

A Managed Change:

**An Agenda for Creating a Sustainable Basis
for Domiciliary Care in Northern Ireland.**

November 2015



**Health and Social
Care Board**

Contact

You can contact us in the following ways:

Telephone:	0300 555 0115
Email:	TYC@hscni.net



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Contents

Foreword	1
Executive Summary	2
SECTION 1 - Introduction	6
SECTION 2 - Information	9
SECTION 3 - The Market.....	17
SECTION 4 - Stakeholder Engagement.....	22
SECTION 5 - Service Interfaces	29
SECTION 6 - Shaping a Future Model.....	35
SECTION 7 - Developing a Service for the Future	46

Foreword

Domiciliary care plays a major role in achieving the Health and Social Care Board's aim of promoting effective delivery of care in the community. Each week in Northern Ireland over 250,000 hours of support is provided to more than 25,000 clients in their own homes. The service operates across the region, in town and country, around the clock, in all weathers by staff working individually or in teams who are among the lowest paid in health and social care. It is a complex, effective and highly regarded service but it is experiencing increasing pressures as additional demands and expectations are placed upon it.

It is the recognition of these difficulties, in a very challenging financial context, which has prompted the Board to undertake this Review. It is clear that if we are to sustain and develop a service which will function effectively in support of our strategic aims, it needs to be based on improved information, maintaining dialogue with providers and service users, encouraging innovation and learning from best practice.

Domiciliary care also faces more immediate challenges arising from workforce regulation, new approaches to procuring the service and changes to remuneration announced in the recent Budget. All of these expectations and changes will radically transform the current service at the risk of creating some instability in the system. We need to ensure that this is managed in order to retain all that is good in domiciliary care and to enhance the effectiveness and quality of delivery. This report aims to inform and shape this important phase of the change process.

Fionnuala McAndrew

*Director of Social Care & Children
Health and Social Care Board*

Executive Summary

Background

In late 2014 the HSCB established a Regional Review Group to lead a review of domiciliary care services. The Regional Group is led by HSCB with membership from HSC Trusts, Local Commissioning Groups (LCGs), Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland Social Care Council (NISCC). The Group also has established links with the voluntary sector, the Commissioner for Older People for NI (COPNI), the Patient and Client Council (PCC) and Trade Unions.

This Executive Summary sets out the terms of reference for the review and the main findings and recommendations of the report. The terms of reference are outlined in **Section 1**. The review aimed to:

- Improve information relating to domiciliary care services;
- Undertake an analysis of the domiciliary care market;
- Consult with stakeholders about their experience of domiciliary care
- Examine interfaces between domiciliary care and other services;
- Analyse and compare existing Trust arrangements for delivering domiciliary care services and identify best practice; and
- Identify a more coordinated regional model for the development and procurement of domiciliary care.

Section 2 of the report sets out the main messages which have emerged from analysis of available information about domiciliary care, and the challenges with it. The review strongly supports the need to improve service information and endorses the continuation of current regional work to achieve this objective.

Section 3 of the report presents an analysis of the domiciliary care market, market shares and volumes, acknowledging the variability in rates across the region and the challenge likely to be presented by the introduction of the living wage in April 2016.

Section 4 is a summary of the output of engagement with service users and carers, service providers and Trade Union representatives. These views are also set within the context of wider environmental factors which impact the service. Stakeholder views demonstrate a high value for the service and the vital role it performs, but also acknowledge the challenges associated with service sustainability and stability.

The service interfaces with domiciliary care are explored in **Section 5**; including; direct payments, self directed support, supported living, telecare, telehealth and community meals. The analysis concludes that the most important interfaces with domiciliary care in terms of future strategic developments are reablement and self directed support.

Section 6 acknowledges that there is no clear consensus on a 'preferred' model for domiciliary care – locally, elsewhere in the UK or further afield, but draws out the features generally associated with successful models. This section also summarises the current service models in each of the HSC Trusts, recognising similarities and variability in approach, with a focus on the increasing challenges of delivering domiciliary care.

Section 7 seeks to revisit the objectives of the review, identifying the actions arising from the analysis, and factoring in a number of relevant recent developments which shape the recommendations of the review. One of the original objectives of the review was to identify 'best practice' as a possible basis for a preferred model for the delivery of domiciliary care. It was not possible to identify any particular Trust because of significant anomalies regarding different tariffs, statutory/independent market shares and brokerage and the implications of pending

procurement exercises. The differences prompt suggestions that more prescriptive commissioning statements could be developed in order to promote greater consistency. The analysis does however reinforce the principles and features of best practice outlined in Section 6 of the report, i.e. advocating the need for:

- An optimum number of providers with longer-term contracts to stabilise the market;
- A move away from ‘time and task’ contractual arrangements and the promotion and development of more outcomes based approaches which are more responsive to client needs
- Promoting more flexible funding arrangements to enable individuals to secure more flexible care options; and
- A greater focus on workforce development terms and conditions.

The review recommendations intend to provide a strategic framework to manage the challenges and realities of the domiciliary care service into the future, focussing on:

- Oversight arrangements and linkages across the region with related initiatives.
- The HSCB should introduce a more managed approach to funding domiciliary support services to address demographic and cost pressures and promote strategic change. This will require greater regional coordination of proposed domiciliary care investments with Local Commissioning Groups as a basis for local decision making.
- Assessing the impact of the living wage in 2016 and beyond, and more precise comparative analysis of the hourly cost of care provided by the statutory and independent sectors.
- The HSCB will continue to work with the DHSSPS who are leading a workforce planning review associated with domiciliary care. The workforce planning review and its action plan will be aligned with the workforce challenges presented in this report. Workforce planning will be taken forward in parallel with the other actions set out in this report.

- Management of tendering processes to coordinate learning and best practice across the region.
- Further research and review of progress in Great Britain of the implementation of outcomes models of domiciliary care to inform local service developments.
- Clarification of Departmental policy regarding charging for services arising from the on-going Departmental review of adult social care, and review of the annual domiciliary care Circular to more accurately reflect current operational practices.
- Continuation of the regional project to take forward a business care in respect of an agreed Electronic Service Monitoring System.
- Trusts should review contingency planning arrangements to deal with any significant domiciliary care market instability.

SECTION 1 - Introduction

Domiciliary Care – Responding to Expectations

1.1 In December 2011 the publication of ‘Transforming Your Care’ (TYC) outlined a commitment to a managed programme of transformation. It acknowledged that much of the content was a consolidation and reinforcement of existing strategic or policy initiatives but a number of issues were given a renewed emphasis.

1.2 There was a particular focus on the impact of demographic change with the requirement to respond to the needs of our ageing population expressed informally as ‘home being the hub of care’ and the need to ‘shift left’. These two terms, taken together, summarise the overall direction of travel which is a process of ‘displacement’ down through the health and social care system, away from high cost, buildings based services and becoming more focussed on community provision and support for carers. This approach will place huge expectations on the capacity of domiciliary care services to respond to the resulting challenges. In view of the pivotal importance of these services in achieving strategic objectives it is timely to assess both their potential and readiness to respond effectively.

The Need for Review

1.3 At the outset however it is important to be clear about what is being examined within this review. The most widely used local definition of domiciliary care from DHSSPS describes it as:

‘The range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home, personal care of the client and other domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home’.

1.4 The focus of this report does not include domiciliary care procured directly by members of the public from their own resources or Trust domiciliary meals services. Reference will be made to supported living which falls within the Regulation and Quality Improvement Authority's (RQIA) definition of domiciliary care. Initiatives such as reablement, direct payments and self-directed support display features of the service DHSSPS definition but are not a primary focus of the review.

1.5 Whilst the need to review domiciliary care was broadly outlined above there are a number of factors which point to the need for a more focussed approach. These are categorised below.

Strategic - The role of domiciliary care in meeting strategic objectives requires a regional analysis of the service.

Risk Management - Learning from local management of recent instability in the nursing home sector strongly indicates the need for a better understanding of market composition and functioning.

Operational Challenges - Feedback from domiciliary care providers, staff representatives and Trusts highlights significant operational and financial difficulties in maintaining levels of service.

Contractual - Future tendering exercises point to the need for a good understanding of the domiciliary care market in order to address any implications of these processes.

Profile- There is increased interest and focus on domiciliary care from the media, policy makers and political parties across the UK.

The Project

1.6 As a result of the issues highlighted above a Regional Project Team involving the HSCB, Health and Social Care Trusts (HSCTs), Local Commissioning Group (LCG) representation, the Department of Health and Social Services and Public Safety (DHSSPS) and the Northern Ireland Social Care Council (NISCC) was established with links to the voluntary sector, the Commissioner for Older People for Northern Ireland (COPNI), Patient Client Council (PCC) and existing trade union liaison arrangements. Membership is detailed in **Appendix 1**.

1.7 The Project Terms of Reference included a requirement to:

- Develop improved regional **information** about current services e.g. service volumes, capacity, expenditure, pricing.
- Produce an analysis of the domiciliary care **market** e.g. market share, provider volumes/coverage/income, market trends.
- Consult with service **providers and users** to identify concerns, challenges, risks and benefits related to service delivery.
- Examine **interfaces** with, and potential development of, greater personalisation through reablement, direct payments, self directed support and telecare.
- Analyse and compare existing **Trust arrangements** for delivering the service and identify innovative/'best' practice.
- Identify a more coordinated regional **model** for the development and procurement of domiciliary care.

1.8 The final objective is the core issue which the other strands of analysis and consultation are designed to examine and test. Ultimately this will require a clear statement about how the development of domiciliary care services in Northern Ireland should be taken forward in the face of a number of major challenges currently facing the service.

SECTION 2 - Information

Improving the Information Base

2.1 Domiciliary care has often fluctuated between being a candidate for increased investment based on changing patterns of need and, conversely, being a potential source of savings in response to funding pressures. This has made it difficult to monitor trends in activity and investment but future financial prospects point to a need to improve systems, processes and definitions to assess, in a more accurate and timely way, the impact on service delivery and the users of the service.

2.2 By comparison with other regions of the UK our information base is relatively weak as we lack the number of internal and external (academic, economic and commercial) analyses which help inform decision making elsewhere. Some of this data will be used for reference purposes throughout this report to illustrate what might be possible but local sources are restricted and need to be developed.

Service Activity

2.3 The primary reference source for domiciliary care activity/volume information is the annual report produced by DHSSPS. It is based on a single week's activity each September which may not reflect average weekly rates throughout the rest of the year. While some aspects of the reporting and annual trends have been both consistent and persuasive there have been challenges in ensuring that -

- standardised definitions and interpretations of what constitutes domiciliary care are used and;
- periodic changes in Trust data are accounted for.

Some recent fluctuations in Trust returns have made trends and regional figures more difficult to analyse. Further work is needed to produce the degree of common 'ownership' that the report requires. Before outlining efforts being made to complement the Departmental report, it may be helpful to comment on the data and key findings from February 2015.

Contact Hours - An estimated 250,798 hours of direct contact with clients, excluding travel time, were provided by Trusts during the survey week. An increase of 1400 hours from the previous year.

Comment - These figures show volume of activity and interactions delivered via domiciliary care, across the region, 24/7 with the added logistical challenges of delivering this complex service. If applicable to the whole year they would indicate a marginal increase in overall investment.

Sector Split - Statutory sector delivered 32% of contact hours:
Independent sector - 68%.

Comment - Individual Trust figures vary and will be examined later. The Care Quality Commission/Institute of Public Care Report (The Stability of the Care Market and Market Oversight in England, Feb 2014) shows a comparative 11%/ 89% split for hours provided by sector.

Average Hours/Intensive Visits/Frequency - The average input is 10.4 hours per client, an increase from 9.8 in 2013. 8,177 clients receive intensive visits, a small increase from 2013. 80% of all clients got 6 or more visits during the week.

Comment - This seems to confirm the reported focus on clients with increased dependency and this is reinforced in the following statistic.

Recipients - A reduced number of clients from 25,330 in 2013 to 24,189.

Comment - This needs further examination to assess if this is due to tighter eligibility, the impact of reablement, a sign of less emphasis on preventative work and possibly hindering service changes elsewhere in the system e.g. reducing reliance on residential care.

Summary - Apart from some outlier statistics the figures are broadly in line with reported trends of how services may be changing and needs are being met. More work is needed on the method and systems used to collect data and what is included in service definitions.

Improving Domiciliary Care Information

2.4 The provision of more timely, consistent and accurate information on Community Information Services generally is a key HSC priority. During 2014/15 the HSCB led on a process to improve the quality of community information including domiciliary care. A key principle of this work has been to ensure that available data is standardised, accurate and supports the development and performance monitoring of services. A key objective of the Domiciliary Care workstream arising from this work has been the development of an agreed Minimum Dataset, including a regionally agreed Definitions and Guidance document to support the information collection and monitoring process.

2.5 HSCB and Trust staff have reviewed current IT systems in 2015 to assess their capacity to collect the key data needed and to highlight gaps in current information collection. It is expected that there will be tangible improvement by late 2015/16, giving performance information such as demand, capacity, workforce, and quality of life outcome measures. Other well publicised issues such as the duration of calls need to be part of this exercise eventually. The Department is exploring the potential of including this key issue in the annual domiciliary care survey. Until all IT developments have been implemented the workstream group has agreed to report on a monthly basis:

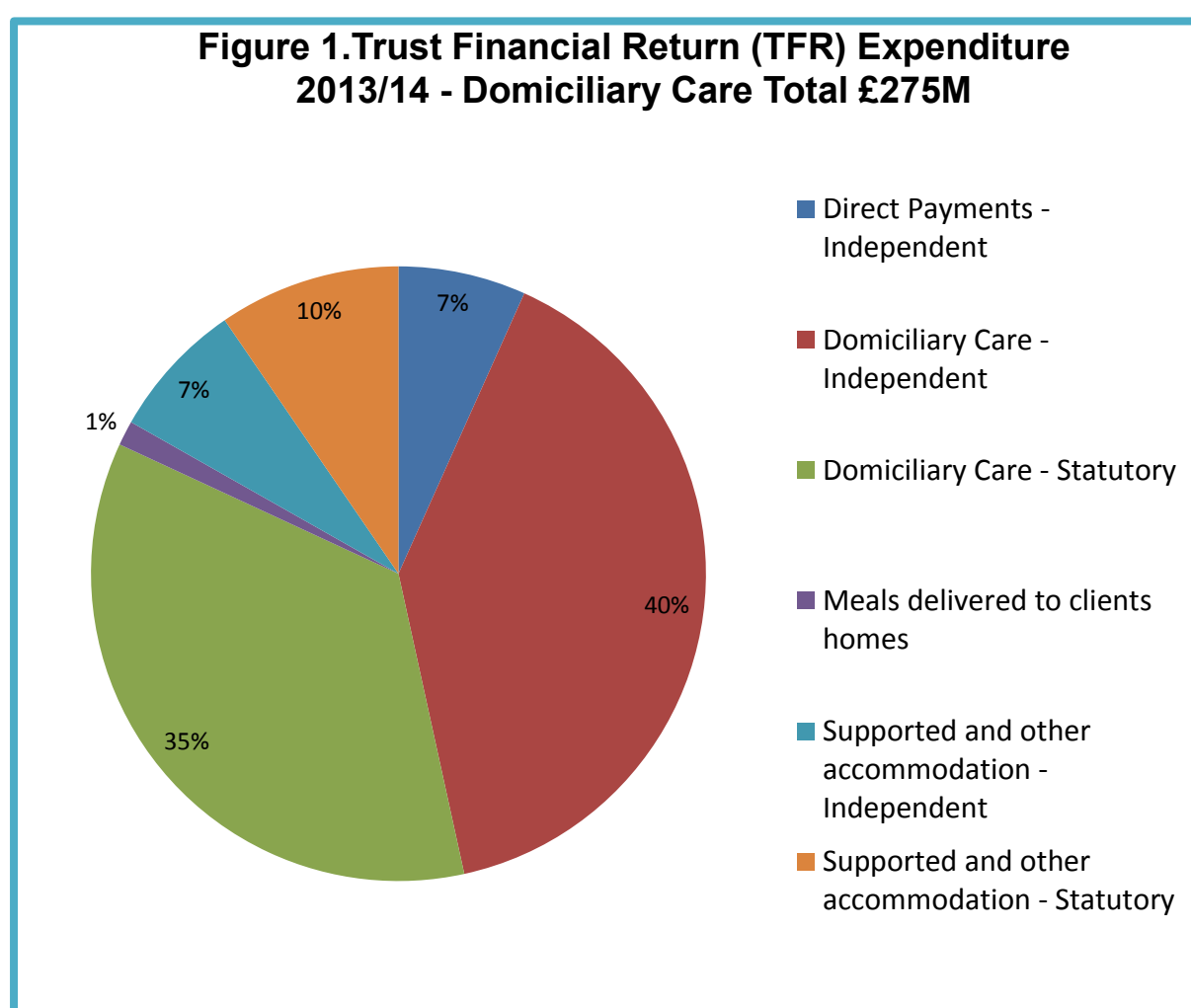
- domiciliary care hourly activity; and
- number of clients in receipt of domiciliary care.

A lead in time is required for Trusts to move to implement and report on the currencies within the Definitions and Guidance document.

2.6 This work is likely to improve current information about volumes and capacity but different Trust IT systems will continue to make analysis and comparison difficult. Trusts have argued that until an effective regional system for monitoring service delivery is procured this will not be resolved. Discussions have started to explore the feasibility of this option and the potential benefits to all of the parties involved in service delivery – service users, staff, commissioners and providers.

Funding

2.7 The most recent returns from Trusts for the 2013/14 financial year indicate that a total of £272m was spent on a range of domiciliary support. Although certain exclusions were referred to in paragraph 1.4 **Figure 1** outlines a range of expenditure including direct payments and community meals, which represent a small percentage (8%) of spend and supported housing at 17% or almost £20m. This analysis may become more significant if we are able to identify other expenditure flows within the total figure e.g. reablement and any future shifts within the overall budget with the development of self directed support.



2.8 The bulk of the funding however is invested in mainstream domiciliary care services across statutory and independent sectors amounting to £206m with £183m spent on direct service provision as outlined in **Table 1**. Approximately 75% of this expenditure relates to

services for older people. The differences in the other costs of procuring, monitoring, administering the services suggest that there may be scope for further efficiencies which would not have an impact on direct service provision in a number of Trusts.

Table 1 : Trust Financial Return 2013/14 - Domiciliary Care Expenditure

Trust	Total Paid to Provider £M	Other Costs within TFR £M	Other Costs % Paid to Provider
Belfast HSCT	34.1	3.4	10%
Northern HSCT	41.9	4.7	11%
Southern HSCT	38.2	5.3	14%
Western HSCT	25.9	5.0	19%
South Eastern HSCT	43.4	4.9	11%
Total	£183.6m	£23.4m	13%

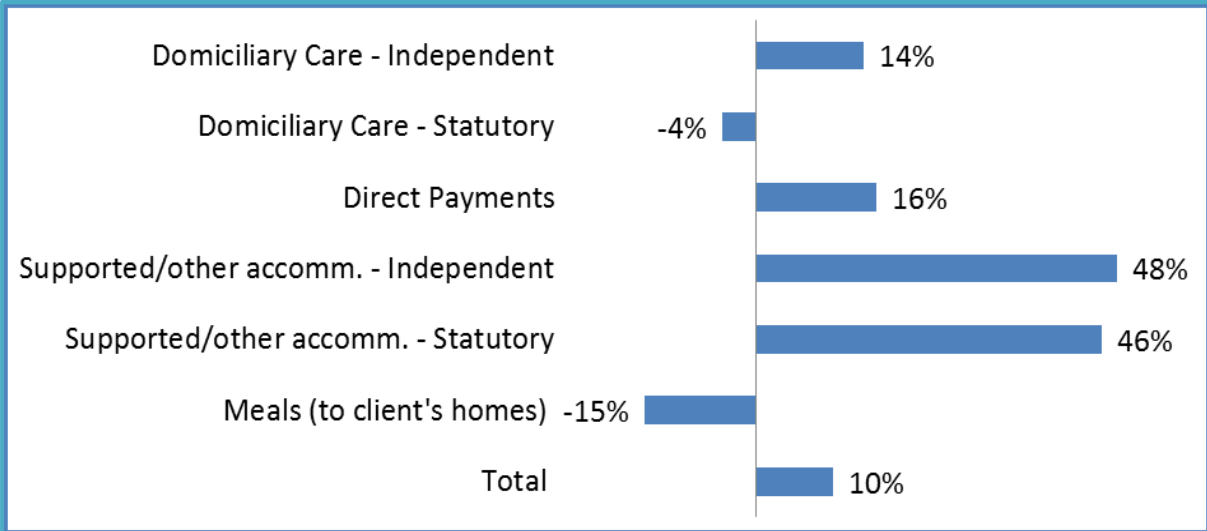
2.9 The pattern and proportion of expenditure on the various strands of domiciliary care have been changing in recent years in line with the strategic objectives of personalisation and the development of supported living options. These are outlined in **Table 2** and **Figure 2**, below, and the trends will need to be continuously monitored to assess the impact of financial pressures and changes to services.

Table 2 : Expenditure by Category 2011-2014

Expenditure	2011/12	2012/13	2013/14
Domiciliary Care - Independent	94	98	107
Domiciliary Care - Statutory	102	98	97
Direct Payments	16	18	18
Supported / other accommodation - Independent	13	19	20
Supported / other accommodation - Statutory	18	22	26
Meals (delivered to client's homes)	4	4	4
Total	247	258	272

Note: All expenditure reported in cash terms, for all Programmes of Care

Figure 2 : % Expenditure Change by Category of Care 2011/12 to 2013/14



2.10 When one focuses on the two primary categories of expenditure, statutory and independent sector provision there are marked differences between the proportionate levels of investment between Trusts. The actual and comparative amounts are detailed in **Figures 3 and 4**.

Figure 3 : % Domiciliary Care Expenditure by Sector 2013/14

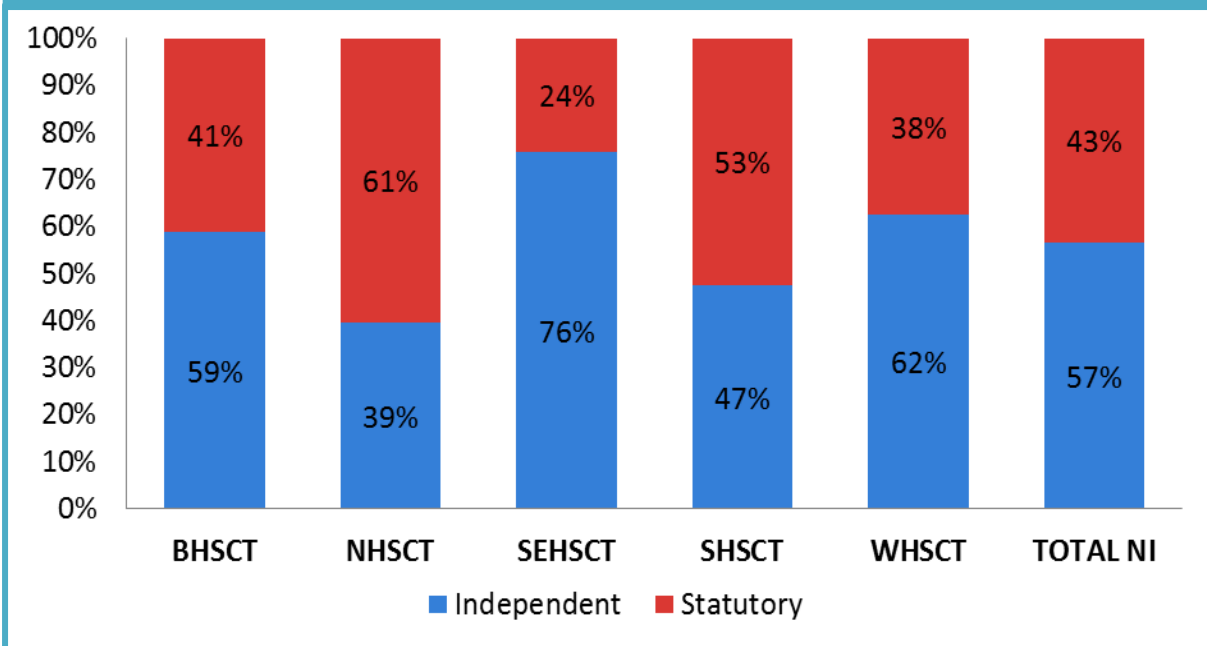
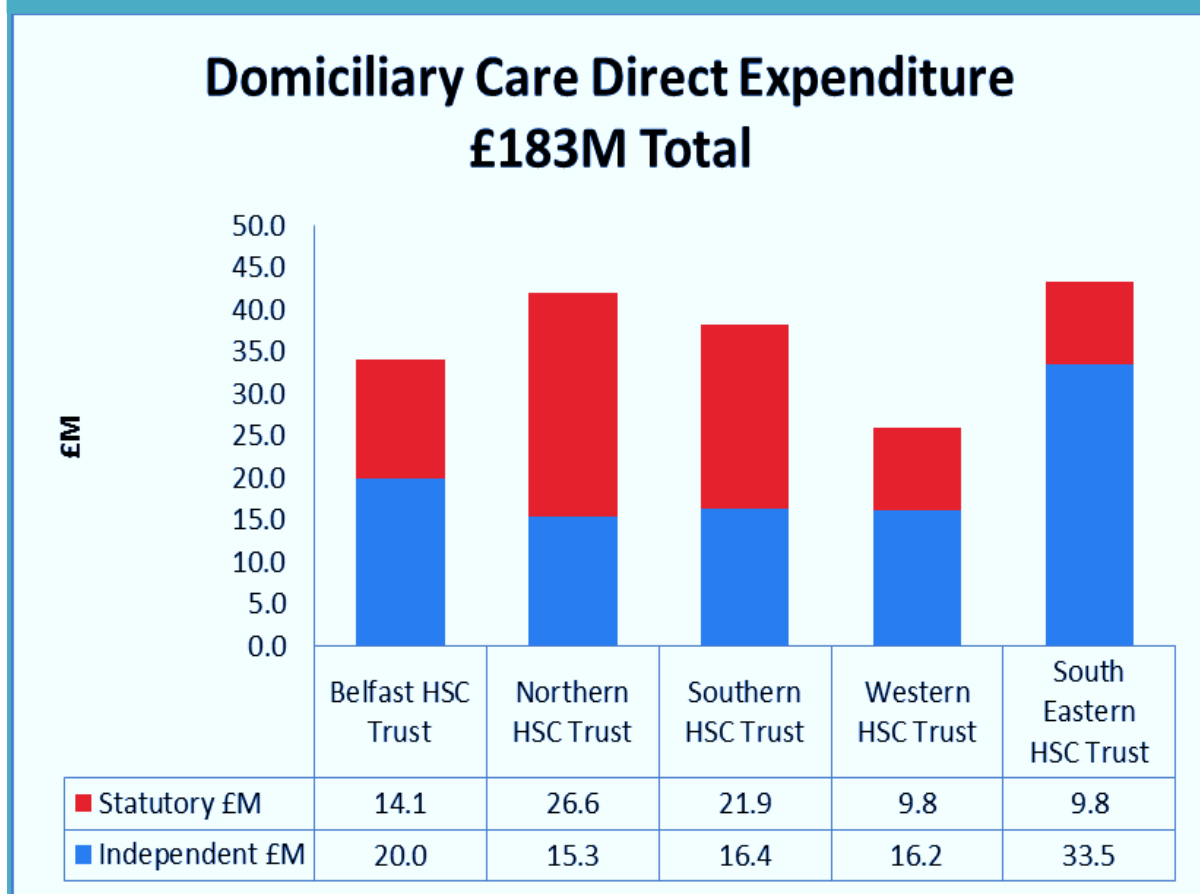


Figure 4 : % Domiciliary Care Direct Expenditure



2.11 The different proportions of Trust expenditure between the statutory and independent sectors suggest scope for further adjustment which may release funding to address demographic and service pressures.

Conclusion

2.12 The opening commentary in this section has acknowledged the challenge of obtaining activity and financial information about domiciliary care which is consistent, comparable and can be used to inform service change and re-design. Whilst the relatively high level of analysis and associated trends indicate that strategic objectives regarding home based care are being proactively promoted there is clearly scope for better quality information to inform the assessment of expenditure and performance. Some current initiatives have the potential to advance this aspiration but more work is needed to achieve the objective. A high degree of expectation is being placed on the procurement of effective

electronic monitoring arrangements but this will be a complex project which requires a high degree of inter-Trust coordination if the benefits are to be realised financially, operationally and in terms of data quality.

SECTION 3 - The Market

Market Function and Stability

3.1 Reference was made earlier to the impact of managing instability in the nursing home sector. The Southern Cross business failure in 2011 resulted in the UK wide transfer of 250 care homes to a range of other providers and was a salutary lesson for commissioners and statutory providers nationally for a number of reasons. It took emergency planning and coordination to new levels. The lack of in-depth knowledge about the process of market shifts, shares, consolidation and financing put statutory services at an initial disadvantage. Contingency plans required swift revision and updating and the potential scale of disruption led to a fundamental review of how this sector should be monitored.

3.2 Recent legislative changes in England and Wales have included plans to improve oversight of the social care market whilst recognising that a rigid system of 'market monitoring' is not achievable. The Care Act requires English Local Authorities to develop a diverse, improving and sustainable care market. This includes additional obligations to ensure that staff are being paid the minimum wage. Some initial survey work by the Local Government Association revealed that many local authorities would not currently be able to provide this level of reassurance. These developments are indicative of the recent debates elsewhere in the UK regarding pay, terms and conditions and the sustainability of the social care workforce and, in particular, domiciliary care.

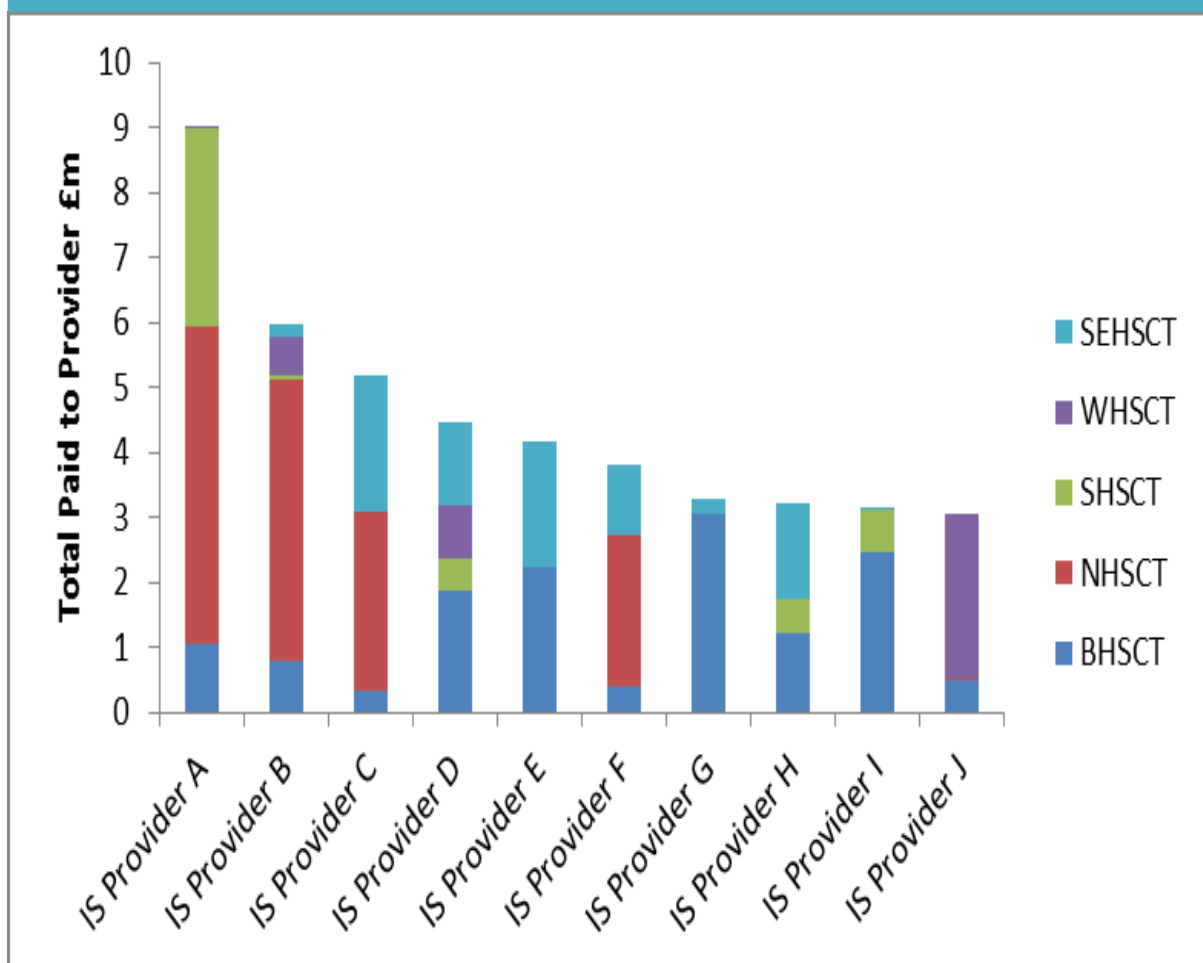
3.3 There has been no, equivalent, local focus on these issues and it could be argued that, in view of a number of significant changes which will be examined later, that it is now time to develop more robust, regional 'intelligence' about these challenges. Whilst developments elsewhere provide both a useful reminder and reference points for examining the issue of market oversight, direct comparability is not possible because of different organisational, financial and legislative arrangements. The changes referenced above will bring this into sharp

relief in the near future and will require a coordinated, regional response.

Market Players, Share and Volumes

3.4 In terms of the current state of market knowledge there has been relatively limited analysis to date. There are currently 82 registered domiciliary care providers with an associated 122 agencies in Northern Ireland, including the five Health and Social Care Trusts. There is a broad range of non statutory sector providers ranging from those with a significant, but not regionally dominant, market share to a number of small, very localised agencies. Within the former category few have a presence in all Trust areas but they can have a large service portfolio in two or more Trusts as evidenced in **Figure 5**.

Figure 5 : % Top 10 Independent Sector Domiciliary Care Providers operating in more than 1 Trust



Cost of Providing Care

3.5 The hourly cost of domiciliary care has been the subject of debate with independent sector providers. The comparative, proportionate activity and financial information outlined in **Section 2** illustrates, at a high level, the difference between statutory and independent sector costs per hour.

3.6 Rates paid to the independent sector by Trust are detailed in **Table 3**. The variations reflect historical decisions about funding, how need is categorised and local economic factors. Four Trusts have agreed varying in-year uplifts to some rates after approaches from providers. The potential for a new procurement exercises to compound or resolve some of the differentials will be considered later in this report.

Table 3 : Domiciliary Care – Hourly Rates paid by Trusts to Independent Sector 2015/16

SEHSCT	Basic rate	£12.16
	Rural rate	£12.52
NHSCT	Primary Providers – range	£11.69 - £12.10
	Secondary providers	£11 - £22.50
BHSCT		£12.16
SHSCT	Personal Care	£11.77
	Practical Care/Sitting	£10.48
WHSCT	Northern Sector	£11.20
	Southern Sector	£10.54

3.7 Recent national and regional analyses by the United Kingdom Home Care Association (UKHCA) identified a regional ‘average’ rate for Northern Ireland of **£11.35**. This figure is already outdated due to the in-

year negotiations referenced earlier but our local rates appear to lie within the lowest quartile of the range of basic fees paid by authorities in Great Britain. The average rate for English Local Authorities cited in the recent Local Government Information Unit Review of the sector is quoted at **£12.26** in 2014/15 although this encompasses a broad range of rates across these organisations. The economic market rate promoted by the UKHCA is **£15.74** per hour although this is being revised to **£16.20** due to the recent Budget announcement about the living wage.

Sector Stability

3.8 Ultimately rates impact on effective market functioning. There has been no firm evidence of significant instability in the wider UK domiciliary sector. Despite financial challenges caused by a dramatic reduction in adult social care budgets in England and Wales the general trends continue to be the shift to people procuring their own care packages and continued outsourcing to the independent sector. Some providers such as Saga and Care UK have begun to view domiciliary care as increasingly less profitable and to withdraw from this work. The local market has not seen the same degree of reshaping but reablement and self-directed support may, eventually, have a similar effect.

3.9 It is difficult to comment precisely on overall sector stability beyond what can be viewed as normal ebbs and flows within the market. The uncertainty created by the protracted nature of tendering proposals may have influenced a number of recent withdrawals from, or reorganisation within, this service area. There is no quantified evidence that this indicates underlying major market instability at this point in time. Regular contact with Trusts, however consistently highlight the significant challenges in delivering and maintaining high quality domiciliary care.

Conclusion

3.10 The rationale for examining the topic of market composition and functioning was to promote a greater awareness and broader view of developments in the sector. Further work is required in order to

- become more attuned to the stresses, both financial and operational, which all providers are dealing with
- prepare for the implications of tendering for services and
- understand the true costs of the service.

SECTION 4 - Stakeholder Engagement

Direct Stakeholder Engagement

4.1 An important element of the review involved the Project Team engaging with key stakeholders about their experiences of the service. In addition to meetings with users and carers the Team arranged engagement events with Independent Sector providers and Trade Union representatives. A range of sources were used to obtain the views of stakeholders including Trust surveys of users of domiciliary care.

Messages from other Stakeholder Research

4.2 The team drew on other sources to obtain service user views including the Patient and Client Council (PCC) – *Care at Home: Older People’s Experience of Domiciliary Care, June 2012*, and the Public Health Agency (PHA) *Regional Findings Relating to Care in Your own Home (10,000 voices)*, in March 2015. 1161 individuals took part in the PCC research with **87%** of respondents rating the quality of care as “good” or “very good”. Respondents viewed domiciliary care as an invaluable service to many older people for the quality of care provided and the support and input from care staff. One of the most positive aspects was the support it provides to help people remain in their own home and maintain independence as an alternative to institutional care.

4.3 The PCC research highlighted respondents’ concern about the future of domiciliary care provision and some criticisms were expressed about the inconsistency and inflexibility of the service. They wanted to be reassured that the care provided to people in their own home was of an acceptable standard. They stressed the need to focus on improving the quality of life of older people living at home rather than reducing the financial cost of social care. These findings reflect the views expressed by stakeholders to the HSCB project team as outlined later in this report.

4.4 The PHA and HSCB jointly commissioned the ‘10,000 Voices’ initiative which asks individuals to share their experience of health and social care services by “telling their story”. A survey was undertaken with

public engagement in a series of regional workshops with patients, families, carers, and HSC staff who were asked about their experience of receiving care in their own home. Between February 2014 and January 2015 approximately 1330 client stories were captured by the survey with **78%** of respondents reporting a positive experience of the service and **82%** stating that domiciliary support in their own home had impacted positively on their lives.

4.5 A high proportion of respondents in all Trusts were very satisfied with the care they receive with many accounts of the compassionate care, help and support which carers deliver. Some stories describe the isolation and loneliness experienced by those who rely on domiciliary care and reflect how much they appreciate and value the service. Residents in supported living accommodation appreciated the security and company that this type of housing offers.

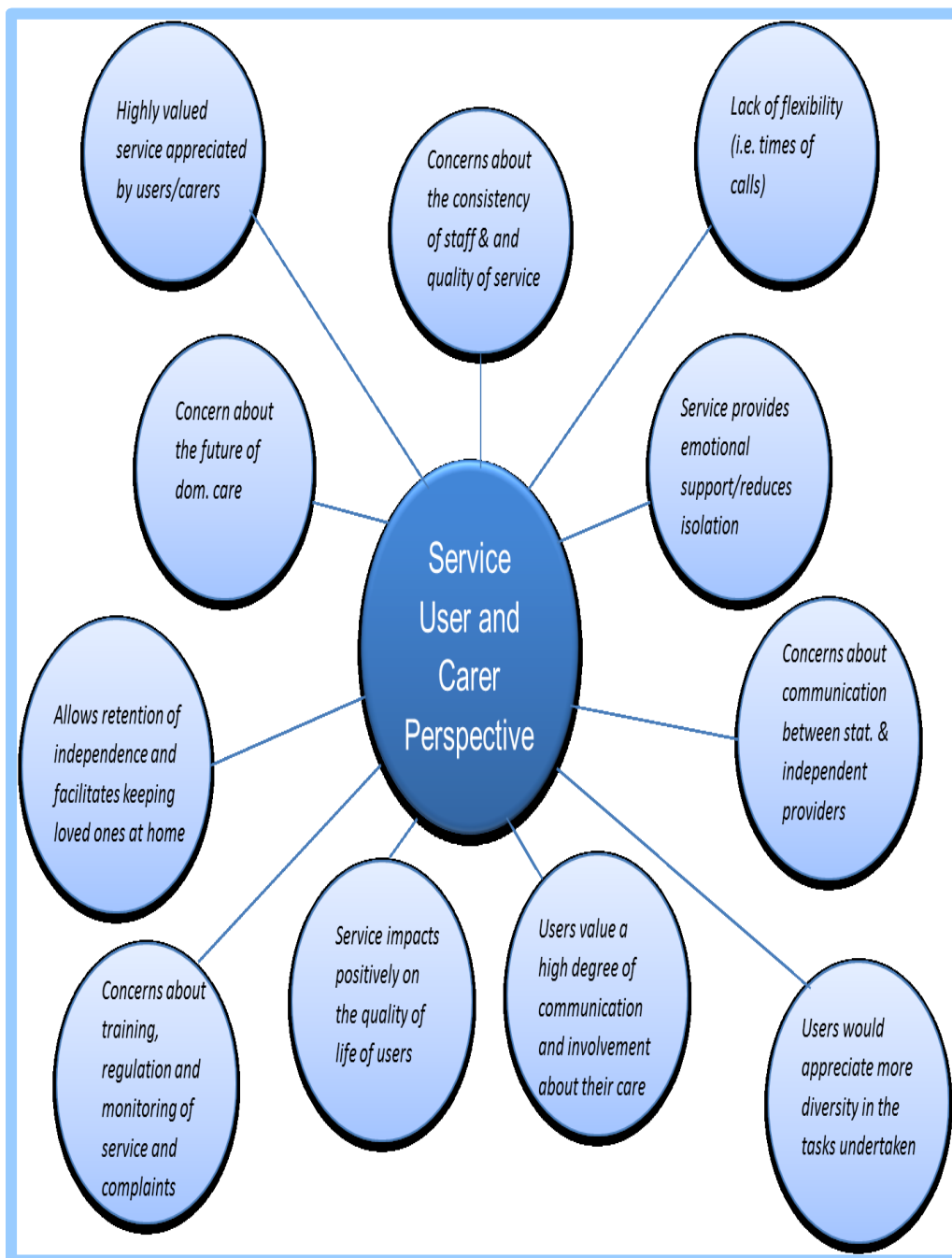
4.6 The survey identifies some areas for reflection, learning and development to enhance the experience of service users including:

- Better communication of information between carers;
- More continuity of care staff;
- Improved timing of calls and allocation of time;
- Ensuring that the privacy and dignity of users is respected by staff;
- Ensuring staff are adequately trained to care for people with dementia;
- Maximising opportunity for client choice in food preparation/meals.

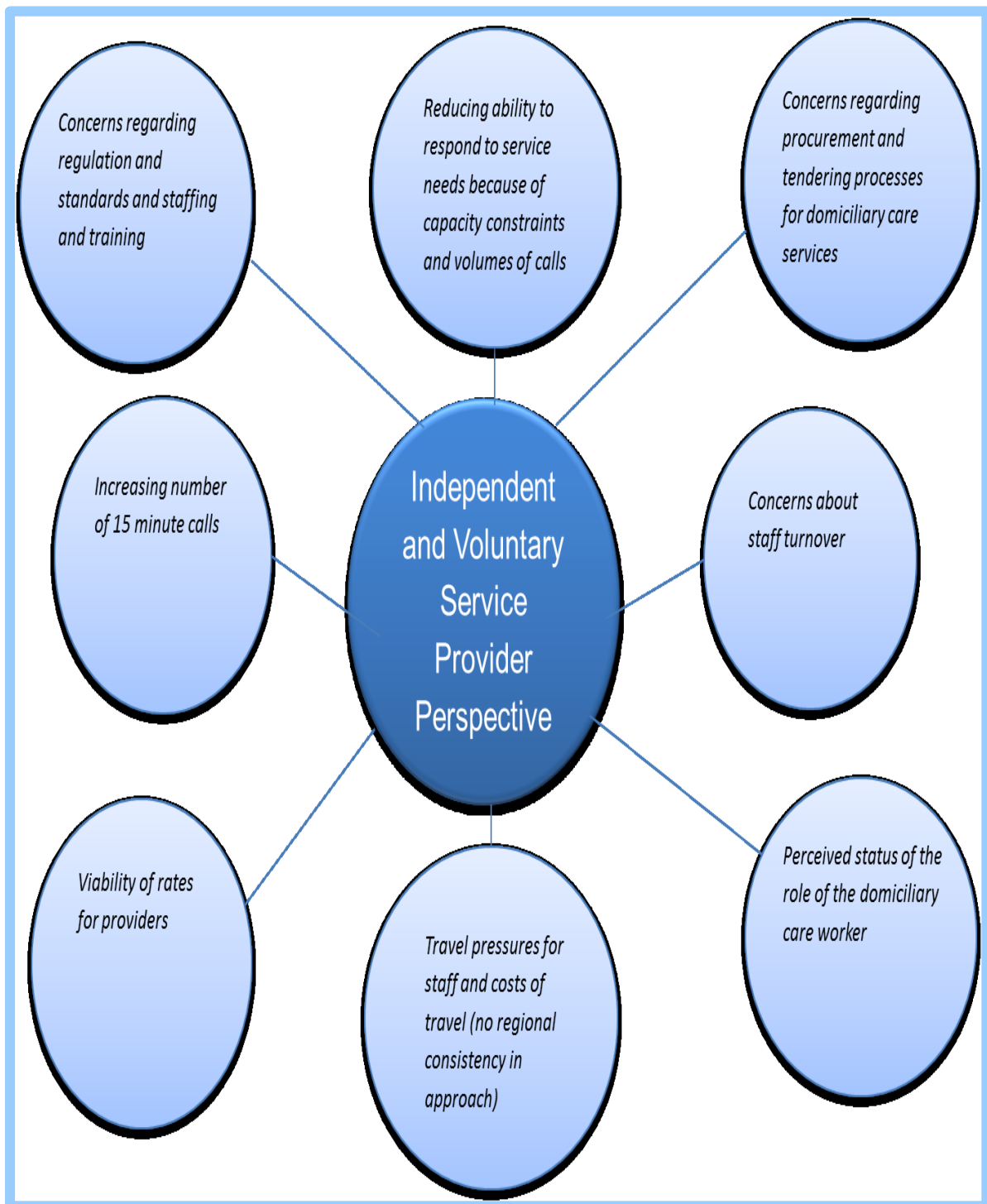
Dialogue with Stakeholders

4.7 In conversations with service users the Project Team asked about what worked well currently with regard to the service, what didn't work so well and areas for improvement. In addition, independent and voluntary providers were asked for their views on what the Board, Trust, Voluntary Sector need to do to ensure a stable domiciliary care market in the future. The following pages summarise the views of a range of significant perspectives and identify wider environmental factors impacting on domiciliary care.

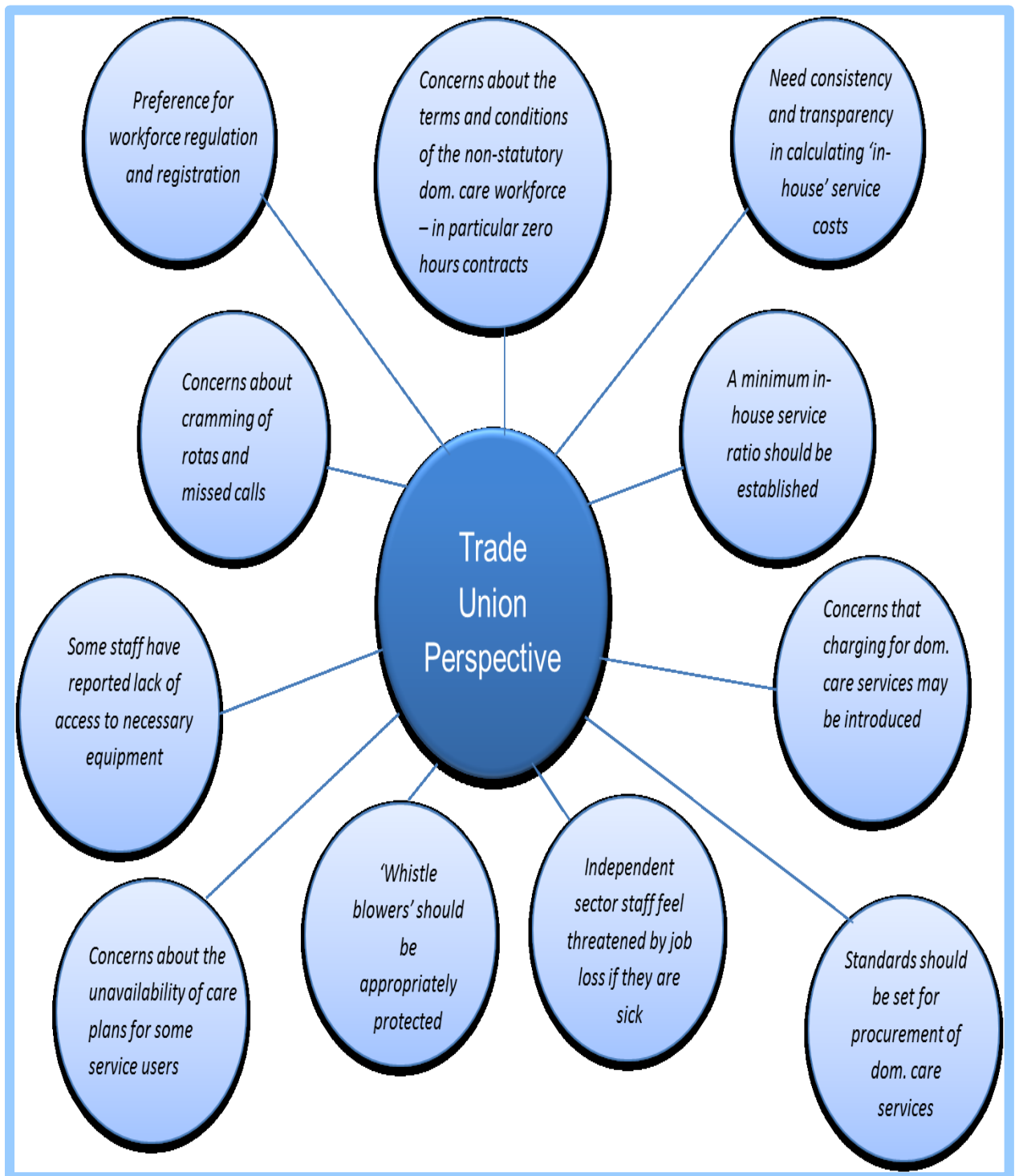
Service users and carers restated many of the views identified in the research material referred to earlier balancing an appreciation and valuing of the service with concerns about communication, care standards and diversity of tasks. These are summarised below.



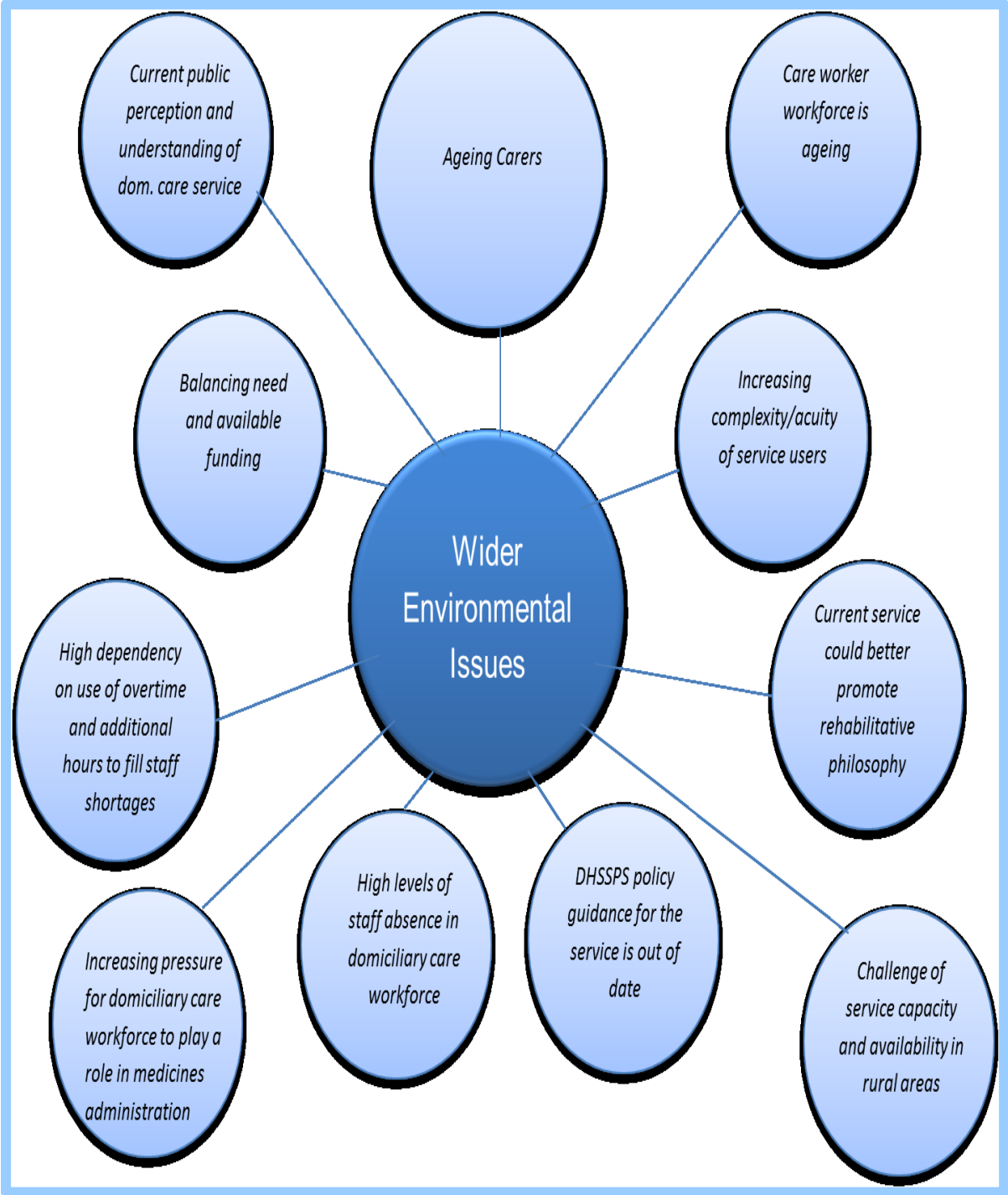
The views expressed by **service providers** largely focus on recruitment, their ability to respond to service needs, standards/regulation and market sustainability. The views are summarised below.



Trade Union perspectives reflect their sense of responsibility to safeguard their members, and a desire to improve regulation and terms and conditions for domiciliary care workers in general. These views are summarised below.



A range of **wider environmental factors** impacting on domiciliary care services was identified by stakeholders. These included.



Conclusion

4.8 The extent to which domiciliary care is valued by such a wide range of perspectives reinforces the vital role which it performs in the effective delivery of community care services. The practicalities, referenced earlier, of delivering such a dispersed service will inevitably create problems and challenges. There was no strong sense, across the different groups of respondents, of a service in crisis but there are clearly two major issues which are impacting negatively on sustainability and ensuring stability.

4.9 The first of these relates to how the service is going to be procured in the future and the second is the availability and development of a workforce to maintain the delivery of a quality service. The former needs to be decisively addressed in the short to medium term whilst the latter requires a major focus on training, terms and conditions and how the service is to be funded. The issues of resourcing the service and valuing the workforce will be developed in the final section of the report.

SECTION 5 - Service Interfaces

The Domiciliary Care Network

5.1 Domiciliary care provides a vital support for many people who wish to remain independent for as long as possible. It does not however operate in isolation and links with a range of other services which support this objective. It is important to briefly consider developments in these areas and how they might impact on future models of domiciliary care delivery. Before doing so however it is helpful to revisit the basic definition offered in **Section 1** of this report and expand on it slightly by applying an analysis developed by the Institute of Public Care (IPC).

5.2 The IPC identifies a continuum of models of home based care including:

- standard domiciliary care;
- reablement and rehabilitation; and
- specialist home care;

which need to be considered when developing any proposals to reshape services. This is important in order to ensure that we do not adopt an over simplified view of what has become a complex service and which is likely to require the imaginative application and redeployment of resources and not simply further investment in existing services. The different elements, their contributions and flexibilities as well as the role of statutory and independent sectors will be explored in the next two sections of the report.

Reablement

5.3 Reablement has been one of the most significant changes to how the need for community services is assessed and delivered since it was first promoted as a regional initiative in 2011. It aims to reduce unnecessary dependence on health and social care services by means of intensive, time limited support with daily living tasks which will help the service user to regain independent functioning. The current regional

model places an emphasis on an Occupational Therapy led approach but it is also heavily reliant on intensive support with back up from dedicated reablement domiciliary care staff. This element of the service has mainly been delivered by Trust in-house domiciliary care which has become increasingly focussed on this kind of more intensive input. The current regional model suggests that reablement should be viewed as a distinct service rather than a version of domiciliary care.

5.4 Elsewhere in the UK the demarcation between the statutory and non statutory sector roles are not quite so clearly defined with reablement in some Local Authorities being contracted out. The emphasis on prevention and diversion makes this fertile ground for exploring the potential for a more outcomes based approach to both service delivery and procurement which is being increasingly promoted in some English Local Authorities. A regional review of reablement has recently been completed and has resulted in a clear service specification for the future development of the model across the region. It will be important to keep this under review in order to assess the impact of the approach and examine its ongoing potential to reshape domiciliary care delivery. Any future model needs to consider how the reablement approach can develop within the continuum of home based support.

Direct Payments

5.5 Direct payments were first introduced in Northern Ireland in 1996 with the aim of providing an individual or their representative with money via their local Trust to allow them to procure social care support tailored to their needs. Embedding the concept locally has involved many procedural challenges and some legislative changes. The current number of recipients of direct payments stands at around 3000 which represents relatively modest progress when compared to other areas of the UK. In recent years the rate of uptake has reached a plateau and there have been small reductions in some Trusts/programmes of care.

The concept however is firmly entrenched in all health and social care planning and strategic intent whether this finds expression as an emphasis on personal budgets or personalisation. It is clear however

that it needs to be re-energised if it is to deliver the scale of benefits that it was originally designed to. The most recent indication of a renewed attempt to do so lies in the promotion of self directed support.

Self-Directed Support

5.6 The term can be described as an attempt to revisit, redefine and ultimately subsume the direct payment approach to promote and widen the degree of choice and flexibility that individuals can have in meeting their care needs. Self directed support allows individuals and families to have an informed choice about the way care is provided. It permits greater control and more flexibility in managing a personal budget. It includes a number of options for getting support.

The individual's personal budget can be:

- taken as a direct payment (a cash payment);
- a managed budget (held by a Trust/the client controls spend);
- the Trust can arrange a service; or
- individuals can choose a mixture of these options.

Self directed support is regarded as one of the HSCB's major reform projects in the delivery of community based care and support for older people and those with disabilities. Targets have been identified in the initial planning stage for 33% of eligible users to be availing of this option by 2019. This mirrors, to a lesser degree, the more ambitious targets set for other regions of the UK where, for example, the robust promotion of the approach in England has resulted in recent government figures of between 55 and 59% of council funded users of community services receiving a personal budget.

5.7 Regional implementation has recently commenced and it is important for two reasons. Firstly as a test of the extent to which it can influence professional culture and social attitudes about how services can be delivered and managed. It will present significant challenges in terms of developing an appropriate network of services and providing a sufficient level of support and advice to negotiate new arrangements and

relationships. The second challenge lies in future funding arrangements underpinning this service shift. The current and prospective financial pressures facing health and social care make it unlikely that self directed support will benefit from additional funding and the accepted alternative lies in the re-direction/re-utilisation of other budgets. Domiciliary care is the most obvious sources of funding to promote the model and there is a need to consider how this resource shift can be achieved. This will be discussed later in **Section 7**.

Other Service Interfaces

5.8 Whilst the developments outlined above present both the greatest challenges and potential in terms of achieving a significantly new approach to domiciliary based care a number of service interfaces would appear to have less influence on any such changes at least in the short to medium term. These include.

Supported Living

5.9 Supported living covers a range of accommodation options ranging from ‘floating support’ (which has similarities with, but is distinct from, traditional domiciliary care), sheltered housing and more specialist supported housing facilities such as Hemsworth Court in the Belfast Health and Social Care Trust or Pine Lodge in the South Eastern Trust. Current funding challenges for both DSD and DHSSPS are likely to limit the potential development of more specialist services, sheltered housing is subject to review and redesign and any increase in floating support services would present significant opportunities in terms of how it might interface with self-directed support.

Telecare

5.10 Telecare has been promoted as having the potential to maintain individuals at home and provide technical alternatives to direct care inputs particularly in terms of monitoring and security. Whilst a number of local pilots have been positively evaluated investment in telecare remains limited and there are no strong indications from Trusts that it will

be vigorously promoted and funded. As with self directed support further roll out of telecare will depend on diverting funds from other budgets such as the eHealth Strategy.

Telehealth

5.11 Telehealth allows people to monitor their health in their own home. Individuals with long term conditions like respiratory problems, diabetes etc. can use simple equipment to measure blood pressure, blood glucose level, oxygen levels and other physiological measures. Help is triggered if measurements are not within normal levels and usually this is provided through specialist community nurses who will visit the person at home or recommend a GP visit. The person can remain independent at home and reduce the number of visits to GPs and unplanned hospital attendances, it also helps give the person a greater sense of wellbeing.

Community Meals

5.12 The provision of community meals which is an element of domiciliary based support has been changing significantly as Trusts have explored alternatives to traditional services. It is a service where changing social norms, community alternatives and developments in equipment and processing have led to major changes. To some extent the reduced reliance on direct Trust services and greater client choice and autonomy shows what might be achievable in other service areas. Some people only require the service for a short period of time perhaps following a period of ill health and it can help older people to prepare a nutritious cooked meal or access assistance with this task and who would be at risk if the meals service was not provided for them.

Conclusion

5.13 The purpose of examining the links between the services discussed above with domiciliary care was to identify the contribution, roles and potential which they might have in changing how it might be delivered in the future. The two initiatives which appear to have the greatest potential are the further development of reablement and delivering on the objectives of self directed support. In view of the

current financial challenges there is a strong argument for managing investment across these service areas in a more coordinated and strategic fashion and identifying a designated regional budget allocation to be managed centrally in conjunction with LCGs. This would, in turn, require standardised monitoring of activity and investment which would build on the work outlined in **Section 2** above.

SECTION 6 - Shaping a Future Model

Setting Development in Context

6.1 Domiciliary care has received considerable attention in recent years in the form of media interest as well as academic and policy based reports and surveys. Whilst this commentary and analysis has helped to inform this report, there is not universal consensus on a 'preferred' model locally, elsewhere in the UK or further afield. It is clear that commissioners and providers are experiencing very similar challenges and that, in the absence of significant new investment, a limited number of options for service redesign have been identified.

6.2 Prior to the initiation of this review project Ernst and Young (EY) was commissioned to provide specific advisory support to Trusts to support the HSCB change agenda. Three Trusts availed of this support to look specifically at domiciliary care reform and this collaborative work drew heavily on a range of major change initiatives which identified common principles, drawn from comparators from within the UK and internationally, which should underpin any future service model.

- A goal-orientated, outcome focussed service;
- Service user and advocate led planning;
- A generic service with access to specialist care as required;
- Providers working in partnership with the commissioner and the community and voluntary sector with the service user at the centre;
- Continuous innovation and service development;
- Improved terms and conditions for domiciliary care staff;
- A well trained and capable workforce;
- Consistent governance and quality requirements across providers;
- Responsive access and exit to/from the service; and
- Equity of access and outcome.

6.3 It is clear that there is scope for some of these to be more robustly promoted in order to bring Northern Ireland into line with developments elsewhere in the UK. The most important features associated with successful models of service provision require further consideration.

- Contracting and monitoring in order to deliver services more flexibly to ensure the client can identify their care priorities;
- Less focus on ‘time and task’ to enable more flexibility and responsiveness to changing client needs;
- An optimum number of providers with longer-term contracts to allow them to develop a stable workforce;
- Ensuring that potential service users are informed of different funding options to secure their care i.e. self-directed support;
- More focus on workforce development and working conditions;
- Greater emphasis on a restorative approach to maintain user independence.

6.4 This is an ambitious change agenda and it is supported, in principle, by the parties referenced in **Section 4**. The crucial question is how this can be achieved in a coordinated strategic fashion. The proposed tendering of services across the region presents an opportunity to rethink how domiciliary care is commissioned and procured and to incorporate many of these objectives in an inclusive, incremental way.

Regional Service Developments

6.5 In order to comment on the changes required to develop a best practice model one of the aims of the review was to undertake a comparative analysis of how current Trust arrangements were operating, planned changes in approach to procuring services, service challenges and governance. This was done using a standardised audit approach involving meetings between the review team and Trust representatives. The discussions focused on three main areas, namely:-

- the current service model;
- contracting arrangements; and
- current service challenges.

6.6 Current Service Model

6.6.1 Management Structure - In all Trusts there is a single senior manager from within Older People and Primary Care Directorates with responsibility for the statutory domiciliary service and further devolvement of responsibility to reflect a locality model of service delivery. Within **BHSCT** there is a separate management arrangement for intensive homecare. Oversight of independent sector provision is undertaken by a separate senior manager in conjunction with Contract and Performance colleagues. In the **WHSCT** a more localised application of this model is used based on budget responsibility. These arrangements cover all Programmes of Care.

Comment- Relatively standard oversight and demarcation management arrangements exist in all Trusts which appear to function effectively. All Trusts had a significant number of independent sector providers to work with; **NHSCT** -17 (5 'primary' and 12 'secondary' providers), **BHSCT**- 23, **SHSCT** - 23, **SEHSCT**- 36 **WHSCT**– 12. There appears to be a correlation between the proportion of expenditure in the independent sector with a higher number of provider options.

6.6.2 Process - Significant attempts have been made by Trusts to create greater centralisation of referrals via the Care Bureau model and associated screening and brokerage arrangements to produce more effective and speedy allocation of cases to available services. The development of reablement has enhanced the rehabilitative options alongside specialist teams for palliative care and dementia. Thereafter in all Trusts, apart from **SHSCT**, brokerage offers cases to the in-house service in the first instance and then to local independent sector providers on a rotational or first responder basis.

The Northern Ireland Single Assessment Tool (NISAT) is not used consistently by Trusts to screen referrals but it is clear that all Trusts have moved to responding to ‘substantial’ and, increasingly, ‘critical’ assessed needs due to financial pressures.

There was little evidence of structured arrangements for diversion to community and voluntary sector alternatives apart from **WHSCCT** and **SHSCT** via Flexicare and Access/Information services.

6.6.3 Information Systems Trusts rely on a wide range of IT systems and linkages to help manage this complex service efficiently with the prospect of further challenges as corporate community information systems are rolled out. These will include the on-going attempts referenced earlier to improve operational data and to support some of the workforce developments discussed later in this report.

6.6 4 Service Linkages In response to questions about the interfaces with other services designed to complement traditional domiciliary care provision there was reducing levels of enthusiasm from the clear acceptance of the interface with reablement as an integral element of community support services to a more muted response to the role of self directed support (from the majority of Trusts) and telecare.

Comment-Trusts have evaluated their processes to manage demand for domiciliary and community services more effectively. There are indications that this may already rely heavily on a strict interpretation of eligibility criteria.

Greater focus and consistency is needed to address the IT needs of the service and more standardised approaches should be adopted. Some Trusts have promoted the merit of a regional domiciliary care monitoring system and associated benefits.

Further work is required to support the culture change needed to promote and develop personalisation initiatives.

6.7 Contracting Arrangements

6.7.1 Introduction In **Section 2** reference was made to the way in which domiciliary care has frequently been viewed as a potential source of savings. In view of increasing pressure on resources procurement of the service has become a major issue within and between Trusts. The variation in local rates detailed in **Section 3** reflects the degree of historical autonomy exercised by previous and current Trusts with limited, if any, attempted collaboration. Recently however there has been a greater focus, involving HSCB and BSO, on more co-ordinated consideration of re-tendering for services across the region. The potential for this to fundamentally re-shape the domiciliary care market in Northern Ireland needed to be explored in the audit exercise.

6.7.2 Tendering Trusts are in very different positions on this issue. The **WHST** has recently gone to tender for a significant proportion of its domiciliary care provision. Extensive preparatory work has gone into progressing this initiative and The Trust is currently considering responses to the tender. It is not yet clear what impact this will have on the future composition of the market and costs.

The **BHST** has consulted on a new strategy for procuring the service which proposes a significant reshaping of the market. It is not clear when the Trust proposes to move to the next stage of the process but the decision is likely to be influenced by **WHST** developments.

SHST has had relatively long established contract planning structures and proposals and, while some localised piloting has been attempted by the Trust, it awaits the outcome of the regional review in addition to considering the implications of the Trust processes referenced above.

SEHST had conducted a scoping exercise regarding a possible tender but has no plans to progress this until the regional review exercise is complete.

NHSCT has rolled forward its contracts in 2015/16 with primary domiciliary care providers and is making preparations for tendering, in early to mid 2016/17

Comment- There is a need to compare Trust approaches to procuring domiciliary care in order to identify best practice and improve commissioning processes.

The outcome of the **WHSCT**'s plans and any associated recommendations from this review is likely to determine whether local replication or more regional coordination is the best way forward.

6.7.3 Statutory/Independent Split A potential consequence of widespread procurement exercises could be a re-balancing of the proportion of care hours delivered by the statutory and independent sectors. As with previous comparisons there is marked variability between Trusts.

NHSCT 50:50 with respondents indicating no strong desire for further outsourcing and emphasising the need for a strong in-house service.

WHSCT 34:66 with indications of the need for retained in-house provision to address specialised/hard to reach cases alongside a requirement to deal with significant in-house cost pressures.

BHSCT 25:75 with indications that this service split requires little, if any, further adjustment at present, with the proviso of a need for a quantum of in-house provision for contingency/specialist purposes.

SHSCT40:60 with indications that it envisaged a possible further 5% reduction of the in-house service to ensure stability and address risk.

SEHSCT 17:83 with a very high independent sector market share. There was some insecurity about capacity for contingencies and sufficient market leverage to deliver specialist or hard to access cases

Comment-The differences in the statutory/independent split are striking and inevitably pose the question about a possible, notional, 'optimum' balance or 'target' for Trusts. References in major market analyses such as the annual Laing and Buisson reports refer to 11% of older people's domiciliary care being provided in-house by Local Authorities. Reference is made to a proportion of the service being delivered by voluntary or not for profit organisations to a degree which is not reflected locally.

In the absence of any recommended mechanism for identifying service shares the drivers are likely to be a combination of value for money, quality standards, the development of more specialist interventions and the outcome of tendering processes.

A regionally coordinated tendering process would allow moves towards greater alignment to be considered.

6.7.4 Market Shaping The 'time and task' model of providing domiciliary care has come in for significant criticism in the media and is often articulated in the currency of '15 minute calls'. Allowance for this level of input, if appropriate, has been reflected in the annual Departmental home help circular which has been issued since 1974. There appears to be a good deal of, mainly, anecdotal evidence of an increasing reduction in the time allocated for inputs to recipients due to funding pressures. This is further compounded by issues such as the distance between calls and associated travel time.

The alternative, referenced earlier, is the 'outcomes based approach' which theoretically starts with assessed need and care outcomes and thereby informs time allocations and costs. In reality there may be little difference between these options if the core budget remains the same. Proposed Trust tendering strategies do not explicitly attempt to reconcile them but the type of changes specified leave scope for further exploration of an outcomes based model of care delivery.

The **WHSCT** tender incorporates features of an outcomes based approach and the outcome of the process will allow this to be tested locally.

The **BHSCT** has consulted on a broadly similar approach as a precursor to proceeding to tender.

The **SHSCT** is currently piloting an outcomes based service in Armagh and Dungannon, for which the evaluation is just being completed. This work has been based on the principles arising from the Ernst and Young work described in **6.2** above.

NHSCT and **SEHSCT** do not currently have a resolved position on formally adopting a revised approach to procurement. The **NHSCT** did however emphasise the importance of clearly defined and agreed Performance Indicators in any outcomes based model. Further developments are likely to be shaped by the review and impact of the proposals outlined above.

Comment - Current tendering proposals will see Trusts procuring variable 'blocks' of service differentiated on a geographical basis. This is likely to result in a degree of market rationalisation and reconfiguration.

It is not possible, at this stage, to predict how the sector will respond to the proposed service model where a greater onus is placed on the provider to deliver a service which meets assessed need and ensures continued viability. Potentially, it may result in increased hourly rates for care.

A recent evaluation of the outcomes based approach in Wiltshire, which has been a 'flagship' Local Authority for the model has identified promising but equivocal conclusions about the approach.

6.7.4 Market Stability The actual or potential impact of the proposals discussed above must be seen in the context of a very complex domiciliary care market. In **Section 4** service users, independent sector and staff side representatives commented on this issue and highlighted a number of concerns contributing to instability and risk in the service. The majority of Trusts gave examples of small numbers of providers withdrawing from and entering the market.

The closure of some enterprises was influenced by profit margins but also amalgamations and the kind of developments outlined above. In the meantime there seems to be an increasing difficulty, in all Trust areas, to get independent sector providers to accept cases where remote location or challenging behaviour are factors. This reinforces the need for Trusts to define the specialist/contingency/fall back role of the in-house service.

Comment-There was a strong view among respondents of a sector that was experiencing, and largely responding to, major operational and financial challenges. Pending tendering exercises contributed to this and it is difficult to try to predict longer term prospects. It is only when this process is complete that an accurate analysis of market stability can be made.

6.8 Service Challenges

6.8.1 Liaison/Communication All Trusts reported on efforts to obtain regular feedback about service provision from users of services and their carers. There is also regular contact with staff side representatives and the independent sector which have been heavily influenced by the financial challenges organisations are facing and the increased focus on the issues of low pay and terms and conditions within the sector.

6.8.2 Staffing When the issues of recruitment/retention, training and terms and conditions were explored the distinction between sectors is significant. There has been consolidation of the in-house workforce via increased contracted hours and efforts to improve deployment and utilisation of the resource. There has been no major reduction in staffing as changes in the proportion of service delivered by the statutory and

independent sectors has been achieved through additional investment in the latter rather than any contraction in statutory provision. The independent sector reports huge challenges in recruitment and retention and unfavourable comparisons with terms and conditions. The same problem exists regarding training provided to support staff in their role. In addition to core induction and training requirements Trusts have development programmes to help staff carry out challenging aspects of their work such as medicines management, dementia care, safeguarding. The independent sector is facing severe challenges in being able to provide these inputs to a similar standard.

Comment - The contrast between the statutory and independent sector workforces in terms of their readiness to meet assessed needs based on tighter eligibility criteria is a crucial factor in the future development of domiciliary care. Any further widening of the differences described above will affect procurement, quality and any attempts at service re-design and modernisation. The training and terms and conditions of the domiciliary care workforce, particularly in the independent sector, will be a major priority in any future change programme.

In March 2015 the DHSSPS led Regional Workforce Planning Group (RWPG) signed off a new Framework for Workforce Planning to be applied on a programme of care basis. The first application of this approach will be on domiciliary care for older people. This work commenced in May 2015 and will be influential in the wider reshaping of the service.

Conclusion

The individual audits indicated significant similarities in approach between Trusts and showed evidence of effective working arrangements to manage this complex service area. They also revealed a focus on increasing challenges to delivering domiciliary care which will need to be closely monitored. There are major differences in relation to issues such

as the statutory/independent sector split and hourly rates which will require further analysis and potential adjustment. The current focus on localised solutions is unlikely to address either the challenges or anomalies in the medium to long term. The evidence does appear to point to consider moving to a more coordinated regional approach to issues such as procurement, exploring different models of service delivery and workforce development.

SECTION 7 - Developing a Service for the Future

Developing The Analysis

7.1 In the introduction to this report the rationale for embarking on a review of domiciliary care was outlined in terms of the increasing profile and importance of the service in delivering major strategic priorities in health and social care, the operational challenges and risks for providers and the likelihood of significant service redesign arising from proposed changes in procurement. The Review's terms of reference attempted to identify the aspects of domiciliary care which required examination in order to inform and shape the response to these challenges.

7.2 The subsequent review and analysis has shown that some of the aspirations underpinning these aims may have been overly ambitious in view of the under developed nature of our information, research and policy basis for providing domiciliary care services. These disadvantages are partly addressed by the way that the various strands of analysis individually highlight and collectively reinforce the issues which need to inform the development of a domiciliary care service fit for the future.

7.3 This concluding section of the report will incrementally develop these arguments by revisiting the original terms of reference, identifying the actions arising from the analysis and then factoring in a number of important recent developments which will reinforce the need for informed and decisive action to influence the future of this crucial service.

Revisiting Objectives

7.4 Information: The Project aimed to contribute to the development of improved regional information about current services in relation to activity and resources.

7.4.1 In terms of the former the work confirmed how poorly developed and limited our information base is. We rely heavily on a single regional source which does not allow for sufficiently confident, comparative and trend analyses to inform operational and strategic planning and monitoring. This regional information is broadly indicative even though it

appears to confirm some of our strategic priorities. Attempts are being made to improve the current mechanism for collecting regional information but a more fundamental review by DHSSPS is needed to get greater buy-in from Trusts to this annual exercise.

This will need to be coordinated by the Department's Regional Information Group in conjunction with the HSCB's Community Indicators initiative to improve commissioning information about domiciliary care services. Whilst this work is at an early stage with the production of monthly statistical outputs a high degree of commitment is needed to develop, refine and regularise data about the performance and delivery of the service. Ultimately both strands of work will need to be included in any future monitoring and contracting arrangements.

The third, potential, contribution to addressing the information deficit is the proposal to procure an effective system for the electronic monitoring of service delivery as the most effective vehicle for producing accurate, comparable, operationally based data. This appears to hold significant potential in terms of helping to modernise the service and preliminary discussions with providers and staff representatives have broadly welcomed the initiative. Further work will be led by the HSCB to develop viable options which will be acceptable.

7.4.2. Obtaining accurate information about the funding of domiciliary care services poses different challenges. Reference was made earlier to the contradictory acknowledgement of the need to invest in what is arguably the bedrock of community based care alongside the annual identification of this funding as a potential source of cost savings. These funding streams will require specific coordination and monitoring, as we move forward, in order to address the prospect of future cost pressures coming through the system and the need to use funding for domiciliary support in an interchangeable and flexible way (See Para 7.7)

This will require a more coordinated approach by the HSCB and LCGs to jointly reviewing any future, aggregated domiciliary care allocations to agree the strategic parameters within which the funding will be applied, volumes and outcomes.

7.5 The Market: Originally the project aimed to produce a detailed analysis of the local domiciliary care market with information about market share, provider volumes/coverage/income, and market trends. Whilst the report covers some of these topics our arrangements for sourcing and analysing this data are poorly developed. Hence, the obvious reliance in the report on comparative information elsewhere in the UK where domiciliary care, as a subject of research, policy and operational analysis, has received much more attention and focus. Any future procurement arrangements must be underpinned by a much better developed understanding of local and regional market functioning on an on-going basis. This support is more appropriately located within the Procurement and Logistics Section (PaLs) of the Business Services Organisation (BSO).

Domiciliary care market monitoring lags behind the arrangements which have been developed for residential and nursing home care following the demise of Southern Cross. These have matured in the interim to incorporate closer links with RQIA, contacts with other regions of the UK and monitoring of market developments. There is a strong argument for combining domiciliary care monitoring within these arrangements and developing a more in-depth working knowledge of market functioning. This is likely to become invaluable as Trusts negotiate the outcomes of future procurement exercises.

An aspect of market management which has not been explored to any great extent in the course of the Project has been the interface with providers. Arguably, this will require consideration as the processes, outlined above, develop. In addition, the relationship with Trusts will pose major challenges when tendering is initiated. The HSCB needs to consider how more formal, on-going arrangements for dialogue can be established to deal with the implications of any new arrangements for service delivery.

7.6 Consultation: The importance of canvassing the views of service providers, users and staff representatives has been recognised and reflected in the analysis presented in **Section 4**. The generally high levels of satisfaction with the service compare favourably with many

other surveys of community care provision. At the risk of over simplification, the challenge which directly, or indirectly, addresses the concerns of all of the interested parties lies in ensuring the availability of a workforce that is adequately trained, remunerated and facilitated to provide the service to appropriate standards. If this can be achieved it will begin to address many of the specific and/or anecdotal problems identified by respondents. It highlights the importance of this issue and the need for workforce regulation and development initiatives to be closely linked with the management of the more technical changes referenced earlier. NISCC and the domiciliary care workforce review recently initiated by Departmental Regional Workforce Planning Group will be important factors in helping to coordinate these initiatives.

7.7 Interfaces: Whilst the opening section of the report identified quite a focussed approach to examining domiciliary care it also acknowledged that no service should be viewed in isolation. The subsequent analysis of other initiatives has helped to bring into sharper relief the:

- region wide consolidation and specialist approach of Trust in-house services, primarily in the form of reablement, and
- significant attitudinal and financial challenges in rolling out self directed support.

The linkages and mutual dependency between reablement and both statutory and independent sector domiciliary care in terms of operating effectively are becoming increasingly apparent. This points to the need to coordinate funding across these services. The same can also be said about self directed support which will be reliant on the availability of domiciliary services and funding for its success. In view of the current financial challenges developments in this area of work need to be coordinated rather than being regarded as individual projects and there is a need to give consideration to more regionalised, strategic arrangements for the use of available funding. This would benefit from the improved information flows and financial management proposed earlier in the narrative.

7.8 Trust models: The audit of Trust arrangements for delivering the service focussed on operational management and structures,

contracting arrangements, service challenges, staffing, finance, user involvement and future developments. One of the original objectives of this exercise was to identify ‘best practice’ as a possible basis for a preferred model for the delivery of domiciliary care. It was not possible to identify any particular Trust because of significant anomalies regarding different tariffs, statutory/independent market shares and brokerage and the implications of pending procurement exercises. The differences prompt suggestions that more prescriptive commissioning statements could be developed in order to promote greater consistency. The analysis does however reinforce the principles and features of best practice outlined in **6.3/6.4** above in advocating the need for:

- An optimum number of providers with longer-term contracts to stabilise the market.
- A move away from ‘time and task’ contractual arrangements and the promotion and development of more outcomes based approaches which are more responsive to client needs.
- Promoting more flexible funding arrangements to enable individuals to secure more personalised care options.
- A greater focus on workforce development and terms and conditions.

The evidence also strongly suggests the need for greater regional consistency in relation to governance, monitoring, contracting arrangements which would, in turn, provide a firm basis for addressing funding and workforce challenges. Comparisons with elsewhere in the UK have been used occasionally in the course of this narrative and the difficulty associated with this has been acknowledged. They can and should be considered as points of reference for targets and performance indicators as part of the changes outlined above.

7.9 Procuring the service: The previous discussion helps move the debate neatly to the final strand of the terms of reference, to the issue which has been a constant theme throughout the report and has now potentially become the most important factor in the future development of domiciliary care in Northern Ireland. The variable in question is the tendering of services. The proposed Trust sequencing was briefly

referenced in **Section 6** but the completion of this report coincides with the responses to the first of the tendering exercises being received.

7.10 Firstly, the response of the market to the WHSCT tender is difficult to predict because the impact on existing providers of uncertainty about the prospect of the tendering process has already been mentioned. The recent reduction in the number of providers in the Trust may increase as a result. It is not clear what proposed costs the Trust may need to consider but a combination of the existing reported pressures within the system and pending developments may significantly increase the overall bill for domiciliary care and the number of hourly rates. There may be other unanticipated consequences which need to be considered but those already identified have the potential to radically reshape domiciliary care delivery in this locality. It is imperative that the HSCB monitors the implications by maintaining close liaison with the Trust.

7.11 The challenges which may emerge from the above scenario will become even more difficult when the remaining four Trusts go to the market. The overall pattern of service providers may see further re-shaping, consolidation, departure which may, in turn, create a degree of short to medium term instability that must be monitored and managed. The possible increase in tariff rates referenced above may proliferate further through an incremental roll-out. This will move the region even further away from the prospect of more standardised rates which might provide a more viable basis for future contract negotiations. An absence of coordinated effort may result in Trusts losing some of the benefits of the similarities between services which, as referenced above, clearly emerged in the audit exercise.

7.12 On balance, an analysis of the potential risks associated with individualised approaches would strongly suggest that the HSCB and BSO should examine options for collaborative working in taking forward tender processes elsewhere. While local considerations and flexibilities need to be respected the longer term, strategic and economic challenges require a strong regional influence on developments.

7.13 For the sake of completeness and in order to reinforce the scale of the challenges and proposed response two other important factors need to be considered – one anticipated and the other unexpected.

The former is the recent Ministerial announcement of the introduction of compulsory registration for social care workers in domiciliary and day care settings, rollout of which commenced in September 2015. In terms of status and public reassurance this is a very welcome development but the implications of the costs of registration cannot be predicted in terms of the preparedness of employees to incur registration costs. Whilst these may be relatively modest it is but one more variable which needs to be closely monitored. The latter is the budget announcement of the introduction of the ‘living’ wage in April 2016. This will require an urgent costing exercise to try to identify as precisely as possible the financial impact upon the service.

A Managed Change

7.15 During the next three years we are likely to will see some of the most far reaching changes to the delivery of community care services since the introduction of care management in the early 1990s. The important distinction to be made is that these will take place in an era of financial retrenchment and a more fundamental renegotiation of the relationships between the service user, provider and commissioner than we have seen previously. Domiciliary care, for the range of reasons outlined earlier, will be at the forefront of these changes. Whilst this presents potentially exciting opportunities to modernise and reform many aspects of care delivery there is a need to acknowledge the very real risks of destabilisation if the process is not carefully managed.

7.16 The original Project aim of identifying a new model for the delivery of domiciliary care in Northern Ireland has proved challenging. This has partly been due to the current procurement processes and proposals but when this is resolved the core issues which need to be resolved are the tensions between local and regionalised approaches, task or outcomes based service provision and how the funding challenges are to be addressed. This must be taken forward in a coordinated way alongside the development of a much more strategic approach to delivering the

service. The following recommendations are intended to provide a framework for managing this effectively.

Recommendations

Based on the findings of this review our recommendations are set out below and summarised in Table 4.

Structure. The management of change will be dependent on effective oversight arrangements which make best use of and link with a range of existing initiatives. The **HSCB** should review the current social care procurement arrangements to separate the technical aspects of procurement from market monitoring and redesign.

- The current **Regional Social Care Procurement Group** will be restructured and focus on the former; and
- A **Community Care Forum/Task Force** should be established to oversee and monitor domiciliary care, developments. It should incorporate the work of the **Reablement Project Board** and oversight of residential and nursing care.

Linkages. The Forum should establish formal links with the **Regional Workforce Planning Group - Domiciliary Care Working Group, NISCC** to develop a coordinated approach to workforce development.

The work of the Forum should be informed by the **Self Directed Support Project Board**.

Developing the Agenda The Forum should prioritise the formation of workstreams focussing on:

- Improving Information;
- Development of regular, formal liaison with service providers.

Investment. The **HSCB** should introduce a more managed approach to funding domiciliary support services to address demographic and cost pressures and promote strategic change. This will require greater

regional coordination of proposed domiciliary care investments with **Local Commissioning Groups** as a basis for local decision making.

Costings. Work should be undertaken by **HSCB** to assess the impact of the introduction of the living wage in 2016 and ensuing years

Detailed work should be undertaken by **HSCB and Health and Social Care Trusts** to identify more precisely the comparative hourly cost of care provided by the statutory and independent sectors.

Workforce Planning. The HSCB are working with the DHSSPS who are leading a workforce review associated with domiciliary care. The review and its action plan will be aligned with the workforce challenges presented in this report. Workforce planning will be taken forward in parallel with the other actions set out in this report, and with the collaboration of the DHSSPS, Board, Trusts and the Northern Ireland Social Care Council.

Procurement. Management of tendering processes should be phased with the WHSCT outcome being evaluated prior to the remaining **Health and Social Care Trusts** working with **BSO Procurement and Logistics Service (PaLs)** to coordinate learning and best practice before moving to local procurement.

Innovation. The **HSCB** should research and examine progress in Great Britain in the implementation of outcomes based models of domiciliary care in order to inform local service developments. The results of the SHSCT outcomes based pilot need to be examined.

Policy. The **HSCB** should seek clarification from **DHSSPS** regarding any determination about charging for services arising from its on-going review of adult social care.

The **HSCB** should formally request the **DHSSPS** to review the annual Departmental Circular in relation to domiciliary care to more accurately reflect current operational practices.

Technology. HSCB and Trusts should progress business case development in respect of an agreed Electronic Monitoring System in dialogue with the sector and staff representatives as appropriate.

Contingency Planning. Trusts should review contingency planning arrangements to deal with any significant domiciliary care market instability.

Table 4 : Summary of Actions and Lead Responsibility		
Recommendation	Lead Responsibility	Target Date
Policy	DHSSPS (clarification that policy will be reviewed)	Dec 2015
Technology	HSCB – Social Care	Dec 2015
Structure	HSCB – Social Care	Jan 2016
Costings	HSCB – Finance	Jan 2016
Contingency	Trusts	Jan 2016
Innovation	HSCB – Social Care	Feb 2016
Procurement	BSO – PaLs	Mar 2016
Workforce Planning	DHSSPS	Mar 2016
Investment	HSCB – Commissioning and Finance	Mar 2016

What will happen next?

The HSCB will take the regional lead in co-ordinating the actions set out above with the relevant stakeholders (DHSSPS, BSO and Trusts). The Board will also take forward further discussions with service users/carers and groups that represent their interests to help shape the specific actions which we need to take the address the challenges set out above.

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