach to personalising adult social care and need to be responsive to individual requirements.*"

4.1.2 England – Home Care Statistics

With regard to Home Care Statistics for England the following information is extracted from *Community Care Statistics 2008 Home Care Services for Adults, England*, published in March 2009. During the survey week in September 2008:

- An estimated 4.1 million contact hours were provided to around 340,600 service users). This represents a 5 per cent increase in the number of contact hours since the 2007 figure of 3.9 million;

[78] Direct Payments and Individual Budgets , Help the Aged Policy Statement, 2008
[79] Direct Payments and Individual Budgets , Help the Aged Policy Statement, 2008
[80] Social Care Institute for Excellence progress report on personal budgets, July 9th 2009, http://www.communitycare.co.uk/Articles/2009/07/02/112000/progress-on-personal-budgets-july-2009-personalisation.htm
[81] Social Care Institute for Excellence progress report on personal budgets, July 9th 2009, http://www.communitycare.co.uk/Articles/2009/07/02/112000/progress-on-personal-budgets-july-2009-personalisation.htm

- 81 per cent of the total contact hours of home care were provided by the independent sector to 262,500 households. This compares with 78 per cent of contact hours of home care and 256,400 households in 2007;
- The average number of contact hours per household was 12.4, compared to 11.6 in 2007. This suggests that more intensive services are being provided for a smaller number of service users, continuing the trend seen over the last 10 years;
- The gross current annual expenditure on home care services was £2.7 billion in 2007-08, a decrease of 1 per cent in real terms from 2006-07;
- An estimated 105,000 households (32 per cent of all households receiving home care) received intensive home care in 2008 (defined as more than 10 contact hours and 6 or more visits during the week). This represents a 2 per cent increase from the 2007 figure of 103,100 households; and
- In 2008, 54 per cent of households who received home care received more than 5 hours of care and 6 or more visits compared to 52 per cent in 2007.

Tables 9 and 10 below are extracted from the publication[82]:

Table 9: Estimated number of service users and households receiving home help or home care by sector, from 1999-2008[83]

England, survey week during September — Rounded Numbers

	Service Users	Households			
		Total excluding double counting	Total including double counting	CASSR	Independent
1999	..	..	421,000	253,100	167,900
2000	414,700	398,100	415,800	225,800	190,000
2001	395,500	381,700	399,900	194,100	205,800
2002	382,000	366,500	383,100	167,600	215,600
2003	373,700	363,000	376,300	149,500	226,700
2004	368,600	355,800	370,900	134,100	236,800
2005	367,800	354,600	370,000	119,800	250,300
2006	359,000	345,500	358,100[3]	104,900	253,200
2007	346,800[R]	334,500[R]	345,300[R]	88,900	256,400[R]
2008	340,600	328,600	338,500[3]	76,000	262,500

R = Revised

Source: HH1 return, Tables 2A, 2B & 3A (2000 onwards)

1. Contains estimates for missing data. Components may not add to totals due to rounding.
2. Households receiving home care purchased with a direct payment are excluded.
3. Home care can be provided by more than one sector. Councils reported this overlap to be 13,000 in 2006 and 9,600 in 2008. This can not be calculated from the figures in the table for 2006 and 2008 due to erroneous figures provided by some councils and the need to estimate for missing data. One council did not complete a return, please see editorial notes for details.

[82] Community Care Statistics 2008 Home Care Services for Adults, England, NHS, The Information Centre for health and social care, March 2009, Tables 5 and 7

[83] Community Care Statistics 2008 Home Care Services for Adults, England, NHS, The Information Centre for health and social care, March 2009, Table 5

Table 10: Estimated number and percentage of households receiving intensive home care, 1999-2008[84]

England, survey week during September — Rounded numbers

	More than 5 contact hours and 6 or more visits[2]		More than 10 contact hours and 6 or more visits[3]	
	Number of households	*Percentage of households*	Number of households	*Percentage of households*
1999	143,500	*34*	68,700	*16*
2000	151,700	*36*	73,300	*18*
2001	156,800	*39*	77,400	*20*
2002	160,800	*42*	81,400	*22*
2003	165,200	*44*	87,100	*24*
2004	172,200	*46*	92,300	*26*
2005	178,900	*48*	98,200	*28*
2006	179,900	*50*	100,500 R	*29*
2007	180,400 R	*52*	103,100 [4]	*31*
2008	183,700	*54*	105,000	*32*

Source: HH1 return and KS1

R = revised
1. Households receiving home care purchased with a direct payment are excluded.
2. The figures include double counting of households receiving more than 5 contact hours and 6 or more visits from both the CASSR and the independent sector
3. Prior to 2000 the figures include double counting of households receiving more than 10 contact hours and 6 or more visits from both the CASSR and the independent sector.
4. Revised figure obtained from KS1. The figure in last years report used provisional data from HH1.

105,000 households received intensive home care in 2008, accounting for 32 per cent of all households. This represents a 2 per cent increase on the 2007 figure and a 14 per cent increase on the 2004 figure (intensive home care is defined as more than 10 contact hours and 6 or more visits during the week). Since 1999, there has been a 28 per cent increase in the number of households receiving more than 5 contact hours and 6 or more visits. In 2008, 54 per cent of households who received home care received more than 5 hours of care and 6 or more visits compared to 52 per cent in 2007.[85]

4.1.3 FUTURE OF COMMUNITY CARE IN ENGLAND

With regard to the future of community care in England, in July 2009, HM Government published the green paper *Shaping the Future of Care Together* with its proposals for reforming the care and support system for adults in England. Reform is deemed necessary due to the fact that the demand for health and care is set to increase significantly due to increased life expectancy generally and the fact that younger adults with physical and learning disabilities are surviving longer. In addition the social care system in also extremely complex with a large number of funding streams.[86] It is beyond the scope of this particular paper to go into detail regarding the proposed reforms, however a short summary of the three proposed funding models that the Government believes could meet its criteria for a National Care Service are outlined below[87]:

Partnership model – In this system, everyone who qualified for care and support from the state would be entitled to have a set proportion, for example, a quarter or a third

[84] Community Care Statistics 2008 Home Care Services for Adults, England, NHS, The Information Centre for health and social care, March 2009, Table 7
[85] Community Care Statistics 2008 Home Care Services for Adults, England, NHS, The Information Centre for health and social care, March 2009, page 12
[86] Poole, T. Funding Adult Social Care in England, The King's Fund, March 2009, The Challenges for Reform
[87] Shaping the Future of Care Together, HM Government, July 2009, Executive Summary

of their basic care and support costs paid for by the state. People who were less well-off would have more care and support paid for, for example, two-thirds, while the least well-off people would continue to get all their care and support for free.

Insurance model – In this system, everyone would be entitled to have a share of their care and support costs met, just as in the Partnership model. But this system would go further to help people cover the additional costs of their care and support through insurance, if they wanted to. The state could work more closely with the private insurance market; so that people could receive a certain level of income should they need care and support. Or the state could create its own insurance scheme. If people decided to pay into the scheme, they would get all their basic care and support free if they needed it. People could pay in several different ways, in installments or as a lump sum, before or after retirement, or after their death if they preferred.

Comprehensive model – In this system, everyone over retirement age who had the resources to do so would be required to pay into a state insurance scheme. Everyone who was able to pay would pay their contribution, and then everyone whose needs meant that they qualified for care and support from the state would get all of their basic care and support for free when they needed it. It would be possible to vary how much people had to pay according to what they could afford. Alternatively, if people wanted to be able to know exactly how much they would have to pay, most people other than those with lower levels of savings or assets could be required to pay a single, set figure, so that people knew how much they would have to save for. The insurance payment would help people to protect their wealth and the value of their homes.

As a first step towards establishing this new National Care Service the Government introduced the Personal Care at Home Bill on 25th November 2009. The aim of the Bill is to provide for those with the greatest care needs to be offered free personal care at home. Existing powers allow local authorities in England to provide certain community care services free of charge for up to six weeks. The Bill will remove this time limit in respect of personal care at home for those in the greatest need. The Government estimates that the Bill would help around 400,000 people with care needs and guarantee free personal care for the 280,000 people with the greatest need. The Bill is currently in Report Stage in the House of Lords and further line by line examination will continue on 17th March 2010.[88]

Although the Bill was generally welcomed by groups representing the elderly and disabled, there has been criticism over the lack of information on how the policy would be funded and who it would benefit, and also over the timing of the Bill given that it seems to cut across all of the options outlined in the green paper described above for the National Care Service.[89]

4.2 SCOTLAND

4.2.1 CURRENT POLICY AND PRACTICE

In Scotland, the basis of recent community care stems from the policy document *'Modernising Community Care: An Action Plan'* which was published by The Scottish Office in 1998 in response to concerns about the way services were being managed

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[88] Personal Care at Home Bill 2009-10, http://services.parliament.uk/bills/2009-10/personalcareathome.html

[89] Gheera, M. and Booth, L. (2009), Personal Care at Home Bill, House of Commons Library Research Paper 09/90, 9th December 2009

and delivered. It aimed to secure better and faster results for people by focusing on them and their needs and sought more effective joint working and partnerships between the statutory sector and the voluntary sector.[90] Chapter three of the policy covers *Caring for people at home* and notes that "*one of the central aims of our community care policy is to allow people to be cared for at home, or in homely surroundings. Home-based care, combined with suitable housing, is what most people and those who care for them prefer*".[91]

The action plan laid out that home care services in Scotland must provide[92]:

- A range of domestic, personal and nursing care;
- Flexible support, day or night, depending on needs;
- Intensive support at critical times, which may taper off as the user becomes more independent;
- A joint service without artificial boundaries between health and social care, and support co-ordinated with housing services;
- Support which is targeted at those most in need and those who will benefit from help;
- Support for carers; and
- Targeted results.

The Scottish Office expected to see five changes in support to people at home across the social work, health and housing sectors;

- A shift towards home care services;
- Better and more flexible home care services, supported by suitable housing;
- More flexible respite services and training to support carers;
- Community-based health services to support the shift to home or community-based care; and
- More cost-effective services.

Currently Local Authorities have a duty for first undertaking community care assessment for those people presenting to them and asking for one. The local authority is then responsible for developing packages of care, planning services and commissioning services. In doing so, the local authority will use their own services, those of the private sector and those of the voluntary sector.[93] The majority of service users receive home care provided by in-house teams but the use of the independent sector is growing. In 2009 38% of publicly funded home care was provided solely by the independent sector, with 11% a combination of local authority and independent sector and 51% provided solely by local authorities.[94]

Individuals have the right to request self-directed support (direct payments) to enable them to pay for their own care from an agency or to employ a home care worker. To receive direct payments, an individual must have been assessed by their local authority as needing community care services. The local authority then makes a payment to the individual who can create their own care package. Councils have a

[90] Payne, J. (2007), Community Care in Scotland, SPICe briefing 07/29
[91] Modernising community care: an action plan, The Scottish Office 1998, Chapter 3, paragraph 3.1
[92] Modernising community care: an action plan, The Scottish Office 1998, Chapter 3, paragraph 3.12
[93] Payne, J. (2007), Community Care in Scotland, SPICe briefing 07/29
[94] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 6

duty to offer direct payments if a person is eligible, but the person concerned does not have to take it.[95]

In Scotland personal care provided by a local authority is free to those over 65 years of age since the Community Care and Health (Scotland) Act 2002. Personal Care is defined as anything done for an individual of a personal nature such as personal hygiene; continence management, food and diet, problems of immobility, counselling and support, simple treatments, and personal assistance. If the care an individual is assessed as needing does not fall into personal care then there may be a charge for that care.[96] The Local Authority Social Work Department may charge for providing some services; however they must make information about the charges available in a Charging Policy. After a care needs assessment an individual must be given full information on charges for any chargeable services, however the exact amount to be paid by an individual will depend on the outcome of a financial assessment[97]. A Financial Assessment will look at an individual's own income and savings and the Local Authority will make a decision about how much they are able to contribute towards paying for the services.[98]

The Scottish Commissioner for the Regulation of Care is the national regulator of care services and inspects care at home and housing support providers according to certain standards. In its most recent report on the quality of care services, it found that people who receive care at home often express a high level of satisfaction with the service.[99]

4.2.2 Scotland – Home Care Statistics

In Scotland an estimated 68,334 people were receiving a homecare service provided or purchased by a local authority in the first week of April 2009, of those 44,660 older people were in receipt of free personal care. As with Northern Ireland and England the pattern is one of increasingly intensive packages of care for those most in need with on average, households receiving 9.5 hours of home care. In 1999 the average was 5.1 hours. Gross expenditure by local authorities on adult home care in 2005-06 was £498 million. Around £224 million was spent on free personal care for home care clients, which is about 73% of total net expenditure on publicly funded home care.[100]

Table 11 below shows the Age, Client Group and Gender of Clients Receiving Home Care Services. Approximately 77% of clients receiving home care services provided or purchased by local authorities were people with physical disabilities and 80% of all clients were 65 years or over

[95] Payne, J. (2007), Community Care in Scotland, SPICe briefing 07/29
[96] Care Information Scotland, website, www.careforscotland.co.uk Personal and Nursing Care
[97] Care Information Scotland, website, www.careforscotland.co.uk Charging Policies
[98] Care Information Scotland, website, www.careforscotland.co.uk Financial Assessment
[99] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 6
[100] An Overview of the UK Domiciliary Care Sector, UK Home Care Association Summary Paper, December 2009, Section 6

Table 11 Age, Client Group and Gender of Clients Receiving Home Care Services, 2009[101]

Client Group	Age Group				Total Clients
	0-64	65-74	75-84	85+	
People with Dementia	116	436	1,752	1,421	3,725
People with Mental Health Problems	1,835	593	529	273	3,230
People with Learning Disabilities	3,645	503	198	92	4,438
People with Physical Disabilities (includes frailty associated with ageing)	5,419	8,110	19,433	19,399	52,361
People with HIV or AIDS, alcohol or drug problems	354	232	94	29	709
Carers of dependent people in groups above	38	18	33	20	109
People in other vulnerable groups	2,212	414	629	507	3,762
Male	**6,626**	**4,184**	**6,842**	**4,948**	**22,600**
Female	**6,993**	**6,122**	**15,826**	**16,793**	**45,734**
Total Clients	**13,619**	**10,306**	**22,668**	**21,741**	**68,334**

Source: Home Care Statistical Return H1

With regard to the level of home care services provided, 30% of home care clients received at least 10 hours of service provided or purchased by a local authority in 2009. This percentage has gradually increased over the last 10 years from 11% in 1998 to 30% in 2008 and 2009. The number of clients receiving less than 4 hours has decreased over the same period from 60% to 39%. Table 12 below shows the number of home care clients by level of service received in 2009.

Table 12 Number of Home Care Clients by Level of Service Received, 2009[102]

	Aged Under 65		Aged 65+	
Level of Service	Number of Clients	%	Number of Clients	%
Less than 1 hour	733	5	2,367	4
1 hour to less than 2 hours	1,363	10	7,819	14
2 hours to less than 4 hours	2,617	19	11,814	22
4 hours to less than 6 hours	1,719	13	6,441	12
6 hours to less than 8 hours	1,316	10	6,515	12
8 hours to less than 10 hours	843	6	4,247	8
10 hours to less than 15 hours	1,475	11	8,649	16
15 hours to less than 20 hours	748	5	3,845	7
20 hours or more	2,805	21	3,018	6
TOTAL CLIENTS	13,619	100	54,715	100

Source: Home Care Statistical Return H1

4.3 Republic of Ireland

The Health Service Executive (HSE) in the Republic of Ireland has responsibility for the delivery of public health, community and home care supports. The range of services provided to support those who could continue to live independently as an alternative to residential care is being expanded by the HSE. Part of this expansion is the Home Care Support Scheme (also known as the Home Care Support

[101] Extracted from Table 2, Home Care Services, Scotland, 2009, November 2009, The Scottish Government

[102] Extracted from Table 4, Home Care Services, Scotland, 2009, November 2009, The Scottish Government

Package) which is an administrative scheme that evolved from a series of pilots over the past five years or so. The scheme appears to be at a relatively early stage as it is not yet a national scheme nor established in law, therefore no individual has an automatic right to the scheme. There are currently no national guidelines regarding the scheme and each HSE Administrative area has responsibility for its operation in that area, for example if services provided directly by the HSE or by voluntary groups or other organisations.[103] The main priority of the Home Care Support Scheme is older people living in the community or those who are in-patients in acute hospitals at risk of admission to long term care but it is also available to younger chronically sick people and others who could continue to live at home provided they had adequate supports.[104]

Unlike the developments in Northern Ireland with the single assessment tool, there is currently no standard assessment of the needs of people who apply for this Scheme. In the majority of cases a public health nurse will assess care needs and determine with the client and their family how these needs can best be met. Services may be provided by the HSE directly, by voluntary and community organisations on behalf of the HSE or in some instances a client may employ a private carer or home help service. In broad terms the services provided are those of nurses, home care attendants, home helps and the various therapies, including physiotherapy and occupational therapy. Support under the scheme may be worth €350-500 per week in respect of each client.[105]

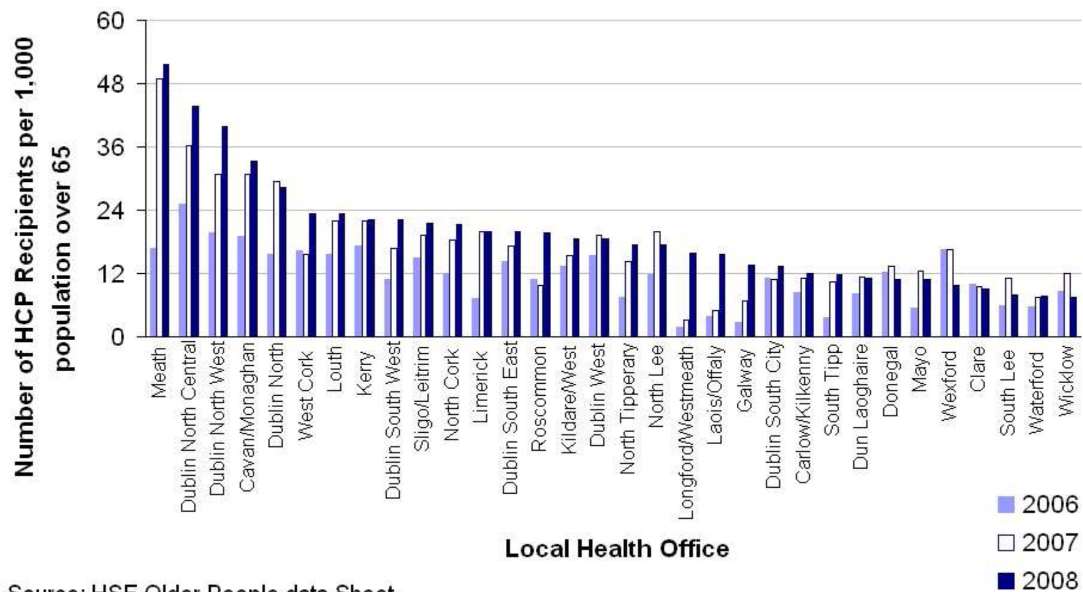
The PA Consulting Group was commissioned by the Department of Health and Children to carry out an evaluation of the delivery of Home Care Packages between 2006 and 2008. . The evaluation involved a review of nationally available data and an in-depth analysis of 999 Home Care Package recipients from eight Local Health Offices (LHO). Some of the main findings are now highlighted and are taken directly from the Executive Summary of the Report[106]. As with domiciliary care throughout the UK, the majority of clients are older people, with (77%) of the Home Care Packages (HCP) for those over 75 years of age and 38% were over 85 years of age. Assistance with washing and dressing was the most common dependency identified and the majority of HCP involved two or more service elements such as physiotherapy and home help. From the recipient files surveyed two clear categories of HCP emerged:

- Short-term package designed to achieve an outcome such as a return to independence; and
- Longer-term packages involving more services to maintain an individual at home.

Figure 1 below shows the variation in the number of Home Care Package recipients per 1,000 population over 65 by LHO 2006-2008

[103] Home Care Packages, Department of Health and Children, Republic of Ireland, www.dohc.ie/public/information/health_services_for_older_people/home_care_packages_for_carers.html, What is the Home Care Support Scheme?
[104] Home Care Packages, Department of Health and Children, Republic of Ireland, www.dohc.ie/public/information/health_services_for_older_people/home_care_packages_for_carers.html, Who is the Home Care Support Scheme aimed at?
[105] Home Care Packages, Department of Health and Children, Republic of Ireland, www.dohc.ie/public/information/health_services_for_older_people/home_care_packages_for_carers.html, How does a Home Care Support Package Work?
[106] Evaluation of Home Care Packages, PA Consulting Group, Department of Health and Children, November 2009, Executive Summary, 5-12

Figure 1[107]



Source: HSE Older People data Sheet

The evaluation points to a number of key strengths in the HCP delivery model:

- HCPs are proving critical to making the multi-disciplinary model a reality;
- HCPs are shifting the focus from acute hospitals to team-based working in the community, with emerging links to the Primary Care Teams; and
- The roll-out of HCPs through existing structures facilitated accelerated delivery of the service with good practice at LHO level;

There are several issues identified as constraining the delivery of HCPs:

- The absence of national guidelines has led to duplication of effort by LHOs and unnecessary variance in local practice;
- Linkages with the acute sector need to be strengthened;
- Inadequate management information is a constraint on effectiveness; and
- ICT systems must be improved to support staff in maintaining client information and knowledge sharing.

With regard to funding, at the time of publication of the evaluation, the ring-fenced funding totalled €120million per year. Based on the recipient file survey data, the average weekly value of a Home Care Package is €318.00 per recipient. However the average values range from €497.40 in Galway to €128.70 in Donegal. The higher cost in Galway is attributed to the fact that it includes costs of mainstream services also. The evaluation noted that the practice of attributing costs should be consistent across LHOs.

5. Concluding Comments

Although the social security system is uniform throughout the UK, the care system with which it closely interacts is subject to significant regional variation,

> "*consequently people with similar levels of need in neighbouring local authorities can be variously eligible or ineligible for social care and receive different levels of social care support. In contrast, because*

[107] Figure extracted from Evaluation of Home Care Packages, PA Consulting Group, Department of Health and Children, November 2009, Executive Summary, page 8

> *the social security system is uniform…these same people do not differ in their eligibility for social security benefits that support disability and care such as Attendance Allowance, Disability Living Allowance and Carers Allowance*".[108]

> "*England, Scotland, Wales and Northern Ireland can each determine their own policies, resourcing arrangements (including level of charges and co-payments) and eligibility criteria for social care*".[109]

'Age Concern Help the Aged NI'[110] reported in *One Voice – Shaping our Aging Society in Northern Ireland* that they have still to witness a significant shift away from institutional care for older people as in ratio terms the proportion of those receiving care in residential or nursing homes still exceeds those receiving a domiciliary care package, accounting for around 59% of those in the Elderly Programme of Care.[111] They have commented that policy directed towards providing care in the home will not lead to improved outcomes for older people if taken in isolation, therefore it must "*be viewed as sitting closely with policies relating to housing, community safety and transport, to name a few…quality of care provision and appropriate levels of care are also fundamental factors to consider when analysing outcomes for the older population*".[112]

The organisation notes that older people have a spectrum of care needs and these will only be met by a range of support including residential care as there are occasions when institutional care will continue to be the most appropriate form for an individual. There is also concern that in recent years there has been a shift away from low and moderate levels of care provision with qualifying criteria being tightened and domiciliary care resources focused on those with high levels of need to the exclusion of those with less intensive care needs.[113]

The NIAO noted that the picture that emerged from its review of domiciliary care in Northern Ireland 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*". The NIAO also stated that it believed there was "*still a pressing agenda of change required to further ensure that services are driven by what really matters most to older people*"[114].

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[108] Glendinning, C. and Bell, D (2008), Rethinking social care and support: What can England learn from other countries?, Joseph Rowntree Foundation, Viewpoint, November 2008
[109] Glendinning, C. and Bell, D (2008), Rethinking social care and support: What can England learn from other countries?, Joseph Rowntree Foundation, Viewpoint, November 2008
[110] These charities have now merged to become Age NI
[111] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[112] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[113] One Voice, Shaping our Ageing Society in Northern Ireland (2009), Section – Outcomes for Older People
[114] Older People and Domiciliary Care, Report by the Comptroller and Auditor General, NIAO, NIA 45/07-08, 31st October 2007, page 20

APPENDIX 1 - Survey of Domiciliary Care Providers in Northern Ireland 2008, DHSSPS, NISRA, 2nd Sept. 2009

Differences between statutory, voluntary & private providers
(Directly extracted from pages 27-29 of the publication)

New or prospective service users

The sectors did not differ significantly in how they said they treated new or prospective service users in all aspects other than whether a member of staff visited new service users in their own homes before they were provided with any domiciliary care services. Significantly more voluntary (32%) than private (10%) providers said they had not visited any new service users before commencing services in the 12 months before the survey.

Introducing new domiciliary care workers

When introducing service users to domiciliary care workers for the first time significantly more statutory than voluntary providers reported providing at least some service users with the names of the new domiciliary care workers and with the names of the staff members responsible for the new domiciliary care workers before the first home visit. All (100%) statutory providers said they gave their service users the names of new domiciliary care workers in at least some cases compared to less than nine in ten (88%) voluntary providers. All (100%) statutory providers indicated they had provided the names of staff members responsible for new domiciliary care workers in at least some cases. Whereas, nearly a tenth (9%) of voluntary providers said they had not provided these names in any instances.

Care plans

Significantly more voluntary (87%) than private providers (61%) said all their current service users had a written care plan. Furthermore, significantly more voluntary (82%) than private providers (55%) said they had specified in all their care plans when the care plans would be reviewed. Nearly all voluntary providers (93%) said they had prepared their care plans in consultation with all their current service users or their representatives. This was significantly more than for both statutory (68%) and private (71%) providers. On the other hand, significantly more private (95%) than voluntary (63%) providers said they had provided at least some of their service users with their care plans before they provided them with services. In addition, significantly more private (94%) than voluntary providers (72%) stated they had specified telephone numbers that could be used to contact them outside of normal working hours in at least some of the care plans. Furthermore, significantly more private (100%) than voluntary (71%) or statutory (63%) providers said they specified in at least some of their care plans when care workers would arrive and leave service users' homes.

Service users' views

The sectors did not significantly differ in the proportion of providers who said they had sought the views of service users or their representatives about the domiciliary care services they received. However, they did differ in how they described attempting to obtain these views. Voluntary providers (71%) were significantly more likely than statutory providers (31%) to say they had asked for service users' views through the use of paper questionnaires in the 12 months prior to the survey. Private

providers (78%) were significantly more likely than both voluntary (35%) and statutory (33%) providers to say they had tried to ascertain service users' views by interviewing them or their representatives for their views.
Significantly more voluntary (30%) than private providers (7%) said they had asked an independent provider or person to seek service users' views for them. Significantly more private than statutory providers said they had allowed their service users input whilst planning their services. Just over seven in ten (71%) private providers reported having asked all service users when would be the most convenient time for domiciliary care workers to visit their homes, whereas, less than two in five (38%) statutory providers said they did this.

Complaints procedures

Significantly more voluntary (88%) than statutory providers (64%) said they had supplied their formal complaints procedure in written form to every service user or their representative. However, private providers (51%) were significantly more likely than voluntary providers (23%) to say they had included an outline of the role of the RQIA in their complaints procedure. Additionally, significantly more private (66%) than voluntary (31%) or statutory (24%) providers said they included contact details for the RQIA. Statutory providers (54%) were significantly more likely than private providers (17%) to say their complaints procedure was available in an appropriate form for people who were blind or had impaired vision.

Occupational Health

Statutory, voluntary and private providers differed in whether they provided their domiciliary care workers with access to occupational health services. Almost all (95%) statutory providers reported providing domiciliary care workers with access to occupational health services. This was significantly more than the 77% of voluntary providers who did the same. Furthermore, both statutory and voluntary providers were significantly more likely than private providers (30%) to report providing any type of access. The sectors also differed in how they catered for their domiciliary care workers to access occupational health services. The vast majority (90%) of statutory providers said they had their own occupational health services. This is significantly more than the one in five (22%) voluntary providers and the one in twenty (5%) private providers who said they had their own occupational health services. Significantly less private than voluntary providers reported having in house occupational health services. Significantly more voluntary (55%) than statutory (5%) or private (25%) providers said they arranged for their domiciliary care workers to access external occupational health services.

Training

A fifth (20%) of private providers who had domiciliary care workers working towards relevant qualifications said they had given any of them paid time off to study during the 12 months prior to the survey. This was significantly less providers than in the voluntary (54%) and statutory (69%) sector. Whilst private providers were the least likely to say they had given staff study leave, they were significantly more likely than voluntary providers to report having provided their employees with training. Almost all (90%) private providers and two thirds (67%) of voluntary providers said they had provided all their domiciliary care workers with training in lifting and moving service users safely. More than four fifths (81%) of private providers and one in two (50%) voluntary providers said they had provided all their employees with training in operating special equipment safely.

Written Records

Almost all (98%) private providers said they had kept written records of care provided in at least some of their service users' homes. Significantly less voluntary providers (82%) said they did this.

APPENDIX 2 - Survey of Domiciliary Care Providers in Northern Ireland 2008, DHSSPS, NISRA, 2nd Sept. 2009

Differences between small and large providers
(directly extracted from pages 29-30 of the publication)

This section details differences in the responses given by providers with up to 50 service users (small providers) and those with 51 or more (large providers).

Care Plans

Significantly more small (92%) than large providers (52%) said all their service users had care plans. Small providers were also significantly more likely to say they prepared their care plans in consultation with the service users or their representatives. More than nine tenths (91%) of small providers reported having consulted service users in all cases compared to just over three fifths (62%) of large providers. However, large providers were significantly more likely to provide their service users with their care plans before they commenced delivery of services. Nine in ten (90%) large providers said they had provided care plans to service users or their representatives before providing them with any services in at least some cases compared to two in three (67%) small providers. The information included in all care plans varied with the size of the provider. Small providers were more likely than their larger counterparts to say they had specified in the care plans when the care plans would be reviewed. The vast majority (86%) of them said they included a review date in all care plans compared to less than half (46%) of the large providers. On the other hand, large providers were more likely than smaller ones to say they had specified when domiciliary care workers would arrive and leave the service user's home. Nearly all (92%) large providers indicated they had included these times in at least some of their care plans compared to just over two thirds (68%) of small providers. Larger providers were also more likely to say they had specified the telephone numbers that could be used to contact them outside of normal working hours. Almost all (96%) large providers stated they had included these telephone numbers in at least some of their care plans compared to just over three quarters (77%) of small providers.

Introducing new domiciliary care workers

Small and large providers differed in how they said they introduced domiciliary care workers to service users for the first time. Small providers were significantly more likely to say they had provided the name of the domiciliary care worker and information on how service users could contact the domiciliary care worker before the first home visit. More than four fifths of small providers said they gave service users the names of new domiciliary care workers (88%) and information on how they could contact new domiciliary care workers (81%) in all cases. In contrast, approximately two fifths of large providers reported having provided relevant names (43%) and contact information (44%) to all their service users.

Occupational Health

Small providers were significantly more likely to say they provided the domiciliary care workers they employed with access to occupational health services. Four fifths (80%) of small providers reported either having their own occupational health services or arranging for staff to access external occupational health services compared to just over half (52%) of large providers.

Training

Whether providers provided their domiciliary care workers with training varied with size. The vast majority (91%) of large providers said they had provided all their domiciliary care workers with training in lifting and moving service users safely compared to less than two thirds (64%) of small providers. Additionally, more than four in five (83%) large providers compared to one in two (51%) small providers said they had provided training in operating special equipment safely to all of their domiciliary care workers.

Written records of care

Small and large providers did not differ significantly on whether they kept a written record in service users' homes of the care that had been provided. Nevertheless, small providers were significantly more likely than large providers to record any contact with the service user's representative or carer about matters regarding the health or well-being of the service user in these written records. Almost all (96%) small providers said they did this as standard practice compared to nearly four fifths (79%) of large providers. Conversely, large providers were more likely to say they recorded the arrival and departure times of every visit by domiciliary care workers. Most (86%) of them said they recorded these comings and goings as standard practice whilst just over three fifths (63%) of small providers said they did this.