Department of Health
An Roinn Sláinte
Männystrie O Poustie
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DOMICILIARY CARE WORKFORCE REVIEW

Northern Ireland

2016 - 2021

31 August 2018

CONTENTS

FOREWORD

Domiciliary care is a vital service provided to around 24,000 service users [1] each week throughout Northern Ireland. The publication by the Expert Panel *Systems not Structures: Changing Health and Social Care* and the response *Health and Wellbeing 2026 – Delivering Together* highlighted the demographic changes and the requirement to respond to the needs of our ageing population. It also acknowledged that for many individuals, being able to stay in their own home, supported by the health and social care system, is their preferred option.

Health and Social Care spends approximately £204 million per year on domiciliary care services. Approximately 24,000 people receive domiciliary care each week and close to 270,000 hours of domiciliary care are delivered every week[1].

Our population is ageing with the number of people aged 65 and over projected to increase by 14% by 2021 (to 332,900) and 45% by 2030 (to 423,000)[2].

In total, it is estimated that the workforce providing HSC Trust commissioned domiciliary care is around 12,000 (both employed by HSC and independent sector). Collectively, this workforce provides vital services to our service users, supporting them to remain at home for as long as possible by assisting them to lead dignified and independent lives.

It is vital that the domiciliary care workforce feels valued, skilled and trained with the ability to be flexible and adaptive to future changes in service delivery models if it is to ensure that the changing needs of service users continue to be met appropriately.

It is well recognised that this workforce is paramount to delivering high quality, safe care to our older population and others with social care needs. To ensure this is achieved, it is necessary to develop this workforce plan providing the right number of people with the right skills in the right place at the right time!

A challenging goal.

[1] Domiciliary Care Services for Adults in NI (2016).
[2] 2014-Based Population Projections for NI (2015) NISRA.

EXECUTIVE SUMMARY

The Department's Workforce Policy Directorate has carried out a workforce review for the domiciliary care workforce following on from the Health and Social Care Board's (HSCB) *Review of Domiciliary Care – A Managed Change*.

Domiciliary care within Northern Ireland is a complex service provided by both the statutory and independent sectors with over 100 registered care providers including the five HSC Trusts. Each week over 268,000 hours of support is provided to over 23,000 service users in their own homes at an annual cost of approximately £204 million.

Domiciliary care is provided to individuals with an assessed need and to three main service user groups:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

Our population is ageing with the number of people aged 65 and over projected to increase by 14% by 2021 (to 332,900) and 45% by 2030 (to 423,000). Many will have long-term complex care needs thus increasing the demand on this service.

In March 2015, the Department of Health accepted the Six Step Methodology (developed by Skills for Health) as the preferred model for all future HSC workforce planning.

The domiciliary care workforce review therefore follows this process.

A Steering Group to oversee the review and a Project Group to carry out the review were established with Terms of Reference agreed.

This review has been undertaken during a period of change, with the Minister's *Health and Wellbeing 2026 Delivering Together* at the fore of all future service delivery. However, as much of the transformation work is at an early formative stage, this report is based on knowledge of existing systems and structures at the present time. The findings of the review are therefore framed in the context of a number of assumptions and constraints about the future delivery of domiciliary care over the next five years.

Assumptions	**Constraints**
Mixed economy – it is acknowledge that care will continue to be provided by both the statutory and independent sectors.	***Tendering process*** – current tenders in place for next five years.
Self directed support – HSCB's policy of self directed support will continue with a	***Workforce data*** – lack of data available, especially in the

target of 33% uptake by 2019.	independent sector, and lack of consistent reporting across the statutory sector.
Eligibility criteria – current criteria remains the same.	***Service delivery models*** – absence of clarity about current and future service delivery models.
Funding – it is acknowledged that sufficient funding will be required to meet future demand.	

The Steering and Project Groups were representative of the key stakeholders in the delivery of domiciliary care comprising Department of Health, Department for the Economy, Health and Social Care Trusts, Health and Social Care Board, Northern Ireland Social Care Council, Public Health Agency, independent sector, with staff side, from a user perspective, being provided by the PHA representative.

In order to engage with a wider group of stakeholders, a stakeholder engagement event was held in Ulster University in June 2016. Over 100 delegates registered to attend the event from across the statutory sector, independent sector, staff side, carers and service users. The event was an interactive e-participation engagement session.

This event focused on three key areas:

- Growing and retaining the domiciliary workforce;
- Stabilising the market; and
- Skills mix and career development.

The review was undertaken using a co-design approach.

Whilst it has not been possible to provide bespoke financial implications, the review has demonstrated that, at present, services are already stretched, with a gap in the supply and demand chain due to unmet need.

Even should we continue to deliver the same level of service to the same percentage of the population, given the projected increase in our ageing population, it is estimated that by 2021 **2,700** service users are going to require support which would result in the need for a further **1,400** domiciliary care staff. This will require investment of approximately **£27 million**.

Training demands are also going to play a role in ensuring that staff have the appropriate skills to deliver the right service to the right people at the right time. For example, the introduction of new technology will have a significant impact on the role of the domiciliary care worker and service users, and up-skilling of this workforce will be critical to ensure optimum benefits are realised from the technology. In addition, with many people living with more complex needs e.g. diabetes, stroke and Alzheimer's etc., staff may also require specialist training.

The Minister's vision for *Health and Wellbeing 2026 – Delivering Together* highlights the need to work in partnership between patients, service users, families, staff and politicians. This is of significant importance in the delivery of domiciliary care as family members and friends, who may currently provide care needs, make an enormous contribution to the economy and society as a whole.

The review outlines a number of recommendations under headings of key themes going forward, e.g. commissioning, recruitment and retention, education and training, career development, workforce planning and partnership and community working.

An Action/Implementation Plan, to be rolled out over the five-year life span of the review, has been developed. Due to the nature of the service being delivered, many of the actions will be led by the employers. However, a high level of Departmental support will be required to ensure that issues such as commissioning, training and partnership working are developed to maximise capacity within the sector.

ABBREVATIONS

AHP	Allied Health Professional
BMI	Body Mass Index
CIB	Community Information Branch
CIS	Community Information System
DfE	Department for the Economy
DHSSPSNI	Department of Health, Social Services and Personal Safety Northern Ireland
DoH	Department of Health
HRPTS	Human Resources Payroll Travel and Subsistence System
HSC	Health and Social Care
HSC Trusts	Belfast, Northern, Southern, South Eastern, Western and Northern Ireland Ambulance Service Trust
HSCB	Health and Social Care Board
IPC	Institute of Public Care
NISCC	Northern Ireland Social Care Council
NISRA	Northern Ireland Statistical & Research Agency
PHA	Public Health Agency
PRTL	Post Registration Training and Learning
QCF	Qualifications and Credit Framework
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group
SDS	Self Directed Support
TYC	Transforming Your Care

1.0 INTRODUCTION AND BACKGROUND

1.1 Strategic Context

Domiciliary care within Northern Ireland is a complex service provided by both the statutory and independent sectors, offering a variety of terms and conditions to staff employed to deliver a range of health and social care to service users. Currently there are over 100 registered domiciliary care providers, including the five Health and Social Care Trusts.[3]

Domiciliary care is provided to individuals with an assessed need and to three main service user groups:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

Each week close to 270,000 hours of support are provided to around 24,000 service users in their own home.

The range and type of domiciliary care and personal support provided in people's own homes varies, but usually includes support with activities of daily living, which may include help with personal care, support the administration of medicines, meeting the needs of service users with specific issues including memory issues and those requiring nutritional support and essential domestic tasks. Domiciliary care also plays a key role in underpinning a more efficient healthcare system through supporting timely discharges from secondary care settings.

The population in NI is ageing; it is predicted that by 2030 the number of people over 65 will increase by 45% and that the number of people over 85 will increase by 81%. These trends are undoubtedly a cause for celebration. However, they will also require a greater demand for support as levels of dependency and disability increase with age. Meeting an increased demand for domiciliary care services presents an enormous challenge for health and social care providers. Workforce planning is a key component in ensuring that there is a sufficient workforce to meet that demand and provide services to those in need, at the time of need.

1.2 Workforce Plan Methodology

In November 2014, the Director of Human Resources at the Department of Health & Social Services and Personal Safety Northern Ireland (DHSSPSNI) commissioned a workforce review of domiciliary care services within the Older People's Programme of Care, with the aim of producing an integrated regional workforce plan and associated recommendations.

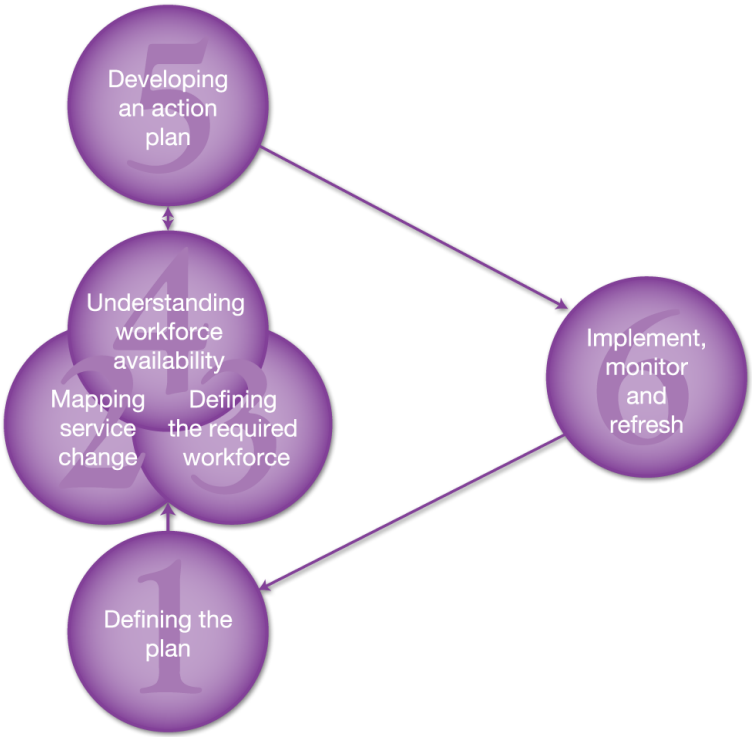
[3] A Managed Change Briefing Paper: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland November 2015

A Regional Domiciliary Care Workforce Planning Steering Group and Project Working Group were established to take this forward. **Terms of Reference** and **Membership** of both groups are set out in **Appendix 1.**

After consideration of a range of established workforce planning practices, the Six Step Methodology (Skills for Health 2009) was adopted and agreed by the Department of Health in March 2015 as the preferred tool for future workforce planning throughout the HSC.

This workforce plan is underpinned by the adapted version of the 'Six Step Methodology' (Skills for Health 2009) (Figure 1).

Figure 1: Six Step Methodology to Integrated Workforce Planning (Skills for Health)



This approach has been accepted across all HSC organisations in Northern Ireland and is a very useful tool in guiding us through the steps; gathering data on the supply and demand, identifying key issues impacting on recruitment, retention and career progression on those employed in this area.

In December 2016 the then Health Minister established an Expert Advisory Panel on Adult Care and Support to assess the many challenges facing the care and support system, and to produce a set of recommendations to reform the system and its funding structures to ensure its future sustainability. Their Report, *Power to People: Proposals to reboot adult care and support in NI* was published in December 2017.

In *Health and Wellbeing 2016 – Delivering Together* the then Minister gave a commitment to tackling many of the challenges which are present within the domiciliary care service, including the availability of a well-trained and capable

workforce. This report will supplement the work of the Expert Advisory Panel in understanding the workforce needs and issues, alongside related pieces of work including the HSC Board's report *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary care in Northern Ireland*.

This report sets out the strategic workforce implications and makes a number of recommendations for the Region over the next five years, and an Action/Implementation Plan has been developed to ensure that recommendations are delivered in an efficient and timely manner.

It is also accepted that some HSC Trusts have already progressed procurement of domiciliary care services for the next five years, which may impact on the ability to shape service models in line with the recommendations within that period.

1.3 Meeting the Terms of Reference

While the development of this report has been undertaken at a time when the Health and Social Care system is undergoing transformation as set out in *Health and Wellbeing 2026 Delivering Together*, some uncertainty exists whilst this transformation is being rolled out.

Therefore, the information contained in this report is based on knowledge of the existing systems and structures for the delivery of domiciliary care services. The findings are framed in the context of a number of assumptions about the delivery of domiciliary care over the next five years and also some constraints impacting on the Six Step Methodology used. This work will need to the updated in line with the outcomes of the Expert Advisory Panel Report, *Power to People: Proposals to reboot adult care and support in NI*.

1.4 Assumptions and Constraints

Assumption 1 **Mixed economy** – It is acknowledged that care will continue to be provided by both the statutory and independent sectors – if that were to change then this would impact on workforce planning.

Assumption 2 **Self directed support** – The HSCB's policy of self directed support will continue with targets set for 33% of eligible service users to avail of this option by 2019.

Assumption 3 **Eligibility criteria** – Current eligibility for domiciliary care support remains the same – any policy change on this would affect projections contained in the report.

Assumption 4 **Funding** – It is acknowledged that sufficient funding will be required to meet the future demands and workforce needs.

Constraint 1 **Tendering process** – a number of HSC Trusts are or have recently been tendering for service delivery and these contracts will apply for the next 5 years.

Constraint 2 **Workforce data** – there is a lack of workforce data, especially in the independent sector, but also in the statutory sector as each HSC Trust may record job roles/titles and activity differently. The compulsory registration of domiciliary care workers will help address this and assist with more robust information being made available for workforce planning.

Constraint 3 **Service delivery models** – the absence of clarity about future service delivery models has restricted the planning process and this review has been undertaken based on existing models of domiciliary care provision.

2.0 DEFINING THE PLAN

2.1 Purpose

This workforce review has been commissioned by the DoH in recognition of the increasing demand for domiciliary care services from an ageing population and in response to current thinking as outlined in *Transforming Your Care* that '***home is the hub***'. Given our ageing population it is reasonable to project that more people will live longer with more complex needs, and the drive now is to deliver more care closer to home or at home. This will undoubtedly put additional pressure on domiciliary care services. In order to respond effectively to this pressure, it is vital that we ensure that we have a sufficient domiciliary care workforce to meet this demand.

Purpose

- ✓ To carry out a workforce review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services.
- ✓ The Review will make recommendations for further training required to ensure a competent workforce that can deliver the agreed model(s) of domiciliary care services to support transformation of care over the next five years.
- ✓ Develop an Implementation/Action Plan to deliver recommendations.

Workforce planning is a key component in setting the direction of travel for the domiciliary care workforce over the next five years. The DoH recognised the need for change, with the impact of demographic changes and labour market challenges increasingly understood. Not only will the needs of service users continue to change and demand for services increase, but the workforce profile and characteristics of our existing staff will also change as our own workforce ages.

This workforce review focuses attention on the issues impacting on the delivery of domiciliary care services and identifies the actions necessary for securing the appropriate domiciliary care workforce with the right skills, in the right place, delivering the right care to service users.

2.2 Aim and Objectives

The overarching objective of the review is to develop a workforce plan which will support the recruitment and retention of a well-trained, skilled, motivated and sustainable domiciliary care workforce with the requisite skills to deliver domiciliary care services to the people of Northern Ireland over the next five year period. This

will enable employing organisations, both statutory and independent, to ensure sufficient numbers of staff are in post to provide care and support, and will give confidence to service users that the service has been developed taking their feedback through co-design into account.

Objectives:

Objectives

- ✓ To ensure the workforce plan is informed by co-design (developed in partnership with service users/families/carers).
- ✓ To provide an analysis of the current domiciliary care workforce in Northern Ireland.
- ✓ To provide an analysis of current and future recruitment and retention issues.
- ✓ To identify potential future recruitment and retention issues.
- ✓ To produce a Workforce Plan to include recommendations to support the outcome of the review.

2.3 Guiding Principles

The following principles were employed to guide the development of this workforce review:

Guiding Principles

- ✓ The plan will focus on an integrated approach with the service user at the centre.
- ✓ The Department, Commissioners and Employers will be central to supporting the development of the plan going forward.
- ✓ The whole of the domiciliary care workforce will be taken into account, including the numbers, skills and skill mix required across both the statutory and independent sectors.
- ✓ The plan will take account of the demographics, health, and social care needs of the service user population.
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required.
- ✓ Stakeholder engagement should be employed throughout the whole process including implementation.

2.4 Scope of the Workforce Review

At the outset of the process, the intention was to confine this workforce review to domiciliary care provided to 'older people', that is, persons aged 65+ receiving domiciliary care. However, it soon came to light during initial data collection that it was not possible to disaggregate the workforce information between the three main service user groups to whom domiciliary care is provided:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

It is significant however, that over 80% of recipients of domiciliary care are older people.

The Self Directed Support (SDS) model, such as Direct Payments and Managed Budgets, is an area of care that is expected to be highly impacted by further service transformation and SDS is expected to increase over the next few years.

The DoH policy to support care services at home includes the use of Self Directed Support (SDS), Reablement and Telemonitoring. In relation to SDS, it is expected that by March 2019 all service users and carers will be assessed or reassessed at review under the SDS approach, and will be offered the choice to access Direct Payments, a Managed Budget, HSC Trust arranged services, or a mix of those options, to meet any eligible needs identified. The aim is that one in three of those individuals in receipt of a social care service will be availing of SDS via a direct payment or a managed budget arrangement.

Self Directed Support budgets can facilitate individuals to purchase domiciliary care directly, shaping the service to meet their individual needs, thus maximising the opportunity of choice and control. Related support plans will allow monitoring of the budgets in line with assessed needs and agreed support.

In assessing future workforce requirements, cognisance will need to be taken of these other interacting services as they develop into the future.

2.5 Ownership

The need to ensure the support and ownership of both the statutory and independent sectors was considered critical in the development of this regional workforce review. A **Steering Group** was therefore established to oversee the workforce plan, co-chaired by the DoH Director of Workforce Policy and the DoH Deputy Chief Social Services Officer. Membership of the Steering Group was drawn from DoH, HSC Trusts (both HR and service delivery representatives), NISCC, HSCB, PHA, Independent Healthcare Providers, PCC, DfE and staff side.

A **Project Working Group** was also established, chaired by the DoH Assistant Director of Workforce Planning with membership drawn from DoH, HSC Trusts (both HR and service delivery representatives), NISCC and HSCB.

Terms of Reference for both the Steering Group and Project Working Group were agreed. A copy of the Terms of Reference and a full list of membership are attached at **Appendix 1.**

The Terms of Reference included:

- To agree a definition of domiciliary care.
- To agree the scope of the review.
- To provide an analysis of the current domiciliary care workforce in Northern Ireland.
- To test a workforce planning model on a 'Programme of Care' approach within a social care context, although recognising that the service user group includes people outside the Older People programme of care.
- To provide an analysis of current and future recruitment and retention issues.
- To identify potential future recruitment and retention issues.
- To produce a Workforce Plan to include recommendations to support the outcome of the review.

A commitment was given by the Steering Group that the review would be developed following a co-design approach. A lot of work had already been undertaken by the PHA, PCC and the HSCB in engaging with service users and staff to inform the HSCB's Regional Review of Domiciliary Care report *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland.* It was agreed that the Project Working Group would draw upon this information to inform the review. A paper was commissioned by the Project Steering Group on this basis, copy attached at **Appendix 2**.

2.6 Definition of Domiciliary Care

This workforce review commenced alongside the HSCB's Regional Review of Domiciliary Care *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland.* It seemed appropriate therefore that, to be consistent, the same definition would be adopted. However, it should be noted that eligibility criteria for domiciliary care is applied by HSC Trusts based on an individuals' assessed need and the Steering Group acknowledges that the definition below does not fully reflect the current range of domiciliary care services provided and therefore requires updating, which has been highlighted in the HSCB's report.

Definition of domiciliary care – *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.

2.7 Drivers for Change

Public expectations of health and social care are changing, and service users and carers expect high-quality services to be delivered close to their homes. The demand on our services is set to increase, with people living longer, with more complex needs. There is an increased expectation for services to be personalised to meet individual needs and the ongoing rollout and promotion of the SDS service model will continue to drive this demand. Therefore, as the health and social care landscape in Northern Ireland continues to evolve, and the shift from acute to community health and social care services grows, there will be a need to ensure that the domiciliary care workforce acquires new skills to match the speed and introduction of new technologies and potentially the introduction of new roles.

At the time of writing, the NI Executive has produced a draft Programme for Government (PfG) for consultation. A significant focus of PfG is improving investment in the economy through strategies for job creation, encouraging those who are economically inactive to enter work and developing and enhancing the skills and capacity of those in employment. These outcomes, coupled with the former Health Minister's strategy for transformation in health and social care, *Health and Wellbeing 2026 – Delivering Together*, form two key strategic drivers which will have an impact on the domiciliary care workforce over the next five years. The interconnection between transforming services and skills and employment strategies should be recognised in order to support the recruitment and retention of a skilled domiciliary care workforce.

There are many other drivers for change, particularly with the recent onus on quality and patient safety which has been highlighted in a range of regional and national strategies and reports including:

- Systems not Structures: Changing Health & Social Care, 2016.
- Mental Capacity Act (NI) 2016.
- Skills Agenda and Apprenticeship.
- Registration of the social care workforce.
- The Dementia Learning and Development Framework 2016.
- A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland, November 2015.
- Domiciliary Care in Northern Ireland: A Report of the Commissioner's Summit, October 2015.

- Public Health Agency Regional Findings Relating to Care in Your Own Home (10,000 voices), March 2015.
- Introduction of new technology e.g. Human Resources Payroll Travel and Subsistence System (HRPTS) and Community Information System (CIS).
- Quality 2020 – A 10-year quality vision for health and social care in Northern Ireland.
- Improving & Safeguarding Social Wellbeing – A Strategy for Social Work in Northern Ireland 2012 – 2022.
- Pension Reform.
- Review into the quality of care and treatment provided by 14 hospital Trusts in England: Overview report Professor Sir Bruce Keogh KBE.
- The Right Time, The Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland December 2014 Donaldson Review 2014.
- The Berwick Report – A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England August 2013.
- The Cavendish Report 2013 – an investigation into what can be done to ensure that all people using Services are treated with care and compassion by healthcare assistants and support workers in the NHS and social care settings.
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013.
- Financial Savings Plans.
- Transforming Your Care – A Review of Health and Social Care in Northern Ireland December 2011.
- Living Matters Dying Matters 2010 – A Strategy for palliative and end of life care.
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.
- Health and Personal Social Services (Quality and Improvement and Regulation) (Northern Ireland) Order 2003.
- Carers and Direct Payments Act (Northern Ireland) 2002; Caring for Carers 2006.
- Regulation of the Domiciliary Care Workforce.

3.0 MAPPING SERVICE CHANGE

3.1 Population and Health Profile

The NI Statistics and Research Agency (NISRA) projects the population of Northern Ireland to rise from 1.85 million in 2015 to 1.91 million in 2021 (an increase of 3%) or 1.98 million by 2030 (an increase of 7% from 2015). With the majority of domiciliary care categorised as being delivered to those aged 65 and over, it is significant to note that the number of people aged 65 and over is forecast to increase by 14%, from 292,000 in 2015 to 332,900 in 2021. The projected percentage increase to 2030 is 45%, with those aged 65 and over expected to total around 423,000. Furthermore, in the period to 2021, the number of people aged 85 and over is expected to increase by 7,500 from 35,100 in 2015 to 42,600 in 2021 (an increase of 21%). The projected percentage increase to 2030 is 81%, with those aged 85 and over expected to total around 63,700 (an increase of around 28,600).

In terms of life expectancy, males aged 65 in the period 2011-2013 can expect to live for another 18.1 years whereas females can expect to live a further 20.6 years. Over the decade 2001-2003 to 2011-2013, male life expectancy at age 65 has improved by 2.2 years whereas that of females has improved by 1.7 years. (Source: Life Expectancy for areas within NI 2011-2013, NISRA http://www.nisra.gov.uk/archive/demography/vital/deaths/life_tables/2011-2013LE.pdf).

The following estimates also bear relevance to the population who might avail of domiciliary care services:

- 26,500 people are estimated to be living with a learning disability, and half are aged between 0-19 years (Bamford Action Plan 2009-11).
- 250,000 adults and 45,000 children and young people are estimated to have a mental health need at any one time in NI (Bamford Action Plan 2009-11).
- 20,000 older people are living with Dementia and this number is expected to rise to 60,000 over the next 30 years (Source: DoH Dementia Strategy).

There are increasing numbers of people with chronic or long-term conditions such as diabetes, coronary heart disease, chronic obstructive pulmonary disease and stroke survivors. The table overleaf indicates the number of patients on GP Registers in Northern Ireland across a range of conditions.

3.2 Statistics from GP Quality & Outcomes Framework 2015/16

Condition:	No. Patients on GP registers with each condition
Asthma	117,613
Atrial Fibrillation	32,701
Cancer (diagnosis since 2003)	42,454
Chronic Obstructive Pulmonary Disease	38,530
Coronary Heart Disease	74,525
Cardiovascular disease (CVD) – Primary Prevention	19,712
Dementia (diagnosis of)	13,617
Depression (patients aged 18+, since 2006)	131,776
Diabetes (patients aged 17+)	88,305
Heart Failure	15,702
Heart Failure due to left ventricular systolic dysfunction (LVSD)	4,237
Hypertension	260,032
Mental Health (schizophrenia, bipolar affective disorder, other psychoses, patients on lithium therapy)	17,114
Osteoporosis (patients aged 50+, since 2012)	4,104
Palliative Care	5,426
Rheumatoid Arthritis (patients aged 16+)	11,899
Stroke and transient ischemic attack (TIA)	36,020

Source: 2015/16 raw disease prevalence trend data for NI https://www.health-ni.gov.uk/publications/201516-raw-disease-prevalence-trend-data-northern-ireland

The 2015/16 Health Survey outlined that a rise in obesity levels, showing that Body Mass Index (BMI) levels are:

- 1% underweight
- 38% normal weight
- 34% overweight
- 26% obese

Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-15-16.pdf

This can have a direct impact on the provision of domiciliary care, as the need for suitable aids or the need for additional care workers for moving and handling tasks must be assessed.

3.3 Current Eligibility Criteria

The eligibility criteria for domiciliary care are based on the DoH (GB) *Fair Access to Care Services* (2003) and have been modified to meet local circumstances. The Department developed *Regional Access Criteria for Domiciliary Care* in 2008, with the criteria based on the underlying principle that people should be supported to remain independent where possible. Each individual's assessment of need determines eligibility for services depending on the level of risk to independence. Consideration of the level of risk is determined by a number of factors including:

- Autonomy;
- Health and Safety;
- Ability to manage daily routines; and
- Involvement in family life.

3.4 Overview of Domiciliary Care Tasks

Domiciliary care workers are part of the registered social care workforce. They sustain and promote social wellbeing through the provision of a range of home and community based personal care and support services to individuals, carers and families. This includes providing care to individuals who have more complex care and support needs.

Where complex care is supporting an assessed health or social care need, the care will be prescribed and reviewed by the relevant health or social care professional, supporting the domiciliary care worker and working in partnership with the wider multi-professional team, in order to deliver well-coordinated and person-centred care.

3.5 Activity Key Facts and Figures

The Department of Health collects information on domiciliary care services provided to service users by means of an annual survey. During the survey week 11th - 17th September 2016, the following facts were recorded:

Contact Hours

- An estimated 268,883 contact hours of domiciliary care were provided by HSC Trusts in Northern Ireland, an increase of 5% (13,674) from the survey week in 2015 (255,209);

- The statutory sector provided 30% of domiciliary care contact hours, with 70% provided by the independent sector; and
- An average of 11.3 domiciliary care contact hours were provided per service user, an increase of 3% when compared to 2015 (11.0).

Service Users Receiving Domiciliary Care

- HSC Trusts provided domiciliary care services for 23,873 service users, 3% more than the number during the survey week in 2015 (23,260).

Domiciliary Care Visits

- 436,174* domiciliary care visits were provided to service users, 31% from the statutory sector and 69% from the independent sector;
- Half (50%) of all domiciliary care visits provided to service users were between 16 and 30 minutes long. Almost three in ten (29%) visits were 15 minutes or less and over one in five* (21%) were more than 30 minutes long; and
- 9,825 service users received a domiciliary care visit lasting 15 minutes or less, over two-fifths (41%) of all service users receiving domiciliary care.

Service Intensity

- Nearly nine-tenths (86%) of all service users receiving domiciliary care services received six or more visits. The proportion of service users receiving six or more visits has increased by 5% (980) since 2012.

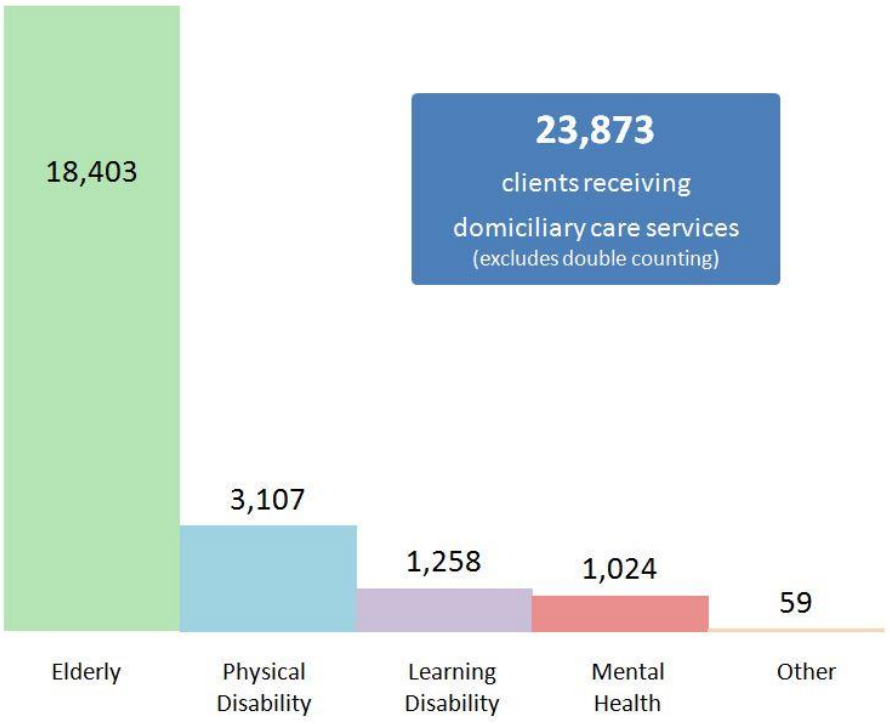
Service Users Receiving Intensive Domiciliary Care

- 8,752 service users received intensive domiciliary care services, 14% (1,059) more than during the survey week in 2015 (7,693).

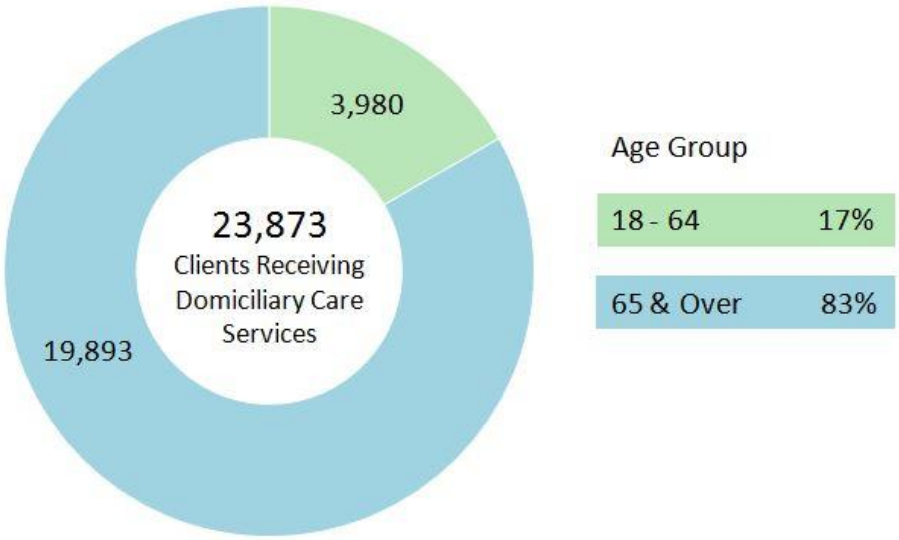
For the purposes of the survey, ***intensive domiciliary care*** *service is defined as 6 or more visits and more than 10 contact hours during the survey week*

***** The total regional visits figure includes an estimate for the number of statutory visits greater than 30 minutes in length for the Northern HSC Trust. The estimate is in line with the 2015 survey findings.

Number of Service Users Receiving Domiciliary Care Services, by Service User Group (2016) – Source: Domiciliary Care Services for adults in NI 2016.



Number of Service Users Receiving Domiciliary Care Services, by Age Group (2016) – Source: Domiciliary Care Services for adults in NI 2016.



Source: Domiciliary Care Services for Adults in Northern Ireland 2016
https://www.health-ni.gov.uk/publications/domiciliary-care-services-adults-northern-ireland-2016

3.6 Financial Challenges

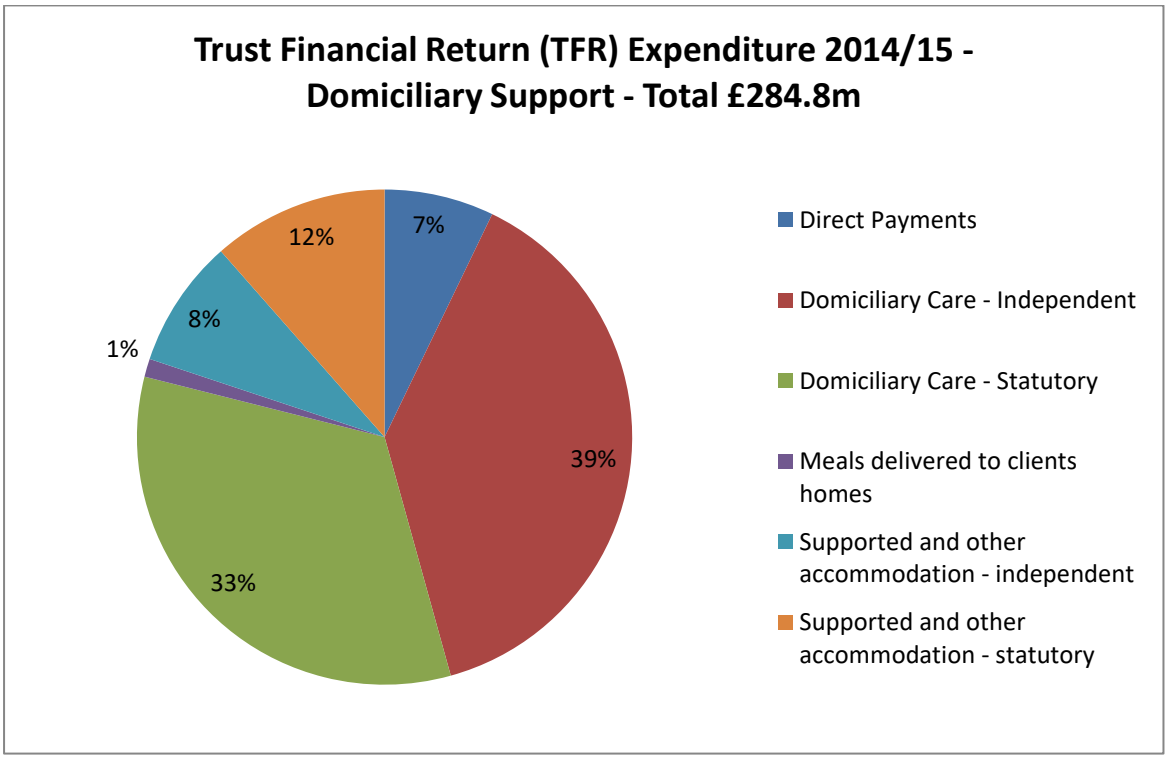
The Health and Social Care sector continues to face significant financial challenges and must work towards delivering the efficiencies required to meet the funding available. Therefore commissioners and providers should be seeking innovative ways of delivering the services required. The implications of the efficiency challenges that face each HSC Trust over the next five years will be significant, particularly in relation to meeting existing commitments.

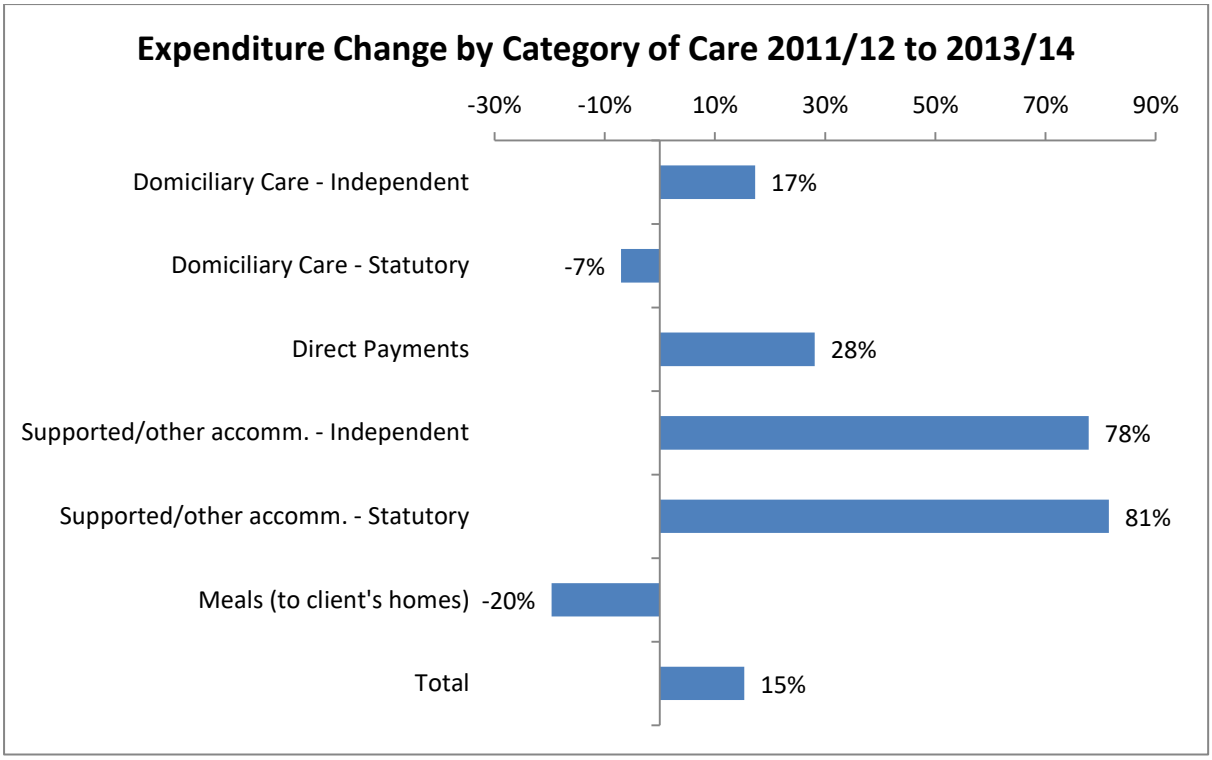
A key element of the transformation of health and social care will be to move services and associated resources into the primary and community sector to provide "***care closer to home***".

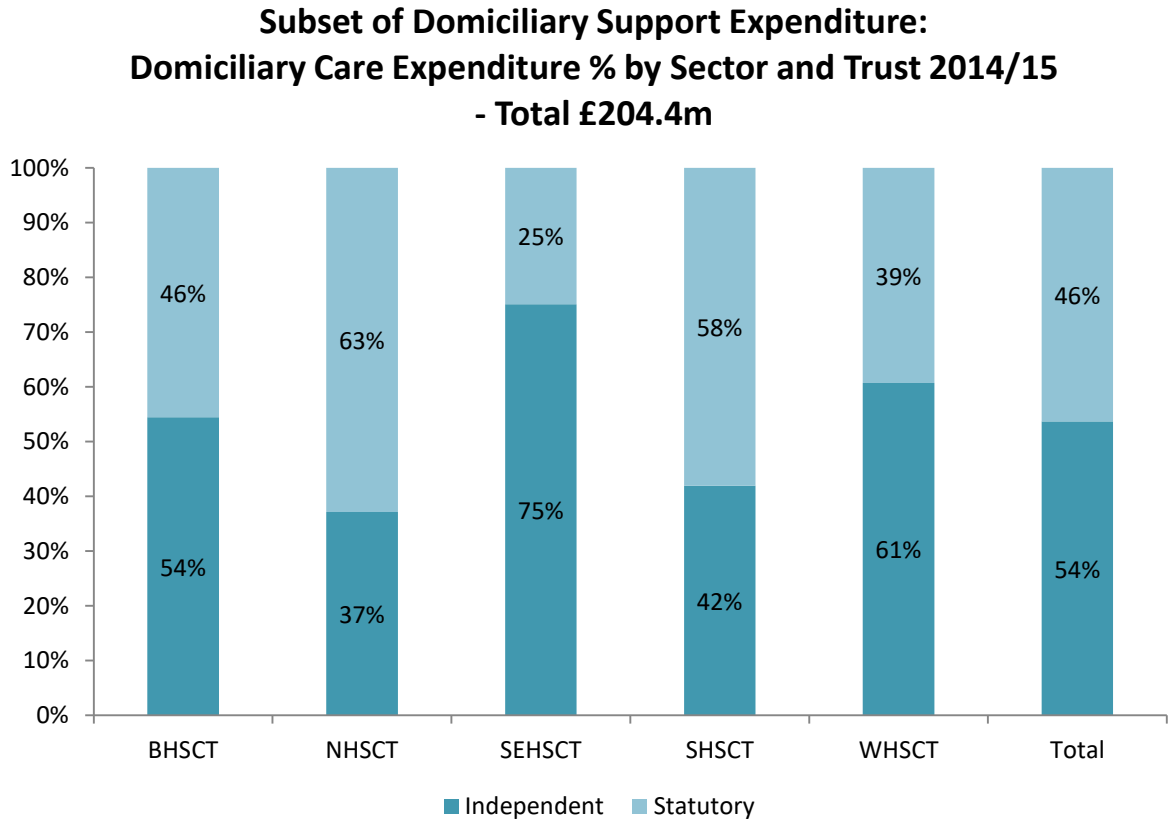
However, it is important to note this is not about seeking efficiencies; rather it is about delivering health and social care services in a different way. We need to ensure that we provide the right care in the right place to the quality standards required, using resources as effectively as possible.

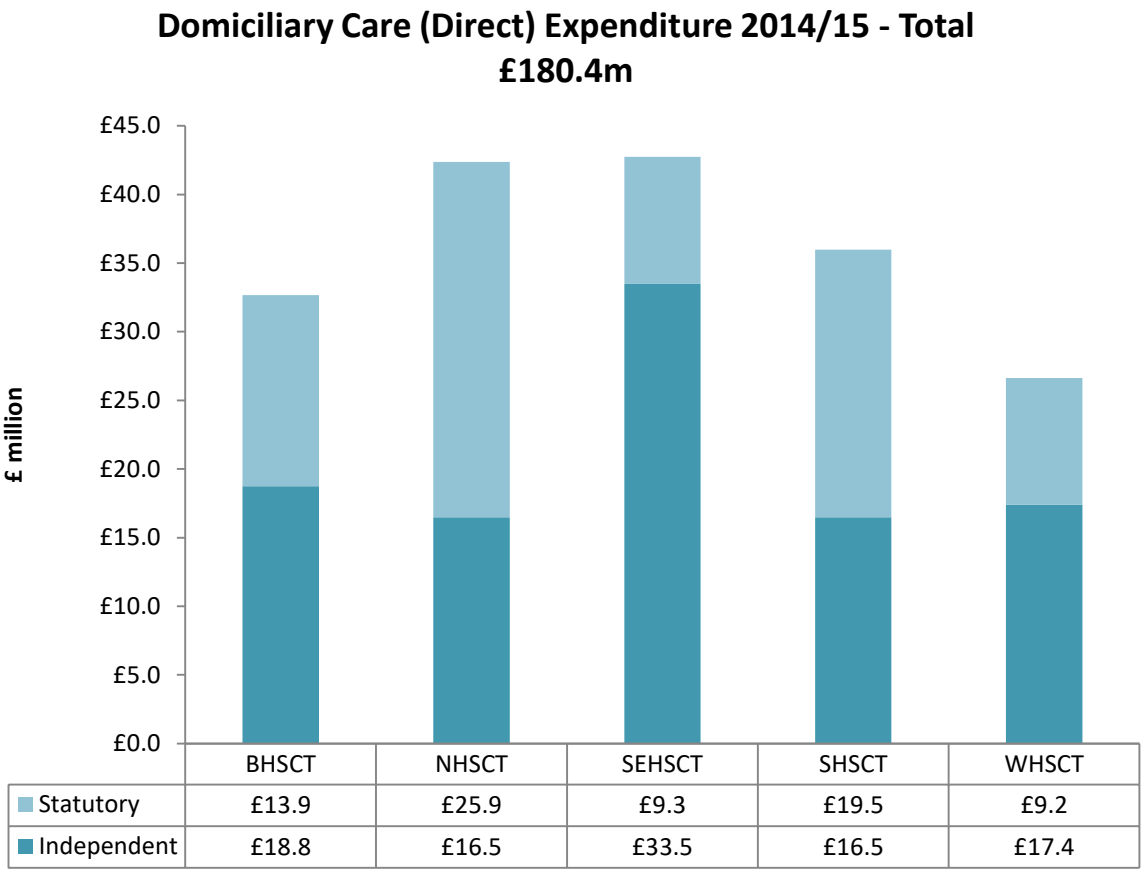
3.7 Expenditure on Domiciliary Support

HSC Trust returns for the 2014/15 financial year indicate that a total of £284.8m was spent on a range of domiciliary support. The figure below outlines a range of expenditure including direct payments and community meals, which represent a small percentage (8%) of spend with supported housing at 20% or almost £56.6m. The bulk of the funding however is invested in mainstream domiciliary care services across statutory and independent sectors amounting to £204.4m.




Expenditure Change by Category of Care 2011/12 to 2013/14
-30%
-10%
10%
30%
50%
70%
90%
Domiciliary Care - Independent
17%
Domiciliary Care - Statutory
-7%
Direct Payments
28%
Supported/other accomm. - Independent
78%
Supported/other accomm. - Statutory
81%
Meals (to client's homes)
-20%
Total
15%


Subset of Domiciliary Support Expenditure:
Domiciliary Care Expenditure % by Sector and Trust 2014/15
- Total £204.4m
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
46%
54%
63%
37%
25%
75%
58%
42%
39%
61%
46%
54%
BHSCT
NHSCT
SEHSCT
SHSCT
WHSCT
Total
Independent
Statutory



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Statutory	£13.9	£25.9	£9.3	£19.5	£9.2
Independent	£18.8	£16.5	£33.5	£16.5	£17.4

3.8 Carers

Domiciliary care services often support both the individual being cared for, and also their carer. *Caring for Carers (2006)* highlighted that whilst the provision of services to the person being cared for is essential, "***a range of flexible, practical support services needs to be in place for the person being cared for and the carer***".

Carers are often family members or people who have a close interpersonal relationship with the person receiving care, and they provide significant amounts of essential support to the people they care for. Whilst many carers view the care they provide as being a core part of their family or relationship role, and would not want to stop caring, it is important that this care is recognised and supported.

There are 213,412 people providing unpaid care according to the 2011 NI Census.

This means that:-

- almost 12% (11.93%) of the population carries out some informal caring;
- 15% of those providing unpaid care were aged 65 and over;
- 57.2% of carers provide between 1 and 19 hours of unpaid care per week;

- 16.5% of carers provide between 20 and 49 hours of unpaid care per week; and

- 26.3% provide over 50 hours of unpaid care per week.

Source: Census 2011

Delivering Together (2016) acknowledges that families and friends take on most of the caring responsibilities for their loved ones and make an enormous contribution to health and social care and to society as a whole. This partnership working is a vital element of service delivery. The needs of carers are changing and we must therefore change the support we provide to them. Carers must be able to access up to date information and, crucially, consider how we can support them to live their own lives. The Expert Advisory Panel Report, *Power to People: Proposals to reboot adult care and support in NI* explored how we can better support carers.

4.0 DEFINING THE REQUIRED WORKFORCE

The notion that more people will live longer with more complex needs forms the basis of this workforce review. We know that:

- we will have more people requiring services;
- they want services available at home or as close to home as possible; and
- service users' expectations are increasing and that they want to have more of a say or influence in the services being provided to them.

Based on existing models of service delivery, it is therefore reasonable to project that more people will be required to deliver this increase in domiciliary care. There will be the need to develop more enhanced skills, potentially at a higher level; particularly those skills associated with supporting people with more complex needs in order to enable them to live at home, and sustain their independence, autonomy and wellbeing. It is likely that this may have a corresponding increase in the level of remuneration for the domiciliary care workforce and a shift in the skill mix.

The main findings from the DoH 2016 Domiciliary Care Services survey indicate that an estimated 268,883 contact hours of domiciliary care were provided by HSC Trusts during 436,174 domiciliary care visits. 23,873 service users were in receipt of domiciliary care with almost two-fifths (9,825) service users receiving a domiciliary care visit lasting 15 minutes or less.

This review looks at ways of ensuring domiciliary care services are provided for the future, particularly the next five years 2016 – 2021. The delivery of services is challenging and we have recognised that they will continue to be delivered in a partnership of care approach, by a mixed economy of both statutory and independent sector providers. In addition, we acknowledge the enormous contribution that family and friends make to the health and social care system and to society as a whole by caring for their loved ones.

It is anticipated that significant workforce change will be required to support predicted demand for domiciliary care over the next five years to an increasingly aged population with more complex needs.

4.1 Workforce Projections - An Illustrative Demand Projection based on Population Change

The DoH survey referred to above shows 23,873 service users receiving HSC Trust arranged domiciliary care during the survey week in September 2016 of which 83% were aged 65 and over (19,893). This represents around 7% of the 65+ population. NISRA's projection for the 65+ population by 2021 (to cover the workforce plan period) is 332,900. If 7% of the projected 2021 65+ population were to receive

domiciliary care, this would equate to an estimated additional 2,800 service users. This would represent a 14% increase in service users from 2016.

Approximate domiciliary care worker numbers are 12,000. This indicates a requirement of 0.5 staff per service user.

Assuming the same average hours per staff member, the estimated additional 2,800 service users would result in the need for a further 1,400 staff. This will require an investment of approximately £27 million.

This is an illustrative staff projection based on existing systems of domiciliary care provision (and, for example, it would need to be adjusted for increases in service users taking up SDS).

4.2 Key Factors Impacting on Workforce Projections

In planning for the future domiciliary care workforce there are a number of key factors which will have an impact on the workforce projections over the next five years and these are outlined in the sections below.

4.3 Unmet need

The welcomed fact that people are living longer, allied with the increasing emphasis on helping people to remain in or return to their own homes does inevitably result in an increasing level of demand. Domiciliary care providers' capacity to meet demand depends heavily on having the right numbers of staff in the right place at the right time and this can present particular challenges in rural areas.

Social care and health care systems are inextricably linked. Domiciliary care supports the prevention of hospital admission by providing care at home and facilitates timely hospital discharges. Pressures on the provision of domiciliary care inevitably impact on the health and social care system.

4.4 Models of Service Delivery

Future models of service delivery will impact on the number and type of care staff required:

- **Self Directed Support (SDS)**

SDS by its nature is a 'personalised' service and therefore service users will seek to procure services which most directly match their needs. These may be different to the current services provided by domiciliary care, which largely focus on personal care needs of service users. The implementation of SDS may see a shifting of skills from the current domiciliary care skills base into skill areas that can meet a 'personalised' agenda.

If we are to deliver on expectations, the future workforce will need to be flexible to meet need as agreed within the context of individual choice and control.

In line with the principles of personalisation, the role of the professional and the care worker within SDS will become less about being a 'fixer' of problems and more about being a co-facilitator of solutions working in collaboration and co-production based on power sharing and mutual respect. Doing things '**with people'** rather than '**to them**.'

As SDS moves towards full implementation, the overall profile of service responses will need to adapt to meet wide ranging personalised support goals. Flexibility will be a key focus for providers moving into the future, with the potential to recognise and recruit a new 'future care/support worker'.

- **Reablement**

Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability, and necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, a deterioration in health or injury.

> "Reablement will help you to do things for yourself rather than having to rely on others".

The regional review of reablement undertaken in 2015/16 resulted in a clear service specification for the future development of the model across the region. This will be kept 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.

Reablement can deliver the benefit of reducing the need for domiciliary care (in some cases completely), or can reduce a service user's reliance on domiciliary care. A Longitudinal Study, undertaken by the HSCB in 2015, sought to quantify the length of benefit of reablement to service users, analysing a cohort of 248. The study found that 83% of those successfully reabled did not require any domiciliary care package afterwards, 12% required the same package and 5% required an increase in the previous package.

During the period to which the study related, 77% of the service users remained out of the system i.e. did not require a domiciliary care package, or admission to a residential care or nursing home. The results demonstrated, as well as the obvious

benefits for service users and carers, that reablement can contribute significantly to demand management in respect of domiciliary care and potentially avoidance of residential and nursing home admissions.

4.5 Domiciliary Care and Linkages to Reablement

Domiciliary care provides a vital support for many people who wish to remain living independently in the community for as long as possible. It does not however operate in isolation and has links with a range of other services that support this objective. The Institute of Public Care (IPC) identifies a continuum of models of home based care including:

- standard domiciliary care (which can include an independence and outcomes based approach);
- reablement and rehabilitation; and
- specialist home care.

These need to be considered when developing any proposals to reshape services.

It is important to ensure that an over simplified view is not taken of what has become a complex service. Imaginative application and redeployment of resources and not simply further investment in existing services is required.

The current regional model of reablement places an emphasis on an Occupational Therapy led approach. However, it is also heavily reliant on intensive support with back up from dedicated reablement support workers. This element of the service has mainly been delivered by HSC Trust in-house staff who are focussed on this kind of more intensive input. The current regional model suggests that reablement should be viewed as a distinct service in its own right.

- **Role Redesign**

HSC Trusts are continually evaluating the service provided to service users and redesigning is an ongoing element of this work. Some examples of good practice are cited below:

NHSCT – The HSC Trust has developed and amalgamated the reablement service and rehabilitation service to form a Recovery Service, which will deliver short term Occupational Therapy-led individual care. The focus being to ensure service users have achieved their maximum level of independence within both the reablement pathway and the rehabilitation pathway.

All long-term care delivered by the HSC Trust core services, may also have a reablement focus, to ensure service users maintain their independence.

SHSCT – In 2015 the HSC Trust commenced a pilot of a new service delivery model in the Armagh and Dungannon area, with a focus away from the "time for task" service to an "outcomes based" service. Individual goal plans are devised and occupational therapists are in post to drive this innovative domiciliary care approach. This service is now being extended to all other areas of the HSC Trust. The focus is on independence – "**doing with rather than for**", and has evidenced both efficiency and quality service provision resulting in satisfied service users.

SEHSCT – The HSC Trust plans to increase capacity of Reablement Teams and Rapid Response Teams across the HSC Trust, to aid discharge from hospitals of patients and further develop the model of care required. Going forward, domiciliary care service will focus on short term intervention work and creating specialist teams.

WHSCT – The HSC Trust has specified, in its contract with the Independent Sector contractors, the expected levels of care for its service users, whilst in conjunction re-aligning the in-house model to a caseload, with contracted hours for staff, supported by variable hours for bank staff.

4.6 User Expectations

It is essential that account is taken of service users' expectations and to ensure that domiciliary care staff in the community have the full range of skills, knowledge and competencies. The HSCB's report *A Managed Change* carried out several stakeholder engagement events to ascertain the views of service users. Individual HSC Trusts have also engaged with service users as this is a key element in the design of any service delivery models into the future. Below are some of the priorities service users identified:

- Timing of calls – same time each day;
- A preference for the same or a small number of Care Worker(s) per Service User with continuity of care a critical factor;
- The importance of adequately trained staff to meet individual Service User needs;
- The need for improved communication between the Provider, Carer and Service User;
- Allocation of sufficient time to carry out care required so that the Service Users do not feel hurried or rushed when care is being provided;

- The importance of the consistency and continuity of the quality of care delivered;[4]
- Explanation of any technology being used and why; and
- A feeling of being safe and secure because someone was calling.

The SEHSCT took part in the 10,000 Voices Initiative and the report, dated February 2015, details the findings on service users relating to their experience of care in their own home. 362 stories were captured which was 28% of the regional total. 88% of service users indicated that they were very satisfied with the level of care received. Critical to their satisfaction was:

- Timing of calls;
- Allocation of sufficient time for calls;
- Small number of carers; and
- Feeling safe and secure.

4.7 Independent Sector

Adult social care services are provided through a mixed economy of care, which includes both direct statutory provision and independent sector provision largely commissioned by the HSC Trusts. There are currently 100 registered domiciliary care providers with an associated 122 agencies in Northern Ireland, including the five Health and Social Care Trusts.

The independent sector now provides the majority of domiciliary care services in Northern Ireland (as commissioned by the HSC Trusts). The proportion of services delivered varies from HSC Trust to HSC Trust, but overall, as outlined in the table below, the direction of travel is towards an increasing independent sector usage.

Survey Week	% Domiciliary care hours provided by statutory sector	% Domiciliary care hours provided by independent sector
2008	49	51
2012	36	64
2013	33	67
2014	32	68
2015	32	68
2016	30	70

[4] Belfast Health and Social Care Trust Consultation on the Proposed Outline Procurement Model for Domiciliary Care Services 2015/16 – February 2015

Source: Domiciliary Care Services for Adults in Northern Ireland publications https://www.health-ni.gov.uk/articles/domiciliary-care

Therefore, workforce planning must take account of issues that are either specific to, or more acutely felt by, that sector. For example, variations in employee terms and conditions across the domiciliary care market, particularly between the independent and statutory sector, can create workforce pressures whereby experienced staff regularly change employer as they seek more favourable rates of pay and terms and conditions.

4.8 Terms and Conditions

Terms and conditions for workers vary across the region and are different in the independent sector and the statutory sector. In the statutory sector, staff are employed under Agenda for Change pay and terms and conditions, a national pay and grading system. The majority of domiciliary care staff are employed at Band 2 level (£14,437-£17,599 - 2016/17 pay values), with some at Band 3 level (£16,434-£19,461) delivering reablement services, and have contracts of employment that include travel time, travel expenses, and paid training time.

Terms and conditions in the independent sector are variable and include features such as workers being paid at or just above the British Government's National Living Wage, 'as and when required' contracts, paid hourly rate to include contact time only, unpaid training time, unpaid travel time, and no or limited travel expenses (often travel expenses are wrapped up in the hourly rate of pay). Terms and conditions will vary from employer to employer, but all employers must comply with the HMRC regulations on the national minimum wage.

Within HSC Trusts, the majority of staff have moved to minimum guaranteed hours contracts, with a degree of variable hours working still available. Within the independent sector, 'as and when required' contracts are the norm (though not having exclusivity clauses as with 'zero hours' contracts).

The procurement of domiciliary care services in the independent sector will be important in ensuring the stability of the workforce in this sector, e.g. procuring block contracts, allowing these organisations to employ their workforce on a more guaranteed hours basis.

The now compulsory British Government National Living Wage (£7.20 per hour [2016] rising to around £9.00 by 2020) could also have a stabilising effect on the independent sector workforce in particular by making it more attractive to new entrants.

4.9 NISCC Registration and Standards of Conduct and Practice

Mandatory registration with the Northern Ireland Social Care Council (NISCC) was introduced to the domiciliary care, day care, supported living and residential care workforces in April 2017.

In order to attain registration, individuals must complete a process that includes the following:

- Be working or have been offered a job in domiciliary care, day care, supported living or residential care services.

- Demonstrate through their application that they meet the good character, conduct and health requirements of registration.

- Agree to work in accordance with the Standards of Conduct and Practice for Social Care Workers.

Once registered, all domiciliary care workers are required to complete 90 hours of Post Registration Training and Learning (PRTL) activity over the five year period of registration. PRTL helps to develop and maintain competence and skills, and may include completion of qualifications that support workers in their job role.

The Standards of Conduct and Practice provide a framework to govern the practice of Social Care Workers. The Standards of Conduct describe the values, attitudes and behaviours expected of social care workers in their day-to-day work. The Standards of Practice describe the knowledge and skills required for competent social care practice.

4.10 Service Regulation

The regulation of domiciliary care workers aims not only to protect the public, but also to raise the standards of this workforce. *The Domiciliary Care Agencies Regulations* and *The Domiciliary Care Agencies Minimum Standards* detail the provision, below which no provider of domiciliary care is expected to operate, and focus on assuring that people are provided with safe, effective and quality assured services. The Regulation, Quality and Improvement Authority (RQIA) is the regulatory body with responsibilities and powers to regulate domiciliary care providers and agencies.

4.11 Training and Up-skilling

A well-trained domiciliary care workforce is key to the provision of domiciliary care. Currently, domiciliary care providers provide staff with Induction Training in accordance with NISCC Induction Standards and must meet RQIA's Minimum

Standard for Domiciliary Care Agencies, which stipulates that staff are appropriately trained to carry out their roles.

The DoH *Personal Social Services Development and Training Strategy 2006 – 2016* sets strategic targets for training for social care workers. While the Strategy is primarily aimed at the HSC Trusts, the voluntary and independent sectors also support the strategic priorities. The Strategy does not specify the training or qualifications required for specific roles in social care. Rather, at a strategic level, it seeks to ensure that social care workers are engaged in either training or qualification attainment appropriate to their job role and associated with continuing registration. This Strategy is currently under review.

In 2014, NISCC carried out a survey within the independent and voluntary sectors to ascertain the qualification profile of the social care workforce (across all grades) in domiciliary care, nursing home care, residential care and supported living settings. There was a 50% return from domiciliary care providers and of those, 48% of staff held a relevant qualification (excluding nursing, social work and Allied Health Professionals (AHPs)).

The survey found that domiciliary care and nursing home care settings were the two service areas where the least number of staff hold a relevant health and social care qualification. It suggested a number of reasons for this, including issues such as time available, cost, lack of confidence and no history of having achieved any formal qualifications.

Models of care for the future will need to take cognisance of the Government Skills Strategies, which can support the training, and up-skilling of the domiciliary care workforce, particularly in the independent sector. Investment for training and up-skilling needs to be secured, especially when dealing with complex care e.g. service users with dementia or more chronic health conditions.

4.12 Career Development

The domiciliary care workforce is part of a much broader social care workforce made up of social care workers and social workers. There are an estimated 33,076 social care workers employed in the statutory, voluntary and independent sectors and 6,052 social workers, the majority of whom are employed in the statutory HSC sector.

Social care workers work in a range of roles in different settings including residential care homes, nursing care homes, day care centres, local community facilities, and in people's own homes (domiciliary care). The majority of social care workers are employed in residential homes, nursing homes or in domiciliary care settings.

People who work in social care come from a wide range of backgrounds. While individuals must meet employer and regulatory requirements to gain entry into social

care work, their values, attitudes and ability to form relationships and work with people who need care and support are key attributes.

The level of competence and/or qualifications required by a social care worker is determined by: the specific job role or job function; ***and*** the nature of the care and support required by an individual; ***and*** the level of responsibility expected of the worker. An estimated 50% of social care workers hold a relevant qualification.

The table below outlines the range of different job roles in social care and the indicative competence linked to Qualifications and Credit Framework (QCF) qualification levels. This is not a prescriptive framework, rather a guide reflecting the diversity of roles at different levels and potential career development opportunities for those working in social care.

4.13 Social Care Job Roles

The wide variety of roles and the diversity of those who use social care services offer a number of avenues for career development and/or progression for domiciliary care workers within social care. The core skills and attributes required of domiciliary care workers to care and support people effectively in their own homes are transferable across social care. This means domiciliary care workers can move and/or progress within domiciliary care or into different roles within and across settings and sectors. There are also career and personal development opportunities for experienced social care workers, including those in domiciliary care, in supervisory roles and management positions.

The experience of working in social care can also support an individual's progression into professional training in social work, nursing and allied health care as detailed in the table.

Competence/ QCF Level	SOCIAL CARE JOB ROLES
QCF 5	**Registered Manager and other Management Roles**. Registered managers in regulated social care services such as Domiciliary, Day and Residential Care must hold a relevant qualification. Relevant qualifications include a number of professional qualifications as well as a QCF Level 5. Registered managers are accountable for the quality, safety and standards of social care provision within the regulated service. They are also accountable for the effective management, supervision, training, development and competence of social care workers.
QCF 4	**Social Care Co-ordinator Roles**. Social care co-ordinator roles include responsibilities for supervision of social care staff and/or co-ordination of the provision of social care services. Job titles may include deputy managers in residential care homes, home care organisers, social care co-ordinators.
QCF 3	**Senior Social Care Worker Roles**. These jobs will entail a higher level of responsibility or skills set to meet specific higher-level needs than social care worker roles and may include staff supervisory responsibilities, or roles which have more complex job functions. Job titles include Intensive Domiciliary Care Worker, Reablement Worker, Day Care Worker, Senior Care Assistant, Key Workers in Supported Living and Homecare organisers.
QCF 2	**Social Care Worker Roles**. Staff in these jobs provide personal care and/or practical support in a regulated social care service. Job titles may include Domiciliary Care Worker, Care Assistant, Driver with Caring duties.
	Initial Entry Level Roles which may require very little formal education or training. These types of role may relate to providing domestic/household services or volunteer services.

4.14 Technology and Technical Skill Demands

Changes in technology continue, and the domiciliary care workforce needs to embrace these changes in order to realise the associated benefits in terms of more efficient and effective working.

Already facilities such as video conferencing, digital dictation, e-learning, electronic prescribing, use of i-Pads and remote/home working are starting to become a reality for many in the workforce. It is difficult to predict how much technology might have changed by the end of this workforce planning period in 2021. However, in order to gain maximum benefit from future technological change it is likely the workforce will require increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

The introduction of new technologies will impact on the way health and social care is delivered in the future and should improve the level of services provided to our service users. Service users will be able to provide essential health information, such as blood pressure readings, through the new technologies, to the care providers without the need to leave their home.

The introduction of new technologies will require specific training for the staff delivering the services and possibly the service users and/or their carers. The Department's new Health and Social Care Workforce Strategy gives an undertaking to continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass, etc. which are designed to support the workforce in doing their jobs. This may be challenging for those with little or no experience of such equipment.

5.0 UNDERSTANDING WORKFORCE AVAILABILITY

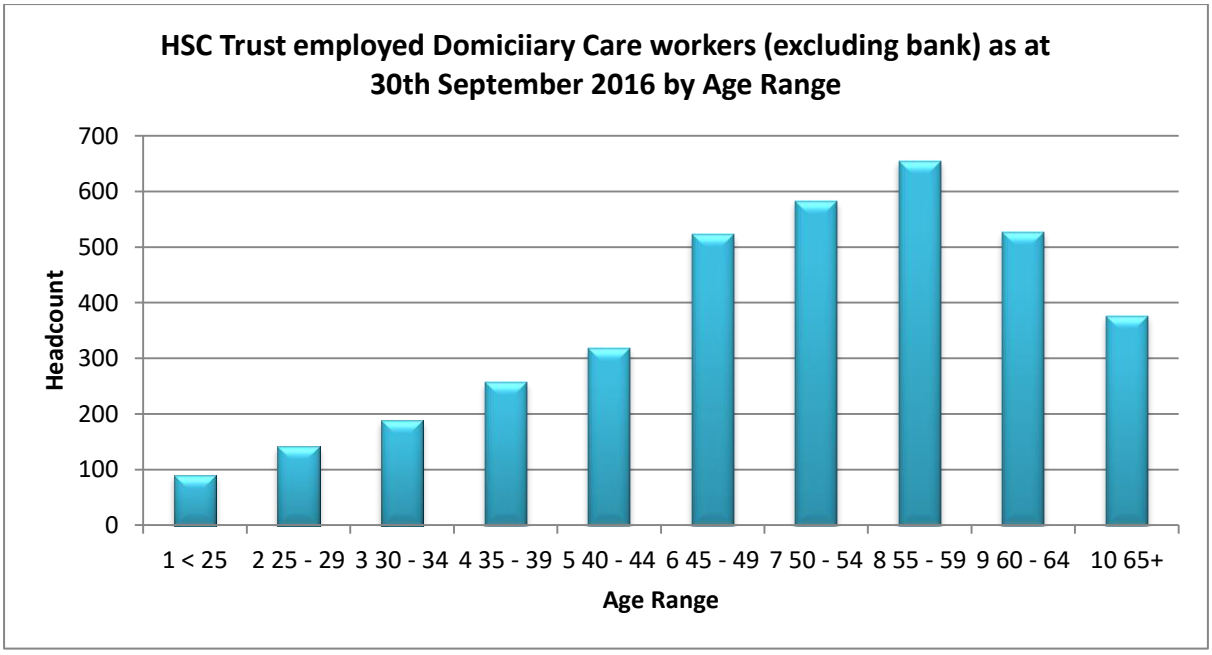
5.1 Workforce Profile

To understand the workforce that is available, it is necessary to consider and analyse the trends amongst the existing workforce.

The following workforce profile in relation to the HSC Trust employed workforce across the region has been downloaded from Human Resources, Payroll, Travel and Subsistence System (HRPTS). This system was introduced in 2013 and deployed to all HSC Trusts in the region. The HRPTS data is continually updated and managed locally by each HSC Trust. The following analysis is based on those graded as Band 2 or Band 3 domiciliary care workers, excluding bank staff, with each person only counted once. As at 30th September 2016, there were 3,659 staff graded as domiciliary care workers.

The HSC Trust domiciliary care workforce is overwhelmingly female (98%). The vast majority of staff (96%) are at Band 2 pay level, with those at Band 3 level usually being reablement workers.

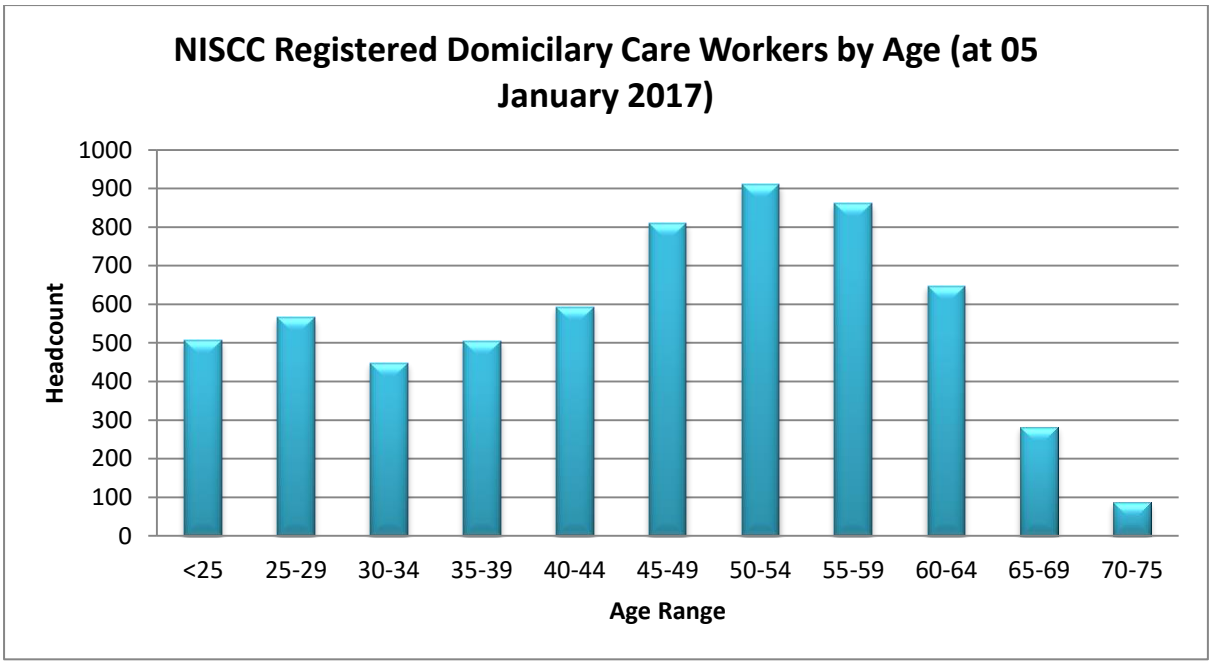
There is an older age profile within the HSC Trust domiciliary care workforce with 43% aged 55 and over as at 30th September 2016.



Comprehensive information on the independent sector workforce is not readily or centrally available; however, we have been able to make good estimates based on workforce information available through the NISCC (c 7,600). It is expected that with the conclusion of the compulsory registration roll out of the domiciliary care

workforce by March 2017 that more accurate information will be available for future workforce planning such as the age and gender profile.

In total, it is estimated that (at the time of this report) the workforce from both sectors providing HSC Trust commissioned domiciliary care is around 12,000. The age profile of those registered with NISCC to date (6,226 as at 5th January 2017) is shown in the graph below. This shows that 30% of those registered so far are aged 55 and over, 28% are aged 45-54 and 42% are aged under 45.



Robust information on the whole-time equivalent contribution of domiciliary care staff is not available at present, however using the service user hours sourced from the DoH domiciliary care services survey week (268,883) and dividing by the estimated 12,000 workforce (both sectors), the average weekly contribution per person is around 22.4 hours.

It is estimated (based on a NISCC employer survey) that while the range of hours worked per week is anywhere from 10 to 60 hours, the majority of care workers in the independent sector will be on 'as and when required' contracts.

There are around 1,000 HSC Trust staff with bank contracts recorded on the HRPTS system, though it should be noted that 18% of permanent/temporary staff also have bank contracts. Bank contracts give no minimum or guaranteed hours; hours are offered to staff on an 'as and when required' basis and staff are not obligated to accept hours. Bank contracts are used for reasons such as filling shortfalls in service delivery due to leave and sick absence. The total level of bank usage and expenditure by HSC Trust for the 12 months to 31st March 2015 was £2,427,341 as illustrated in the following table:

HSC Trust Domiciliary Care Bank Usage and Expenditure 2014/15

Health and Social Care Trust	Bank Spend	Estimated Bank Hours
Belfast	£384,481	33,031
Northern	£1,333,000	122,631
South Eastern	£98,860	7,784
Southern	0	0
Western	£611,000	50,512
TOTAL	£2,427,341	213,958

The qualifications profile of the workforce in domiciliary care suggests that 51% have a minimum QCF Diploma level 2 qualification across the statutory sector. Recent qualifications profile work for the independent sector points to 48% of staff having minimum level 2. NISCC has 435 registered domiciliary care managers who are required by the minimum standards to have at least QCF level 5 qualifications.

5.2 Projections for Retirement

Statutory Sector - On the assumption that those over the age of 60 today may retire in the next five years, there is potential for 25% of the HSC Trust domiciliary care workforce or 903 staff to retire over the next 5 years. Whilst an older age profile and working beyond normal retirement age is common amongst the HSC Trust workforce, it is possible that there will be a decrease in the proportion of staff now likely to work beyond retirement age due to the increasing demands of the job.

Independent Sector - Equivalent estimates are not currently available for this sector. The current registration of all domiciliary care staff will assist with providing more robust data in the future.

5.3 Recruitment and Retention – Statutory Sector

The table below highlights the number of new appointments made during the period 1 April 2015 – 31 March 2016 within each HSC Trust:

Health and Social Care Trust	New appointments 2015/16	Number of applicants
Belfast	23	N/A
Northern*	64 permanent, 162 bank	281
South Eastern	16	79
Southern	126	297
Western	NIL	NIL
Northern* notes that appointments figures may count individuals more than once, where they have been appointed to more than one post.		

5.4 Staff Turnover

BHSCT – The turnover rate within the domiciliary care workforce for the year ending 31 March 2016 was 5.14% based on both band 2 and 3 levels. A total of 33 domiciliary care staff left the HSC Trust during this time.

SHSCT – A total of 119 Band 2 domiciliary care workers left the HSC Trust's employment (i.e. excludes internal transfers/movers) in 2015. This represents a turnover rate of 11.7 %, which is significantly higher than the HSC Trust total turnover rate of 6.6%.

SEHSCT – Turnover of domiciliary care workers for financial year ending March 2016 is 6.06%.

NHSCT – Turnover of staff in financial year ending March 2016 is 5.9%.

WHSCT – The Western HSC Trust has been implementing the reform and modernisation of its Domiciliary Care Services. This will result in a single Western HSC Trust Homecare service working to a standard model of service delivery. It will involve transferring Home Help staff into care teams on a rota basis. This realignment will ensure current and future service user needs are able to be met by staff working in a secure, stable and sustainable working environment. Until this process is complete, the HSC Trust will not recruit new staff until existing waiting lists are fully utilised.

5.5 Recruitment and Retention – Independent Sector

The independent sector has reported repeated difficulties with recruitment and retention of the domiciliary care workforce. Many independent providers are required to undertake repeated recruitment campaigns due to the poor response and high turnover of staff. For the purposes of this review, the NISCC liaised with independent providers of domiciliary care to gain an understanding of the recruitment difficulties they face. Six independent providers supplied information in relation to their current recruitment difficulties. There was a lot of similarity across the challenges each provider faces.

The main challenges facing recruitment and retention of staff in the independent sector include:

- **High turnover of staff** – this is due to a variety of factors including limited career prospects, realisation that job wasn't for them, job being accepted as stop gap temporary employment.
- **Unfavourable terms and conditions** – low wage for an increasingly complex job, anti-social hours, travelling distances with little or no mileage allowance, poor level of job satisfaction – staff not feeling their role is valued.
- **ACCESS NI** – applicants are responsible for paying for this service and cannot take up employment until certificate has been received often resulting in delay of job being offered, by which time they have secured alternative employment.
- **NISCC Registration** – additional expense to applicant.
- **Ageing workforce** – difficulties ahead with recruiting sufficient numbers to replace a competent well-motivated workforce.

Independent sector providers also put forward suggestions as to how some of the issues cited above could be addressed:

- **Getting the funding right** – allowing staff to be paid appropriately for the work undertaken, guaranteed hours, service delivered outcome focused, not x minute time slots. In some instances funding ceases should a service user be hospitalised, resulting in workers' hours being reduced.
- **Better terms and conditions** – one provider has increased the hourly rate paid to staff and introduced Induction Training, followed by ongoing training on specific areas e.g. dementia awareness, skin care, brain injury communication skills etc. This has been well received by staff and feedback is very positive. This provider is anticipating that this will help with staff retention.

- Raising the **sector's profile** and getting the message out that this job is a professional care service being provided to people with complex healthcare needs.

- **Media campaign** – showcasing the role of the domiciliary care worker in order to attract applicants who have an understanding or experience of dealing with people's needs.

- Developing all age **apprenticeships** within the domiciliary care sector.

6.0 STAKEHOLDER ENGAGEMENT

An important element of the review involved stakeholder engagement. The Project Team comprised of representatives from DoH, HSCB, HSC Trusts and NISCC. The Steering Group comprised of representatives from DoH, HSCB, HSC Trusts, DfE, NISCC, PCC, Independent Sector and Staff Side, Carers NI were also invited.

A range of sources were used to obtain the views of stakeholders including availing of information gathered during the HSCB's review *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland, November 2015*; the Patient and Client Council – *Care at Home: Older People's Experience of Domiciliary Care, June 2012*; and the Public Health Agency's *Regional Findings Relating to Care in Your Own Home (10,000 voices), March 2015*.

In addition, the Project Group hosted an 'Engage' event on 15 June 2016 at the Ulster University, Jordanstown Campus. Over 100 delegates registered to attend the event from across the statutory, independent sector, staff side, carers and users. The purpose of the event was to consult on the development of the draft Domiciliary Care Workforce Review NI for 2016 – 2021. The event took the format of an interactive e-participation 'Engage' session.

The engage discussion focused on three main topics:

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

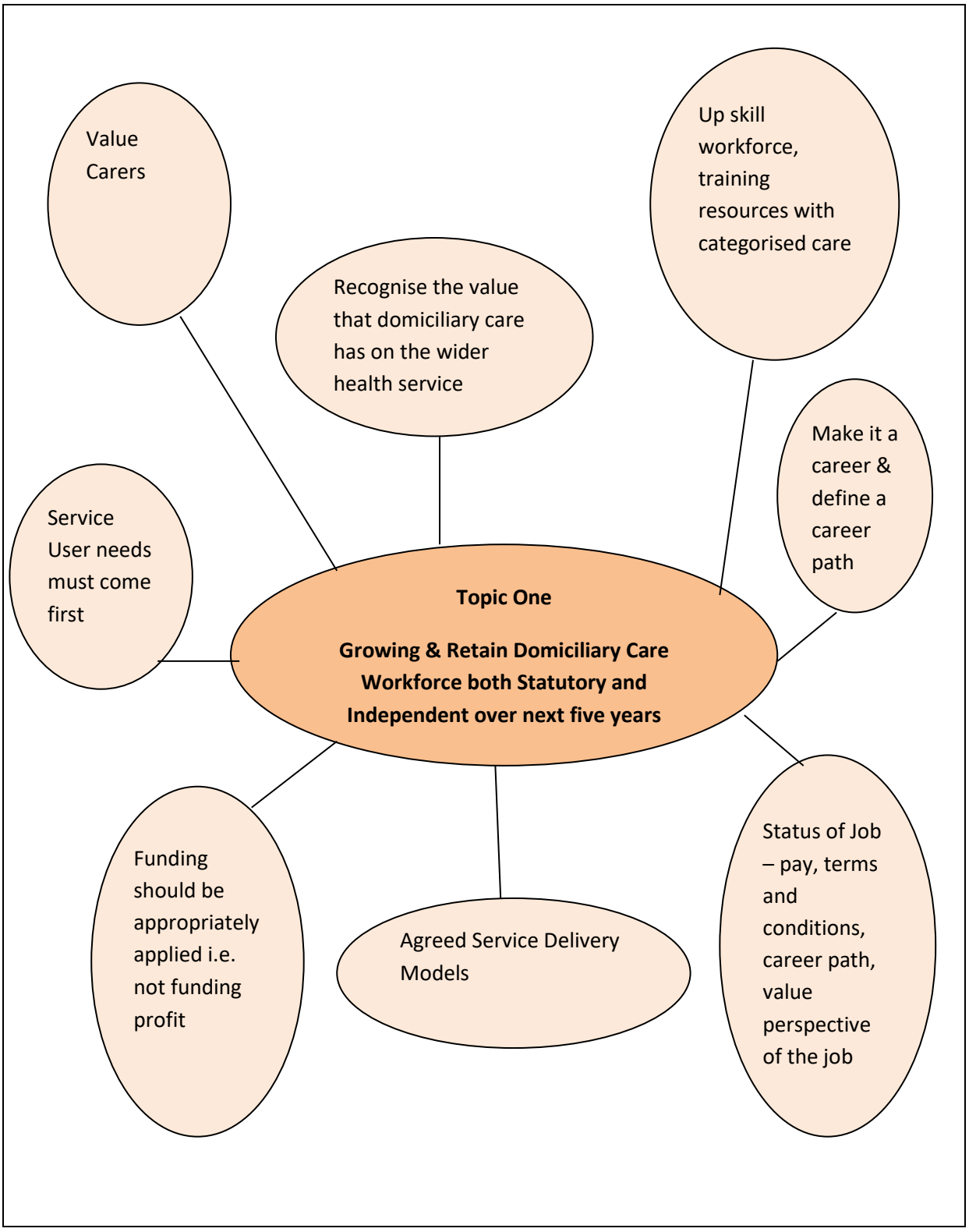
Topic Three:How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

The audience on the day comprised of Statutory 48%; Independent 36%; Voluntary & Community 6%; Service user and carer 3% and Other 6%.

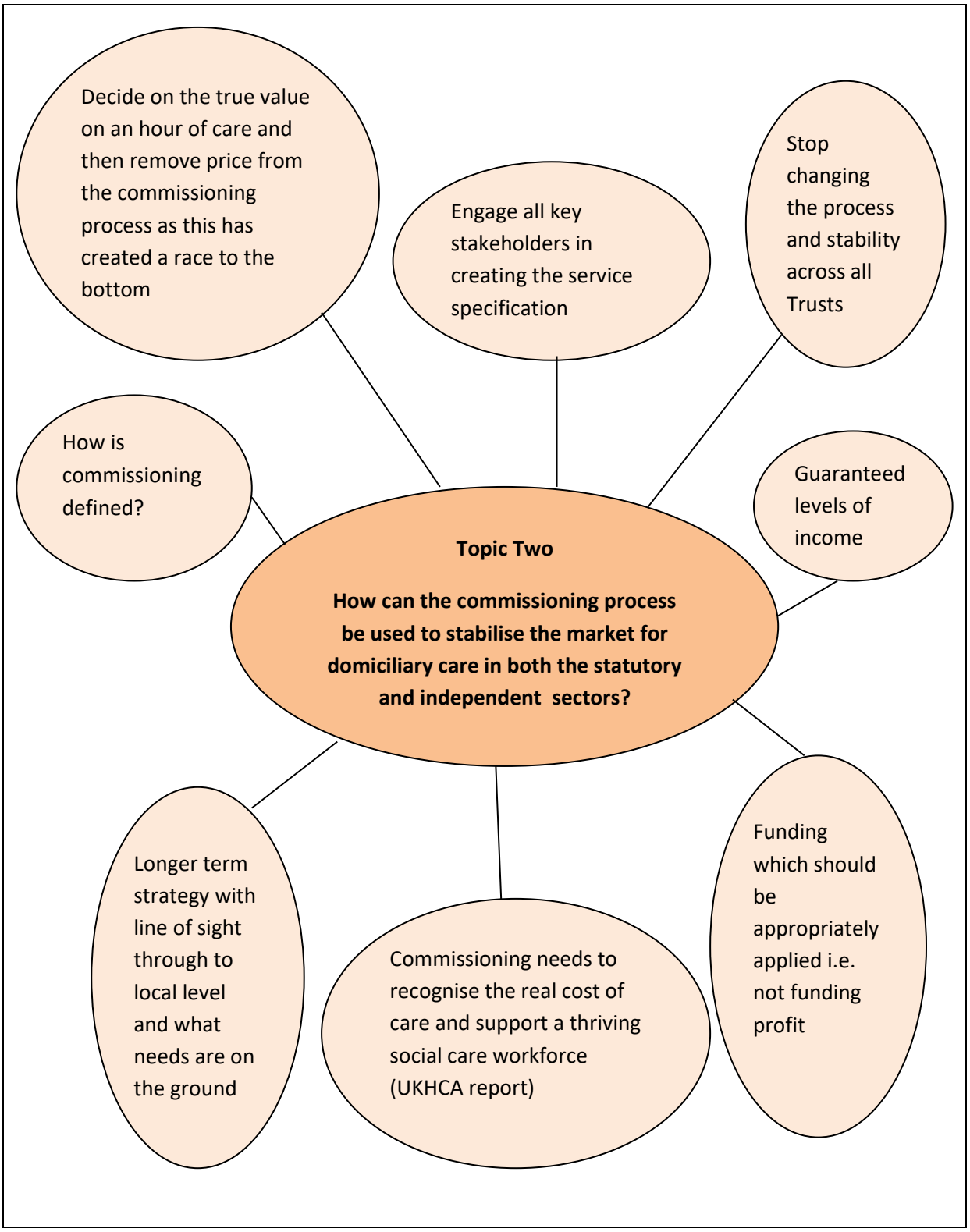
The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

The full report of the ‘Engage’ can be found at **Appendix 3**.

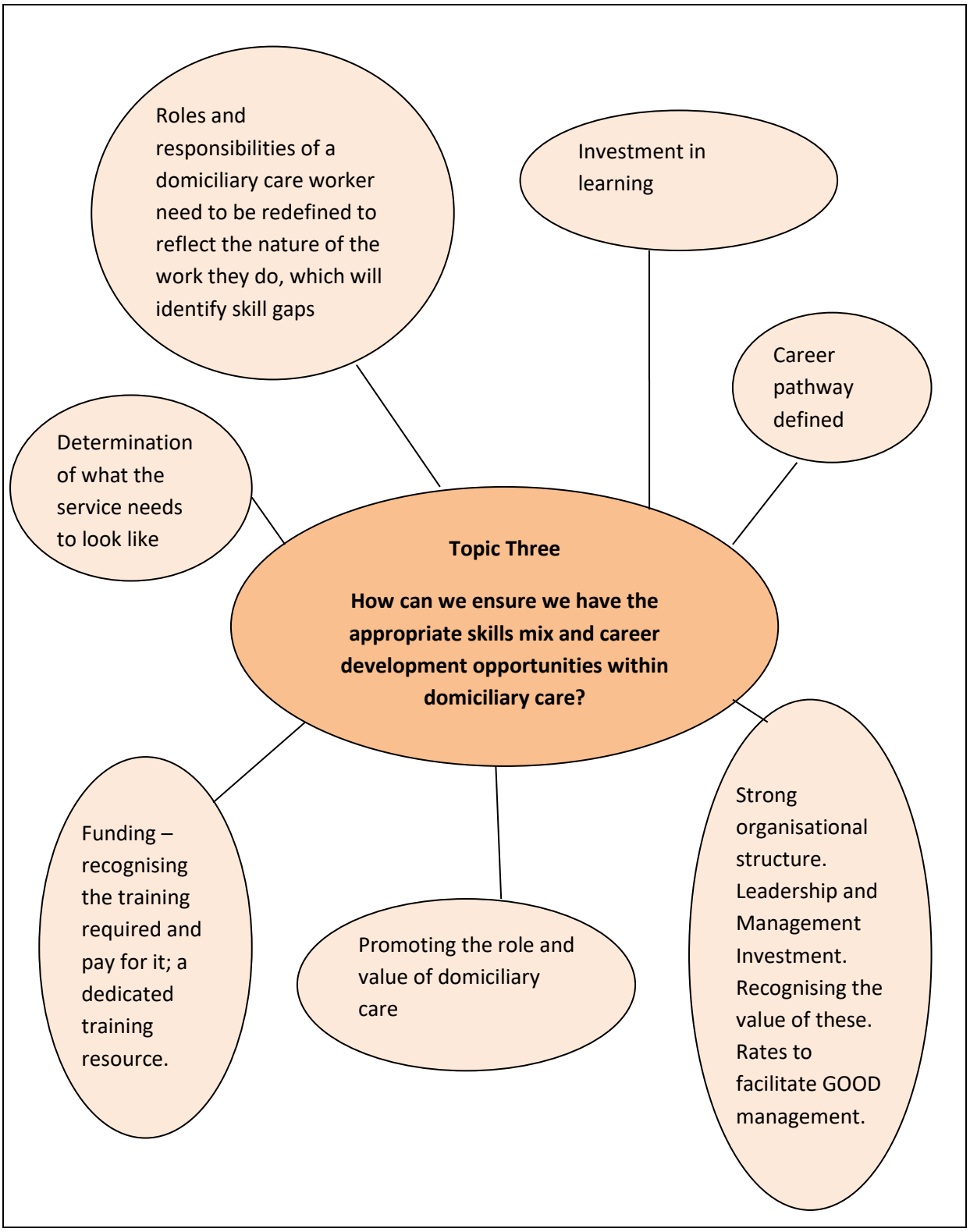
6.1 Topic One


Value Carers
Up skill workforce, training resources with categorised care
Recognise the value that domiciliary care has on the wider health service
Make it a career & define a career path
Service User needs must come first
Topic One
Growing & Retain Domiciliary Care Workforce both Statutory and Independent over next five years
Funding should be appropriately applied i.e. not funding profit
Agreed Service Delivery Models
Status of Job – pay, terms and conditions, career path, value perspective of the job

6.2 Topic Two


Decide on the true value on an hour of care and then remove price from the commissioning process as this has created a race to the bottom
Engage all key stakeholders in creating the service specification
Stop changing the process and stability across all Trusts
How is commissioning defined?
Guaranteed levels of income
Topic Two
How can the commissioning process be used to stabilise the market for domiciliary care in both the statutory and independent sectors?
Longer term strategy with line of sight through to local level and what needs are on the ground
Commissioning needs to recognise the real cost of care and support a thriving social care workforce (UKHCA report)
Funding which should be appropriately applied i.e. not funding profit

6.3 Topic Three



7.0 CONCLUSIONS

Domiciliary care services provided by the workforce both in the statutory and independent sector are highly valued. Many of our service users would find it difficult, if not impossible, to survive without the care and support which this workforce delivers 24/7. In addition to the healthcare support the service user receives, in many instances the carer is the only human interaction they may have that day and this often adds to the quality of life for the service user. We heard many voices at our stakeholder event and we know that, especially the elderly recipients of domiciliary care, have a preference for continuity of service being delivered by the same people. They like the familiar face, the regular time slot etc. This helps develop trust and confidence in the services being delivered.

We know that our society is getting older; people are living longer, often with long-term health conditions. It is estimated that by 2030, for the first time there will be more over 65s than under 16s. By 2030, the population aged 65 and over will have increased by 45% compared to the position in 2015. Similarly, the population aged 85 and over will increase by 81% over the same period, which will see their share of the population increase from 1.9% to 3.2%. These statistics alone will present a huge challenge in terms of the demands and pressures on health and social care in partnership with carers and family support. Domiciliary care will play a big part in services being delivered.

Looking to the future, the draft Programme for Government and the Health Minister's *Health and Wellbeing 2026 – Delivering Together* documents emphasise outcomes-based approaches. The providers of domiciliary care are faced with a challenging opportunity to seize the moment and help contribute to building the future of person-centred care in which people:

- are supported to keep well in the first place;
- have access to safe high quality care and are treated with dignity, respect and compassion; and
- are empowered and supported to look after themselves for as long as possible in their own home and environment.

The review has highlighted the need for growth in the domiciliary care workforce over the next five years based on existing models of care and support. The impact of other service delivery models on workforce requirements, such as SDS, Reablement and Telemonitoring will need to be further assessed.

7.1 User/Carer Engagement

This review adopted a co-design approach, taking account of the Service Users and Carers' views on their needs and expectations. A lot of information was made

available via the 10,000 Voices Report, *A Managed Change* and the stakeholder 'Engage' event held in June 2016.

We must acknowledge the responsibility families and friends take for caring for their loves ones as this makes an enormous contribution to the HSC and to society as a whole. Carers require support to enable them to be carers and the Health Minister has pledged support in working along with other government departments and their agencies to provide that support. We need to encourage and enable greater use of personalised budgets where appropriate.

7.2 A Managed Change

The HSCB carried out a review of domiciliary care services *A Managed Change: An Agenda for Creating Sustainable Basis for Domiciliary Care in Northern Ireland* published November 2015. In order to avoid duplication this review has taken account of the recommendations contained within the HSCB report especially in relation to workforce planning. The recommendations contained within the HSCB's report cover areas listed below and will not be duplicated in the recommendations of this workforce plan:

Structure – reviewing current social care procurement arrangements.

Linkages – establish formal links with the Department of Health and the NISCC to develop a coordinated approach to workforce development.

Developing the Agenda – improving information and regular formal liaison with service providers.

Investment – managed approach to funding domiciliary support services.

Costing – assess the impact of the introduction of the living wage.

Workforce Planning – work closely and in collaboration with Department of Health, HSC Trusts, NISCC.

Procurement – management of tendering processes, coordinate learning and best practice.

Innovation – explore implementation of outcomes based models of domiciliary care.

Policy – Clarifications regarding charging for services arising from current review of adult social care; seek updated Departmental Circular in relation to domiciliary care.

The full Managed Change report is available at http://www.hscboard.hscni.net/download/PUBLICATIONS/DOMICILIARY%20CARE/An-Agenda-for-Creating-a-Sustainable-Basis-for-Domiciliary-Care-in-NI.pdf

8.0 RECOMMENDATIONS AND ACTION PLAN

The Health Minister's vision for *Health and Wellbeing 2026 – Delivering Together* highlights the need to work in partnership with service users, families and staff to ensure we are delivering the best possible services to those in need of them.

It is of vital importance that any future planning of domiciliary care services is based on reliable information going forward. The aim of workforce planning is to ensure that we plan for delivering the right staff with the right skills in the right place at the right time.

This Review sets out a number of recommendations designed to ensure that the future of domiciliary care is effective and efficient, commencing with the need to develop service delivery models. The review has been hampered by the absence of service delivery models, as they would more accurately inform the future workforce needs.

Whilst it is acknowledged that there is not a 'one size fits all' model, it is of paramount importance that clear models of service delivery are in place to ensure safe practices and access and equity of service to those in need. A lot of good work is happening all around us and there are examples of good practice across employers both in the statutory and independent sectors, which could be harnessed to ensure models are developed that deliver maximum outcome focused results for users.

The Recommendations and Action/Implementation Plan aims to ensure that our objective of '***delivering the right staff with the right skills in the right place at the right time'*** is met whilst realistically looking at the horizon of a five year implementation period therefore targeting the recommendations accordingly.

The Action/Implementation Plan will be monitored by the Department's Workforce Policy Directorate. In addition, updates on the recommendations listed in the HSCB's report *A Managed Change* will be requested to inform the way ahead.

8.1 Recommendations

Based on the findings of the review the key recommendations are set out below, these have been structured under key headings and will inform the Action Plan.

	RECOMMENDATIONS	
COMMISSIONING	**1**	(a) Regional Commissioning process linked to achievement and outcome focused. (Recent procurement exercises may delay any new service models being introduced.) (b) Service delivery models need to be developed to ensure standardisation of services across the region. Service delivery models should be outcome focused to inform the commissioning process.
RECRUITMENT & RETENTION	**2**	Standardised approach to recruitment of domiciliary care workers including job descriptions and role profiles ensuring that the recruitment process is a user-friendly and efficient process with a quick turnaround from advert to appointment that will attract wider interest from the labour force.
EDUCATION & TRAINING	**3**	Employers to support social care staff to comply with NISCC Registration and post registration requirements.
	4	Employers must recognise this is a mixed skills economy and ensure staff have the appropriate skills to deliver effective high quality care in line with service delivery models. Staff should also have access to appropriate and timely training to facilitate new initiatives, including technological advancement.
	5	Employers to support managers ensuring they have the appropriate training to support staff in their roles.
CAREER DEVELOPMENT	**6**	Employers to create career pathways ensuring access to training and personal development to include: • opportunities for staff seeking to gain access to management structures. • entry into alternative careers to include nursing, social work etc. • developing apprenticeship opportunities. • recognition of experiential learning gained in the workplace by

		domiciliary care staff. • promoting the value of domiciliary care workers through awards and other celebratory events.
	7	Employers to build relationships with schools and colleges thus promoting healthcare as a viable career option.
WORKFORCE PLANNING	**8**	Better recording of workforce data, especially in the independent sector, to ensure more accurate data sets which can be used.
	9	Employers to grow the domiciliary care workforce in order to meet the increasing demand for services over the next five years aligned to the models of service delivery.
PARTNERSHIP & COMMUNITY WORKING	**10**	Develop further linkages to community services e.g. pharmacy, GPs, voluntary organisations, carers and families.

8.2 DOMICILIARY CARE WORKFORCE REVIEW - ACTION/IMPLEMENTATION PLAN 2016 - 2021

	RECOMMENDATIONS		ACTIONS	LEAD RESPONSIBILITY	IMPLEMENTATION TARGET DATE
COMMISSIONING	**1**	(a) Regional commissioning process linked to achievement and outcome focused; (Recent procurement exercises by some HSC Trusts may delay any new service models being introduced in the short term.)	(i) Regional overview of domiciliary care market should be undertaken by a regional body to standardise commissioning practice, provide scrutiny of contracts and promote a collegiate regional approach.	HSCB / HSC Trusts (Commissioners)	TBC
			(ii) Ensure commissioning process is more directly linked to achievements of outcomes for service users and consideration should be given to the inclusion of social clauses in procurement.		TBC
			(iii) Request Circular HSS (SS) 1/80 in relation to the future provision of the home help service in Northern Ireland is updated/revised to include an update definition of domiciliary care currently provided.	DoH	TBC
		(b) Service delivery models need to be developed to ensure standardisation of services across the region. Service delivery models should be outcome focused to inform the commissioning process.	(iv) Develop models of service provision to take account of: • Reablement. • Self directed support. • Intensive/complex domiciliary care needs.	HSCB	TBC

RECRUITMENT & RETENTION	**2**	Standardised approach to recruitment of domiciliary care workers including job descriptions and role profiles ensuring that the recruitment process is a user-friendly and efficient process with a quick turnaround from advert to appointment that will attract wider interest from the labour force.	(i) Develop a Values-based Recruitment model for pilot (similar to the Skills for Care Model). (ii) Develop materials that promote domiciliary care as a valuable career choice.	HSC Trusts NISCC	TBC
EDUCATION & TRAINING	**3**	Employers to support social care staff to comply with ongoing NISCC Registration and post registration requirements.	(i) Provide regular updates on the levels of registered social care staff. .	NISCC	Ongoing for duration of review March 2021
	4	Employers must recognise this is a mixed skills economy and ensure staff have the appropriate skills to deliver effective high quality care in line with service delivery models. Staff should also have access to appropriate and timely training to facilitate new initiatives including technological advancement.	(i) Learning and Improvement Strategy for Social Workers and Social Care Workers 2017 – 2025 to support knowledge and skills development of the domiciliary care workforce.	DoH – OSS	Ongoing for duration of review March 2021
	5	Employers to support managers ensuring they have the appropriate training to support staff in their roles.	(i) Develop a range of appropriate training and qualifications to support managers including the development of induction standards for managers.	HSC Trusts/Employers Training Providers NISCC	March 2018
			(ii) Provide development opportunities to staff and managers.	HSC Trusts/Employers Training Providers NISCC	Ongoing for duration of review March 2021

CAREER DEVELOPMENT	**6**	Employers to create career pathways ensuring access to training and personal development to include: • opportunities for staff seeking to gain access to management structures. • entry into alternative careers to include nursing, social work etc. • developing apprenticeship opportunities. • recognition of experiential learning gained in the workplace by domiciliary care staff. • promoting the value of domiciliary care workers through awards and other celebratory events.	(i) Staff to be provided with access to appropriate training to enable them to seek accredited social care qualifications within the QCF framework to assist with career progression.	HSC Trusts/Employers Training Providers	Ongoing for duration of review March 2021
			(ii) Work with employers, FE and HE colleges to develop qualifications to support career progression including access to higher level apprenticeships.	DoH – OSS HSC Trusts NISCC	Ongoing for duration of review March 2021
			(iii) Work with Department for the Economy to influence the Apprenticeship Framework criteria to reflect the needs of the Social Care Sector including domiciliary care.	DoH DfE NISCC	Ongoing for duration of review March 2021
			(iv) Establish recognition events to promote success and achievements among the domiciliary care workforce.	HSC Trusts/Employers	
	7	Employers to build relationships with schools and colleges thus promoting healthcare as a viable career option.	(i) Continue to work with local educational establishments and provide workplace opportunities where possible. (ii) Career materials - Cross-reference to 6 (ii).	HSC Trusts	Ongoing for duration of review March 2021
WORKFORCE PLANNI	**8**	Better recording of workforce data, especially in the independent sector, to ensure more accurate data sets which can be used.	(i) Improve the quality of information available on HSC Trust employed domiciliary care workers especially hours worked.	DoH/HSC Trusts	Ongoing for duration of review March 2021

			(ii) Explore registration data as a source of information on the entire domiciliary care workforce to include the independent sector.	DoH NISCC	Ongoing for duration of review March 2021
	9	Employers to grow the domiciliary care workforce in order to meet the increasing demand for services over the next five years aligned to the models of service delivery.	(i) Sufficient and timely recruitment exercises to ensure sufficient workforce to meet need.	HSC Trusts	Ongoing for duration of review March 2021
			(ii) Expand reablement – outcome focused service delivery.	HSC Trusts HSCB	Ongoing for duration of review March 2021
			(iii) Encourage uptake of self directed support initiative – cross-reference to HSCB targets.	HSC Trusts HSCB	Ongoing for duration of review March 2021
PARTNERSHIP & COMMUNITY WORKING	**10**	Develop further linkages to community services e.g. pharmacy, GPs, voluntary organisations, carers and families.	(i) Develop opportunities to enhance co-production with service users, carers and families and communities. (ii) Build on established forums, groups to encourage co-design of services by engaging with service users and carers to inform service delivery.	This will require a joined up approach across the entire HSC to include: DoH HSCB HSC Trusts NISCC PCC PHA	Ongoing for duration of review March 2021

Appendix 1

DOMICILIARY CARE
PROJECT STEERING GROUP
TERMS OF REFERENCE

WORKFORCE REVIEW – DOMICILIARY CARE

Purpose

1. The purpose of the Steering Group is to oversee and direct the Workforce Review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services. The Review will consider the recommendations for the future skills required to ensure a competent workforce that can deliver the agreed model(s) of robust domiciliary care services into the future to support the implementation of Transforming Your Care over the next five years.

   Definition of domiciliary care– *The range of services put in place to support an individual in recognition of their human rights 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.*

   While it is not possible to disaggregate between groups (older people, adults and children with a range of care needs) without disproportionate cost, it is significant that approximately 80% of recipients of domiciliary care are Older People.

Membership/Timeline of the Project Steering Group

2 Membership of the Steering Group has been drawn from DoH, HSC Trusts both HR and service delivery representatives, NISCC, HSCB, Independent Healthcare Providers, DEL and staff side. A full list of membership is attached at **Annex A.**

The Steering Group will meet 4 – 6 weekly and at appropriate times to guide the work of the Project Working Group. Meetings will be held in Castle Buildings and secretariat to the group will be provided by DoH.

It is anticipated that the workforce review will be completed by 31 March 2016.

Role and Responsibilities of the Steering Group

3. The Steering Group has been convened to oversee and direct the review and its role will be to:-

- agree the terms of reference of the Project Working Group to include the scope of the review;
- quality assure the workforce intelligence gathered;
- advise on the strategic direction of the domiciliary workforce including the need for capacity building within the public health service to meet the need for domiciliary care;
- support and contribute to the development of the report;
- provide advice, guidance and validation to the review;
- facilitate provision of information from their organisations in a timely manner;
- input information and advice drawing from their own expertise;
- ensure effective communication and dissemination of information between participating organisations; and
- receive, make recommendations and approve the Workforce Plan on Domiciliary Care.

Annex A

WORKFORCE REVIEW DOMICILIARY CARE

STEERING GROUP MEMBERSHIP

Name	Organisation	E-mail address
Heather Stevens (Co-chair)	DoH – Workforce Policy Director	Heather.stevens@dohni.gov.uk
Christine Smyth (Co-chair)	DoH - Deputy Chief Social Services Officer	Christine.smyth@dohni.gov.uk
Peter Barbour	DoH – Workforce Policy Directorate	peter.barbour@dohni.gov.uk
Erin Montgomery	DoH - Information and Analysis Directorate	Erin.montgomery@dohni.gov.uk
Mervyn Langtry	DEL – Head of Skills Solution	Mervyn.langtry@del.gov.uk
Anne Speed	Staff Side	A.Speed@unison.co.uk
Margretta Chambers		Margretta.Chambers@southerntrust.hscni.net
Pauline Shepherd	Independent Health & Care Providers	Pauline.shepherd@ihcp.co.uk
Marie Ward/Raymond Irvine	Western HSC Trust	Marie.ward@westerntrust.hscni.net
Melanie McClements	Southern HSC Trust	Melanie.mcclements@southerntrust.hscni.net
Una Cunning	Northern HSC Trust	Una.cunning@northerntrust.hscni.net
Kevin Keenan	HSCB	Kevin.Keenan@hscni.net
Patricia Higgins	NISCC	Patricia.higgins@niscc.hscni.net
Joanne McKissick	Patient and Client Council	Joanne.McKissick@hscni.net
Await nominee	Carers NI	Follow up correspondence 5/10/15, advised short staffed in NI at present.

DOMICILIARY CARE PROJECT WORKING GROUP

TERMS OF REFERENCE

WORKFORCE REVIEW – DOMICILIARY CARE

Purpose

1. The purpose of the Project Group is to carry out a Workforce Review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services. The Review will consider the recommendations for the future training required to ensure a competent workforce that can deliver the agreed model(s) of domiciliary care services to support the implementation of Transforming Your Care over the next five years.

   Definition of domiciliary care– *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.*

Membership of the Project Working Group

2. Membership of the Project Working Group has been drawn from DoH, HSC Trusts both HR and service delivery representatives, NISCC and HSCB. A full list of membership is attached at **Annex A**.

The Project Working Group will initially meet monthly. Meetings will be held in Castle Buildings and secretariat to the group will be provided by DoH.

Scope

3. Domiciliary care as defined above has been identified for this workforce review. This review will cover all recipients of domiciliary care as it is not possible to disaggregate between groups (older people, adults and children with a range of care needs) without disproportionate cost. However, it is significant that over 80% of recipients of domiciliary care

are Older People. It has been accepted that Older People applies to those aged 65+.

4. This review will include domiciliary care purchased directly by service users via Self Directed Support or Direct Payments. This is an area of care that is expected to be highly impacted by TYC and early evidence points to a growing demand in this service delivery area which will be critical for future profiling.

5. The Project Group should access all available data in relation to domiciliary care provision across the various occupational groups and providers so that the review can be as inclusive as possible and any recommendations coming forward have an evidence base.

6. The review should include costing any workforce implications for implementing recommendations emerging from this review to include new models of delivery, training etc.

Objectives of the review

7. The objectives of the review will be:
   - To provide an analysis of the current domiciliary care workforce in Northern Ireland.
   - To test a workforce planning model on a 'Programme of Care' approach within a social care context, although recognising that the service user group includes people outside the Older People programme of care.
   - To provide an analysis of current and future recruitment and retention issues.
   - To identify potential future recruitment and retention issues.
   - To produce a Workforce Plan **by December 2015** to include recommendations to support the outcome of the review.

Methodology

8. The methodology being applied will be the six step model contained within the Department's Workforce Planning Framework document:

   - Defining the Plan.
   - Mapping Service Change.

- Defining the Required Workforce.
- Understanding Workforce Availability.
- Developing an Action Plan.
- Implement, Monitor and Refresh.

Project Steering Group

9. A Domiciliary care Workforce Steering Group will be convened to oversee the review comprising membership from HSC Trusts, HR, DoH, HSCB, staff side, education, and the independent sector.

10. The Domiciliary care Project Group will report directly to the Steering Group who will in turn report to the Department of Health.

Annex B

WORKFORCE REVIEW DOMICILIARY CARE – OLDER PEOPLE

PROJECT WORKING GROUP MEMBERSHIP

Name	Organisation	E-mail address
Peter Barbour	DoH – Workforce Policy Directorate	peter.barbour@dohni.gov.uk
Catherine Donnelly	DoH – Workforce Policy Directorate	catherine.donnelly@dohni.gov.uk
Alison Dunwoody	DoH - Information and Analysis Directorate	Alison.dunwoody@dohni.gov.uk
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Sarah Browne	South Eastern HSCT – AD Director – Older People	Sarah.Browne@setrust.hscni.net
Maura Mallon	Southern HSCT -	Maura.mallon@southerntrust.hscni.net
Gill Smith	HSCB	Gill.smith@hscni.net
Marian O'Rourke	NISCC	Marian.O'Rourke@niscc.hscni.net

Appendix 2

Applying a Co-design Approach to Regional Workforce Planning Domiciliary Care Plan

A co-design approach has been approved to effectively support the development of this workforce plan. This means that service users and staff will be involved in the development of the planning in partnership.
The approach to co-design to inform this plan will in the first instance take account of relevant available reports, surveys and all available evidence to:

1. identify common themes and key considerations for the DoH;
2. inform how the service looks based on what service users have identified is important to them; and
3. inform how the service works; how the workforce understands the model of care and their ability to deliver to it.

The evidence presented in this paper will help inform the work of the group. A number of sources have been consulted and they are detailed at the end of the paper. It is recommended that the final plan be considered by both service users and staff in a real time feedback session prior to final sign-off.

Priorities for People, Common Themes in literature reviewed:

- Having a say in the type of care they receive/involvement in care plan.
- Preference for having regular/familiar carer(s)/knowing who is providing their care/being introduced.
- Expected time of call and reason for call/care needs to be met.
- Due to high levels of loneliness, social isolation, service users value the added benefit of social contact/connection.
- Communication.
- Flexibility.
- Quality care.
- Training; Support Workers being able to provide the things people need, but also clients/service users knowing what they can expect from a visit.

A number of the above reported priorities are also identified NICE standards. Interestingly, in regards to home visits NICE specifically advise that a home visit shorter than thirty minutes should only happen if:

1. The home care worker is known to the person;
2. The visit is part of a wider package of support; and

3. It allows enough time to complete specific, time limited tasks or to check if someone is safe and well.

How the Service looks currently:

- The majority of people report they are satisfied/very satisfied with the service.
- Service users want to stay at home for as long as possible and this may suggest a further vulnerability and consequent unwillingness to complain if the service is not as expected/suitably delivered.
- Many would like more support. For some this may mean that they don't feel their current package is enough hence the role of the Key Worker, care plan provision and its regular review comes into focus.
- People have said they would like an idea of what to expect from the service and how they will be supported.

Additional identified considerations from evidence reviewed:

- Value based recruitment interviews to identify personal attributes and attitudes of staff
- Consider service user/carer involvement in recruitment panels
- Medicine management/pain management training/preventative care/ independence training for staff.

How the service works:

- Staff are under pressure to complete visits to time.
- With ever increasing level of complexities mean there are increasing demands on staff to deliver higher level care tasks
- Strategic direction to have a mixed economy of providers.

Challenges:

Many people are supported by older carers for the vast majority of the week. 50% of the 557 carers PCC spoke to were over 55 (2015:14). If we want to sustain this level of care provision we need to support those that deliver it. Central to this is completion of a carers assessment which is built on and frequently reviewed to ensure suitable support (respite) is provided within a partnership model to help support those who provide care to sustain their level of involvement. Capacity issues in all sector is a further concern. Additionally, there are recruitment and retention issues. There is an identified need to grow the workforce to increase capacity rather than appoint other providers staff.

Recommendations for this group:

1. Whole systems approach across HSC and at Government Policy Level to provide required cross-departmental working at each level to assist in seamless delivery e.g. "ensuring all benefits received can be considered in implementing a comprehensive care package"; OT liaison with NIHE colleagues to complete housing adaptations; partnership approaches with Policing and Community Safety colleagues to ensure service users feel safe and secure in their own home.
2. Implementation of a partnership model which effectively identifies need and ensures care and support for the service user by involving the family/carer, third sector and community and HSC to provide an agreed wraparound programme of support and care for the service user.
3. Reinforcement of the importance of a care plan and specific details of what is to be commissioned/delivered, completed in partnership with the service user and implemented by care staff.
4. Key Workers are essential taking embedding a person centred approach with regular reviews to manage/plan for changing circumstances.

Conclusions

To be able to deliver the above recommendations a new partnership model is a priority. Service users and staff both need to be clear on what standards they can expect and indeed the standard/type of care they are expected to deliver. A standard operating model developed in partnership is a critical success factor for this piece of work. The development and agreement of such can help inform/determine how the service is going to be delivered and procured into the future and consequently to evidence the development of an accessible workforce to maintain the delivery of a quality service that meets patient needs.

References

- Making Life Better 1st Progress Report 2014/15. PHA
- A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary care in Northern Ireland. HSCB November 2015
- Home care: delivering personal care and practical support to older people living in their own homes. NICE guideline published: 23 September 2015
- Carers' Priorities: Carers views on future priorities for Health and Social Care in Northern Ireland, November 2015. The Patient and Client Council

- Phase 2, Regional Report Relating to Care in Your Own Home, October 2015. 10,000 Voices, PHA/HSCB
- Outcome Based Care, Domiciliary care, Case Study October 2015. SHSCT
- Domiciliary care Service User Engagements 2011/2012. SHSCT
- Domiciliary care Satisfaction Questionnaire, June 2014. SHSCT

Appendix 3

‘Draft Domiciliary Care Workforce Review NI 2016 -2021 Development’

Wednesday 15th June 2016

10.00am – 14.00 pm

Loughview Suite, Ulster University - Jordanstown Campus

engage - Instant Report

engage

This ‘engagement’ real-time e-participation engage event is facilitated by Professor Jonathan Wallace, Dr Michaela Black and Brian Cleland from Ulster University.

While all comments and votes stored in the engage system are anonymised, the final report from the event will be distributed to all participants, and may be passed to colleagues within the participating organisations, and other interested groups.

Table of Contents

The Engagement

What is an 'engagement'?

An 'engagement' has evolved out of the concept of a Town Meeting. A Town Meeting is a form of participation in local government practiced in the U.S. region of New England since colonial times, when an entire community was invited by government officials to gather in a public place to formulate suggestions or provide feedback on policy actions.

In its modern version, the electronic Town Meeting (eTM) and now an 'engagement', the most fundamental features are that information on the discussion topics are provided thanks to electronic means and the stakeholders can participate in debates and express themselves individually on those issues.

The main features

The method combines the live aspect of small-scale discussion with information and communication technologies: on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system.

The 'engagement' consists of four different work steps, all aimed at facilitating the participants' discussion of the themes at issue:

- Information and in-depth investigation, allowing the participants to gain confidence with the topics of discussion;
- Discussion in small groups, allowing reciprocal listening and the confrontation between different perspectives;
- Reflection, during which the results of group work are summarised and sent back to the whole assembly; and
- An optional polling step, in which participants may be asked to individually answer questions generated during discussion.

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Contents of the engagement

Context - Setting the Scene – why is the workshop important?

The Department of Health hosted this engagement workshop to consult on the development of the draft Domiciliary Care Workforce Review NI for 2016 – 2021.

In order to do this it was important that they gather the views of the many stakeholders involved.

The purpose of this interactive e-participation 'engage' session, which took place in the Loughview Suite at the Ulster University's Jordanstown campus, was to facilitate engagement between all attendees and encourage open discussion and debate

The engagement discussions were divided up into three main topics:

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

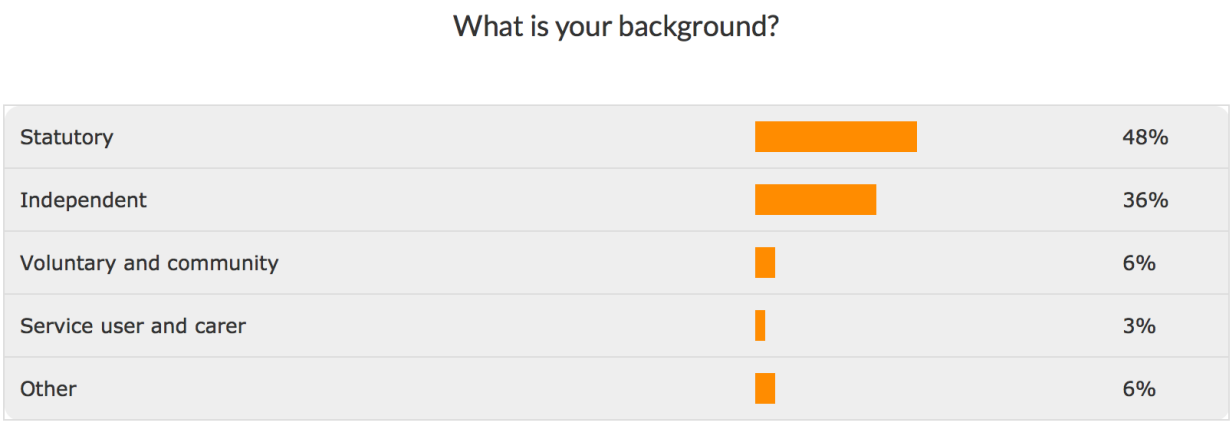
Format of the Engagement

The topics described above formed the basis for discussion on the day. The overall structure of the Implementation Workshop was as follows:

10.00am	Registration – Tea & Coffee and Networking	
10.30am	Welcome	Peter Barbour–Deputy Chief Social Services Officer - DHSSPSNI
10.45am	Introduction to the engage e-participation tool & process; and initial polling questions	Professor Jonathan Wallace, Dr Michaela Black and Brian Cleland – Ulster University
10.55am	Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?	
11.25am	Ranking By Table for Topic One – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic One.	
11.35am	Feedback on Topic One Discussion	Dr Michaela Black
11.45am	Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?	
12.15pm	Ranking By Table for Topic Two – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic Two.	
12.25pm	Feedback on Topic Two Discussion	Dr Michaela Black
12.35pm	Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?	
13.05pm	Ranking By Table for Topic Three – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic Three.	

13.15pm	Feedback on Topic Three Discussion	Dr Michaela Black
13.25pm	Close	Heather Stevens – Director of Human Resources – DHSSPSNI
13.35 pm	Lunch and Networking	

Engagement Audience Demographics



Discussion Outcomes

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

- Raise the value of social care
- Value the workforce
- Opportunities for career development
- Need to make domiciliary care a career pathway needs a greater identity
- Full career pathway to various gateways nursing, social services and allied health etc.
- Better forward planning
- Clear distinction in care staff roles
- Training and QCF resources and support
- Investment – both monetary and skills
- Positive media coverage
- Fund it!
- Need to understand the different terms and conditions of statutory and independent staff
- Service User specific comment: Service users feel we need to pay the staff appropriately, train staff appropriately and recruit staff that actually care for the service user instead of 'doing onto me' with no conversation - just the basics. Workers need to be mindful of what else is going on in my life, their presence in my home. Value based recruitment as part of it - how you interview more than an application - need questions like district nursing to suss out integrity, what your value system is. Recruiting the right people with right qualities.
- Career progression, schools and colleges to promote 'care' as a profession
- Staff terms and conditions attract independent sector staff e.g. sick pay

- Need to have a full understanding of the workforce in all sectors
- Recognise the value of domiciliary care
- What is the role of the independent sector play? - e.g. market share, service model?
- Training, is critical - communication, value of service user involvement in recruitment and meet service users as part of induction processes
- More partnership in delivering care between the statutory and independent sectors needed
- 100% statutory services in domiciliary care will not work and will not encourage the independent sector to invest until there is clarity
- Need to standardise terms and conditions for sustainable workforce
- Appropriate terms and conditions for Independent sector staff as well as statutory.
- Increased budget for training and development
- Unison rep noted from their perspective that this engagement meeting is a bit premature and had no response to-date to departmental meeting as requested and was therefore registering his disappointment.
- More partnership in delivering care between the statutory and independent sectors needed
- Open the workforce - female and male care staff, service user choice of provider/carer and offer staff security e.g. minimum guaranteed hour contracts
- Need to build in some flexibility - not just a task model as needs change day to day
- Need to raise profile of the home carer as a career starting in schools
- Recruitment needs to account for the fact that this is a vocational role
- Care staff want training - it is not just a requirement but part of their desire to deliver quality services
- Domiciliary Care staff want to be part of a team and feel like they are valued
- Staff need to be heard and listened too
- Better partnership approaches across the statutory and independent sectors
- Domiciliary care is not prioritised
- Increased budget for training and development
- Appropriate terms and conditions for Independent sector staff as well as statutory.
- Issue of comparative terms and conditions of staff in independent and statutory sectors.
- Care should be categorised - Elderly Mentally Infirm (EMI/ Memory), high dependency care and ensure staff are allocated care packages according to their abilities
- We need to define the job, what we require and the outcomes we expect
- Quality of life indicators and outcomes need to be defined
- Need to have regular partnership meetings with the Trusts - seem afraid to engage with independent providers because of the procurement legislation
- Need to utilise the potential of the Apprenticeship scheme
- Rethink the definition of domiciliary care - states personal care & other domestic services. No mention of social interaction, medication, protection and complex care - this doesn't reflect the higher acuity of services and skills required by Domiciliary Care workforce
- Need support from community nursing teams e.g. older peoples/memory for general training and support, competency / refresher and targeted service user specific care support.
- All domiciliary care workers should have the reablement ethos to prevent decompensation - delivering care with, rather than just for users.
- All dom. care providers have the same live call monitoring system to ensure face-to-face care is equitable across providers.
- Need to retain trained staff
- Increased budget for training
- Review job titles and roles

- Mileage allowance for staff need to be standardised across Statutory and Independent sectors
- Need to respond to what matters to the service user - what are their preferences - needs to be person centred service
- We should be taking the lead in the UK and not waiting for England to do it first. We have many good practice exemplars - let's grow them.
- There has to be a closer link between health care and social care
- Professionalise it - attract the right people
- Need to retain a local workforce to address defined local needs to have a sustainable service
- Change the culture of the Northern Irish public in relation to the Health Service in general and domiciliary care services specifically.
- There is a clear need to forward plan and almost start again as we have created jobs that are no longer attractive to people. Need to consider how to make domiciliary care attractive
- The Domiciliary sector would save a lot of money if investment was made into it
- Are we doing too much - need to partner with families to provide the care that they should or could be providing - the dynamics of society have changed.
- Need to promote good quality standards in domiciliary care
- Rapid response services worked and all it took was a couple of pound more an hour and it saved on A&E waiting times and bed blocking - lets apply the learning

Topic 1: Ranked

Table 1

1. Value our carers with better terms and conditions on a level playing field
2. Raise the profile of domiciliary care as a skilled and valued profession
3. Improved working partnerships with the Trust and key stakeholders, including the independent providers and Service Users

- Communication, communication, communication!!

Table 2

1. Make it a career
2. Standardise pay, terms and conditions
3. Strategic view of the service - what is provided, who should provide

Table 4

1. Service user needs must come first regardless of sector provider. Needs to be an agreed service delivery model
2. Attract a wider pool of applicants by raising the profile of social care, strategies to widen the pool of applicants and more targeted, providing career pathways, apprenticeships, equal terms and conditions for all sectors
3. The document needs a 5th scenario to state working in partnership with all sectors, where staff can develop skills needed, including use of technology. Need an outcomes matrix to measure service users needs are met. Partnership, commissioning and outcomes for service users are linked

Table 5

1. Funding which should be appropriately applied i.e. not funding profit.

2. Education and raising the profile of the service.

3. Career structure to include apprenticeships to attract the right people in to the workforce.

Table 6

- Status of the job; pay, terms and conditions, career path, value perspective of the job.
- Too much political interference in health instead of from the people that know
- The care part has been squeezed out because of time
- Promote as caring job, person centred care, training, should be a public sector but challenge is attractiveness
- Same challenge is there for independent sector, so challenge in domiciliary care sector as a whole
- Need a long-term plan for the sector
- Concern that those making decisions not fully aware of the challenge, things have changes with regard to profile of service user base and the consequences of decision making
- Is domiciliary care valued?
- Giving service user a choice of what provider provides care; if independent what independent agency, this will help place emphasis on who is best - service users to determine what agency provides care

Table 7

- Defined career path
- Ensure staff feel less vulnerable
- Fair pay structure

Table 8

1. Up skill workforce, training resources, with categorised care
2. Investment - putting the independent sector resources on a power with the 'Trusts', Independent sector have attracted younger staff where the Trusts have better retention of staff and then leading to an older workforce. Must develop younger staff new to the industry to enable them to progress their career and remain in the industry.
3. Public relations - positive public media coverage, public image to the industry and this as a career! Visible career choice and to be seen as a profession, rewarded through salary! Redefinition of Domiciliary Care

Table 10

1. Recognise the value that domiciliary care has on the wider health service.
2. Fund accordingly for sustainability for both staff members and the business and also for the effect on the acute sector
3. Partnership approach with the service users needs in mind. Removal of barriers between statutory and independent and others to ensure the best for the service users

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

- Engage all stakeholders to consult with regard to service specification
- Commissioning process needs to align itself to what the expectations are of the domiciliary care service.
- Needs to be a regional approach to commissioning
- There has to be a fair balance between independent & statutory provision of domiciliary care.
- Commissioning needs to recognise the real cost of care
- Commissioning should be based upon realistic funding to prevent a "race to the bottom" i.e. competing for the lowest price and compromised quality.
- What is the commissioning model? Is it purely financially driven or does it include quality of service provided?
- Procurement process should focus on quality rather than just driving the price down as seems to be the current position
- There needs to be a large statutory service operating alongside the independent sector. Can't put all of our eggs in one basket.
- There is instability in the market due to the fact that there is variance in the proportion of domiciliary care in NI sitting with independent sector providers.
- Links between acute care and domiciliary care need to be more joined up to prevent delayed discharges and the need to re-procure care packages.
- UKHCA have produced a costing model for the cost of care which should be considered
- Must consider the demographics and rurality of service users
- Decide on what is a fair price as of TYC
- Focus on partnership and quality
- Categorising care
- Tendering process - Value the quality rather than the price
- Need better information on exactly what a service user requires from brokerage or commissioners

- Better communication between agencies who deliver "dual provided" packages, information sharing, local resolution
- Remove competition - define the rate for a level playing field - understand the cost of care
- Capping how much a service provider takes on to ensure they can provide an excellent service.
- Continuity essential, new structures might create opportunity for that line of sight, top to bottom. Use the opportunity in changes to commissioning with a link in to the local knowledge.
- Should we move to means tested?
- Need to commission outcomes - not time
- Need a prescriptive piece around what domiciliary care is and what 'good' looks like
- Fair distribution of service users across the Trust and Independent sector
- Ensuring a safe service is provide taking into account what the service user requires on a day to day basis co-design and partnership critical to designing the care package with clear expectation set of what is and is not realistic
- Greater flexibility in the commissioning process, currently quite rigid and needs to be more flexible to respond to service user needs and outcomes
- Procurement is a legislative requirement - however there is difficulty sourcing packages with the number of ever decreasing providers - how is this going to solve commissioning of services
- Ensuring a safe service is provide taking into account what the service user requires on a day to day basis, co-design and partnership critical to designing the care package with clear expectation set of what is and is not realistic
- Look at what's best for the service user as well as the Tax Payer
- Need to share the risk with the providers - partnership approach
- Commissioning has to be able to support service user choice particularly within Self Directed Support (SDS)
- Shouldn't be able to dictate the number of providers in a tendering process. For example only allowing 5 providers to win a tender for a whole trust area.
- Reducing the price over the last 5 years has caused the problem
- Need to commission individual care packages not hours
- Need to factor in fair and consistent hourly rate and terms and conditions for domiciliary care workers
- Stop changing the process and stability across ALL Trusts
- Tendering process, quality should be priority

Topic 2: Ranked

Table 1

1. Engage all key stakeholders in creating the service specification
2. Regional approach to commissioning services for consistency across the board
3. Tender service specification should specify terms and conditions for domiciliary care staff to match what the Trust provide so that independent providers can include this in their pricing

Table 2

1. Guaranteed level of income
2. Incentive to achieve good outcomes
3. Shared risk

Table 4

1. Commissioning needs to recognise the real cost of care and support a thriving social care workforce (UKHCA report)
2. Commissioning process needs to be more flexible to support service user choice, particularly within SDS
3. Commissioning needs to support innovation and skills development within all sectors

Table 5

1. Funding which should be appropriately applied i.e. not funding profit.
2. Education and raising the profile of the service.
3. Career structure to include apprenticeships to attract the right people in to the workforce.

Table 6

1. Longer term strategy with line of sight through to local level and what needs are on the ground
2. Increase profile of domiciliary care in DoH, and across Executive, other Depts. (Education - career path, vocational training); Communities (third sector, older peoples commissioners) et al. – a whole of government approach
3. Acknowledge that it is a hands on job and don't try to complicate it- at commissioning level

Table 7

1. How is commissioning defined?
2. Commissioning of services depends on the programme of care.
3. Commissioning decisions need to be made with knowledge of the job and what is expected from the carer.

Table 8

1. Stop changing the process and stability across all Trusts!
2. Lack of information regarding the service user, package details and their needs.
3. Trust should stop providing conventional services and 'cherry picking'.

Table 10

1. Decide on the true value on an hour of care and then remove price from the commissioning process as this has created a race to the bottom
2. Define the role each part of the sector has in delivering and commissioning the service.
3. Set this in legislation where responsibilities lie in terms of workforce - e.g. the Care Act in England
4. Learning from other countries that have been more successful.

Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

- Start at schools / FE colleges level to attract people into apprenticeships.
- Need a clear career pathway
- Redefine the roles and responsibilities of a domiciliary care worker
- Domiciliary Care minimum standards need to be reviewed
- Provide Clinical facilitator to Domiciliary Care in the same way as Nursing Homes
- Linking with schools and colleges
- Better coverage in the media to encourage people to show an interest
- Identifying a career path
- Domiciliary can have an impact on reablement / independence of service users
- QCF is very expensive - necessary for certain roles! Discounted/free places available if under 25 yrs. old but working <21 hrs. p/w, not considering the aged workforce, discounting people from the industry.
- Self Directed Support (SDS) - can people focus on the social side instead of the health side
- Support providers to have more control over the needs and skills of the staff and support with funding.
- Ensure clear practise based competencies are developed for the job
- Ensure a Career Pathway is defined
- Ensure a standardised generic induction programme is available
- The role has changed so much that it needs redefined role to future proof it.
- Transferable police check
- Develop creative ways to look at learning outcomes - vocational learning
- Essential Independent providers provide learning and development opportunities beyond that which is mandatory and that these align with career paths.
- Once the roles and responsibilities of a domiciliary care worker are redefined to reflect what the job has become, training must be provided and the commissioners fund to address skill gaps

- Support providers to have more control over the needs and skills of the staff and support with funding.
- Registration of the workforce can be a driver to support skills development
- Standard regional guidelines a "suite of training" / competency framework for domiciliary care staff to provide clarity on tasks undertaken by dom. care staff for both statutory & independent sector.
- Carry out a comprehensive costing of training to include release costs / backfill / programme costs so that the requirement for funding can be recognised.
- Learning based approach to redefine training
- Mentoring and shadowing mix of on the job and focussed training
- Ensure resources are available for training - new technologies.
- Use of technology to make learning and development more accessible e.g. mobile apps etc.
- Training costs should be recognised in the contract specification and hourly rate for commissioned services.
- "Price driven" procurement does not allow for care staff to be properly invested in - lower level care staff need developed as a professional
- Determination of what the service being delivered is - movement from a more social orientation and household tasks to a more clinical delivery based on more complex needs/multimorbidities
- Build in flexibility within role of carer support with ability to work in a number of settings, perhaps on rotation or based on needs of service- this broadens skill mix and profile of staff and capacity of service to deliver.
- A pin / badge for recognised achievements and skills.
- Explore with universities and FE colleges the possibility of progression courses for domiciliary care staff that can move through to Social Work, Nursing, Management and AHPs.
- What is the training pathway after level 5 QCF?
- Develop training academies for Dom Care including e-learning
- Funded secondment.
- Management and leaders should understand/be competent in tasks if they expect staff member to complete them
- Develop a training hub - something we could log in to share information on courses
- What can our universities do to promote career in care?
- Partnership with the Trusts - Open up their training to everyone
- More structured approach to training from the Trusts to include other providers
- Different levels - staff can progress up through the levels. This would be different pay scales which could also help with SDS budgets
- Training for the manager of the company as well. Train the trainer accredited for the manager - everyone across the board will then be delivering the same level of service
- Introduce a 'charge hand' / team leader role Band 3?
- Invest in leaders and managers to drive the service forward!
- Giving care staff the confidence in themselves and their training, to stick to policy, procedure and relevant legislation. Not to be controlled by others including families.

Topic 3: Ranked

Table 1

1. Roles and responsibilities of a domiciliary care worker need to be redefined to reflect the nature of the work they do, which will identify skill gaps
2. Funding needs to be available to provide the standard of training required and career pathways
3. Domiciliary care providers need to engage more with each other in terms of training to ensure a high standard of delivery and to support each other in creating efficiencies

Table 2

1. There needs to be investment in learning
2. Define the roles and competencies required at each level
3. Develop skill set for specialist areas.

Table 4

1. Promoting the role and value of domiciliary care
2. Skills strategies and resources need to support social care skills and career development e.g. Apprenticeships
3. Clarity about the model of care to inform skills development

Table 5

1. Funding - recognise the training required and pay for it; a dedicated training resource.
2. Career pathways with buy-in / support from the department to open up secondment opportunities for those who demonstrate abilities to progress into Social Work / Nursing / AHP careers
3. Competency framework / suite of training to provide clarity of tasks undertaken & training required across both statutory and independent sectors.

Table 6

1. Determination of what the service needs to look like
2. Determination of skills mix to deliver said service
3. Don't complicate it, build in flexibility and apply a co-design orientation to get it right

Table 7

1. Career pathway defined
2. Standard generic induction programme
3. Specific professional training for individual service users needs

Table 8

1. Strong organisational structure. Leadership and management investment. Recognising the value of these. Rates to facilitate GOOD management.
2. Educational/clinical facilitator
3. Provision of low cost training available to everyone!

Table 10

1. Investment for more training and development.
2. Linking with schools and colleges to encourage more interest in the care industry and to provide people with the skills needed to do the job. Run a course within the college for domiciliary.
3. With the correct investment from the department we could create different levels within the company so a staff member can progress and develop their career and skills.


Push bar to open
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engage