South Eastern Health and Social Care Trust

Home Care Reform

Summary Report

Quality Improvement & Innovation SEHSCT

South Eastern Health and Social Care Trust

Home Care Reform Introductory Summary

Programme Overview

The Social Care Reform in Northern Ireland addresses critical challenges stemming from an aging population, a reduced workforce capacity, and financial constraints. Recognizing these pressures, the South Eastern Health and Social Care Trust (SEHSCT) designated Home Care Reform as a Corporate Improvement Priority, dedicating resources and focus towards transformative change in service delivery.

Programme Methodology

The reform process employed innovative systems thinking to identify both the challenges and opportunities facing the sector, with coproduction—engaging multiple stakeholders—as a core guiding principle. Key elements of the reform included strong senior sponsorship, the appointment of a dedicated project lead, integration of digital tools, and continuous reflection on progress.

A dynamic and collaborative relationship was cultivated between operational managers, frontline teams, and Quality Team.
Through ecosystem mapping and data analysis, a comprehensive strategic improvement plan was developed, comprising four main initiatives:

1. Establishing a Home Care Assessment Service (HCAS).
2. Implementing a Collaborative Approach to address the Unmet Needs List.
3. Introducing a three-tiered model for coproduction in service delivery.
4. Developing an integrated digital dashboard for real-time monitoring and decision-making.

Programme Impact

The program's measurement plan embedded quality metrics to monitor and assess the impact of the changes. Early results indicate significant success:

- The Unmet Needs List has been reduced from 800 individuals awaiting service in October 2022 to just 168 in February 2025.
- The reform of service provision through HCAS has led to a 198% increase in service hours between January 2024 and September 2024.
- The estimated cost savings to the service are £1,059,154.
- Improved patient flow, particularly in supporting timely hospital discharges.

Programme Outcome

The positive outcomes of the reform programme have included a cultural shift empowering Home Care Workers through feedback mechanisms and collaboration in decision making in relation to the unmet need list. The three-tiered coproduction model exemplifies inclusive healthcare design, engaging service users in shaping their care experiences.
In conclusion, the Home Care Reform initiative stands as a robust example of successful service transformation. It offers valuable lessons in redesigning complex healthcare systems, with potential for broader application across the sector.

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Contents

Section 1: Corporate Improvement Priority

Regional Context; Social Care Reform

Social Care Reform in Northern Ireland has been an ongoing and dynamic process aimed at addressing the challenges posed by an ageing population, a decreasing working-age population, an increasing demand for services and financial constraints.

Over the past 10 years, the Department of Health has been focused on strategic reform efforts, initiating a comprehensive review of adult care and support in 2012. In 2017, the Department established an Expert Advisory Panel to develop informed proposals, publishing a report outlining 16 proposals to reform adult social care. These proposals emphasised the essential role of social care in individuals' lives and highlighted the need for a system that is responsive to changing demographics and public expectations. In 2020, the Department released a detailed consultation document, presenting 48 proposed actions to reform the adult social care system over the next decade. The publication of the "Reform of Adult Social Care Consultation Summary Report", in 2021 provided an independent analysis of responses and feedback from the public consultation. This report identified key themes under 6 strategic priorities and was used to inform the next steps in developing adult social care reforms. The Department of Health's 2022 "Consultation on The Reform Of Adult Social Care" set out a vision for the future of adult social care services, at the centre of which was: 'an evidence based, whole systems approach to the design and delivery of adult social care in co-production with service users and carers'.

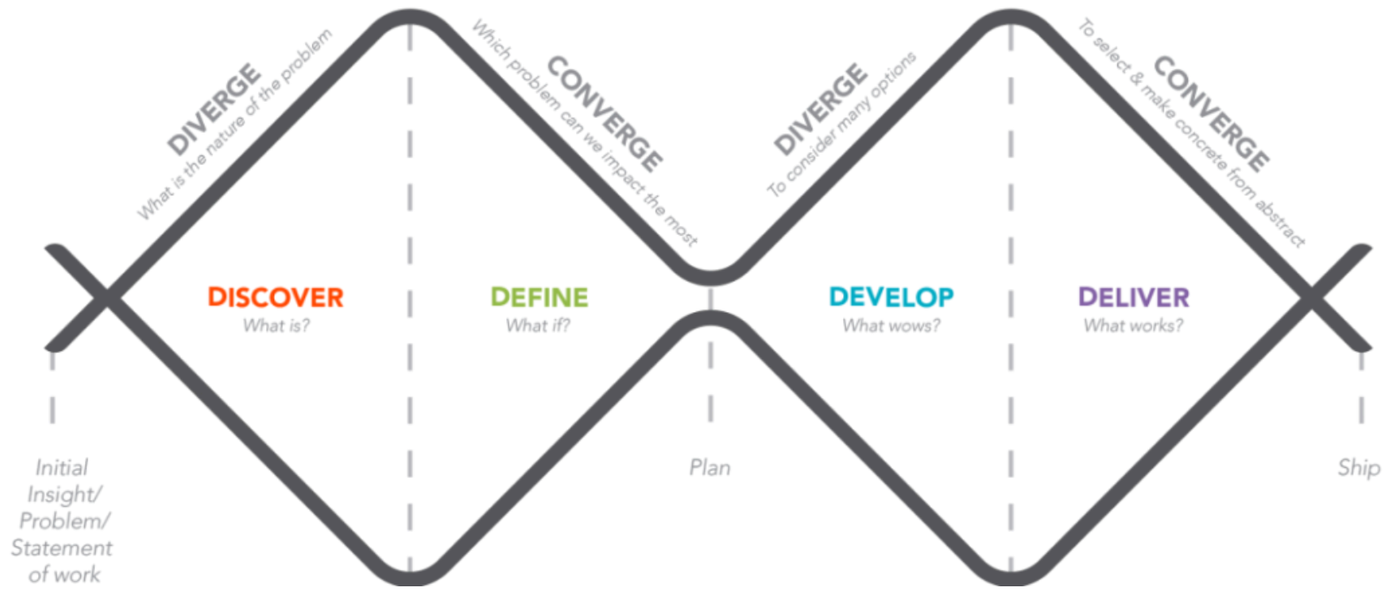
Systems Thinking

To address long-term challenges in Health and Social Care, a new approach was required—one which embraced the complexity of population health across sectors. Systems Thinking, particularly the **Double Diamond methodology**, offered a structured way to transform services across sectors. The Double Diamond process divides into four phases: Discover, Define, Develop and Deliver.

1. **Discover:** Beginning by questioning the challenge and conducting research to understand user needs.
2. **Define:** Analysing the research to align user needs with the problem, creating a clear design brief that defines the challenge.
3. **Develop:** Focusing on creating, testing and refining multiple potential solutions.
4. **Deliver:** Choosing the most effective solution and preparing it for implementation.

This iterative process emphasised user-centred design and continuous testing to ensure that solutions meet the real needs of those involved. Recognising the challenges of increased pressures on Home Care Services, the Quality and Primary Care and Older People Teams applied the Double Diamond approach.

Design Thinking **'Double Diamond'** Process Model



Source: Design Council UK 2025

Section 1: Corporate Improvement Priority

An SET Corporate Improvement Priority

The South Eastern Health & Social Care Trust's (SEHSCT) Home Care Services are under acute pressure with high demand and limited capacity. This has had an impact on both service users and staff working within Home Care, but also has also created significant consequences for other healthcare pathways which rely on the Home Care capacity to help individuals in their own homes and ensure time-efficient discharge from hospital.

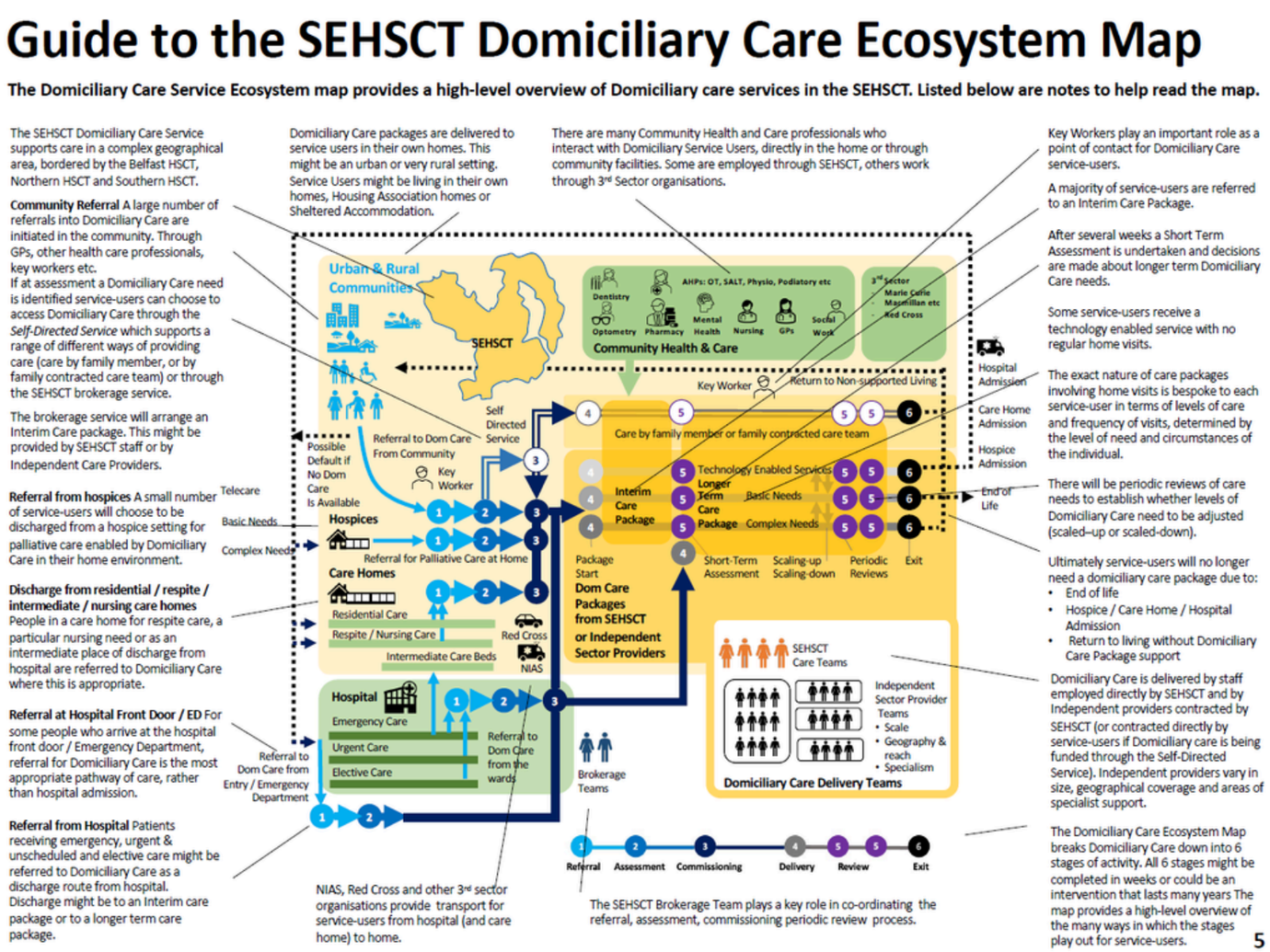
In the future, challenges facing the SEHSCT's Home Care Services will continue to grow. Northern Ireland Statistics and Research Agency's (NISRA) projections estimate that between mid-2018 and mid-2043, the population aged 65 and over will increase by over 50%, and the population aged 85 and over will increase by over 100%.

Against the backdrop of these pressures, strategic landscape and growing demand for Home Care Services, Home Care was made a SEHSCT Corporate Priority in 2021. The Trust applied a Quality Management approach and set out to create a comprehensive map of the current Home Care ecosystem.
Partnering with a System Designer - Tom Inns - a series of inductive workshops were conducted with an extensive group of stakeholders from community and voluntary organisations, councils, SPPG, PHA Trust, Independent Home Care providers and service users. Over 90 people participated in exploring the interactions and service user journey across the system. **Ecosystem Mapping** is the development of a high-level visual representation of: the key pathways that make up Home Care, the stages within these pathways, connections with other services and a representation of the journey of service users through the system. The Ecosystem Map was then used as a catalyst to provide a shared understanding of Home Care in SEHSCT, as well as to inform and prioritise future improvements across the service.

The Ecosystem Map was used to visually outline the recommendations and opportunities for reform and improvements across the service.

To **view the full Ecosystem Report link here**

Eco-System Mapping; Where we started



Section 2: How the Projects Were Developed

Introduction

In pursuit of strategic improvements to Home Care Services within the South Eastern Health and Social Care Trust (SEHSCT), a collaborative partnership was established between the Quality Improvement Team and the Home Care Team. Recognising the complexity of implementing transformational change, a Project Lead was appointed to spearhead this initiative for one year; adopting a novel and innovative approach that integrates expertise in improvement science with an in-depth knowledge of service delivery.

Establishment of the Project Team

A multidisciplinary Project Team was formed, comprising of representatives from relevant Directorates. These included the Home Care Service, Quality Improvement Service, Contracts Department, Hospital and Intermediate Social Work Service and the Community Older People's Service. In its initial stages, the Team convened to review recommendations outlined in the Ecosystem Map, using these insights to identify key areas for focus and determine the strategic direction for the modernisation of Home Care Services. Due consideration was given to the availability within the aforementioned services to engage with the improvement work; in particular considering disruption caused by the launch of the new Encompass system across the SEHSCT in 2023.

With Home Care being a Trust Corporate Improvement Priority, the programme received senior sponsorship and thus the Team were tasked with providing quarterly updates to the Trust Board.

Project Lead: Pamela Fillis

The Project Lead was responsible for taking forward the project's key reform elements and implementing them into the development of a new model for Home Care Services. These were in line with the Regional direction for the delivery of care and support in individuals' own homes. They also had a key role in the organisation of arrangements related to the implementation of the new service model: working with Trust staff, providers, users and carers; including future procurement arrangements.

The Project Lead had weekly mentorship meetings with the Assistant Director of Quality Improvement and Innovation to develop the programme, as well as to aid the leadership and systemisation of change.

Section 2: How the Projects Were Developed

The Team identified the following priority areas requiring attention to advance the modernisation efforts:

1

Complex Delays

- Persistent delays in providing Home Care services for individuals awaiting discharge from hospital remained a challenge. These delays necessitated urgent intervention to streamline processes.

2

Over-Prescription of Care Packages

- The tendency to over-prescribe care packages was identified as an area requiring review to ensure efficiency and appropriateness of care delivery.

3

Service Delivery Variances

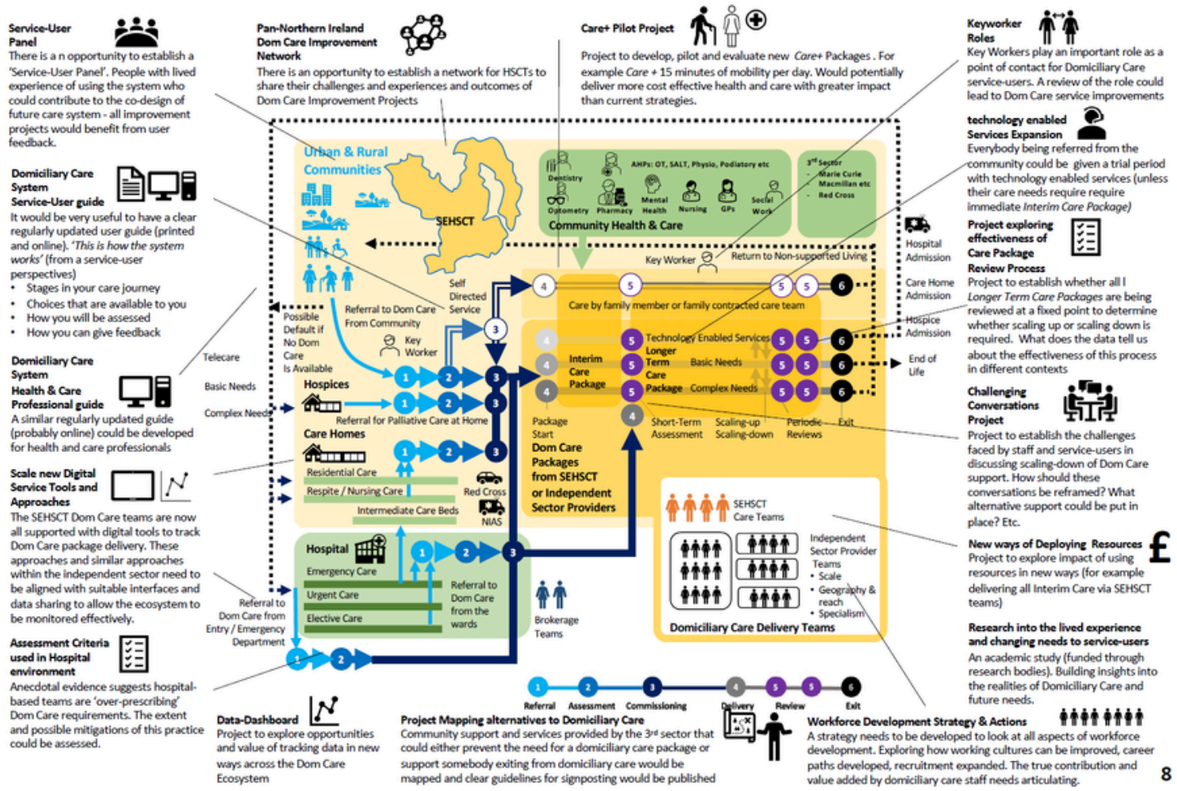
- Significant variances were observed within and between Independent Sector providers and Trust Home Care teams in their delivery of services. These discrepancies posed challenges to the development of new and sustainable service models.

4

Care vs Support

- The underutilisation of varied Self-Directed Support (SDS) options was highlighted as a critical issue. This limitation directly impacted the Unmet Need List (the live list of the number of service users waiting for a Trust Managed Home Care service), necessitating strategies to increase the uptake of all SDS options. This included managed budgets and direct payments, rather than all service user needs being met by a Trust Managed Service.

The Ecosystem Mapping exercise was employed to actively identify potential opportunities for transformation within Home Care Services. These opportunities were then prioritised through an evaluation matrix, which took into account regional and organisational strategic priorities, as well as the tacit knowledge and experiences shared by service users and caregivers. Following this, a series of projects were developed and coordinated to support the modernisation of Home Care Services.



Impact of System Thinking

This strategic initiative represented an innovative approach within SEHSCT, applying System Thinking principles to a complex challenge. This has since fostered a synergy between improvement science and service delivery expertise. By addressing the identified focus areas, the Project Team aimed to modernise and optimise Home Care services, ensuring they were sustainable, efficient and responsive to the needs of the wider population within SEHSCT.

Section 3: Core Fundamentals of Change

Introduction

For system transformation to be effective, it is essential to address the Core Fundamentals that underpin sustainable change. These foundational elements, which encompass processes, mindsets, and systems, must be integrated throughout the iterative improvement process. In the modernisation of Home Care services, four key components were identified as critical to the successful implementation of change: Senior Sponsorship, Digitalisation, Co-Production, and The Power of Pause. These components are outlined as such:

Core Fundamentals of Change

Senior Sponsorship

Senior Sponsorship provided the leadership, authority, and resources necessary to drive meaningful change. Their influence ensured that the project received visibility, support and engagement across all levels - fostering a culture of accountability and commitment and removing barriers that might hinder progress. Additionally, Senior Sponsorship signalled the importance of the initiative: motivating teams and stakeholders to collaborate and maintain focus on achieving sustainable improvements.

The Project Lead

This transformation project required the creation of a unique role, where someone experienced in service provision was selected to become a specialist in System Thinking and improvement methodology. This was done with cognisance of the Team's structures, processes and culture modelling opportunities for change. The Project Lead was embedded in the Quality Improvement Team, enabling them to apply robust implementation science methodology to lead and systemise change.

Digitalisation

The investment in Digitalisation within the Home Care Service aided the Quality Improvement Projects by offering access to accurate and timely data, which enabled evidence-based decision-making. More broadly, by leveraging digital technologies, the Projects were able to scale and sustain Quality Improvement more effectively, advancing innovation and producing better outcomes.

Development of a Three Tier Model for Co-Production

Engaging service users fostered a deeper understanding of challenges, uncovered insights that may be overlooked by professionals and ensured solutions were practical and meaningful. Their participation enhanced trust, promoted equity and helped to build a sense of shared ownership; increasing the likelihood of sustainable success.

The Power of Pause

The Power of Pause in Quality Improvement Projects highlighted the importance of taking adequate time to plan, reflect and adjust; in order to ensure meaningful success. It fostered intentional decision-making, reduced the risk of rushed errors and created space for creative problem-solving. By deliberately incorporating time to reassess and refine strategies, teams were able to adapt to evolving circumstances and ensure that improvements were sustainable. The Power of Pause was key to achieving impactful and lasting results.

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Section 4: Home Care Reform

Aims

The Improvement Journey

Defining our focus

For the system transformation to remain focused, it was important to clearly define aims for the work to be undertaken. This enabled a clear understanding of the purpose, scope and timeframe of the work. Additionally, by setting clear aims, subsequent clearly defined metrics including outcome and process measures were able to be identified to demonstrate that change was leading to improvement. Two key aims were set: a Global Aim defining the context for the work, and a Specific Aim to state the aspiration and expectation for the work on reducing unmet need.

Specific Aim

To reduce the number of Service Users waiting for Home Care Services on the Unmet Need list by 15% between September 2023 and December 2024

Global Aim

With the projected growth in population of people aged over 65, it is predicted that an increase in related Health and Social Care needs will place further demand on an already saturated Home Care Service within SEHSCT. The importance of reforming the Home Care model is paramount to ensuring available capacity to meet both current and future population needs. Home Care Reform commences with understanding our unmet need and ends with balancing demand and capacity. By working on this now, SEHSCT will reduce unmet need and provide responsive services to meet individual needs .

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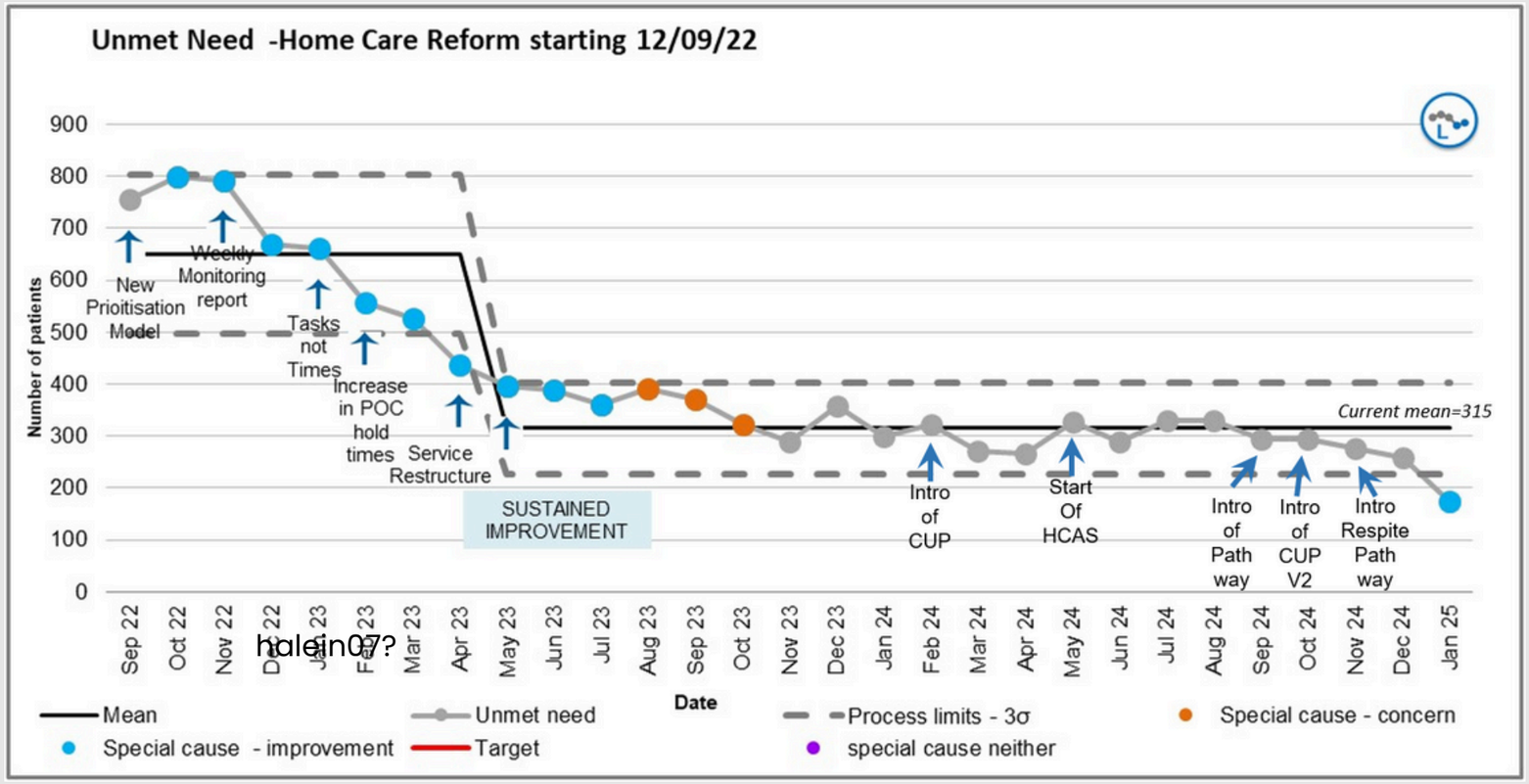
Section 4: Home Care Reform

Outcomes

The Improvement Journey

A strong focus on data and core metrics has enabled improvements driving system transformation to be captured and has focused decision making. A Statistical Process Control (SPC) chart capturing the reduction in Unmet Need clearly articulated the introduction, testing and developing the key change ideas (outlined below) and their impact. The SPC chart started with wide variation and a monthly mean of 650 people with unmet need from September 2022 - May 2023; following which there was a move to sustained improvement with reduced variation and a monthly mean of 318 people with unmet need. A relentless focus on improvement is driving further reduction from July 2024 and at December 2024 was indicative of a 30% decrease in the unmet need list



New Prioritisation Model: An allocation model was introduced to enable the Care Bureau to prioritise referrals as they come in from varied sources, such as:
P1 (priority 1) -hospital referrals
P2 -interim care bed referrals
P3 -emergency community referrals
P4- community referrals

Weekly Monitoring Report: An unmet needs list validation task was sent out weekly to Community Teams for review of the Unmet need list- this was introduced for a period of 3 months.

Tasks Not Time: A refocus of how care plans are written and agreed, where the time allocated would be redefined and articulated as 'up to' and based on how long it takes to carry out the prescribed tasks. This reduced unnecessary non-value-adding waste where previously time was spent in the home during the allocated time frame with no assessed need tasks to complete.

Increase in Package of Care (POC) Hold Times: A POC is held open during the time in which someone is admitted to hospital or respite care. This timeframe was extended from 15 to 19 days.

Service Restructure: A restructure of the Home Care Service into two core Teams:
- A **Care Bureau** to manage new referrals, arrange allocations, manage Unmet need list, and with overall responsibility for training and governance across the entire Home Care service.
- A **Home Care Team** responsible for the direct provision of care service.

Collaborative Unmet Needs Panels (CUP): The introduction of a process to identify and categorise unmet need, and promote proactive, collaborative strategies for risk mitigation and prioritisation.

Home Care Assessment Service (HCAS): The introduction of a new model integrating the role of the Care Bureau/ SET Home Care Service directly into the management of service user outcomes and flow.

The 4 initiatives key to reducing unmet need are outlined in more detail through out this report.

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Projects Outlined

Summary

Through the process of Ecosystem Mapping and the formation of the Project Team, 4 key initiatives were identified and prioritised for action. This approach allowed for the alignment of the projects with corporate priorities, creating the greatest opportunities for improvement. Strategically prioritising immediate and long-term gains, the Trust ensured that resources were directed toward initiatives with the highest potential impact.

Projects

Development of a Short-Term Long-Term Model for Home Care Services

Home Care Assessment Service (HCAS): This was the new model for the delivery of short-term Home Care Services within SEHSCT. The service was available to anyone over 18 years old who required a period of assessment alongside their Home Care Service. The service harnessed the live information that Home Care had available to them on how service users utilise their services, and shared this with the relevant professional involved to enhance the assessment process.

Development of an Unmet Need Management system

'CUP'- Collaborative Unmet Need Panels: This was a new process introduced to offer enhanced understanding, oversight and management of the SEHSCT Unmet Need List; looking specifically at service users who were awaiting a Home Care Service for over 90 days.

Development of a User Guide to Care & Support Services in SEHSCT

A User Guide; Accessing and Navigating Care and Support in Adult Services: This was the development of an interactive and informative guide to enhance the public understanding of how Home Care Services were assessed, accessed and supported throughout an individuals' journey.

Data Driven Service Monitoring and Future Service Planning

Developing a Data Dashboard for Home Care Services: This was the development of a user-friendly, scalable and secure Data Dashboard which enabled the Home Care Service to enhance operational efficiency, deliver high-quality targeted care and anticipate and adapt to future challenges and demand.

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Project One: Home Care Assessment Service (HCAS)

Project overview

The primary project for the transformation of Home Care Services was set out to develop a short-term/ long-term model for Home Care delivery within SEHSCT.

The objectives of the project were to:

- Improve flow for hospital discharges
- Improve capacity within the Home Care system
- Ensure equity for all service users entering the system
- Ensure processes are in place to avoid saturation of short term Home Care services
- Introduce real time feedback loops that are patient centred at point of care.

Primary Change Ideas

Idea 1:
Integration of the Care Bureau and SET Home Care Service roles into management of service user outcomes

Idea 2:
12 Week Short-Term Home Care Service

Idea 3:
Provision of Service User Reports from Home Care Workers

Primary Change Ideas

The new model for short-term care within South Eastern H&SC Trust implemented 3 primary change ideas:

1) Integration of the Care Bureau and SET Home Care Service roles into management of service user outcomes
The new model integrated the role of the Care Bureau/ SET Home Care Service directly into the management of service user outcomes and flow. Following service user consultation it was agreed that the service would be called the Home Care Assessment Service (HCAS). This service sat outside of any one service. For example: hospital, Older People's Short Term Assessment Team (STAT) and Early Review Team; and was available for all Adult Social Care Teams to utilise under the following criteria-
Service users who:

- Are discharging from hospital
- Are discharging from an interim care bed
- Are engaging in rehabilitation or re-ablement services
- Are experiencing significant changes in their care needs
- Requiring end of life care and support

2) 12 Week Short Term Home Care Service
The HCAS offered a Home Care Service for up to 12 weeks while service users engaged in an assessment journey under their allocated key worker team. Previously, there was no established time frame or goal for how long the short-term care team would provide care to a service user. This change was designed to enable a more dynamic assessment process, enabling assessments to be conducted in a truer environment which also provided the opportunity for recovery.

3) Provision of Service User Reports from Home Care Workers
The Home Care Team provided key workers with service user progress reports at week 4 and week 8 (or as required), to inform the key worker/MDT assessment of how their care was being used in real time. The report then advised if the care was:

- Being delivered as per care plan
- Evidence for decrease in the service, either to number or calls or length of calls
- Evidence for an increase in the service
- Evidence for an extension to assessment period
- Evidence for discharge

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Project One: Home Care Assessment Service (HCAS)

Measurement Plan

A Measurement Plan was embedded into the development of the service to understand the impact of the changes tested and establish a clear understanding of the benefits of the initiatives.

Measures

Flow Rate: Used to measure the variation between demand into the HCAS and the capacity released. This demonstrated that the service did not saturate and the flow rate had limited variation.

Discharge Outcomes: Stratifying the 3 outcomes of the service users discharged from HCAS:

- Discharged and no longer requiring a Home Care Service
- Transferred to a long term care provider
- Admitted to hospital.

Savings: Savings attributed to the improvement work. These proposed savings included service users who were:

- Discharged and no longer requiring a service
- Transferred to long-term care providers with decreases in their service
- Estimated savings for impact on hospital discharges.

Aims

Flow Rates: The aim of the project was for the short-term model of Home Care to increase available capacity within our short-term care teams and move from a negative flow rate to a positive flow rate, this was tested between November 2023 and December 2024.

The flow rate of the HCAS service was defined as the variation between the demand into the HCAS through new service users started and the capacity released back into the service through discharges from HCAS. A positive flow rate equated to the variation being close to 0.

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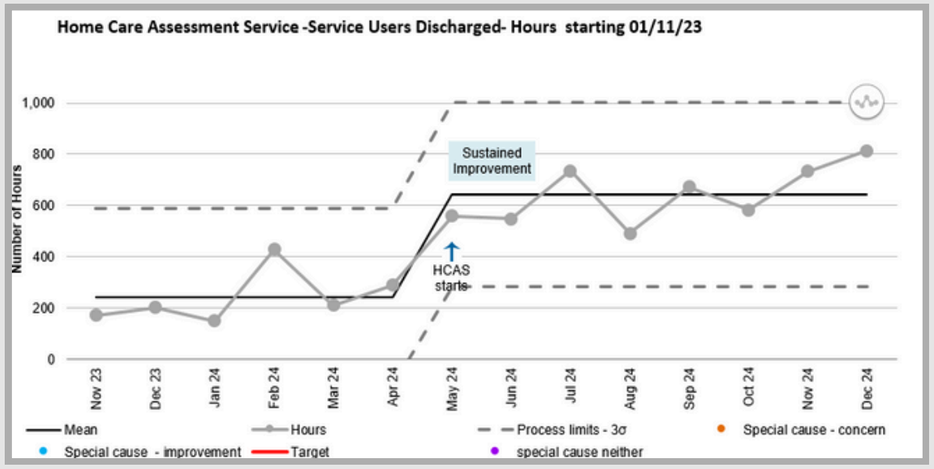
HCAS Outcomes: Flow Rate

Project Outcomes

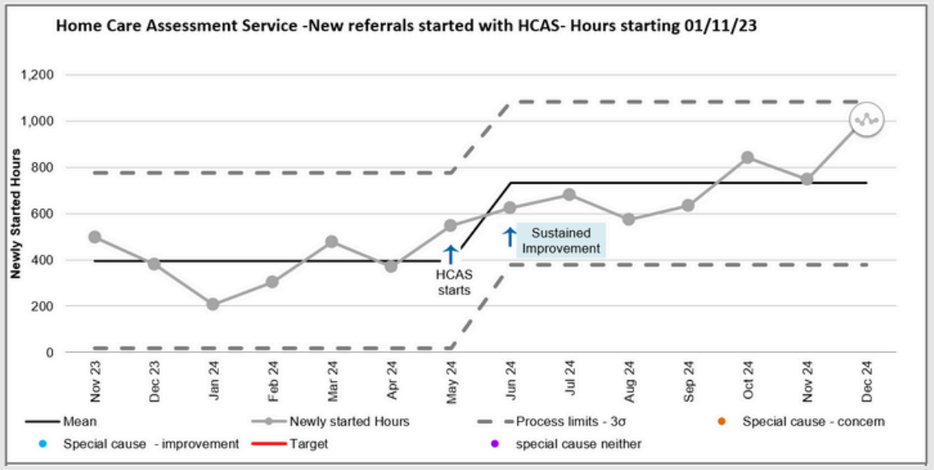
The following SPC charts show improvement in capacity (hours) released for Home Care through the introduction of the HCAS model. This in turn has significantly contributed to availability of hours to meet the demand of new referrals to the service.

Chart 1



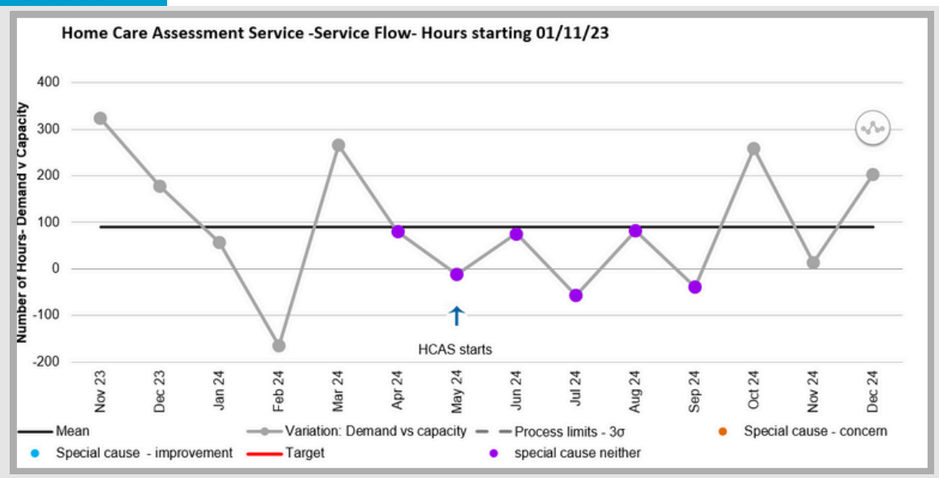
- HCAS demonstrates a sustained improvement in capacity released back into Home Care Services. This was achieved through a closer focus on assessed service need and an earlier move to discharge where need was no longer identified
- This represents a **170% increase in hours released** (discharges) within HCAS compared to pre-HCAS levels in Q4 2023/24 to Q3 2024/25.

Chart 2



- HCAS demonstrates a sustained improvement in managing the demand within the service, through increased acceptance of new Home Care referrals
- This represents a **198% increase in capacity (hours)** within HCAS compared to pre-HCAS levels in Q4 2023/24 to Q3 2024/25
- Based on pre-HCAS Q4 2023/24 figures, this represented **an additional 279 hospital discharges facilitated by the HCAS.**

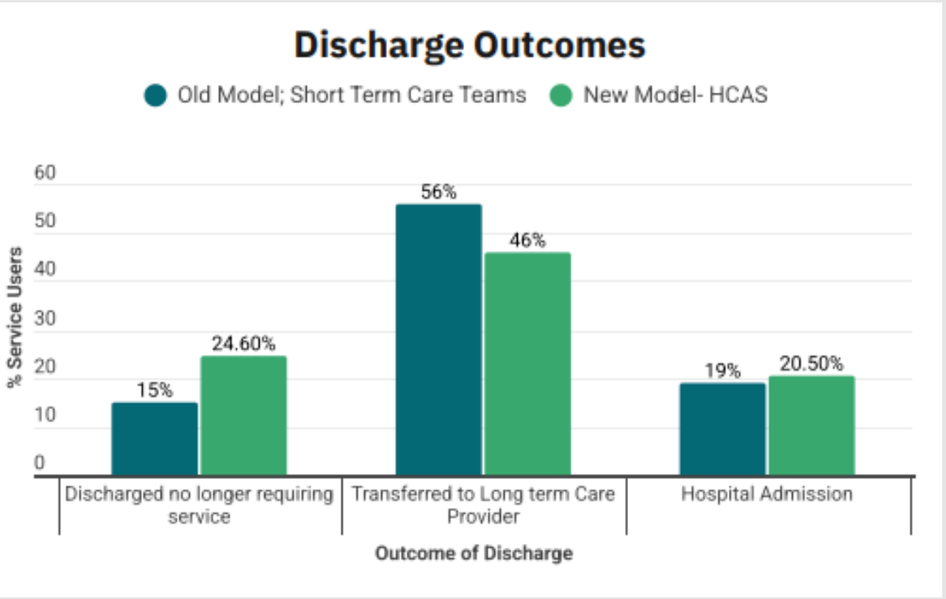
Chart 3



- HCAS flow has been maintained, with the variation demonstrating a period of limited variation and the majority positive variation - this is in line with a growing service. But further monitoring and understanding should be given to this moving forward with spread and scale.

HCAS Outcomes: Discharges & Impact

Project Outcomes



The use of data provides insights into how the HCAS model is impacting service delivery. Within the scope of the project, changes in the profile of discharges were noted relating to people who either no longer required a Home Care Service, were transferred to longer term providers or required hospital readmission as can be seen in the bar chart opposite. Within the context of discharge from the service the following is noted:

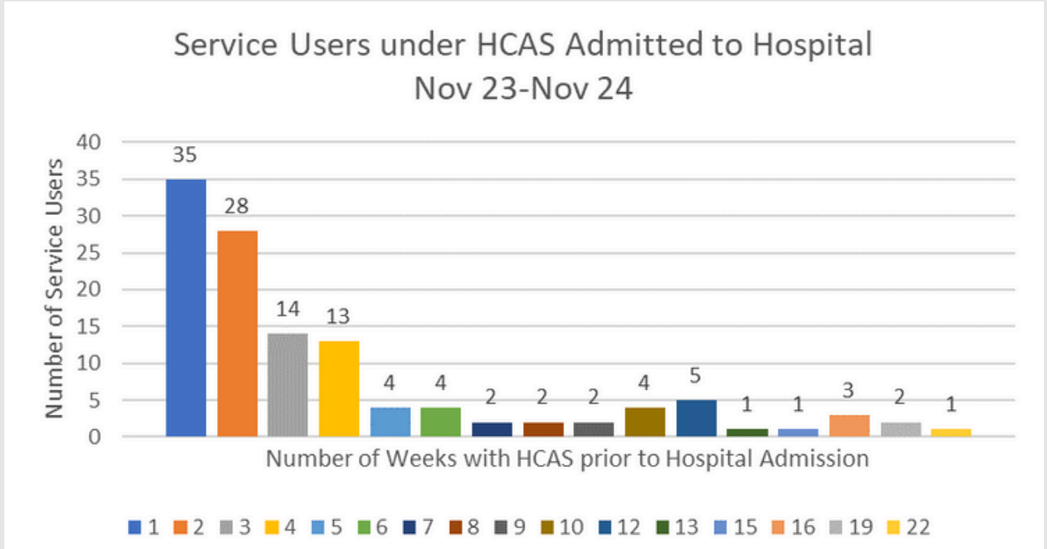
- Through the introduction of the HCAS a positive correlation was observed between the number of service users who were transferred and those who were closed due to hospital admission or no longer required the service

- An increase in the number of service users who were discharged (as they no longer required a Home Care Service), was directly related to a decrease in the number of service users transferring to long-term care providers.

A better understanding of people discharged from the HCAS due to hospital readmission has informed decision making. The bar chart opposite provided data on the length of time (weeks) a person was within the HCAS prior to hospital admission.

- Discharges from the HCAS due to an admission to hospital represent 23.4% of total HCAS discharges, of which:

  - 87% were readmissions
  - 29% were admitted within 1 week
  - 52% were admitted within 2 weeks
  - 75% were admitted within 4 weeks.



Impact Analysis: In the Impact Analysis of the 12 week timeframe for the HCAS the following key themes were identified -

- Longer time within the HCAS was associated with service users transferring to a private provider
- The monthly average use of HCAS for service users transferred to a private provider was between 7-10 weeks
- The monthly average use of HCAS for service users closed to the service was been between 4-6 weeks
- The average use of HCAS for 'Discharge no longer requiring service' was 10 weeks; this indicated that there were gains to be made in the extension of the time frames given
- The average use of HCAS for service users who were discharged from HCAS due to 'Hospital Admission' was 4 weeks. This had a direct impact on the lower average usage time average of closure rates Vs. transferred rates.

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Project Outcomes

HCAS Outcomes: HCAS Reports

HCAS Reports: Establishing real time feedback is fundamental to good quality management of a service. This new model introduced reporting made by the Home Care Workers at the point of care, connecting service users and staff in decision making. The level of need of care provision varies over the time from hospital discharge and these reports provide the current information to make appropriate assessments. This is a new way of working for both the Home Care Workers and key workers - the culture of a dynamic relationship was essential to foster. First Quarter of the HCAS found a positive correlation between the key worker response to the Home Care Assessments Service utilisation reports, and the number of discharges from Home Care Assessment Service.

Month	Key Worker Response Rate	Capacity Released
May 2024	7.5%	52
June 2024	39%	55
July 2024	84%	68

The data gathered at this initial quarter was limited, and could not prove that this change had led to the improvement. While the significant improvements in key worker engagement was positive, further considerations were required as to how the outcomes and impact of the HCAS reports could be collected, understood and used to target further improvements.

Month	Discharged no longer requiring a service - no HCAS Report	Discharged no longer requiring a service- No HCAS report
September 2024	23%	32.4%
October 2024	23.3%	17.4%
November 2024	17%	36.4%

From September 2024 new data sets were established to further analyse the information available. The first data set looked at the number of HCAS reports generated and their recommendations compared to key worker actions taken. The second looked at service users' outcomes where no HCAS report was generated.

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Project Outcomes

Impact of HCAS Team Report

Creating Real-time Feedback to Support Decision Making

Home Care workers are an essential conduit in the delivery and decision making about the level of care a person requires as they recover from a hospital stay. By inputting into the feedback loop with reports conducted whilst the person is back in home, the Home Care worker is providing essential real-time information. These reports can be augmented by conversations with patients and carers, Early Review Team assessments for the Key workers to make decisions about the on going level of care. This new way of working is utilising the expertise of the whole team and creating an agility to decision making whilst keeping the focus clearly patient centric.

Home Care Assessment Worker:

"My biggest takeaway is the speed in which changes can be made."

"Within in a day they [the patient] were able to be up to four calls a day from two, and that meant we could be there for them…"

Home Care Assessment Worker:

"My biggest takeaway is the shared success: watching clients progress and reach their goals through my support and encouragement."

Home Care Area Manager:

"My experience with Home Care assessment is the shared feedback that comes from both staff and service users. It's a very positive shared experience for both of them and it reflects back on the goals and the purpose that was set out in the Home Care assessment module."

For changes to be systemised into practice and culture, the staff must see the benefit to themselves and the service users. As part of the change programme, team members contributed to the service design, testing stages and implementation. As part of the iterative process the Home Care Team were consulted with, their input and experience were fundamental to the Co-Design of HCAS.

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HCAS Outcomes – Savings

Savings

Month	Capacity Released in Discharges (Hours)	Cost Savings - Weekly hourly rate; Discharges	Average Monthly Savings estimate; Discharges	To year end savings estimate	Capacity released in decreases (Hours)	Cost Savings - Weekly hourly rate; Decrease	Average Monthly Savings estimate - Decrease	Amount in Savings in each month	To year end savings	Total HCAS Savings to year end
Apr	56.25	£1,125.56	£4,839.91	£58,078.90	0	£0.00	£0.00	£4,839.91	£0.00	£58,078.90
May	130.85	£2,732.36	£11,710.45	£128,814.93	5.25	£105.05	£451.73	£12,162.17	£4,517.26	£133,332.19
Jun	103.25	£2,066.03	£8,883.93	£88,839.29	0	£0.00	£0.00	£8,883.93	£0.00	£88,839.29
Q1 Total			£25,434.29				£451.37	£25,886.01		£280,250.37
Jul	159	£3,461.73	£14,885.44	£133,968.95	14	£280.14	£1,204.60	£16,090.04	£10,841.42	£144,810.37
Aug	75.25	£1,855.93	£7,980.50	£63,843.99	17.5	£350.18	£1,505.75	£9,486.25	£12,046.02	£75,890.01
Sept	157.5	£3,536.77	£15,208.11	£106,456.78	19.25	385.19	£1,656.33	£16,864.44	£11,594.29	£118,051.07
Q2 Total			£38,074.05				£4,366.68	£42,440.73		£338,751.45
Oct	98	£3,303.65	£14,205.70	£85,234.17	67.1	£1,342.67	£5,773.49	£19,979.18	£34,640.91	£119,875.08
Nov	105	£2,767.90	£11,901.97	£59,509.85	33.05	£661.33	£2,843.72	£14,745.69	£14,218.61	£73,728.46
Dec	87.5	£1,750.88	£7,528.76	£30,115.05	35	£700.35	£3,011.51	£10,540.27	£12,046.02	£42,161.07
Q3 Total			£33,636.43				£11,628.71	£45,265.14		
Jan										
Feb										
March										
Q4 Total										
			£97,144.76					£227,183.76		£854,766.43
								£302,911.68		

HCAS: Projected Impact on Hospital Discharge

The 198% increase in referral capacity translated into an additional 279 hospital facilitated discharges.
If each of these hospital discharges represented a 1 day reduction in delayed discharge, that is a saving of £103,230.
When extrapolated to the average time to source a Package Of Care from hospital, this would represent at minimum of £204,388.00.

Estimated Total Savings: £1,059,154.43

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HCAS: Systemisation

Systemisation

Implementation of change requires systemisation of process and culture. Consideration of the following strategies were essential.
By following these steps, the outcomes of the HCAS were systematically embedded into long-term practices, enabling scalability while maintaining or improving impact.

1. DEVELOPMENT OF STANDARDISED PROCESSES AND PROTOCOLS:

- **Referral and Discharge Flow**: Creation of detailed, standardised workflows for referral and discharge processes are essential.
- **Assessment Timeframes:** Establishing clear guidelines on the optimal HCAS duration and construction of protocols that allow for flexibility and encourage adherence to evidence-based timelines.
- **Outcome Reporting**: Standardisation of data collection and reporting for key performance indicators (e.g., key worker response rate, capacity released, discharge outcomes). Consideration of the use of dashboards for real-time tracking and periodic review.
- **Integration of QI skills within the Home Care Team:** For on-going engagement with data, and establishment of linked person within QI Team for on-going support.

2. ENHANCEMENT OF DATA COLLECTION AND ANALYSIS:

- **Data Standardisation**: As the HCAS grows and the data collection process becomes embedded, ensuring the process and definitions remain standardised and streamlined where possible.
- **Comparative Analytics**: Regularly comparing outcomes between users from within and without HCAS reports to highlight the value added.
- **Longitudinal data**: Collection of long-term data to assess sustainability of impact, particularly reductions in hospital stays and transfers to long-term care.

3. BUILDING STAFF CAPACITY AND ACCOUNTABILITY:

- **Training Programmes**: Training staff on the benefits of HCAS and the importance of timely, accurate key worker responses. Including workshops, simulations, and data interpretation sessions.
- **Key Worker Engagement**: Setting response rate benchmarks based on initial data (e.g., aiming for 80%+ monthly response rates). Using incentives or recognition programmes to encourage compliance.
- **Role Clarification**: Clearly defining roles and responsibilities within the HCAS process to ensure accountability at every stage of assessment and discharge.

4. EXPANDING AND SCALING:

- **Expansion of HCAS Teams:** Scaling HCAS into other SE Trust areas, using standardised processes and lessons learned. Collection of data from these to refine the system further.
- **Stakeholder Investment**: Presenting clear evidence of cost savings and improved outcomes to secure funding and stakeholder support for broader implementation.
- **Adaptation for Other Services**: Considering the regional HCAS model for other areas of healthcare where similar assessment services could optimise flow and reduce costs.

5. MONITORING AND IMPROVING:

- **Feedback Mechanism**: Establishment of feedback loops from key workers, Home Care Workers, service users and stakeholders to identify challenges and areas for improvement.
- **Quarterly Reviews**: Conduction of quarterly reviews of performance metrics (e.g., response rates, capacity released, service user outcomes) to measure progress and adjust change ideas.
- **Continuous Improvement**: Using data from new datasets to refine HCAS processes over time.

6. COMMUNICATION AND DISSEMINATION OF LEARNING:

- **Reporting Success**: Developing clear, concise reports showcasing the impact of HCAS, including cost savings, service user outcomes and operational efficiencies.
- **Knowledge Sharing**: Hosting workshops, forums or conferences to share findings and best practices with teams as well as other organisations.
- **Case Studies**: Considering opportunities to gather case studies from service user and staff perspectives illustrating successful outcomes and lessons learned during implementation and future spread and scale.

Next Steps

- The next phase of implementation was embedded HCAS into the current workforce, sharing the learning and positive impact of care
- Decisions then made by senior management about the extension and adaptation of HCAS across the inhouse Home Care Team.

South Eastern Health and Social Care Trust

Project 2: Collaborative Unmet Need Panels (CUP)

Project overview

The Home Care Unmet Need list represented a critical bottleneck in service delivery, often reflecting the gap between growing demand and available resources. This project sought to develop a comprehensive process that not only identified and categorised unmet need, but also promoted proactive, collaborative strategies for risk mitigation and prioritisation.
Drawing upon the collaborative decision-making framework established within the SEHSCT Children's Social Work Service, known as 'CUP' (Collaborative Unallocated Process), there was a recognition for the potential to adapt these principles to address challenges in adult Home Care Services. An approach was introduced that similarly utilised joint decision-making to manage risks and service demand more effectively.

The project emphasised shared responsibility between the Home Care Service and referring professional teams. By applying the principles of risk assessment and joint accountability, this project aimed to deliver a more cohesive and responsive model for managing unmet need in adult Home Care, ensuring that individuals requiring support were served with greater equity and efficiency.

Roles in CUP:

Host of Panels: Home Care Service Lead and Social Care Service Lead

- Co-host monthly Panel
- Direct discussion and decision making, offering service information from Home Care capacity
- Review the data/ quarterly governance report to identify any learning or barriers,
- Escalate to senior sponsor team and agree strategy to address these and progress further improvement of the service
- Share learning and outcomes with wider social care services to maintain the profile of the service and celebrate outcomes

Coordinator of Panels: Home Care Service Manager

- Set up Panel dates: book a room for the Panel and set up teams link for team leaders
- Generate monthly CUP list for each service; using agreed criteria (waits over 90 days)
- Email CUP list to team leader, 1 week prior to CUP
- Attend panel and record all actions and outcomes.
- Email Spread sheet to Team leaders for action.
- Email outcomes to be actioned by Care Bureau.
- Collate monthly CUP outcomes onto Data Report.
- Collate outcomes onto quarterly governance report, for discussion with service lead

Presenting cases at Panels: Social Care Team Leaders

- Review CUP list and discuss with allocated key worker to bring and present updated information to CUP
- Attend CUP with all required updates
- Follow up with any actions or decisions made at CUP
- Share any updates to pathways with teams
- Engage with shared learning from CUP outcomes

The Aim

To reduce the number of Service Users waiting for Home Care Services on the unmet need list by 15% between September 2023 and December 2024, improving the management of demand and supply for Home Care Services.

South Eastern Health and Social Care Trust

Collaborative Unmet Need Panels (CUP)

The Process

Monthly panels were held between the Home Care Service and Community Social Care Service, where the cases were presented by the associated Team Leaders that had oversight of service users waiting for a Home Care Service on the SEHSCT Unmet Need list.

Setting up a Panel:

Home Care Service Manager collated a monthly spread sheet per service to include all service users awaiting a Home Care Service on the unmet need list that fell within the agreed criteria, outlined below:

- Home Care Service Manager email spread sheet to Team leaders
- Home Care Service Manager shared details of time and date of CUP with Social Care Service Leads and Team Leaders
- Team Leaders shared list with allocated key worker and directed on required information to be presented at Panel
- The panel lasts for one hour time allocated per locality in Older People's teams and 30 minute per other services; i.e. Learning Disability, Adult Disability and Mental Health.

Cases presented at the 'CUP' Panels fall under the follow criteria:

Waiting for over 90 days

Respite Requests

Categorised as 'Moderate' or 'Low' level need

Care plans explored during the Panels :

- What other supports/services were currently in place?
- Had alternative SDS options been explored?
- Were there any factors attached to the request that could limit Home Care ability to source; e.g. specific days/times/carer?
- Was there a commissioned service in the area for the request?

The decision outcomes made at the Panel included:

- Removed from the Unmet Need list
- Required further assessment from Key Worker
- Amendments made to the brokerage request: number of calls, duration of calls, tasks within calls such as medication
- Remained on the brokerage list
- Bespoke sourcing required: where the nature of request would require additional coordination or training from a provider
- Key Worker unknown and to be allocated
- Confirmed that services have been sourced.

Measures

Unmet Need List: The primary measure for this project was the impact on the Number of People on SEHSCT's Home Care Unmet Need list

Referral Rate: The project also took into consideration new demand, reporting on the number of new referrals coming through for a home care service.

Savings: The Project outlined what savings, under cost avoidance, can be attributed to the CUP model.

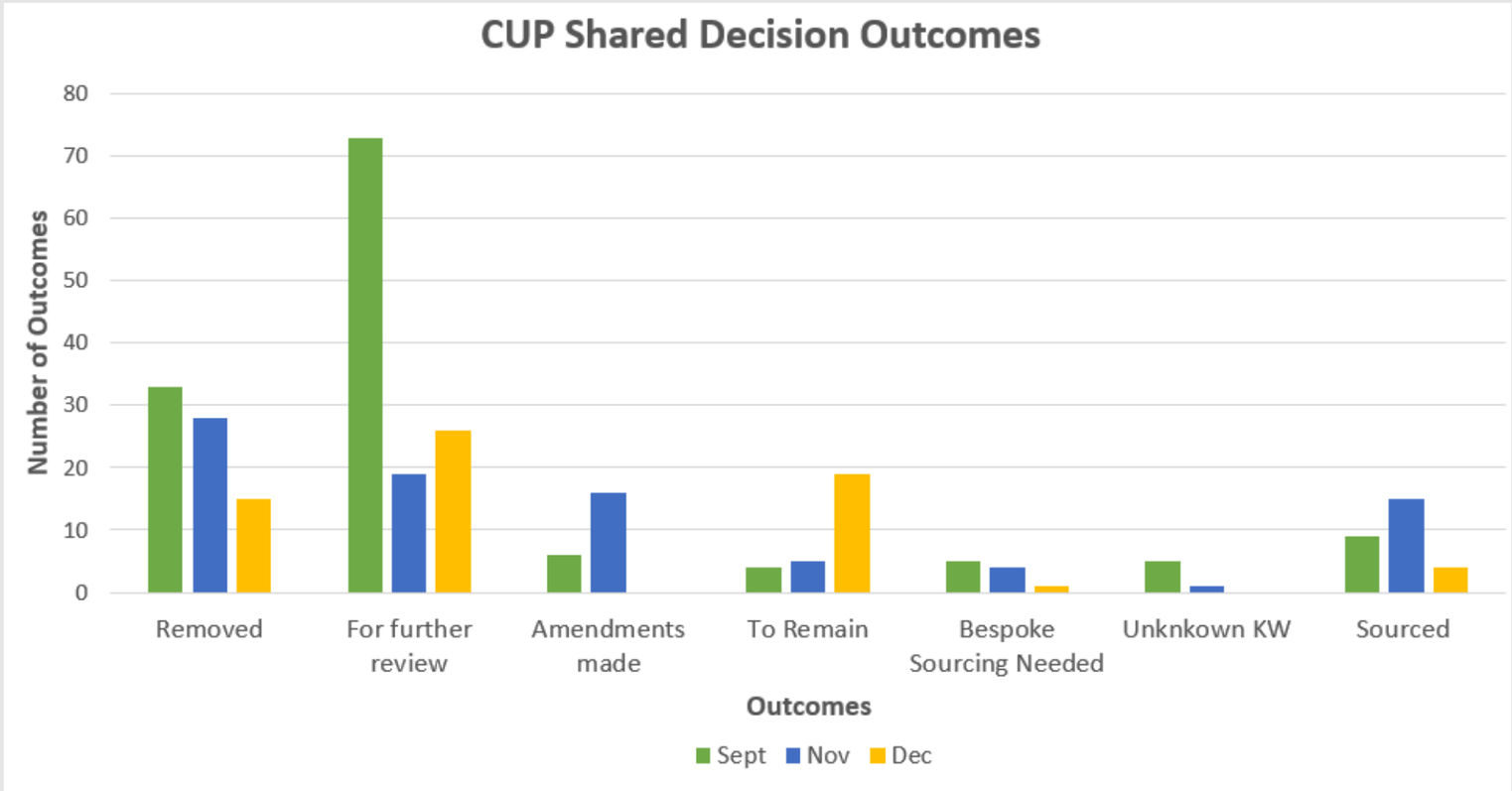
South Eastern Health and Social Care Trust

Collaborative Unmet Need Panels (CUP)

Project Impact/Outcome

Panel Decision Outcomes:

The CUP model was found to be a collaborative process, bringing together the Care Bureau's knowledge of the system alongside the key workers' knowledge of the service users' needs, with an understanding that both were dynamic and changeable factors.



The Key enablers to change and improvement within this project were:

- **Staff Engagement:** The Project Lead was able to offer one-on-one time with each team, creating the vision for the CUP and overcoming barriers within current culture and practice through open discussion, case examples and sharing initial outcomes.

- **Senior Sponsorship:** The active role of the senior sponsors within this project enabled the time required to ensure the model was optimised, as well as setting out the expectations for attendance and engagement.

- **The Role of Home Care Services:** Throughout this project, the underutilisation of the knowledge and expertise of the Home Care Service was highlighted. The processes that were wrapped around the CUP model required the Home Care Service to assert their role more fully, and was central to enabling a successful model with positive outcomes.

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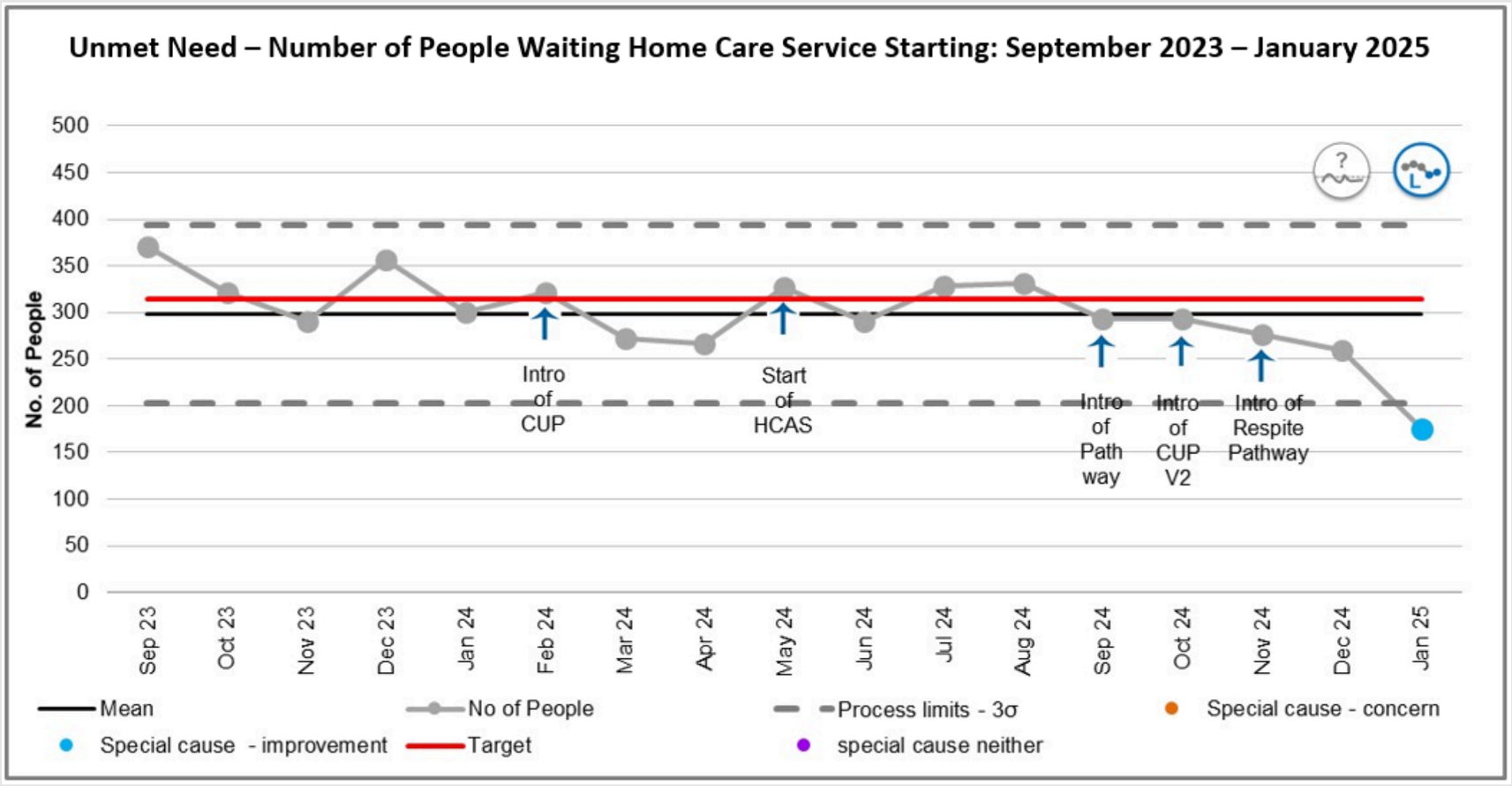
CUP Outcomes: Unmet Need List & Referral Rates

Unmet Need List



By applying and utilising a collaborative decision-making framework (CUP) to manage risks and service demand more effectively **the Unmet need list was reduced by 30% between September 2023 and December 2024.**

An SPC chart was used to track the number of people per month with unmet need who are waiting on a Home Care Service starting. The chart displays when CUP and HCAS commenced as well as further iteration testing as the process developed. Following a period of embedding there are encouraging indicators from August 2024 that the continued implementation of the CUP model will demonstrate sustained improvement by the end of 2024/2025. The SPC will continue to track the data and inform further iterations.

Referral Rates

Demand	Referral Hours	Referral Packages
September 2022	4986	469
September 2023	5459	494
September 2024	5740	516
Variance over one year; Project timeframe (23-24)	**+281 (5%)**	**+22 (4.3%)**
Variance over two years Reform timeframe (22-24)	**+754 (15%)**	**+123 (13%)**

Understanding the increasing demand for Home Care services due to the changing population demographics is vital in service planning for the future. This table outlined the increase in demand of referral numbers in the month of September across 3 years. The increase in demand from 22-24 was 15% in referral hours requested and in the timeframe of this change project 23-24 an increase in demand of 5%.

The successes in the reduction of the unmet need were set against the increase in demand for services. It highlighted the need to ensure that the management of supply and demand continued to balance both the 'front door' of new referrals against the 'back door' of service users who wait for Home Care Services.

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CUP Outcomes: Savings

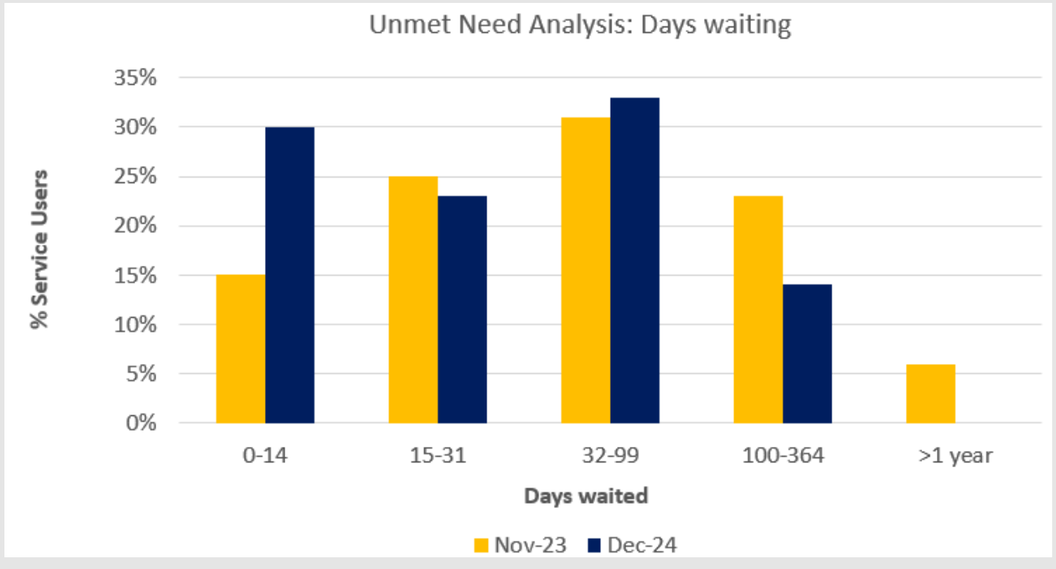
Savings

The following 'non cash' savings or cost avoidance figures were taken from service users removed from the unmet need list as part of the CUP. The savings accounted for the predicted Home Care hours that would have been used as people allocated care off the unmet list. Calculations were made based on the finance teams' model 'to year end' projections of over £246,000.

Non-Cash Cost Savings	Total Weekly Hours	Weekly Savings	Savings to year end
September	276.8	£5,538.77	£149,546.74
November	162.8	£3,257.63	£58,637.30
December	146.25	£2,926.46	£38,044.01
		Total	£246,228.05

Unmet Need Analysis

The importance of providing timely care to people to support living well at home and flow for hospital discharge. A comparison of the unmet need analysis from Nov 2023 to Dec 2024 demonstrated changes within the waiting times for unmet need:



- As of Dec 2024 no service user was waiting over one year for a Home Care Service
- As of Dec 2024 service users waiting between 100 days and a year represented the smallest cohort of the unmet need
- The largest portion of service users on the Unmet Need list remained waiting between 32-99 days.

Summary

The CUP model was proven initial gains in the bridging of the gap between demand for services and available resources. The initial results demonstrated a positive impact on capacity within the Home Care Service, while also improving service user access to the right care, at the right time, in the right place. There is still much to do, but there has been significant improvements in the service delivery through the intentional assessment of the unmet need list.

South Eastern Health and Social Care Trust

Collaborative Unmet Need Panels (CUP) - Systemisation

Systemisation

By systemising these components, the CUP model can achieve long-term sustainability and adaptability, ensuring its benefits are realised on a broader scale.

1. STRENGTHENING KEY ENABLERS:

- **Staff Engagement:**
  - Introducing regular workshops with the team and establish feedback loops to maintain the "hands-on approach"
  - Fostering cultural and practice changes.
  - Recognising and rewarding staff contributions to improvements to sustain morale and engagement.
- **Senior Sponsorship**:
  - Formalising senior sponsorship roles and expectations with defined responsibilities to champion the model and secure resources.
- **Asserting Care Bureau's Role**:
  - Highlighting the Care Bureau's successes through regular reports and case studies to reinforce its value.
  - Integrating the Care Bureau into strategic decision-making bodies to sustain its influence.
- **Dynamic Data Sharing Systems**: Consideration of a digital platform to allow real-time sharing and updating of service user needs and system knowledge, ensuring both remain dynamic and responsive.

2. ENHANCING AND EMBEDDING THE PROCESS:

- **Document Processes**: Creating clear, accessible documentation on how the Home Care Service and key workers collaborated effectively. These included, recording templates, meeting structures and decision-making approaches.
- **Dashboard Creation**: Consideration of the future use of Encompass to enable a collation of the 'Unmet Need list' in a centralised dashboard to display key metrics (e.g., waiting times, unmet needs, referral rates) for stakeholders to monitor progress.

3. EMBEDDING REFERRAL RATE MANAGEMENT:

- **Capacity Planning**: Using historical and current referral data to forecast demand and align staffing and resources accordingly.
- Consideration of partnering with the Data Institute to explore opportunities to apply large language models to enable this.

4. ADDRESSING SERVICE USER WAITING TIMES:

- **Targeted Action Plans**: Consideration of future options for targeting and reducing waiting times for the 32–99 day group by identifying bottlenecks and deploying additional resources as needed.
- **Service Prioritisation Framework**: Consideration of how to integrate a standardised framework for prioritising service users based on urgency and need, ensuring equitable resource distribution through the allocations process with independent sector.

5. MONITORING AND EVALUATING SUSTAINED IMPACT:

- **Longitudinal**: Utilising the data collated monthly , consider how to assess the CUP model's impact over a sustained period of time. Including focusing on service user outcomes, cost savings and staff satisfaction/engagement.
- **Feedback Mechanisms**: Establishment of mechanisms for continuous feedback from service users, staff and stakeholders to refine the model over time. Considering embedding feedback into the quarterly governance report; e.g. a case example from a key worker and/or service user outcome from CUP.

Next Steps

- Senior Sponsors to establish CUP model as business as usual across teams establishing an expected cadence of meetings.
- Reporting structures established to assess CUP outcomes and impact.
- Creating a learning structure for staff to understand the definitions and criteria for Home Care assessment and alternative pathways for support.

Project 3: User Guide

Project overview

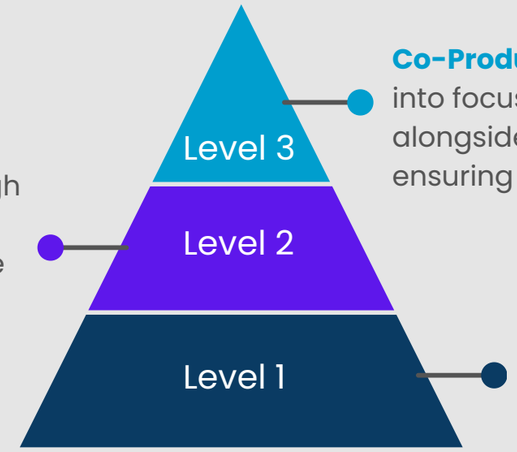
The Quality 4 All Strategy at SEHSCT had the central tenet of 'People at the heart of what we do'. Co-production of services and communication required an intentional approach to collaboration and creating true spaces for shared design.

During the Ecosystem Mapping, it was evident across servicer users, staff and other key stakeholders that there was a lack of clear information about the service criteria and pathways of Home Care. It was reported that this lack of information often resulted in additional stress, frustration and a negative impact on the communication and relationship between service users and professionals.

The development of the Home Care Services User Guide was undertaken to create a resource that genuinely reflects the needs, preferences and voices of the individuals who rely on these essential services. Central to this initiative was the implementation of a 3-tier model of involvement, designed to ensure a meaningful and inclusive approach to user engagement at every stage of the process. The 3-tier model enabled involvement at a level that suited the individual, as they were able to opt into any or all of the involvement levels.

The 3-tier model included:

Consult: Deeper involvement was facilitated through attendance at meetings and group discussions, enabling more detailed feedback and collaborative discussions about service improvements.

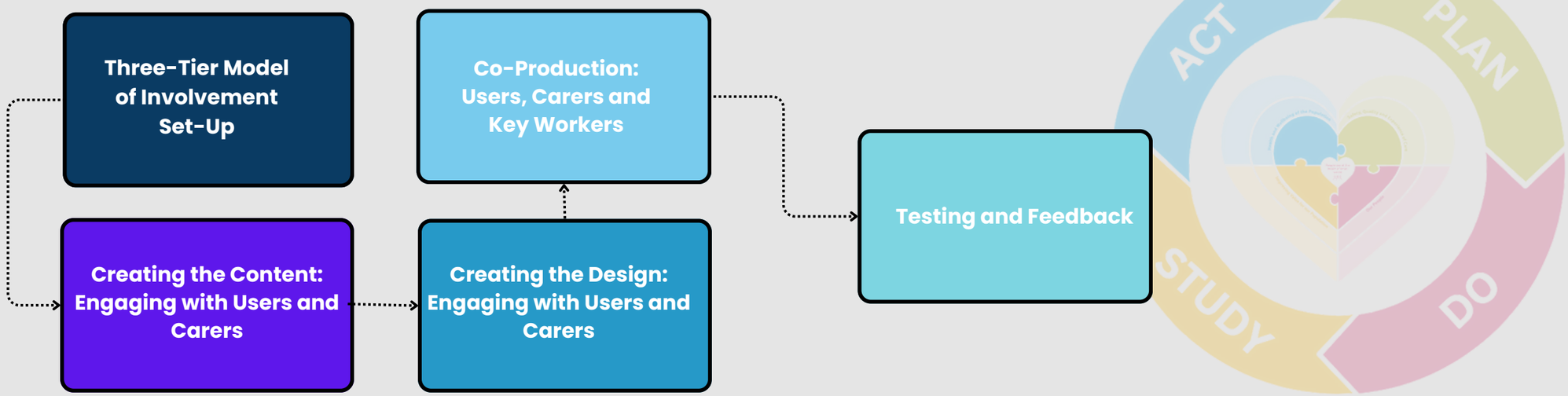


Co-Produce: The highest level of involvement brought users into focus groups and workshops, where they worked alongside stakeholders to co-design and refine the guide, ensuring it was both practical and user-focused.

Engage: Initial engagement with service users was achieved through activities such as surveys and questionnaires, allowing for broad participation and gathering diverse perspectives.

This tiered approach ensured that the voices of service users were not only heard, but actively shaped the development of the guide, fostering a shared sense of ownership and aligning the final product with the real-world needs of its intended audience. Iterative testing through Plan Do Study Act (PDSA) cycles at each stage of development assured robustness of the product.

Developmental Stages of the Service User Guide:



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Project Three: User Guide

Project Impact/Outcome

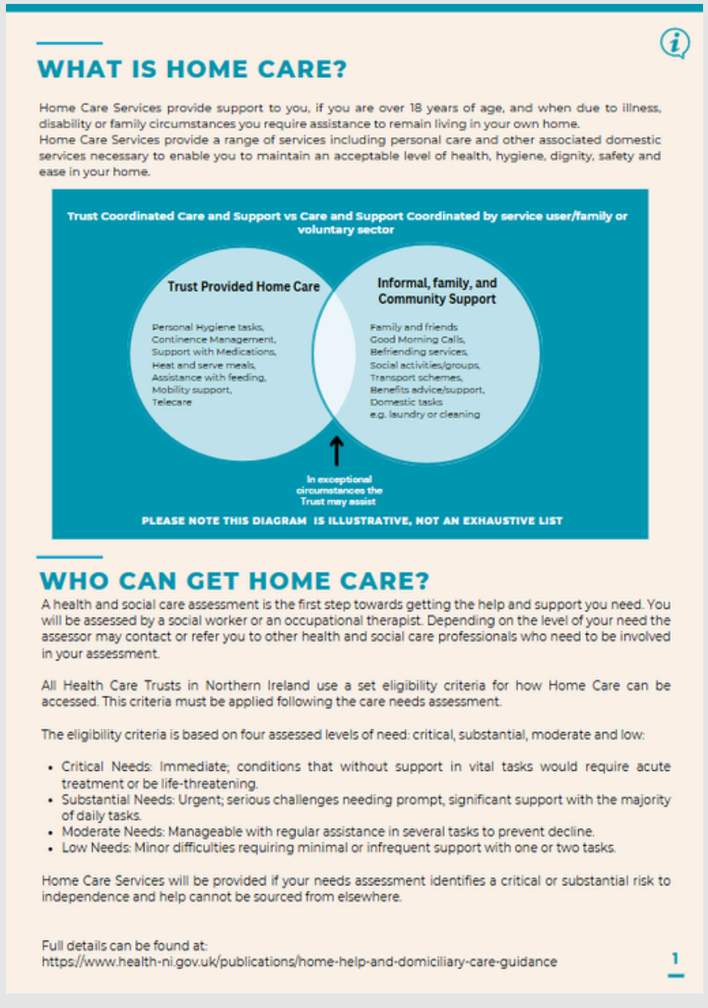
6 Engagement Events Held

Over 75 Service Users Participated

Over 125 Professionals Participated

The Process

The Home Care Services User Guide Project successfully produced a comprehensive and user-focused guide through an enhanced engagement process. By involving both service users and professionals, the project collaboratively defined the guide's purpose, content and design. The content aimed to offer the clarity of information that service users were keen to see, through its inclusion of summarised definitions such as: 'Home Care tasks', 'Access Criteria', 'The Care Pathways' and the 'Jargon' section. The design aimed to ensure that it was interactively used, this was prompted throughout the guide with 'notes' sections where service users could note more personalised information or questions. Key workers are able to better clarify information or queries and record discussions. This created the balance that both users and professionals wanted to see in the content and design; clear, concise and useful information, without being overloaded or overwhelmed. This co-creative approach ensured that the guide was both practical and meaningful to its intended audience.



Testing

The draft guide underwent iterative testing in practice. The guide was sent to users who had signed up to be engaged at level 2 and level 3, as well as 25 copies to key workers from across hospital, Short Term Assessment and Community Social Care Teams. It was used directly with service users at differing stages of their assessment journey, with prompt questions to gather feedback. Two focus groups were then held to review the feedback gathered. This iterative process allowed for final edits and ensured the guide was fit for purpose prior to distribution.

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User Guide Content

Project Impact/Outcome

INFORMAL AND COMMUNITY SUPPORT

There are a range of benefits designed to ensure financial stability, improve quality of life, and provide essential support for health and mobility to individuals in Northern Ireland. Some examples of this may include:

Benefit	Description	Intended Use
State Pension	Regular payments based on National Insurance contributions.	Provides a basic income for daily living expenses and financial security in retirement.
Pension Credit	Income-related benefit to top up weekly income.	Ensures a minimum income level, helping with essential living costs such as food, utilities, and housing.
Attendance Allowance	Financial support for those who are over state pension age and need help with personal care due to a disability.	Covers additional costs associated with personal care or supervision needs.
Winter Fuel Payment	Income-related benefit to help with heating costs for those who are over state pension age, and are in receipt of Pension Credit.	Assists with heating bills during the winter months, reducing the risk of fuel poverty.
Free Bus Pass	Age related entitlement to free travel on public buses and train services	Provides free public transport, enhancing mobility and access to services and social activities.
Personal Independence Payment (PIP)	This has replaced DLA, and is for people aged 16 or over and under State Pension age. It is not means tested and can can claim if you are employed or unemployed. The benefit is made up of two elements; a daily living component and a mobility component	Designed to help with some of the extra cost arising from living with a long-term health condition or disability lasting 12 months or longer

If you would like support in understanding what you might be entitled to and how to apply, you can phone through to 'Make The Call' on 0800 232 1271

3

UNLOCKING THE JARGON

EQUIPMENT AND AIDS

This is assessed by a community pharmacist. Blister packs, sometimes called Medidoses, are a sealed medication management solution that enables your pharmacy to group patient medication according to day and time dosage requirements.	*Blister Pack*
This is assessed by a nurse. It is sometimes also referred to as a commode chair or commode toilet, it is a movable piece of furniture that acts as a portable toilet. If you or someone you care for is living with limited mobility and finds it difficult to get to the bathroom independently or easily, a commode could really help.	*Commode*
This is assessed by a nurse. Continence pads are worn inside underwear to soak up urine. If you have mild to moderate incontinence you can buy thin, discreet pads or pull-up pants for men and women from many supermarkets and pharmacies. For people with severe leaks, continence clinics and district nurses can supply incontinence pads.	*Continence Pads*
This is assessed by a nurse. This is a mechanical device designed for lifting and moving individuals from one place to another, such as from a bed to a wheelchair or into a bath, with minimal discomfort and risk. There are primarily three types of hoists: mobile or wheeled hoists, stationary hoists and ceiling hoists.	*Hoist*
This is signposted by a Key Worker. Key pads or Key safes are a secure storage devise for placing keys into to allow access to your home. Key safes can allow family, carers and emergency services to access your home if you cannot get to the door. Key pads are privately arranged by the individual or family and can be easily purchased online or at a local hardware store.	*Key Safe*
This is assessed by a nurse. A profiling bed is a specialised type of bed designed to be adjusted to various positions to enhance comfort and support for users, particularly those with medical needs. These beds are commonly used in healthcare settings such as hospitals, nursing homes, and private residences for people with limited mobility, chronic illnesses, or disabilities.	*Profiling Bed*
This is signposted by a Key Worker. Personal alarms and monitoring systems can alert call centres or carers if you experience a problem, either at home or outside, such as a fall - you may hear this called Telecare. They can be: • carried or worn, for example around your wrist or your neck • attached to a button or pull cord in your home to use if you need help These can be purchased privately.	*Personal Safety Alarms*
This is assessed by an Occupational Therapist. A raised toilet seat is usually a frame that sits over your toilet, and can increase your independence by making it easier for you to get on and off the toilet.	*Raised Toilet seats*

14

EQUIPMENT

COMMUNITY OCCUPATIONAL THERAPIST – EQUIPMENT

Following assessment by the Occupational Therapist, many people often ask us if they have to pay, so here is a simple breakdown of how South Eastern HSC Trust is able to deliver services:

Small Equipment

There are a wide range of everyday living aids available for private purchase to maintain independence with everyday living tasks.
These small aids range from assisting someone with care tasks such as; personal care, toileting, meal preparation to tasks such as getting in and out of the car. Examples include: Sock aid, long handled shoe horn, button hook, jar openers, swivel cushion for car and many more.
There are also small aids available to allow people to continue to partake in hobbies following injury or disability. Examples include: Reading aids, gardening, playing card holder and many more.

Assistive Technology

There are also a wide range of assistive technology devices available for private purchase, to improve or maintain people's functional abilities and to maintain a level of safety for yourself or loved one.
Examples for this include: Pendant alarms, falls detectors, door alarms, medications prompts and many more.

Equipment

This includes:
- Bathing
- Toileting
- Seating
- Mobility equipment

This equipment is provided by the Trust for as long you need it. The manufacturer's instructions and a copy of the South Eastern Trust guidelines for use will be issued with every piece of equipment. You will also be provided with the contact details (Tel: (028) 9536 1414) of how to return the items if it no longer meets your needs or you leave the Trust geographical area.

Large equipment

Items including:
- Stair lifts
- Vertical through-floor lifts
- External step-lifts
- Ceiling-track hoists

These are provided through the Estates Service for people living in owner occupied or privately rented properties. If you live in a NIHE or Housing Association property, the relevant housing body would be responsible for fitting the above items in their own properties.

Notes (What daily tasks do I need assistance with?)

8

Impact

The final guide served as a two-way communication aid, empowering service users and professionals to navigate the complex and deeply personal journey of Home Care Services together. It fostered better understanding, clarity, and collaboration - ultimately enhancing the quality and accessibility of care.

Click HERE to access the home care user guide **Or scan the QR code**

User Guide Outcomes - Impact

Project Impact

During the initial Ecosystem Mapping exercise, there were many challenges highlighted across the Home Care system; especially the deficit of clear information exchange. In a collaborative response, stakeholders explored possible opportunities for change and system redesign. The development of the Home Care Services User Guide provided a structured approach to addressing several key recommendations from the initial Ecosystem Map for Home Care.

1) Service User Panel: There was an opportunity to establish a 'Service-User Panel', enabling people with lived experience of using the system could contribute to the co-design of future care system - given that all improvement projects benefit from user feedback.

2) Home Care User Guide: It would be very useful to have a clear, regularly updated User Guide to explain how the system works.

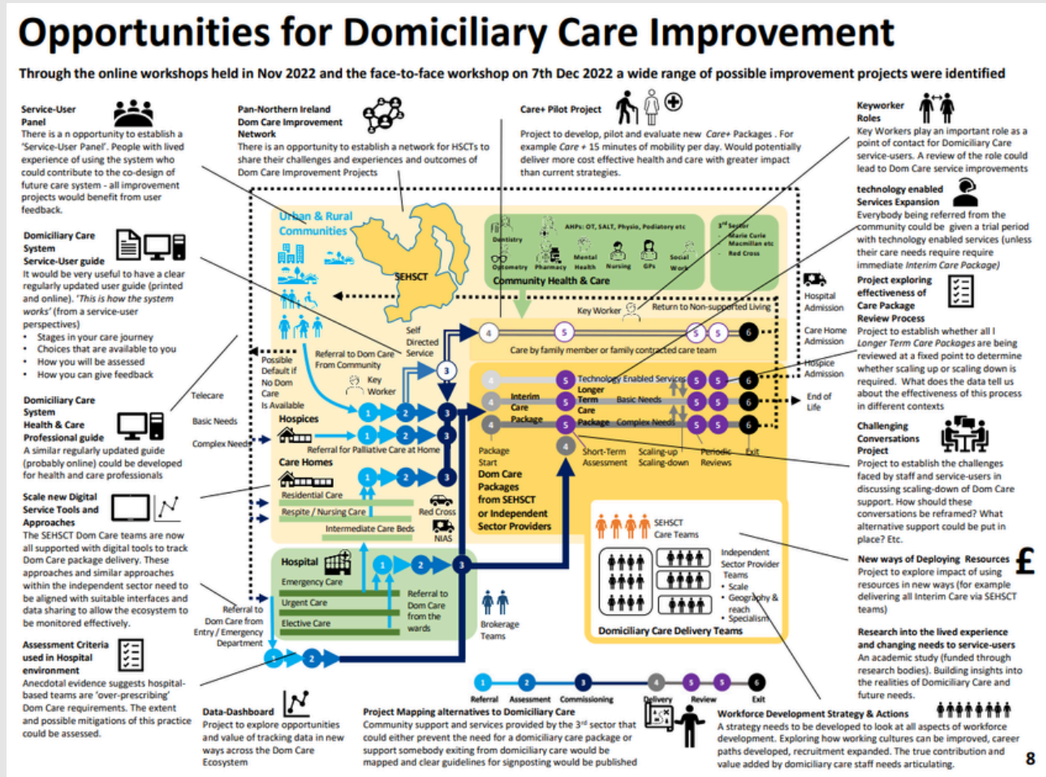
3) Professional Guide to Home Care: A guide for Health and Care professionals that demystified services was developed, with regular updates.

4) Mapping alternative to Home Care: Clear information and guidelines of the community support and services provided by the 3rd sector that could either prevent the need for a Home Care package or support somebody exiting from home care.

5) Challenging Conversations: Focus needed to understand the challenges faced by staff and service users in discussing scaling-down of Home Care support.

6) Exploring Care Package review process: A critique of all Longer Term Care Packages being reviewed at a fixed point to determine whether scaling up or scaling down was required.

7) Key Worker Role: Key workers play an important role as a point of contact for Home Care service users. A review of the role could enable to Home Care Service improvements.



By integrating these elements, the guide became a foundational tool for navigating and improving the home care experience.

Summary

Looking ahead, the guide has the potential to serve as a central platform for communicating and managing changes within home care services. As the sector faces future pressures and transformations, the guide has the ability to support transparency, facilitate engagement, and align public expectations. By systemising its use, the guide can ensure consistent communication and provides a reliable resource for adapting to the evolving landscape of Home Care Services.

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User Guide - Systemisation

Systemisation

To maximise the utility of the Home Care Services User Guide and embed it into standard practices, the following strategies could be implemented.

By embedding the guide into both operational workflows and strategic planning, it can become a cornerstone of effective communication, decision-making, and service delivery within the home care system.

1. **INTEGRATION INTO TRAINING AND INDUCTION PROGRAMMES**:
   - Ensuring that all professionals involved in Home Care, including new staff, are introduced to the guide during training. This establishes the guide as a key resource for navigating care processes and engaging with service users effectively.

2. **ACCESSIBLE DIGITAL PLATFORM:**
   - Hosting the guide on an easily accessible online platform, enabling real-time updates and broader distribution. Including interactive features such as FAQs, video tutorials, and feedback forms to enhance usability.

3. **REGULAR UPDATES AND FEEDBACK MECHANISMS:**
   - Establishing a process for regularly reviewing and updating the guide based on user and professional feedback, policy changes, or shifts in service demands. Engaging service user panels and professional groups in this review process to maintain relevance. This process will be coordinated by the Home Care Service, however will require an identified point of contact from the key stakeholders to ensure the guide remains fit for purpose.

4. **CENTRALISED COMMUNICATION TOOLS:**
   - Using the guide as a standardised framework for all communications between users and professionals. This could include incorporating the guide into care package review meetings, consultations, and decision-making discussions.

5. **MONITORING AND EVALUATING:**
   - Tracking the guide's usage and effectiveness through user and professional surveys, case studies and performance metrics. This data can help refine the guide and demonstrate its impact.

6. **RESOURCE FOR PUBLIC AWARENESS CAMPAIGNS:**
   - Leveraging the guide to manage public expectations by using it in awareness campaigns to explain the scope and limitations of home care services, particularly during periods of change or strain.

7. **CROSS-SERVICE ALIGNMENT:**
   - Aligning the guide with related services such as alternative care options, healthcare providers and community support initiatives to create a cohesive system. This would enhance its role as a comprehensive resource for navigating Home Care.

8. **POLICY ADVOCACY TOOL:**
   - Using insights from the guide's implementation to inform policy discussions and advocate for systemic improvements in Home Care Services.

Next Steps

- Senior Managers embedding the User Guide into practice across hospital and community services, including team training and accountability.
- Strengthening of the 3-tier model of co-production for all service improvements.
- Establishment of Lead with accountability to manage and update the User Guide.

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Project 4: Developing a Data Dashboard for Home Care Services

Project overview

Good Quality Management in an organisation requires real-time data to plan well and leverage information for holistic decision making. The management of Home Care Services is highly complex due to rising demands, diverse service user needs and difficulties in the recruitment and retention of care staff. Current approaches to data collation and analytics are not optimised to fully enable responsiveness, operational efficiency, decision–making and service quality. Data is collated on various platforms operating in silos and reporting aggregated with delays.

Project Objectives

The primary goal of this project was to develop a user-friendly, scalable and secure Data Dashboard that enables the Home Care Service to:

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Developing a Data Dashboard for Home Care Services

Current State

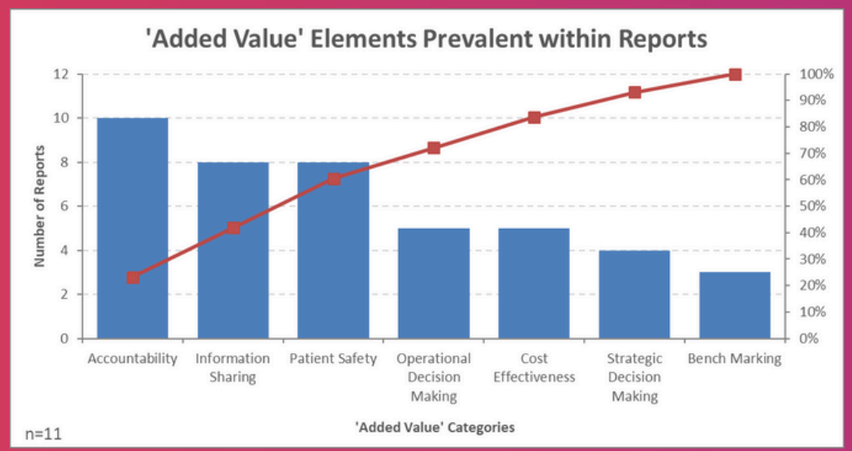
A Data Mapping workshop took place, bringing together the key services whose data intersect and impact with the management of Home Care in the SEHSCT. This included Home Care Service, Contracts Team, Finance Team, HR business partners and the Quality Improvement and Innovation Team. The workshop collated the reports and data collected in relation to Home Care, and then considered this using Lean Methodology - exploring value added activity and the 7 Wastes of Healthcare.

Data Adding Value:

11 reports were analysed using 7 different categories to identify where the data being gathered was adding value:

Data Adding Value

- Enables Operational Decision Making
- Supports Patient Safety
- Sharing Information between Services
- Important for Strategic Decision Making
- Other Domains



Wastes in the System

- Duplication
- Batching Information
- Averages not understanding variation
- Validity of Data Set
- Incomplete data can be unusable and lead to incorrect conclusions

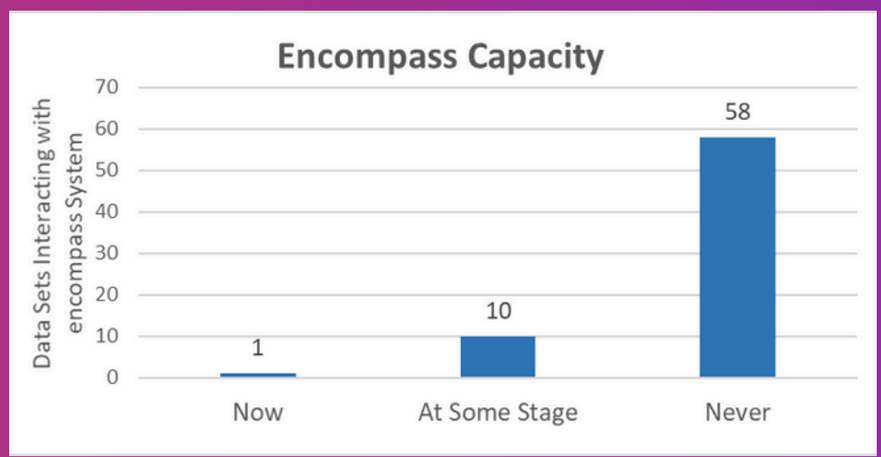
Wastes in the System: 64% of reports identified process wastes within data collection:

- **Incomplete Data**: Can be unusable and lead to incorrect conclusions
- **Duplication**: Many reporting same data and in cases by same people
- **Averages Only**: Averages of monthly activity, not understanding variation
- **Information Batching**: Data reported on monthly/quarterly/annually
- **Validity of data set**: Data quality not of any value
- **Not Exploring Variation**: Through information batching/frequency of reporting and display of data.

encompass Interoperability

The data sets within the reports were also considered in relation to their intersection with encompass, to give consideration as to the potential within the newly rolled out electronic Health Care System and its function in generating data and reports.

The participants identified that of the 69 data sets gathered across the 11 reports, 84% have no interaction with the encompass system.



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Systemisation

Developing a Data Dashboard for Home Care Services - Systemisation

The project findings highlighted a number challenges within the use of data in the management of Home Care:

- **Data Fragmentation**: Care data was often siloed across multiple systems, making it difficult to obtain a holistic view of patient care and operational metrics.
- **Resource Optimisation**: Balancing service capacity with service user needs required real-time insights into scheduling, workload distribution and geographic considerations.
- **Compliance and Reporting**: Regulatory requirements necessitated accurate and timely reporting, which was cumbersome without centralised data access.

With the implementation of encompass throughout Northern Ireland, the immediate development and implementation of a Data Dashboard for Home Care was not progressed within the parameters of this project. However, due consideration should be given in order to continue to weigh the benefits and outcomes that this could offer. Investing in the development of a Data Dashboard can enable the Home Care Service to achieve a strategic advantage in delivering a service that is responsive to meeting the evolving demands of the sector.

A data dashboard could offer the Home Care service:

1. **REAL-TIME DECISION SUPPORT:**
   - A centralised dashboard providing instant access to critical metrics such as service user demographics, Home Care capacity and schedules, and service efficiency, enabling data-driven decision-making.
2. **IMPROVING RESOURCE ALLOCATION:**
   - By visualising Home Care capacity and patient needs, the dashboard streamlined service planning and minimised inefficiencies, leading to cost savings and improved service user outcomes.
3. **PREDICTIVE ANALYTICS**:
   - Introduction of predictive modelling using dashboard analytics to forecast patient needs, resource requirements and potential service bottlenecks.
4. **CUSTOMISABLE VISUALISATIONS:**
   - Provides intuitive charts, graphs and dashboards tailored to various user roles, including service delivery teams, service management and stakeholders.
5. **REGULATORY COMPLIANCE AND REPORTING:**
   - The ability to generate automated reports could reduce administrative burden and improve audit and service review readiness.
6. **DATA INTEGRATION:**
   - Seamlessly combines information from multiple teams across directorates that intersect with Home Care Services, such as the Contracts team and Finance Team, to enable robust decision making.
7. **SCALABILITY FOR FUTURE NEEDS:**
   - As the demand for Home Care Services grows, the Dashboard could scale to accommodate increased data volume and new functionalities, ensuring the system remains relevant and effective.

Next Steps

- This project represents a crucial step in the potential ability that leveraging technology could support in the modernisation and transformation of the Home Care landscape. Senior decision makers should explore the potential of developing the dashboard.

Project Conclusion

Insights from the Home Care Modernisation Project: The Core Fundamentals to Systemise Change

The Importance of Senior Sponsorship

Senior Sponsorship is a key complement to systemised implementation. As a Corporate Improvement Priority this programme of work was accountable to the Trust Board, which elevated the significance of the work, connecting it to regional direction and providing a critical lens to its progress.

The PCOP director provided the leadership, authority and resources necessary to drive meaningful change. Firstly by funding the Ecosystem Mapping exercise and then by recognising the effort and expertise needed to create change by financing the Project Lead role for 18 months.

The Assistant Director for PCOP, Social Work and the Home Care senior managers were key proponents of this work, mobilising teams and contributing to service redesign and new ways to collate, analyse and report service data. Working with the Project Lead, they successfully applied improvement methodology in practice.

The Assistant Director in Quality Improvement and Innovation and the wider QI team contributed to the strategic direction of this programme, localising and applying system design across the programme. Upskilling the Project Lead was a crucial element to the success of the change. The SEHSCT Quality Improvement Fellowship Course, in which the Lead was a participant, was a key enabler for systemised implementation.

The Significance of the Project Lead Role

Having the invaluable resource of the Project Lead (holding knowledge of Quality Improvement (QI) science and experience within the service), created a unique synergy that drove meaningful and sustained change. This combination bridged the gap between theory and practice, and through applied system thinking and implementation science have ensured that QI methodologies are not just applied but are adapted to the real-world complexities of service delivery.

From the perspective of QI science, the Project Lead was able to harness a structured, evidence-based approach to identifying problems, testing the changes and measuring outcomes; supported by the Quality Improvement Team. The Lead was able to navigate the data, methodologies and tools to guide teams through systematic improvement. Meanwhile, the direct knowledge of services allowed them to understand the context, culture and challenges faced by staff and service users. This dual expertise enabled them to anticipate barriers, tailor interventions and foster buy-in from teams, who could see the value in practical and relevant solutions. This integration of QI science and service knowledge ultimately accelerated progress by creating solutions that are impactful, resilient and deeply rooted in the operational fabric of the organisation. It empowered teams to co-create meaningful changes that endure beyond initial implementation.
The project lead participated in the HSCQI Delivering Value Programme which enhanced their knowledge and skills and connected the work regionally.

It is crucial to take the learning from this approach and consider how similar roles could be adopted across other services to drive reform and improvement. By identifying and nurturing individuals with both QI expertise and service experience, teams/services can replicate this model to address their unique challenges and opportunities. Sharing best practices, success stories and frameworks from this approach can inspire other teams to embed these roles - ultimately fostering a culture of continuous improvement and innovation across sectors.

Project Conclusion

Insights from the Home Care Modernisation Project: The Core Fundamentals to Systemise Change

Digitalisation

Prior to the current change programme, the Home Care Team were already pioneering regional innovation by implementing Care Line Live to support scheduling and service capacity. There was a willingness in the team to explore new approaches to plan, coordinate and analyse Home Care Services. The Quality approach has promoted the interrogation of accurate and timely data to enhance decision making prompted in-depth analysis of demand, service provision and outcomes. The learning from this work has led to an ambition to develop an integrated reporting system with related dashboard to enable real-time decision-making in order to maximise the productivity and efficiency of the service. The leveraging of digital technologies will be an important component of Home Care services in the future.

Co-Production

SEHSCT Quality 4 All Strategy has Co-Production of services as a central tenet to care. Throughout the 4 stages of the Double Diamond design, service users and stakeholders were fundamental in understanding the current state, creating a shared vision and testing and applying learning and experience to service design. The success of this work has focused the diverse experience of stakeholders across the system which has amplified the interdependences across the sector and where the challenges and opportunities lie.

By intentionally establishing the 3-Tier Model for Co-Production, it has enabled opportunities for service users and carers to influence the design of the Service User Guide, but also the process of how information is exchanged and how care decisions are made. Sensitivity to the availability and capacity of service users to contribute has enabled varying opportunities for people to interact via surveys, design conversations and project teams. Service users' participation has enhanced collaboration, promoted equity and helped to build a sense of shared ownership; these are recognised in literature as components for sustainable change.

This tiered model for co-production is an exemplar for the Trust with plans to share and scale across the organisation.

The Power of Pause

Complex challenges in Health and Social Care need a systems approach to creative problem solving. The Ecosystem Mapping required a pause to consider the current state, challenges and opportunities. The visualisation of the mapping provided an overview the system and the stakeholders involved in and experiencing Home Care. It is through this discovery phase that the collective understanding highlighted the complexity of the current service impacting patient experiences, and outcome and flow. It was this facilitated pause that enabled best practice elsewhere to be explored, and an extensively collaborative exploration of possibility and shared purpose to be explored also.

The pause enabled this work to move from microsystem improvement to strategic transformation through multiple workstreams that were focused on a common goal. It also enabled time for people to become involved in the work and feel time to contemplate the opportunity and create shared ownership.

Incorporating time to reassess and refine strategies, teams were able to adapt to evolving circumstances and ensure that improvements were sustainable. The Power of Pause was key to achieving impactful and lasting results, as a Trust it would be advantageous to source a discovery phase before embarking on major transformation.

Project Conclusion

Insights from the Home Care Modernisation Project: Key Transferable Learning

1. **Integrating Design Thinking into System Change:**
Introducing a holistic approach to understanding and improving complex situations, considering the interconnections between components, stakeholders and processes. Allocating the time, expertise and resource required for a discovery phase.

2. **Centralising Co-Production into Transformation:**
Establishing a 3-Tier Model for service user and stakeholder collaboration.

3. **Establishment of new structures integrating across Home Care Provision:**
Integrating the Care Bureau and Home Care Services with clear service inclusion criteria and assessment timeframes to be disseminated across all teams.

4. **Developing Standardised Processes and Protocols for the new Home Care Assessment Service:**
Creating clear workflows and guidelines for the service to be tested and implemented, improving the quality of care and efficiency of the service.

5. **Introducing Real-Time Feedback on Service User Need Through Home Care Workers Report:**
Establishing a structure for dynamic assessment and decision making by empowering Home Care Workers to reflect care need and service provision.

6. **Enhancing Data Collection and Analysis:**
Ensuring that definitions and data collection are standardised and digitalised where possible. Analysing data conducted in real time and integrated into service planning. Predictive modelling of increased future demand to support planning.

7. **Establish Collaborative Panels to manage the Home Care Unmet Need List:**
Introducing a multidisciplinary monthly panel to provide oversight, governance and alterative pathways for people on the Unmet Need List. Reflecting CUP learning for staff education and clear assessment practices.

8. **Enable Clear Communication about Home Care Services:**
Disseminating the Home Care User Guide for widespread use across the Trust, empowering service users and families in making decisions about care provision. Integrating the guide into key worker interactions with service users, enhancing the autonomy of care planning.

9. **Creating a Clear Evaluation Plan for the Modernisation Project:**
Systemising change across the sector, embedding an extensive evaluation plan using quality metrics to define service impact.

10. **Future Extension of the HCAS:**
Increasing the gains of the modernisation project, exploration of the extension of the HCAS within the SET Home Care team. This involves spreading the programme, including all the components cited in this report. Senior Sponsorship and resource to implement this next phase of change. Consideration of regional learning and adoption.

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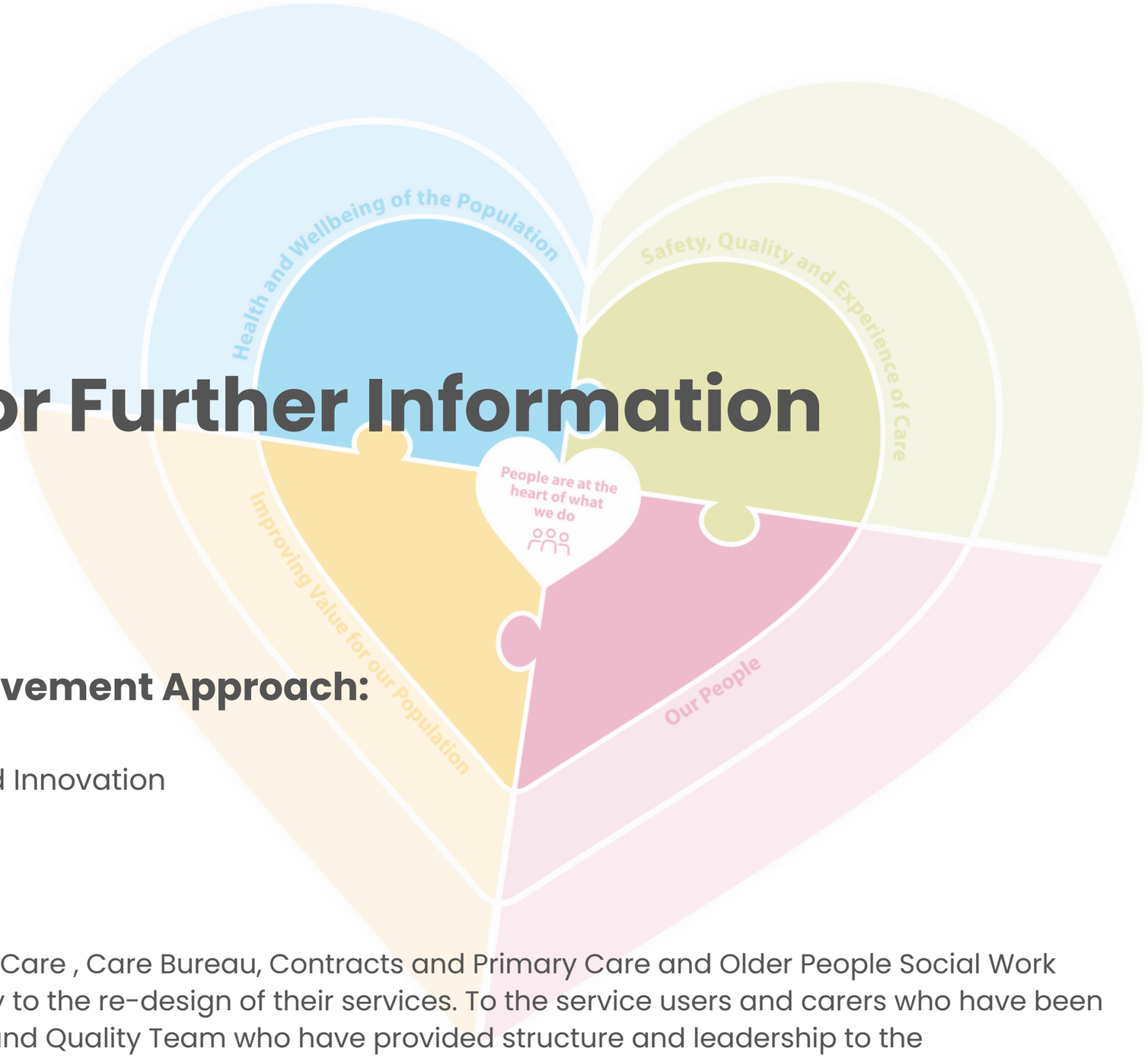

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Acknowledgements
Acknowledgement should be given to the Home Care , Care Bureau, Contracts and Primary Care and Older People Social Work teams who have brought positivity and creativity to the re-design of their services. To the service users and carers who have been foundational in the process. To Claire Robinson and Quality Team who have provided structure and leadership to the modernisation programme.
Special thanks To Pamela Fillis, Alistair Fitzsimmons, Karen Kinkead, Jo Burns and Clare-Marie Dickson for their visionary leadership that has created sustained change.