

REVIEW OF COMMUNITY CARE

FIRST REPORT

**Department of Health, Social Services & Public
Safety**
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábhálteachta Poiblí

April 2002

FOREWORD

Following the pressures on health and social services during the outbreak of the flu-like illness in the winter of 1999-2000, two of my first actions as Minister were to ask the Chief Medical Officer to review intensive care provision and the Chief Inspector of Social Services to review community care.

"Facing the Future: Building upon the lessons of Winter 1999/2000" recommended a comprehensive review of community care policy and I endorsed that recommendation in October 2000.

As a first stage an extensive consultation exercise was carried out through July, August and September of 2001 to take the views of statutory and independent sector providers, voluntary organisations and the health and social care professions. The objective was to identify barriers to the delivery of good community care services, to identify good practices and to bring forward recommendations for improvements. I have considered the findings in the report and now wish to make it available for your information and consideration.

Section 5 of the report identifies improvements that can be introduced in the short term. I have been encouraged by, for example, the number of innovative schemes in place aimed at preventing admission to hospital and to providing safer and faster discharge for those considered medically fit for discharge from hospital. The use of such schemes shows a widespread recognition of the changing face of community care and the need to further develop and improve the way in which community care services are delivered across health and personal social services. One of the next steps will be to make available detailed information on the range of innovative practices to all service providers, to encourage the sharing of experience across Trusts and to ensure that good practice is replicated elsewhere. That work is now in hand.

Section 6 of the report includes a number of recommendations of a more long-term nature and my Department is now considering how best these can be progressed. In the meantime, it is important that specific elements of the review are taken forward without delay and that an appropriate amount of the new investment in community care is targeted at the recommendations in this report. With new investment and the ideas emerging from this phase of the review I would expect to see improvements in service delivery happen quickly.

Minister for Health, Social Services and Public Safety

RÉAMHRÁ

I ndiaidh an oiread sin brú ar na seirbhísí sláinte agus sóisialta le linn an ráig tinneas fliú le linn gheimhreadh 1999-2000 ba iad an chéad dá rud a rinne mé mar Aire ná a iarraidh ar an Príomh-Oifigeach Liachta athbhreithniú a dhéanamh ar an soláthar dianchúraim agus ar an bPríomhchigire Seirbhísí Sóisialta athbhreithniú a dhéanamh ar an an gcúram pobail.

Mhol "Facing the Future: Building upon the lessons of Winter 1999/2000" athbhreithniú cuimsitheach ar pholasaí chúram pobail agus d'aontaigh mise leis an moladh sin i nDeireadh Fómhair 2000.

Mar chéad chéim rinneadh obair chomhchomhairle leathan le linn Iúil, Lúnasa agus Mheán Fómhair 2001 chun tuairimí soláthróirí san earnáil statúideach agus san earnáil neamhspleách, eagraíochtaí deonacha agus na gairmeacha sláinte agus cúram sláinte a ghlacadh san áireamh. Is é an aidhm a bhí leis sin na constaicí maidir le seachadadh seirbhísí maithe chúram pobail a sheachadhadh a aithint, chun deachleachtais a aithint agus moltaí faoi fheabhsúcháin a thabhairt chun cinn. Bhreithnigh mé na torthaí sa tuarascáil sin agus is mian liom í a chur ar fáil anois mar eolas daoibh agus le go bhféachfaidh sibh uirthi.

Aithníonn Roinn 5 san tuarascáil feabhsúcháin is féidir a thabhairt isteach sa ghearrthéarma. Údar misnigh dom mar shampla an líon scéimeanna nuálacha atá bunaithe agus atá dírithe ar chosc a chur ar iontráil chuig ospidéal agus a sholáthródh scaoileadh amach níos tapúla agus níos sábháilte ina measc sin a bheadh oiriúnach, ó thaobh liachta, le scaoileadh amach as an ospidéal. Léiríonn an leas a bhaintear as na scéimeanna sin an t-aitheantas fairsing a thugtar don athrú atá ar chúram pobail agus an gá atá le tuilleadh forbartha agus feabhsúcháin a chur ar an tslí a ndéantar seirbhísí cúraim pobail a sheachadadh feadh seirbhísí sláinte, sóisialta agus pearsanta. Ceann de na chéad chéimeanna eile ná mioneolas a chur ar fáil ar an raon cleachtas

nuálach chuig gach soláthróir seirbhísí chun roinnt na taithí a spreagadh feadh lontaobhas agus a chinntiú go ndéantar aithris ar dheachleachtas gach áit. Tá an obair sin ar bun anois.

Áirítear i Roinn 6 den tuarascáil roinnt moltaí níos fadtéarmaí agus tá mo Roinn anois ag féachaint ar an mbealach is fearr chun iad a chur chun cinn. Idir an dá linn tá sé tábhachtach go ndéanfaí gnéithe sonracha den athbhreithniú a thabhairt chun cinn gan mhoill agus go ndíreofaí méid chúí den infheistíocht nua ar na moltaí sa tuarascáil seo. Le hinfheistíocht nua agus leis na smaointe atá ag teacht chun cinn ón gcéim seo den athbhreithniú bheinn ag súil feabhsúcháin a fheiceáil ag tarlú go tapa maidir le seachadadh seirbhíse.

Minister for Health, Social Services and Public Safety

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SECTION 1

INTRODUCTION

- 1 The Minister of Health, Social Services and Public Safety commissioned a review with the following Terms of Reference:
 - “to review the implementation of the community care policy with a view to ensuring that adequate levels of service are available, and preventing inappropriate hospital admissions and discharge arrangements”, and
 - “to consider the effectiveness of the current arrangements for delivering community care services and to make recommendations to Minister by September 2001 about the levels and type of community care provision appropriate for the future, identifying areas for possible improvement in the light of likely need of these services”.
- 2 A Project Board was established during April 2001 under the chairmanship of Mr Brian Coulter, Chief Executive of the Fold Housing Association. The membership of the Project Board (Annexe 1) was selected to give an independent and informed direction to the review.
- 3 A multi-disciplinary Project Team (Annexe 2) was set up to carry out the review. Initially they were asked to speak to all those involved in the planning and delivery of community care services within the voluntary, statutory and private sector. Planners and professional advisors, doctors, pharmacists, the professions allied to medicine, care managers, nursing and social care staff, were to be consulted to give everyone concerned with the delivery of community care services the opportunity to comment on how they think future services should be provided. In June 2001, following initial discussions, the Minister agreed that in this early phase the review should concentrate on investigating the hospital/community interface, with a particular focus on services for older people.
- 4 Over the summer months, therefore, there was an extensive consultative exercise with a wide range of service users and providers across all Board areas (Annexe 3).
- 5 Section 3, which forms the main part of this report, presents the findings of the consultation exercise. This consultation process was a very worthwhile exercise as the service providers and users gave the review team a great deal of useful information about the current problems in delivering community care. They also

gave their views on a wide range of innovative approaches and initiatives that have been, or might be used, to resolve identified problems.

- 6 In Section 4 the findings of the consultation exercise are analysed and the Project Board, using their collective experience of community care, have agreed the key problem areas on which action is now urgently required. The next phase of the review process will require these areas to be examined in detail. The consultation demonstrated a consensus about many of the key problem areas and their possible solutions. However, the review will need to independently assess potential solutions so as to ensure that any changes to the system eventually recommended will be balanced, realistic and achievable.
- 7 Section 5 identifies areas in the Community Care Service where there is room for real and immediate improvement. It identifies and describes examples of schemes and innovative practice that the Project Board believes could, if implemented in a pragmatic and evolutionary way, enable Boards and Trusts to have a realistic and positive impact throughout the service.
- 8 Section 6 presents the Project Board's view on the best way forward to complete the full review of community care services. This proposed work programme is, in effect, an evaluation of the implementation of the 'People First' policy. This policy continues to provide a focus for actions designed to ensure that all users of community care services have access to high quality and responsive care in the setting most appropriate to their needs. These services should optimise choice, promote independence and ensure fairness and equity. Section 6 gives an outline of the tasks that need to be taken to complete the review and we intend, as our next step, to develop a more detailed plan that will reflect the full complexities of the issues to be addressed.
- 9 As an aide to understanding the background to this review, we have included a statistical profile of the current state of community care (Annexe 4) which illustrates the main demographic and operational pressures within the system.
- 10 As part of the analysis of the strategic context for this review, a literature review was also commissioned, which sought to analyse any documents and reports relevant to the implementation of the key objectives of 'People First'. This literature review can be obtained as a separate document.

SECTION 2

THE CONSULTATION PROCESS – THE APPROACH

- 1 A range of stakeholders were consulted, including health and social services staff, representatives from the voluntary and private sector, and users of the service and their carers. The Project Board would like to take this opportunity to record their thanks to all those who contributed to the review.

- 2 Six workshops were held at different locations throughout the four Board areas. A range of professionals attended these workshops and all Trusts, Boards and Health and Social Services Councils were represented. Further workshops were held specifically for the voluntary sector, Registered Homes Confederation and General Practitioners. Over 230 people attended these workshops. The aims of the workshops were to:
 - Identify barriers to the effective implementation of the community care policy;
 - Identify initiatives which work well in the delivery of community care and in reducing the instances of unnecessary admissions to hospital, and
 - Identify key short and long-term measures to improve the attainment of the objectives of the community care strategy.

- 3 Site visits were also made to a number of Community and Hospital Trusts. The aims of these visits were:
 - To focus on hospital/community interface issues, with particular reference to older people;
 - To investigate further examples of good practice which had been identified by participants at workshop sessions, and
 - To gain further understanding from the Trusts involved about how we might prevent inappropriate admissions to hospital and reduce the incidence of delayed discharge.

- 4 The user consultation consisted of two focus groups, the North Belfast Community Forum for Elderly People and the Omagh Elderly Forum. The Health and Social Services Councils arranged these focus groups. The Northern HSS Council also provided the Team with the results of a user satisfaction survey it had carried out.

The aims of these focus groups were:

- To listen to users' first hand experience of community care;
- To identify elements of good practice, and
- To identify areas where improvements could be made.

- 5 Advertisements inviting comments and views from the general public were placed in local newspapers.
- 6 Professional journals were provided with a copy of an article requesting a personal or professional opinion on current service delivery, possible improvements, and examples of 'Good Practice', or more effective ways of working.
- 7 A letter was issued to all 1,080 General Practitioners, and 77 Geriatricians and Psycho-geriatricians, inviting them to make their views known on what they saw as the main issues in the delivery of community care services. The Medical Practitioners were also asked to put forward their suggestions for improvements in the service.
- 8 There were also individual meetings with Jane Graham from the Eastern HSS Council, Dr Brian Patterson of the BMA, representatives from the Royal College of General Practitioners and the Advisory Committee of the Therapeutic Professions Allied to Medicine.
- 9 In total, approximately 350 people participated in the consultation. The consultation report (Section 3) does not ascribe particular views to individuals or organisations since a very wide range of topics was covered in these meetings and it would have been quite difficult, and not particularly helpful, to attempt this. Instead, the responses from consultees are presented under a series of broad headings, to provide a potential focus for future actions on our part. This is not a verbatim report of what was said, but an attempt to give as objective an account as possible of the essential points made, grouped and summarized where appropriate.

SECTION 3

CONSULTATION REPORT – THE FINDINGS

Introduction

- 1 The main messages during the consultation were that people believed they had a Community Care system which was under severe pressure. They believed that there was a general lack of resources, and that the ageing community were generally not well provided for.

The Views Of Older People

- 2 During the consultation older people expressed the following views:
 - They were often made to feel a burden on society.
 - They felt that the system militated against families who wanted to keep their loved ones at home.
 - They were concerned for their carers who they felt required more help.
 - An increasing number of carers were also elderly and frail. This was worrying for users and carers who feared a crisis that would, almost inevitably, lead to admission into care.
 - They were dissatisfied with the means testing system as older people did not want to have to sell their homes to pay for residential care.
 - They believed care packages were not sufficient to maintain people in their own homes and that they had to depend on the good will of care assistants and home helps for the extra service they need. One home help described how she regularly worked one to two hours unpaid per day.
 - They were concerned at the insecurity of community care packages that are often cut back without warning. One 87 year-old gentleman caring for his 85 year old wife had recently had his home help service reduced on the day following her discharge from hospital.
 - They believed that services such as social centres and clubs, which increased social contact and helped keep older people active, required more support. A significant theme identified during the consultation was loneliness.

Many expressed feelings of loneliness and isolation, where the only visitor is often the home help.

- 3 Overall the responses from the consultation process indicated that there was widespread commitment to the original aspirations and principles of 'People First: Community Care in Northern Ireland for the 1990s', amongst professionals and users alike. However, there were many concerns arising from the experience of implementing the community care reforms since 1993. In particular there was concern about what the future will hold in relation to the increasing demands, expectations and pressures that are anticipated to increasingly affect the service.
- 4 The views expressed throughout the consultation process were wide-ranging but consistent. Many echoed and built on issues that had been raised in the February 2000 SSI Report, 'Review of Care in the Community', and evidenced in the literature review. There was considerable enthusiasm amongst those consulted to engage with these complex and difficult issues and to share the experience that they had gained over the previous seven years.
- 5 Many participants expressed the view that while this review of Community Care was much needed, its focus on the care of older people and hospital discharge was too narrow. It was widely felt that the care of older people should not simply be viewed in the context of the interface between acute hospitals and community care. Indeed one view frequently expressed was that it was quite inappropriate that major decisions about the long-term care of older and vulnerable people were regularly being taken in such a pressurized context. Many participants felt strongly that a review of community care should not solely look at the needs of one group of service users.
- 6 Consultees drew attention to many examples of new and innovative practice that they felt could be used as a basis for developing community care. They believed these concrete examples of action could improve the effectiveness of the arrangements for community care in the short-term. However, at the same time they also said that the answer did not lie in "*quick-fixes*". They urged that an in depth review be undertaken to look at the considerable body of experience and practice that was now available, both locally and from further afield.
- 7 They continually drew attention to the difficult decisions that would have to be taken in light of the ever-increasing demands on the health and social care system. There was a consensus that to develop a high quality care system that effectively promoted independence and choice for service users would need a strong, shared vision and significant investment. They expected demand for services to continue to increase and there was a strong feeling that as a society

we all needed to look now at how we want to see our community care system develop over the next 20 to 30 years.

The Hospital Community Interface

- 8 It became clear during the consultation that there were considerable variations across Northern Ireland in the arrangements with regard to hospital community interfaces and, in particular, the extent to which liaison procedures and protocols had been developed between hospital and community Trusts. This appeared to be more complex in those situations where hospitals had to relate to a number of different Trusts, each of which had uniquely different arrangements and procedures.
- 9 It appeared that systems worked best where there was face-to-face contact amongst hospital and community staff and a shared commitment to common goals and procedures. It was felt by many that this was difficult to achieve in an environment where there was often competition between hospital and community priorities. Many felt that there was an imbalance in power, with acute hospitals having a much higher public and political profile, and therefore more power in attracting resources.
- 10 There was some concern about the extent to which community care and, in particular, care management, had become driven by the pressure on hospital discharge. It was claimed that service users were being discharged "*quicker and sicker*" than in the past. A number of participants expressed the view that this placed additional pressures on community resources, a trend which had not been taken into account in planning and resource allocation.
- 11 Concern was expressed during the consultation that discharges were often being processed much faster than previously was the case and that in some cases this might be inappropriate, leading to re-admission. It was felt that not enough was known about re-admission rates. It was also felt that there was a need to look at the point of admission as well as the point of discharge, and to ask why there were such high rates of admission to acute care in the first place.
- 12 Many participants in the consultation workshops felt that there was much that could be done to improve integrated working across hospital/community interfaces. They supported the view that face-to-face approaches worked best and they gave specific examples of more effective ways of working. These included discharge co-ordinators, home from hospital schemes and joint planning groups.

- 13 Discussion of issues around acute care was highly emotive. While those consulted were very mindful of the press coverage that was given to people waiting on hospital trolleys for a hospital bed for lengthy periods, many realised that this tended to mask a situation whereby Northern Ireland continues to have higher rates of admission than elsewhere in the UK. There was concern that even short stays in hospital and institutional environments could result in increased dependency and loss of resilience in older people. Many focused attention on the admission stage and gave examples of schemes designed to prevent inappropriate admission to hospital.
- 14 Consultees described initiatives which recognised the risk of infection and disruption to social well being that acute hospital settings bring. They suggested that there was scope for increased use of an approach that delivered expert services in domestic settings. Examples given included schemes aimed at sharing specialist expertise in Chronic Obstructive Pulmonary Disease (COPD) and in wound management.
- 15 Widespread concern was expressed by professional staff that assessment in a pressurised, unfamiliar, clinical environment could not give an accurate picture of a service user's full ability and potential. There were worries that while a person may be judged medically fit, they may not yet have made a full recovery from illness. There was a widespread belief that assessment in an acute hospital environment could lead to admissions to institutional care that, with a different approach, might have been avoided. They also felt, for the same reason, that some patients may leave hospital with inflated care packages that could be difficult to reduce at a later date.

16 Hospital Community Interface - Ideas for Change

- Common discharge planning policy and procedures on a multi-disciplinary basis and standardised across all hospital and community Trusts;
- Regular review and update of discharge policies and procedures;
- Increased and meaningful face-to-face contact between staff in hospital and community Trusts at senior management and operational levels;
- Increased use of working arrangements that bridge the interface between hospital and community. For example, discharge co-ordinator, liaison staff etc;
- Making permanent decisions about a person's future care in an acute hospital setting should be avoided wherever possible;
- Hospital staff should have access to budgets for services for people with less complex needs, e.g., home helps, to ensure that service users are not unduly delayed in hospital for minor reasons;
- Improved and speedier communication between hospital consultants and GPs is needed. This should be possible with the better use of electronic mail;
- There should be shared access by hospital and community staff to aids and equipment;
- More focus should be placed on the extent of inappropriate hospital admission and the development of suitable preventative strategies, and
- Increased use of pre-admission screening and assessment for service users facing elective surgery. This is aimed at shortening hospital stay by identifying in advance those service users who will be likely to require additional support on discharge so that planning can begin sooner.

BETTER PRACTICE

Innovative Schemes and Good Practice Models

17 Trusts demonstrated to us a number of schemes and models of innovative practice that they had developed. The majority of these focused on bridging the gap between acute hospital and primary care. Many had been developed using the funding that had been made available to relieve winter pressures on acute care. They included various hospital-at-home schemes, rapid response schemes, intermediate care schemes and rehabilitation schemes. Many were focused on the premise that increased investment in care in the short-term could be more cost-effective in the long-term by:

- Preventing inappropriate admission or re-admissions to hospital;
- Facilitating early discharge and recovery once a person in hospital is medically fit; or
- Preventing admission to institutional care.

The key features of these schemes were:

- Having dedicated multi-disciplinary teams
- Being user focused
- Targeting specific patients
- Having clear admission and discharge criteria
- Setting measurable outcomes

It was argued that these innovative developments offered working examples of best practice that, if developed into core mainstream working, could provide solutions to many of the difficulties that were highlighted during the consultation.

18 The main issue raised by Trusts about these schemes was their non-recurrent funding which had led to stop-start planning arrangements and had resulted in difficulties in recruiting temporary staff to work on these schemes.

Prevention

19 Consultees emphasised the need for a philosophical shift which would re-affirm the value of prevention in the care of older people. They said that in the current climate there had been little focus on the role of prevention, with most efforts focused at the sharp end of provision. Many felt that the end result of this was counterproductive, both in cost terms, and in health and social well-being

outcomes for older people. It was their opinion that, in the long run, screening and early detection of unmet need was the more cost effective option.

- 20 They also pointed out that the vast majority of people being cared for by community care services were not within the formal care management process. There was a strong view that there should be an increased focus on the needs of this group if the issue of prevention was to be seriously tackled. It was suggested that targeting resources on those in most urgent need had led to a decline in support for less complex need, such as the traditional home help service, and that the vital role of these services in prevention should be recognised.
- 21 Consultees believed that if more could be done to develop primary care services less people would need to go into hospital beds for treatment since it was now increasingly possible to deliver quite complex treatment in service users' own home, or in GP surgeries.
- 22 They also stated that supported housing schemes and technological aids had a much greater potential than was presently employed, and their wider use would significantly contribute to preventing the need for more disruptive and expensive forms of institutional care.

Rehabilitation

- 23 Many expressed the view that there was little or no effective rehabilitation for older people, either in the community, or before service users were discharged from hospital. They felt that the effect of recent developments had been to focus professional time disproportionately on assessment activity. They also stated that where rehabilitation is started in hospital it is not generally carried on when service users move into residential or nursing care homes. They said that this wasted the valuable input already made and prevented older people from regaining their full potential. A number supported the view that institutional environments are often "*de-habilitating*" in that they actually lead to increased dependency, loss of individual resilience and ability to cope independently.
- 24 They gave a number of examples of innovative developments that they believed supported the view that investing in rehabilitation in the short to medium term could have considerable long-term benefits in terms of quality of life and cost of care. They claimed that in these cases a significant proportion of service users made good recoveries and were consequently much less dependent on long-term services. One example given of such an innovative community-based rehabilitation scheme was the delivery of person-centred stroke rehabilitation in the service users' own homes following their discharge from hospital.

Other Intermediate Care Schemes

25 Consultees discussed a number of intermediate care schemes which were focused on bridging the gap between acute hospital and primary care. These had also been developed using winter pressures funding. They included various rapid response schemes and step-down arrangements. They believed that these underpinned the idea that increased investment in care in the short-term could lead to more cost-effectiveness in the long-term by:

- Preventing inappropriate admission or re-admission to hospital;
- Facilitating early discharge and recovery once a person in hospital is medically fit, and
- Preventing admission to institutional care.

Evaluation, Research And Sharing Of Good Practice

26 Many examples were cited of new and innovative practice in the area of intermediate care in Northern Ireland. It appeared, however, that these had been developed in isolation. Indeed, frustration was expressed about the lack of sharing, both between Trusts and at regional level. It was claimed that there were few forums or opportunities for staff to share the development of good practice either within or between Trusts, and they welcomed the opportunity given by the consultation workshops to share ideas and concerns.

27 It was stated that there was a general lack of bench marking or evaluation of what works. Although some of these schemes had been evaluated or audited, there was no clear consensus about how this information could be effectively shared.

Sustaining Innovative Developments

28 One particular cause of frustration for health and social care staff was the difficulty of sustaining innovative projects that had been developed with short-term project funding. This was the case for both the statutory and voluntary sectors. Many in the voluntary sector expressed the view that the flourishing independent sector that was envisaged in People First had not developed as intended. They also felt that partnership working was underdeveloped and voluntary sector providers often felt that they were effectively "*sub-contracted*", rather than working in partnership. There were particular concerns from some voluntary sector providers that in certain cases costs were being driven too low to provide care at the quality they would wish.

29 They clearly expressed the view that a way of adequately funding and sustaining schemes that can be shown to work effectively should be found. A strong strategic lead was required to determine if such funding could be released from existing sources, or whether additional, recurrent, funding was required.

30 Better Practice - Ideas for Change

- Collective experience of new, innovative work that has developed should be reviewed to draw out the lessons that could be applied across the board;
- The feasibility of focusing less professional therapy time on assessment, and more into rehabilitation, prevention and treatment, to achieve maximum independence for service users, should be considered;
- New and innovative practice should be evaluated and audited on a more regular and widespread basis.
- Opportunities for sharing of good practice should be increased;
- When examining good practice there should be an emphasis on comparative costs and resources, avoiding duplication and ensuring consistency;
- Effective means of rolling out and mainstreaming successful working models of practice must be found;
- The current patchy and stop-start provision of funding should be addressed;
- Access to, and choice of, opportunities for prevention, rehabilitation and recovery to all people who can avail of them, irrespective of age and disability, should be increased, and
- Partnership with the independent sector should be given further investment and development.

RESOURCING COMMUNITY CARE

Funding Uncertainties

- 31 Widespread concern was expressed that the funding available to the community care system to cope with the present needs of service users was already insufficient and that this was likely to be compounded in the future by increased demand and expectations from the public.
- 32 Explanations were given as to why resources are currently under pressure. Primarily, they said, that since the outset of the community care reforms in 1993 the predicted turnover in care had not been as high as had been expected. They said that this was because the average life expectancy of service users receiving community care was now significantly longer than the average of three years anticipated in 1993. This meant that the total number of people needing support at any one time tended to be significantly higher than first predicted. They believed that there were other factors that led to increased pressures on community care systems, such as the reduction in acute sector beds that had occurred. Another explanation put forward was that, since "*preserved rights*" monies were not recycled into the community care budget, this effectively meant a decrease in the resources available.
- 33 They also believed that costs had risen in other ways not anticipated at the outset of the 1993 reforms. As well as the implications of changes in the labour market, which had already been raised, they drew attention to the SSI report, 'Review of Community Care'. They stated that more attention should be paid to what it had to say on the impact of recent changes in pay and working conditions such as the minimum wage, the working time directive, and increased public sector pay awards.
- 34 Other cost increases cited were those associated with increased regulation, such as the guidance on lifting and handling. They said that these had added substantially to the cost of care packages. They also said that there would be additional costs associated with the pending regulation of the social care workforce.
- 35 In every consultation session with staff, three areas emerged where resource difficulties are giving particular cause for concern and seen as needing urgent attention:
- Recruitment and retention of skilled care staff;
 - Supply of private sector bed places, and
 - Supply of aids to daily living and housing adaptations.

Recruitment And Retention Of Skilled Care Staff

- 36 Attention was repeatedly drawn to the often very poor pay and conditions still experienced by many frontline care workers. As one participant stated, *"Why would someone go out on a cold winter's night for two hours to drive through icy country lanes for half-an-hours pay?"* Managers reported that this situation had been further exacerbated by the growth within other sectors of the economy, for example, in the retail sector, with supermarkets often offering much better pay and conditions for easier, less stressful jobs. It appeared that this problem was worse in rural areas with their higher travel costs. It was stated that this high turnover of staff meant that there were often many workers, some new and inexperienced, involved with an individual service user and this made it difficult to provide continuous quality care. Managers felt that these issues needed to be tackled urgently and that care workers should be more highly valued and better rewarded both by employers and by society.
- 37 While recruitment and retention of staff was a general issue across all grades of staff, we were told that there was a definite lack of skilled staff to carry out assessments, treatment and rehabilitation. There was a widespread feeling that there needed to be improved long-term planning to tackle these issues based on realistic predictions of the future need for care staff.
- 39 Consultees believed that there was scope for improved efficiencies in this area and they drew attention to the potential duplication of effort arising from systems and structures they believed to be overly complex. They expressed a firm view that there was room for improvement in the general skills mix, in particular with the better targeting and sharing of the time and expertise of skilled specialist staff. It was stated that streamlining of systems and structures and development of new ways of working were required to make all this possible and that this would require a strong strategic lead. Without this, they said, the scope for local improvement remained very limited.

Independent Beds

- 40 The independent sector indicated that they were fast approaching a time when the residential and nursing home business would no longer be profitable. Although it had been argued by others that this sector is over used, they told us that that demand for their services is still growing. They discussed whether this situation might not provide an opportunity to develop a new service for older people, in partnership with the independent sector, which would enable a shift of emphasis from residential accommodation to rehabilitation and prevention. The main points the private sector representatives made were that:

- The independent sector had not been fully involved as equal partners in the development of community care;
 - Their relationship with the statutory sector had become quite strained, and
 - The contract prices for basic levels of care needed to be agreed.
- 41 Many of the staff consulted were deeply concerned about the decline in availability of independent sector beds. They reported that demand was beginning to outstrip supply in some areas, with particular problems emerging in the supply of EMI beds. While staff accepted that the use of nursing home and residential beds in Northern Ireland is still relatively high compared to usage in Great Britain and the rest of Ireland, there was some feeling that this difficulty had arisen here because there had been insufficient growth of alternatives to nursing home and residential care.
- 42 Consultees said that there was a need to provide more choice and diversity in future arrangements, including more use of rehabilitation in nursing and residential settings. They recognised that independence would be at the centre of future practice development. However, it was their expectation that in all likelihood there would continue to be significant numbers of frail people who would continue to need considerable support. They believed that a wider range of supported living situations should be developed which would give better choices for frail older people.
- 43 Another view expressed was the need for more transparency in the actual cost of provision of private care. Other consultees said that there needed to be better working arrangements between the statutory and independent sectors, with clearer arrangements about what the private sector was expected to provide, and how much they would be paid for it. There was broad agreement on the scope for improved working relationships and sharing of expertise.

Equipment And Housing Adaptations

- 44 In talking to Trusts, widespread variations in arrangements for housing adaptations were revealed. Evidence offered showed that in many areas, while minor work was not an issue, major work could be slow and fraught with bureaucracy. Examples were cited where, apparently, on a number of occasions, the service user was placed in residential care before the home adaptation was completed.
- 45 It also appeared that in many areas there are long waiting lists for equipment. Instances were reported where service users were delayed in hospital while waiting for relatively small and inexpensive items. This situation was apparently

exacerbated in areas where there was no distinction made in the waiting lists between small and large pieces of equipment.

- 46 Another problem reported was the ever-faster development of newer, more modern appliances. This meant equipment becomes obsolete faster, further increasing overall equipment costs. Desirable "*state of the art*" equipment was reported as being increasingly costly, subjecting funding to even greater pressures.
- 47 Particular concern was expressed that, once purchased, equipment is frequently not adequately tracked and that expensive pieces of equipment that had ceased to be required by the service users to whom they had been allocated were often lost in this way.

- A planned approach to the resourcing of community care should be developed which would allow key decisions to be made now about how the future needs should be resourced;
- It should be implicitly recognised when resource planning that good quality care is expensive. It should also be recognised that providing poor quality care is even more expensive;
- The issue of increasing costs should be addressed, in relation to:
 - The upward trend in demand for community care services;
 - The pressure for improved pay and conditions for care staff, and
 - The new costs associated with regulation and training needs.
- It should be recognised that better management of resources is needed in terms of:
 - Workforce planning;
 - Better targeting of expensive professional time and more appropriate use of skill mix, and
 - More efficient systems for tracking equipment.
- The position of the private sector vis-a-vis costs, profitability and increased demand for managing more complex care should be reviewed, and
- More choice should be offered to service users through the development of a wider range of supported care options.

MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

- 49 It appeared that there were considerable variations in the arrangements for multi-disciplinary and multi-agency working. Attention was frequently drawn to the demise of collaborative working. Consultees said that this was as a result of the development of the competitive market based culture that had been encouraged in the delivery of public sector services through the late 1980s and part of the 1990s.

- 50 Managers and staff said that at a strategic level they would like to see improved working and collaboration between the following:
- Government Departments;
 - Professional disciplines;
 - Trusts;
 - Hospital and Community based staff;
 - Statutory sector and the voluntary and community sectors; and
 - Statutory sector and the private sector.
- 51 Managers believed that at an operational level there was often relatively successful collaboration, especially where staff had good day-to-day working relationships. They also believed that effective community care needed dedicated multi-disciplinary teams and gave a number of good working examples where multi-disciplinary teams, based in primary care settings, were working well. However, they also said that there were still too many barriers in place. A number of those consulted expressed the view that there was insufficient integrated team working. They believed that in some areas there was still a uni-discipline team culture, and situations with multi-disciplinary working "*getting lip service only*". They believed that cultural and attitudinal change was required, otherwise professional jealousy and competition would continue to undermine care provision.
- 52 A note of caution was also sounded about the extent to which we actually have a specialised and professionalised care service. Some said that this sometimes "*fragmented*" care delivery and worked against a "*holistic*", person-centred, approach. They believed that it was important that individual service users should not be "*bombarded*" by too many professionals and that there should be collective staff agreement on the key personnel who would interact directly with service users. They also said that it was vital that service users should be at the centre of goal setting in regard to their own care plans and that this should not be taken over by professionals. Otherwise, they said, there was a risk that professionals might have differing goals and perspectives, either from each other or from the service user.

53 Multi-disciplinary and Multi-agency Working - Ideas for change

- There should be a cultural shift towards more collaborative working;
- Approaches should be encouraged that ensure lack of duplication through development of closer links;
- The use of common assessment tools amongst professions should be encouraged, and
- There should be an increase in the use of person centred approaches, where service users set goals in consultation with profession staff.

MEDICINES MANAGEMENT

54 A number of issues around the area of medicines management surfaced during the consultation. Concerns were expressed about the following issues:

- Service users and informal carers were often confused about medicines and when they should be taken;
- Undesirable side effects and inappropriate use of medicines were major factors leading to increased admissions to hospital and increased risk of falls;
- Ineffective systems for reviewing medicines led to "*polypharmacy*", and
- The difficulty of obtaining drugs out of hours, particularly for palliative care.

They stated that more effective medicines management should have an enormous impact in cost savings and improved quality of life, reduction in falls, and inappropriate admissions due to side effects.

55 There was a strong view amongst those consulted that pharmacists, particularly community pharmacists, had an important role to play in improving medicines management. This requirement appeared to exist not only at primary care level, but also in residential homes, nursing homes and domiciliary care situations, and also at the hospital-community interface. Our attention was drawn to a wide body of evidence based on recent research in this area which should be taken into account if the need for improved medicines management is being looked at.

56 As well as identifying a role for the increased involvement of community pharmacists in community care, we heard expressed the general need for a higher awareness of these issues to be achieved right across the care spectrum, including qualified and unqualified health and social care staff, service users, carers and the general public.

57 Medicines Management - Ideas for Change

- Increasing involvement of community pharmacy in primary and community care systems;
- Increasing awareness of the issues around medicines management across all staff;
- Making medicines review a routine part of the care review process, especially for older people and those in residential and nursing settings;
- Updating repeat prescribing systems and dispensing repeat prescriptions monthly, rather than three monthly, to increase review and decrease medicines wastage;
- Educating and training of carers on the safe use and administration of medicines;
- Improving hospital admission and discharge arrangements with routine medicines review;
- Giving better information and advice to patients and/or before hospital discharge, and
- Giving consideration to increasing the current three day prescribing period at discharge as an increased convenience for people leaving hospital and their carers.

STRUCTURES AND SYSTEMS

- 58 Some participants in the workshops felt that overall there were simply too many Trusts. Others argued forcefully that there was a need for a more common focus on community care across all Trusts, and particularly between hospital and community Trusts. It was reported that there were considerable variations both in working arrangements and in the extent of collaboration between community and hospital trusts. It was also made plain that the continuing competition for scarce resources led to a lack of collaboration and that those in the community sector often felt that excessive resources are targeted at acute provision.
- 59 Consultees said that within community Trusts the relationship between primary and community care, care management, conventional services and programmes of care is subject to complicated systems and structures. Some expressed the view that differences in multi-disciplinary and single-disciplinary practices between Trusts often added to this complicated situation. It was also made clear that the sheer number of systems, and the many interfaces between them, often present difficulties for service users and for those who are attempting to support them.
- 60 There was a general opinion that there was a great deal of scope to simplify the bureaucracy and paperwork that accompanies the different arrangements in working practices, policies and procedures. They believed that all this resulted in unnecessary pressure on staff time. One idea that surfaced frequently during these discussions was the idea of moving towards a standardised assessment tool.
- 61 They also identified communication systems as having considerable scope for rationalisation and simplification. In particular, they saw shared information systems as highly desirable. One popular view expressed identified a core problem as *"IT systems which don't talk to each other and professionals who don't talk to each other"*.

62 Structures and Systems - Ideas for Change

- Communication between professionals and between systems, particularly IT systems, should be improved:
- There should be further development of approaches to improve integration and reduce duplication, such as one-stop shops, joint working between hospitals and communities, and service-user held records;
- Service users should be provided with information describing the structures and systems in place and detailing the range of community care services potentially available to them;
- There should be more use of regional approaches in terms of development of practice and procedures for working;
- Staff should be encouraged to work in collaborative, rather than competitive ways, and
- There should be rationalisation to reduce the number of systems and structures that exist.

CARE MANAGEMENT PROCESSES

- 63 Considerable concern was expressed that care management had not developed in the way that was originally envisaged whereby service users would be offered greater choice and access to innovative care options. Consultees said that there was too much emphasis on assessment activity and discharge from hospital and that this led to a strong focus on residential and nursing home solutions. They saw this as creating perverse incentives within the systems which resulted in most placements becoming long-term. It was claimed that if review was not timely or meaningful – which was often not the case – then the decisions made rarely change so that, even if the user initially had the potential to return home, most people did not move out of care again.
- 64 We were told that large caseloads meant staff did not always know clients well enough with, in some cases, perhaps only one visit per year. They said that at times care management and its associated underdevelopment of real alternatives to residential and nursing care was driving a culture of dependency rather than independence. They forcefully put to us that the current system was

maintaining and accommodating service users, doing things "to them" and "for them" rather than with them.

65 Developing this theme, some consultees highlighted the emphasis on giving priority to people with complex needs. This tendency, they alleged, had now become disproportionate. Participants often expressed concern that the emphasis and priority on complex needs resulted in borderline service users being pushed into the "*complex category*" in order to receive a service. They said that this was because the system had become service-led rather than person-centred, resulting in assessments that were too mechanical and clinical. This was, they said, because the model of care provision that dominated was medical rather than social.

66 Care Management Processes - Ideas for Change

- Common assessment tools should be developed;
- The balance between demand and resources should be fundamentally reviewed;
- There should be a move in emphasis from assessment towards increased use of review;
- More intermediate care options should be developed;
- There should be investment in those approaches which, although more expensive in the short-term, are more cost effective in the long-term;
- A wider range of innovative care options should be developed, and
- There should be an increased use of Direct Payments.

BUDGETS

67 A particular issue raised by participants during the consultation was the inflexibility of budgets. An example quoted was where Trusts' budgets for institutional care and domiciliary care were separate and inflexible. It appeared that under this system the numbers who stay at home and the numbers who go

into care are pre-determined in the budget allocation. The general view was that, overall, domiciliary care is under funded.

- 68 It was also reported that when speed of hospital discharge became the main performance indicator, tensions could surface between hospital and community staff over budgetary issues, with each tending to feel that the other is placing pressure on their budget. Consultees said that there were considerable variations in practice, with some areas giving total priority to service users seen as at risk in the community while others give their priority to those being discharged from hospital.
- 69 They also believed that financial and budgetary incentives worked against the development of alternatives to institutional care. Since moving service users into residential and nursing home settings can be charged for, unlike domiciliary care which is free, some said that this was creating a perverse incentive to do the former. They also pointed out a tendency for formal, or informal capping of domiciliary care costs by Trusts as a response to financial pressures.

70 Budgets - Ideas for Change

- There should be more flexibility in budgets to facilitate greater innovation and creativity in response to need;
- Alongside increased flexibility there should be a degree of ring fencing, especially for new money or finance, that can be easily "raided" to pay for overspends elsewhere;
- There should be clear guidance in specific areas about who pays for what, for example, non-drug tariff items;
- There should be some funding that could be spent very flexibly to alleviate unforeseen difficulties that are causing major delays;
- Additional funding should be made available to pump-prime innovative work, and
- Long-term funding streams should be identified to sustain and mainstream new approaches, either through new resources or re-allocated resources.

CHARGING POLICIES AND USE OF SOCIAL SECURITY BENEFITS

- 71 A widespread view was that there were untapped sources of funding already in the system in terms of service user contributions. They debated existing charging policies and focused on the use, or non-use, of relevant social security benefits in purchasing care, such as Disability Living Allowance (Care Component) and Attendance Allowance,
- 72 Their discussion around these issues confirmed that it was a difficult and controversial area and the debate revealed that very disparate views were held. There appeared to be widespread uncertainty over present legislation and policy. It was also clear that not all participants were aware of the Departmental guidance that already exists in the area of Disability Living Allowance and Attendance Allowance. While others seemed aware of it, some of them clearly disagreed with it.
- 73 They also discussed the use of Direct Payments. Some of the consultees saw this as generally underdeveloped and a potential alternative source of funding for innovative service development. Others saw it as a barrier to further development, citing issues around infrastructural support for service users.
- 74 It was stated that since residential care is subject to means assessment, while the bulk of domiciliary care is provided free of charge irrespective of income, this situation led to inequity between those who go into care and those who stay at home. They suggested that, in some instances, formal or informal capping takes place in terms of the cost of domiciliary care once it exceeds the cost of residential or nursing care. They made the criticism that those who cannot afford to buy extra help are disadvantaged over more wealthy service users who can afford to pay. Some also commented on other anomalies, such as the inability of Trusts to charge for services where service users had received high compensation claims, part of which have been based on their care needs.

75 Charging Policies and Use of Social Security Benefits - Ideas for Change

- Steps should be taken to ensure that existing guidance to Disability Living Allowance and Attendance Allowance which has already been clarified, is widely known, and
- There should be continued support for development of Direct Payments and the necessary infrastructure to support this.
- There should be a review of charging policy, with particular reference to work already completed by the Department in 1997;

STRATEGIC PLANNING AND DIRECTION

- 76 Consultees were still in broad agreement with the original vision for community care, which had the development of choice and independence for service users at its core. However, there was also a strongly held view that service development was not always driven by this vision and that managers at local level were often struggling to develop services without clear direction. They believed that there was a need for improved strategic planning and direction to replace approaches that are based on crisis management and reactive working. They said that staff and managers often felt that they could not *"get their heads above water"*.
- 77 Across the board they expressed a definite view that the Community Care policy needed to be looked at again, especially given that it was ten years since 'People First' was produced. Many believed that policy and planning had not been sufficiently evaluated to take account of actual experience and that this contributed, to some extent, to the resource problems that have subsequently emerged. They said that it must be recognised that costs have risen in ways that could not have been anticipated at the outset of the policy and they instanced unforeseen economic, legislative and demographic changes during the intervening years.
- 78 They said that in a climate where it was known that the pressures over the next ten years were certain to increase, the Community Care Review needed to develop a strong regional vision and strategy for the future and that the Department should take the lead in this. They also said that all future strategic planning in community care needed to adopt a multi-professional, user-centred, and collaborative approach.

79 Strategic Planning and Direction - Ideas for Change

- There should be a review of the existing community care policy to give a new, up-to-date vision for community care, taking into account changes in the policy and legislative climate, new best practice and the vast body of experience that has been gained in recent years both within Northern Ireland and beyond;
- Links should be made to ensure that the interim findings of the community care review are taken into account in the development of the new Regional Strategy. Links should also be made between the review of community care and other recent reviews such as the Acute Hospitals Review and the 'Way Forward' consultation report on Primary Care;
- Mechanisms should be developed to give a strong regional lead to the future development of community care;
- Targets and performance indicators for community care should be linked to the revised vision for community care, and
- Full consideration should be given to resource implications when developing future strategy.

OTHER KEY ISSUES

80 During the consultation workshops consultees repeatedly raised three other important issues. Although they did not develop these in-depth, they made it clear that they regarded these as vital issues which they felt must be picked up and developed more comprehensively as part of the review and any subsequent consultation work that takes place. These three issues were:

- Quality assurance;
- Equality; and
- Involving people and communities.

Quality Assurance

81 During the consultation workshops participants raised a number of issues about Quality Assurance. They said that:

- In a situation where resources are constantly under pressure and over-stretched, the aspiration to deliver high quality community care services was constantly being undermined.
- There was a need for improved staff development, training and supervision, particularly where there was a high turnover of unqualified staff working at first-hand with service users.
- There was a need for improved regulation of aspects of the service, although it was acknowledged that, to some extent, this was being picked up through the improvements for regulation of the social care workforce that are already underway.
- There was a need for clear regional standards for community care provision. They felt that although much work had already been done in this area it needed to be given a much higher profile.
- The National Service Framework for Older People, whilst not adopted here, may provide a valuable source to be drawn on for further development of local standards.

82 A particular debate that was raised in many consultation sessions was the difficulty that existed with regard to risk-taking in an increasingly regulated working environment. In general, experienced staff held the view that there needed to be an accepted degree of risk taking if older people are to be allowed a reasonable quality of life. Many believed that they were working in a "blame culture" with an increasing likelihood of litigation if they were to get it wrong. They frequently expressed the view that ways needed to be found to allow older people to take risks, if that is what they desire, in order to maintain a reasonable quality of life. They said that there was a need to move from a "*blame*" to a "*learning*" or "*educative*" culture.

Equality

83 Consultees raised a number of issues in regard to inequalities that they believed existed within the present system. They said that these would need to be tackled in light of the current statutory equality duties on service providers. Highlighting the need to ensure that all future community care policy and practice development takes equality fully into account they said that:

- The equity issue in funding arrangements between Trusts has not been fully addressed and this has led to unacceptable differences in the range and level of services available across Trusts' areas.
- The different priorities and different eligibility criteria that exist between Trusts means that service users in different Trust areas experience inequalities in provision.
- There are particular equity difficulties in regard to rural areas, since it can be easier and cheaper to develop innovative provision in urban areas where staff supply is better and economies of scale are more possible.
- In our society general attitudes to ageing and elderly care are often negative or subject to ageism and that, as a consequence, many older people experience considerable social exclusion from everyday life.
- Older people are often less vocal or radical than other groups of service users and some are unlikely, or simply unable, because of disability or isolation, to participate in consultation. There is a need to address these missing voices in any consultation work.

Involving People And Communities

84 Consultees saw a pressing need for involving service users, carers and communities in the improvement of care policy and delivery. They said that:

- There was a need for a more person-centred approach to the care of older people.
- Although service user and carer involvement are vital to future planning and policy development, we do not know enough about what older people want.
- There has been less capacity building for involvement of older people than in other groups of service users.
- As people become older their care seems to be increasingly located in a medical model of care. This needs to be redressed and it should be acknowledged that older people do not wish to be viewed solely in the context of their health status, but as adult human beings with the same emotions and feelings as younger, fitter people.

- Carers' needs should always be considered in service provision and planning and, in particular, the needs of the growing number of older carers need to be heard.
- At community level participation and involvement is still underdeveloped and there was concern that we are often not listening to communities. In part this was attributed to a system that is still driven by a strong medical model, whereby "professionals know best".
- Consumer expectation amongst younger age groups is rising. In the future, as they age, there will be increased numbers of older people requiring care and these people will demand higher standards. There was a need for a debate about how younger people could be encouraged to make better plans for their own old age.

SECTION 4

THE CONSULTATION PROCESS – OUR RESPONSE

- 1 The members of the Project Board have carefully considered what was said during the consultation process. While much of what we were told was not supported by direct evidence, from our collective experience of community care, and from the variety of information sources that we do have access to, it seems to us indisputable that significant weight must be attached to the comments and criticisms we have received to date.
- 2 Before we give our response we wish to take this chance to express our admiration and support for those who endeavour and, to a remarkable degree in difficult circumstances succeed, in delivering community care services to those in need.
- 3 While Community Care has had some successes, as evidenced in many SSI Inspections, the pressures that impact on community care, rising expectations, demographics, funding conflicts, and inter-agency and inter-disciplinary failures are indisputable and well rehearsed. We recognise that these pressures will continue to intensify in the future.
- 4 In starting the second phase of this work we believe that a systemic review of the community care services should have, at its core, a re-evaluation of the 'People First' policy. While there was a clearly expressed opinion that the objectives of 'People First' remain valid and desirable, there was considerable disquiet about the way in which they had been implemented over the last seven or eight years. Indeed there was a view that as we have moved into the new Millennium, and given the major changes being considered in other areas of the Health and Social Services system, it would be wrong if this opportunity to revisit 'People First' was not taken.
- 5 How we would propose to take this work forward is the purpose of the next two sections. In the remainder of this section we give a summary of our response to the issues raised in the consultation and attempt under the headings used during the consultation, to present our view of what the problems are and what needs to be done to deal with them.

The Hospital/Community Interface

- 6 We agree that the community care system works best where there is face-to-face contact amongst hospital and community staff, with a shared commitment to common goals and procedures. However, there are obviously significant variations in how individual delivery systems work in practice and much could be done to improve integrated patterns of working across hospital/community interfaces.

Better Practice

- 7 Good practice, improved standards and innovation should be the cornerstones of a developing community care service in a changing environment. There are many excellent examples of new schemes and approaches, the initial findings from the vast majority indicate positive outputs and outcomes. However, we noted that few have been independently audited. Many of these are small in scale and many are subject to short-term funding arrangements. There are no obvious mechanisms to publicise and, where appropriate, roll out these schemes regionally. We feel the service is severely inhibited by the failure to share good practice among Trusts, which have very few opportunities for staff to share the development of good practice. The Department and Trusts need to establish mechanisms and processes to remove these barriers.
- 8 Preventative services, targeted at those at risk, should make it possible to maintain people in their own homes for longer. There is a clear need to begin to identify, evaluate and promote schemes which are not simply crisis interventions, but involve a more long-term approach to identifying people at risk and supporting them before they require crisis interventions.
- 9 Rehabilitation is fundamental to enabling older people to recover from illness or accident and to continue to enjoy the later stages of life. The consultation process confirmed our view that effective rehabilitation can help people stay at home, provide a direct alternative to hospital, facilitate early discharge and reduce readmission to hospital. We share the widely expressed concern that the balance has shifted from rehabilitation to maintenance. There is also evidence of a reluctance to put in intensive help in the early stages of a person's return home in case they become dependent on this. However, if an older person was able to receive adequate help on discharge this could facilitate their rehabilitation. There are many examples of innovative schemes based on a rehabilitation model and we must ensure that steps are taken to redress this imbalance. We need to initiate a process that will benchmark models of good practice to ensure there is sound evidence that schemes are achieving their desired outcomes, and then ensure that this good practice is rolled out.

- 10 The contribution carers make towards helping people remain in their own homes and staying independent cannot be over stated. This level of service could not be delivered by the formal care system and this important fact should be recognised and supported. We need to think of ways in which the system can recognise the valuable role of carers and provide more comprehensive support for them. In considering this issue, we will need to work closely with the development of the Carer's Strategy.

Resourcing Community Care

- 11 We accept that the resourcing of Community Care is highly problematic, with a number of prominent pressure points. For instance, the cost of domiciliary care packages has risen sharply, due mainly to the increasing complexity of care packages and the introduction of new working rules. Additionally, the terms and conditions for domiciliary care employment have become uncompetitive with other sectors of the economy, causing acute recruitment and retention problems. We also accept, with some concern, that there has been a decline in the availability of independent sector beds, even though we note that the use of nursing home and residential beds in Northern Ireland is still relatively high compared to usage elsewhere in the UK. Finally, we recognise that waiting lists for equipment and housing adaptations are increasing and, in some instances, this is contributing to delaying discharge from hospital. We accept that there are further problems surrounding retrieval of re-usable equipment and meeting the demand for "state of the art" equipment.
- 12 A principal objective of "People First" was that older people should receive services to enable them to live as full and independent a life as possible within their own homes. There has been a decline in the ratio of people receiving care packages in their own home, compared to people receiving care in residential or nursing homes. Where users are receiving care at home, it is often inadequate in quantity and unsatisfactory in quality. However, we believe that at this time we do not have a comprehensive explanation of why this is happening. This issue must be properly explored so that meaningful proposals to effectively reverse the trend can be developed.
- 13 The availability of a well-trained and committed workforce is obviously essential if both the volume and quality of care services are to be increased from current levels. The sector is labour intensive and will remain so, in spite of some technological advances. Furthermore, labour market trends suggest that today's problems will be exacerbated in the future as women become better qualified and therefore less likely to fill the gaps left in the service by retirements. Any planned expansion in the service will worsen this position. To rectify the

situation we need first to accurately establish the scale of this problem by working closely with the DHSSPS Workforce Planning project.

- 14 We acknowledge that there are obvious problems in the provision of residential and nursing home places, which are overprovided in some areas and underprovided in others. We also accept that there is a trend to rely on nursing home provision rather than domiciliary care. The current residential and nursing home provision needs to change to provide a wider range of services to meet increasingly complex need. We know that the independent sector has a valuable role to play in the provision of community care to people who can no longer remain in their own home. We must work with the independent sector to determine how the residential and nursing home market is currently operating and identify what changes are required to bring greater confidence and stability into this sector.

Multi-Disciplinary and Multi-Agency Working

- 15 Multi-disciplinary and inter-agency working has long been recognised as the best way of delivering good community care to older people. It is also clear that such professional collaboration is optimised where staff have close day-to-day working relationships. We believe that while multi-disciplinary teams based in primary care settings are often working well, there are still many barriers to overcome. Indeed, overall, it is our view that there is insufficient integrated team working within the system. We need to ensure a better skills mix in community care provision. There should be an evaluation to determine whether dedicated multi-disciplinary teams have better outcomes for service users than the traditional uni-disciplinary approach and to identify transferable models of good integrated team working.

Medicines Management

- 16 We accept that medicine related problems are frequently encountered in the delivery of community care and that there are particular needs for carers and patients in residential and nursing homes. Effective medicine management strategies should form an integral part of community care provision. We learnt that there were many examples of innovative practice already in place and that we need to explore the introduction of integrated management systems, in particular the role of community pharmacists in community care. This could best be done in conjunction with the planned Community Pharmacy Strategy.

Structures And Systems

- 17 We need to consider seriously the potential for rationalisation of the overall community care management, both between and within Trusts, looking to simplify where possible. We also need to look at the existing communication systems with a view to rationalising and simplifying them, and, where possible, to develop new systems which can readily pool and exchange information. This is particularly important when we are developing a more accurate way of recording unmet need.

Care Management Processes

- 18 We heard and sympathised with the view that care management has contributed to a service-led rather than person-centred service, with the result that assessments are often too mechanical and clinical. The concern that the system does not offer appropriate choice and often fails to identify an appropriate "*exit*" point for users seems to us well-founded. We recognise that the system may be creating perverse incentives leading to inappropriate long-term solutions. In practice, this results in too much focus on residential and nursing homes. We also accepted that there was a tendency for border-line service users to be pushed into the "*complex*" category in order that they might access care management. This tendency highlighted the fact that assessments and services are targeted at those with most complex needs while those with less complex needs are often left without service. We are also concerned that the present system of service delivery has led to inequity. There is some evidence to support the view that the level and type of service can very much depend on your geographical area or postcode.

Budgets

- 19 We know that people are living longer and that the costs of community care are rising. Good quality community care is expensive and costs are increasing at a rapid rate and, while there are a lot of very positive developments taking place to improve services for older people, these also cost money. There was an understandable demand for community care budgets to be ring-fenced or protected.
- 20 Currently there are a number of funding sources underpinning community care and it is not always clear how these are spent. We need to examine the current use of resources from all funding streams, core funding, People First funding, Belfast Regeneration Office, and European funding including Peace monies. We will also need to consider the level of personal funding by individuals and the

independent sector. Finally, any future work in this area should be linked to the current Needs and Effectiveness study.

Charging Policies

- 21 It seems sensible to us that, where it is appropriate and fair, Social Security benefits should be used to complement the objectives of Community Care policy. We need to develop ways in which this can be done, in a manner that is equitable and non-discriminatory. We see a need to revisit our existing charging policies to help achieve this outcome.

Strategic Planning and Direction

- 22 Community Care needs a strategic vision that all sectors can give commitment to and feel ownership of, and which could be the driver for collaborative practice across the service sectors. To ensure that it is given appropriate priority throughout the service it will need to be clearly expressed and presented. We will require a clear understanding of current provision, its trends, projections and resources. We will also need to identify all gaps, deficiencies, and duplications to develop such a Strategy. It needs a firm understanding of the service's priorities and the implications for funding of the expected growth in services. We, therefore, need to examine current service provision to form a comprehensive and evidenced picture of how services are currently planned and delivered, how they have changed, and how they need to be developed to meet local needs and circumstances.

User involvement

- 23 We know service user and carer involvement are vital to future planning and policy development. However, we accept we do not know enough about what older people want. We also accept that older people are often not given enough information to make informed choices. Information is quite often restricted to a generic leaflet which many older people find difficult to understand. There is a need for simpler and more personalised information exchange within the community care system.

SECTION 5

SHORT-TERM IMPROVEMENTS

- 1 This section aims to identify areas in the community care service where there is room for real and immediate improvement. It identifies and describes examples of schemes and innovative practice that the Project Board believes could, if implemented in a pragmatic and evolutionary way, enable Boards and Trusts to have a realistic and positive impact throughout the service.

Innovative Schemes And Models

- 2 The review highlighted that there are now very many good working examples of new and innovative practices in the area of community care. However, the extent to which most of these have been developed in isolation is striking. Staff frequently expressed frustration at the lack of sharing that occurs between Trusts and at the regional level. Many believe this is a by-product of the competitive environment within which Trusts previously operated. As a result there are few opportunities for staff to share the development of good practice, either within or between Trusts.
- 3 Trusts will be actively encouraged to work collaboratively with each other to share learning and develop new ways of working which will help shape the future strategic direction of community care. The Project Board recognised that some of the schemes and practices cited in this report may not have been independently evaluated or scrutinised to the extent that they would have wished.
- 4 The section will report under the following headings:
 - (A) Strategic Planning And Direction
 - (B) Integrated Health And Social Care
 - (C) Hospital/Community Interface
 - (D) Hospital Discharge Arrangements
 - (E) Rehabilitation Approaches
 - (F) Involving Users And Communities
 - (G) Providing Support For Carers

 - (H) Medicines Management
 - (I) Independent Sector Provision
 - (J) Human Resource Planning
 - (K) Equality

(A) STRATEGIC PLANNING AND DIRECTION

- 5 It is clear that we need to look again at the Community Care policy in the light of the ten years experience since the "People First" policy was introduced. There is evidence that the implementation of the policy has not been sufficiently reviewed in recent years to reflect the actual experience and practice on the ground. This lack of strategic planning and direction has contributed to approaches that are sometimes based on crisis management and reactive working and have, in the view of many, contributed to some of the difficulties service users are experiencing. Trusts, voluntary organisations and professionals on the ground have responded to these difficulties with a variety of innovative schemes and practice designed to meet their local needs. While some of these schemes have yet to be independently evaluated and verified, there is already some evidence to suggest they can provide a basis for deciding what future community care should look like.
- 6 The Community Care Project Board has therefore formed the view that the Department should now give a strong regional lead in the future development of community care provision. This requires a long-term planning process which reflects the needs of the population as it is now, and takes on board the changes that have occurred during the last decade. Only then can the Department, Boards, Trusts and professionals begin working collectively towards implementing a modern, shared vision for community care.
- 7 There is an awareness that effectively shaping an "integrated" approach to community care will involve ensuring the review establishes a close alignment with the prospective developments within primary care and the acute hospitals sector. Evidence gathered during the consultation process suggests the design and development of a vision and regional strategy for community care should be based on the following principles:
 - Future strategic planning in community care needs to adopt a multiprofessional, user-centred, collaborative approach;
 - Promotion of inclusion, independence and helping users realise their potential as the drivers of strategic thinking;
 - An integrated vision for secondary, primary and community care is essential; Strategic planning needs to be bottom up as well as top down;
 - Users and communities need to be centrally involved in the development of a modern vision for community care;
 - All Government Departments need to be involved in creating a healthier population using the widest definition of health;

- The statutory, voluntary and independent sector all have significant and integral roles to play in the development of regional community care vision and strategy; and
- All new strategy and subsequent policy should be developed with regard to issues around equality, discrimination, inclusion and human rights.

Recommendation

- 8 A review of the existing community care policy is required to give a new, up-to-date vision for community care which takes into account changes in the policy and legislative climate, new best practice and the cumulative body of experience that has been built up over recent years.

Action

- 9 The next phase of the community care review will revisit the objectives of "People First", with the aim of developing a new community care vision based on the principles identified above. This phase will use as its starting point the many examples of good practice already identified during the first phase. Attention will be paid to building a seamless service, with proper linkages between primary, secondary and community care. It will develop effective partnerships with other public sector bodies, Government Departments and with the independent sector which has a unique contribution to make in addressing individual and community expectations. The overall goal is to develop a new vision that uses innovative and creative ways of working for the benefit of the community.

(B) INTEGRATED HEALTH AND SOCIAL CARE

- 10 Although Health and Social Services have been the responsibility of a single Department since 1973, the review has found evidence that in many Trusts separate systems of primary health care and community care have been maintained. This has reduced the seamlessness of the service and at times has led to duplication of effort. It is clear people requiring community care have a diversity of needs which require a diversity of responses from across the spectrum of Health and Social Services. In order that the best outcomes can be achieved for service users and carers we need an informed approach to service commissioning, development and delivery, which results in the appropriate skills mix. The review's findings confirm that the current skills mix, at all levels, requires review and re-engineering.

Recommendation

- 11 An integrated and multi-disciplinary approach to community care delivery is required, involving improved working and collaboration between the:
- Professional disciplines within Trusts;
 - Hospital and community based staff;
 - Statutory sector and the voluntary and community sectors; and
 - Statutory sector and the independent sector.

The next phase of the community care review will explore ways in which multi-disciplinary and collaborative working can be improved. One of the projects proposed will look specifically at the prospect of developing common assessment tools to ensure a holistic approach, encouraging person centred care, where goals will be set by service users in consultation with professional staff.

Immediate action

- 12 Trusts should begin to identify models designed to reduce the number of interfaces a user has to negotiate after initial contact with the community/ primary care service. They should explore models of integrated primary health and social care teams appropriate to their local infrastructure and needs. Once established, these multi-disciplinary, integrated teams will then require considerable capacity /team building to ensure that professionals are empowered to work in a more collaborative way. Down Lisburn Trust have developed such a model, which other Trusts may find a useful starting point.

13 An Integrated Primary Health And Social Care Model: Down Lisburn Trust

Down Lisburn Trust have put forward a model of working that could be used as a template for more effective and accessible community care. The model involves Primary Care Teams, encompassing health and social care practitioners, built around common groups of service users. Teams are organised around GP practice lists as a common group of clients and patients and include the GP, district nurses, social workers, care managers and support staff.

This model was the subject of a piece of research carried out by Mr Brian Dornan (Director of Community Services) in 1999. His research established that there was overwhelming support in all disciplines for integrated primary/community care teams attached to primary care practices. Practitioners preferred to work in multi-disciplinary rather than uni-disciplinary teams. Services provided were judged to have improved. Shared buildings and team rooms, alongside team effectiveness training, were identified as significant in promoting team working. It is understood that this team model could be extended to include other professionals including professions allied to medicine (PAMs).

(C) HOSPITAL/COMMUNITY INTERFACE

- 14 During the first phase of the community care review most health and social care staff expressed concern at the ongoing (and highly publicised) difficulties at the hospital community interface. Delays in discharging patients from hospital or delays getting patients admitted to hospital wards are viewed, by almost everyone consulted, as a symptom of a much wider and complex problem in the funding, planning and delivery of community care. Many also believe that the recent focus on moving patients out of hospital to nursing and residential homes has only had a limited effect on the hospital problems and has led to an overuse of this provision. The Project Board believes that the solution lies in a fundamental shift in thinking, away from the outdated belief that acute care should always be synonymous with hospital care. There is a growing body of evidence to support the view that the chronic illness often associated with older people can and should be treated in the community. Evidence suggests such treatment is much less disruptive for older people, allowing them to stay at home and thereby avoiding the risks of cross infection and cognitive deterioration.

Recommendation

15. The solution to this problem requires the development of a community infrastructure and services that will gradually facilitate the movement of traditional hospital based services into the primary/community care setting. This solution will not only involve a shift in thinking but will need significant investment or re-engineering to increase the capacity of primary/community care, including GPs. It is only when this issue is addressed that the stress caused to the system by delayed discharges will be alleviated and the number of patients who are admitted unnecessarily to hospital in the first place will begin to reduce. How such a long-term strategic objective can be achieved will be addressed in a comprehensive way in the second phase of the community care review.

Immediate action

16. Trusts should begin to move forward in a pragmatic way testing out some of the ideas, which have been generated by professionals on the ground. The Community Care Project Board have identified a number of innovative schemes and practices which may provide some guidance to Trusts attempting to develop local solutions to the pressures they are experiencing. The majority of schemes and practices cited have focused on bridging the gap between acute hospital care and primary care. They are designed to either prevent hospital admission or facilitate early and appropriate discharge. Many have been set up using funding that has been made available to relieve winter pressures on acute care or the re-engineering of existing services. They include various one-stop assessment schemes, hospital at home schemes, rapid response schemes, intermediate care schemes and some fall prevention initiatives.
17. These schemes have the common themes of being user-orientated, offering users more choice and have a clear independence focus. The key features of these schemes are that they:
 - Are user focused
 - Are targeted at specific patients
 - Have dedicated multi-disciplinary teams
 - Set clear admission and discharge criteria
 - Have measurable outcomes

18 One-Stop Assessment Centre – Ulster Community and Hospitals Trust

Elderly patients make up the majority of emergency admissions and may be admitted to an acute hospital for non-specific reasons, such as “gone off their feet”. Such an admission may have been avoided if the patient had been assessed promptly prior to admission and alternatives considered.

This one-stop assessment centre provides a consultant-led, multi-professional resource for GP referrals within an agreed protocol. The service can cope with up to 3-4 multi-disciplinary assessments per day and has immediate access to laboratory services, ECG, pharmacy etc. Admission is viewed as a last resort and alternatives are sought by the Ulster Hospitals Discharge Team and the Community Care Department.

This service, through the referral protocol, targets older patients where GPs feel there is the likelihood of referral for acute admission within 48-72 hours that might be preventable. Conditions include exacerbation of chronic obstructive airways disease, congestive heart failure, cardiac arrhythmia’s, anaemia, etc. Statistics presented indicated there were 230 referrals between November 2000 and September 2001, resulting in 140 patients being treated outside hospital; only 40 patients were admitted to an acute hospital bed.

This project provides a patient-centred service with prompt assessment leading to rapid intervention. It also gives GPs more confidence to manage patients for short periods in the community while awaiting assessment by experienced clinicians. The outcome of the evaluation indicates the potential for fewer patients being referred for emergency admission, particularly out-of-hours.

19 Specialist Chronic Obstructive Pulmonary Disease Nurse – Ulster Community and Hospitals Trust

This project aims to support patients with chronic respiratory conditions in the community through a proactive approach to prevent deterioration, which has often led to hospital admission. A specialist COPD nurse provides clinics in hospital settings, health centres, and occasionally the patient’s home. The COPD nurse performs respiratory function tests and advises on interventions such as alterations to the patient’s drug regimes. This specialist nurse links with a consultant chest physician to provide an efficient proactive monitoring of chronic respiratory conditions. The scheme has the potential to both prevent admissions and improve patient-centred care.

20 Tissue Viability Project – Ulster Community and Hospitals Trust

Leg ulcers, especially in older patients, can deteriorate if not managed appropriately and can lead to an admission to hospital. By ensuring local access to early treatment and regular review by specialist staff this project aims to prevent a hospital admission, which can often be quite lengthy. The project involves a specialist nurse as well as district nursing services. Clinics are held in Ards and Bangor Community Hospitals. Patients are reviewed and treated according to best practice guidelines. The nurses link with a dermatologist and a vascular surgeon. The specialist nurse also contributes to the development of good practice standards throughout the Trust.

21 A&E Diversion Scheme – Homefirst Community Trust

This scheme consists of nurses employed by Homefirst Trust who are located in Antrim Hospital A&E. Consultants in A&E can refer patients to the scheme if they feel the patient could be managed at home rather than being admitted. The nurses assess patients and draw up a community based care plan. This care plan is then implemented in the most appropriate setting, which may be in the patients own home, with the support of a domiciliary care package, or in a nursing or residential home. This scheme is aimed at preventing avoidable admissions to hospital by offering A&E staff an alternative, which at times of pressure they may have not otherwise been able to explore.

22 A Regional Falls Audit

A Regional Falls Audit, funded by the Regional Multiprofessional Audit Group, is currently being conducted as part of a National Audit involving the College of Occupational Therapists and the Chartered Society of Physiotherapists. The purpose of the audit is to identify older people at risk and to minimise that risk through appropriate preventive measures in order to enable people to remain safely at home. Such measures will aim to prevent hospital admissions and/or dependency on expensive packages of care. It is intended that the Audit findings and agreed guidelines will soon be published and shared with all relevant staff in both the statutory and independent sectors to help promote awareness and collaborative practice with a view to minimising risk of falls

23 **North And West Falls Project Team**

This project identifies people aged over 65, resident within North and West Belfast, who attend the local A&E Department following a fall. The project comprises of a multi-disciplinary team undertaking a comprehensive domiciliary assessment of the circumstances surrounding the fall. The aim of the scheme is to: reduce a number of hospital admissions as a result of a fall; complete a Risk Assessment of the home environment; identify the cause of the fall and any potential hazards; complete a nursing assessment to identify any underlying medical cause for the fall; ensure appropriate management of any identified need is undertaken by referral to an appropriate provider in the statutory/independent sectors; notify the patients in writing of the completed assessment; ensure there is awareness among professions about falls, prevention and appropriate intervention; educate older people about home safety, and improve quality of life by reducing the fear of falling.

24 **Rapid Response Scheme South And East Belfast Trust**

This is an example of a community/primary care service operating at the sharper end of treating acute illness at home. The scheme operates with a multi-disciplinary team responding to patients providing early intervention, 24 hours a day, 7 days a week. The South and East Belfast Trust rapid response team had 3,579 referrals between December 1997 and February 2001 which prevented the same number of people being admitted to hospital.

25 Hospital At Home Scheme Down Lisburn Trust

Hospital at home provides care in the patient's home as an alternative to hospital admission or through early discharge from hospital. It was originally piloted in GB (Peterborough) to provide a service to patients with fractures. In Down Lisburn Trust the idea has been developed and expanded to include patients from a variety of specialties, including general medicine, surgery, orthopaedics, gynaecology and palliative care. The scheme not only facilitates early discharge, but accepts direct admissions onto the scheme from GPs for intravenous fluids, intravenous antibiotics, and blood transfusions. Where patients cannot be accepted onto the scheme because of home conditions, arrangements can be put in place for patients to be managed on the scheme in the local elderly person's resource centres. While the hospital at home scheme is nurse led, it is a dedicated multi-disciplinary team.

The success of the Hospital at Home Service in Down Lisburn Trust has been documented in two independent evaluations and has also been the research subject of a Masters thesis in Health and Social Service Management at the University of Ulster. During the 12 months July 2000 to July 2001, there were 380 admissions to the scheme saving an estimated 3,430 bed days. The Down Lisburn Trust scheme has also attracted visits from a number of other HPSS Trusts and at least one other Trust is beginning to replicate this service.

Home From Hospital Schemes

- 26 Home from Hospital schemes are in operation in a number of Trusts. Homefirst, Down Lisburn, Ulster Community and Hospitals, and South and East Belfast HPSS Trusts all provide excellent examples. These schemes are designed to provide intensive short-term domiciliary support / convalescence to patients leaving hospital to help prevent unnecessary re-admissions.

Intermediate Care

- 27 Intermediate care beds facilitate the transition from hospital to home and provide more intense medical, nursing and PAM intervention, than can be provided within an individual's home. These beds may also be used to prevent admission to acute hospital by admitting patients where the required level of care and monitoring by healthcare staff cannot be provided in the patient's normal place of residence. Generally patients suitable for intermediate care have conditions such as respiratory infections, urinary tract infections, recovering stroke,

palliative care, leg ulcers, heart failure, top-up blood transfusions, rehabilitation following acute hospital stay, routine post-operative patients.

28. Intermediate Care Beds – Whiteabbey Hospital

This has been provided since December 1997 by GPs from 4 local practices in collaboration with United Hospitals Trust. The project had a review of activity between March 1998 and April 1999 which showed bed occupancy of 75% and an average length of stay of 8.5 days. Their evaluation also showed admissions to be appropriate when judged by a panel of GPs and consultants against the standard of care equivalent to hospital care. This would appear to be an effective targeted scheme.

29 Intermediate Care Beds – Donard Commissioning Group

The beds are located in 2 nursing homes in Castlewellan and allow patients to be managed closer to home, facilitating visits by relatives and allowing patients to be cared for by staff known to them (their own GP and district nurse). Occasionally care can also be provided locally for patients in the last days of their lives. Patients are not required to contribute to the cost of care in the nursing home as these beds are seen as an alternative to hospital admission. Donard Commissioning Group carried out an audit of the service between November 2000 and April 2001 showing overall patient satisfaction and lower cost of intermediate care beds compared with acute beds in the Downe Hospital.

30 Step-Down/Intermediate Care Scheme – Craigavon & Banbridge Community Trust

This scheme aimed to free up acute and assessment/rehabilitation beds and provide intensive rehabilitation outside the acute sector. The scheme takes referrals of patients aged over 65 years who would either remain in or be admitted to hospital if not on the scheme. The scheme accepts referrals from GPs, community personnel and A&E. The scheme offers time-limited (total approximately 6 weeks) interventions in the form of domiciliary packages and/or within local residential or nursing homes. This model provides more flexible local care than using a hospital site and enhances skill development within residential home/nursing homes. The emphasis on time-limited intervention and rehabilitation allows efficient use of resources.

31 Northern Board Contract With Healthcare At Home

Healthcare At Home is a private company, which supplies nursing staff. Currently the Northern Board uses the staff for two innovative schemes. The first scheme allows patients to receive treatment, usually blood transfusion or intravenous chemotherapy, at home, given under the supervision of a nurse rather than the patient having to attend haematology unit or rheumatology as a day patient or even as an inpatient. The relevant hospital consultant maintains responsibility for the patient during this period. The second scheme involves the treatment at home by a nurse of various conditions (varicose ulcers, pneumonia and other infections) for approximately a 3-4 day period and routinely would include the use of intravenous antibiotics. If required, the patients attend the A&E unit to be reviewed by the consultant. Both these projects increase the role for nurse specialists as well as providing appropriate care for the patients in their home. The second project in particular is innovative and has been submitted to a national journal for publication.

Support services

- 32 Trusts should also explore the scope for earlier support services which may help older people remain healthy, active and socially included. Low level core services were cited as a lifeline to people wishing to remain at home. However, in recent years many of the low level services such as day centres, home help services etc have tended to be the target of efficiency savings. This situation needs to be reviewed to ensure people do not develop complex needs prematurely. Health promotion initiatives should also get added emphasis. The Project Board believe there is a long-term educative issue for the general public e.g. anti smoking campaigns, promotion of physical activity, preventing loneliness, isolation and depression. They believe that public health should be promoted in the wider context of social services, housing, leisure services, and social security.

(D) HOSPITAL DISCHARGE ARRANGEMENTS

- 33 While many professionals have expressed concern at the undue emphasis placed on the issue of patients delayed in hospital, which they believe may result in expedient decision making for vulnerable people leaving hospital, there is evidence of room for improvement around the hospital discharge process. While acknowledging the need for a longer term strategic solution and increased investment in community infrastructure, the Project Board have identified a number of initiatives/practices which may help Trusts develop a more user

responsive discharge process. In 1997 the Social Services Inspectorate carried out a multidisciplinary inspection of hospital discharge arrangements entitled "From Hospital to Home". The Project Board believe the recommendations of this report can provide Trusts with reliable guidance on how to improve this process.

Recommendation

- 34 The next phase of the Community Care review will seek to develop a long-term strategy for dealing with the pressures on acute hospitals caused by patients remaining in beds long after they have been deemed medically fit for discharge. This will involve research into alternative service provision, identification of preventative measures, and seeking ways to implement the "culture change" required if more acute care is to continue to move into the community. Another project proposed for the next stage will also specifically examine the various funding streams for community care to ensure value for taxpayers' money. It will also consider how the "new" service should be paid for and if there is scope for significant resources to be redirected to develop the necessary infrastructure to treat people in the community who traditionally have been treated in hospital. It will consider the key sources of funding and track how it is spent right across the entire spectrum of health and social care services. Recommendations should emerge about the appropriate use of funds, revised targets, desired outcomes and value for money.

Immediate action

- 35 Trusts should revisit the SSI report "From Hospital to Home" 1997 to ensure recommendations contained therein have been given due consideration and appropriate implementation. Trusts should embark upon a continuous quality improvement process to ensure proper ongoing evaluation and improvement of their hospital discharge procedures. Issues to be explored should include an evaluation of users and carers experience. Many users reported dissatisfaction around their discharge from hospital. They said they often felt as if they were on a conveyer belt and a burden to those providing the service. Trusts should seek to develop mechanisms that would positively address these issues, reduce delays in assessments, improve effectiveness of communication between hospital, community and primary care services and hold professionals to account for practice.
- 36 These recommendations are based on the premise that patients being discharged from hospital must be treated with respect and dignity, that their human rights must be protected and that they should receive the most appropriate treatment and service to ensure the fullest recovery possible. They

are further based on the premise that all policy procedures and practice are free of ageist or discriminatory language and undertones. Every organisation and professional involved in planning or providing services for older people should reaffirm the positive value of older people to our society.

- 37 The Project Board were informed of a number of initiatives/schemes that had been developed in some Trusts which may help inform those wishing to seek ways of improving the service provided to users at this very vulnerable time.

38 **Discharge Co-ordinator Post**

This hospital-based post was in place in Sperrin Lakeland, Altnagelvin, Foyle and City Hospital Trusts. The main aims of this post are to: facilitate the provision of a seamless service in relation to the discharge of patients back into the community from hospital; one point of contact for multi disciplinary hospital and community staff; maximise the potential for effective working relationships and communication between multi-disciplinary hospital primary and community care teams; improve communication of service details to patients and carers; act as a key link person in the co-ordination of services to highly vulnerable patients being discharged from hospital; provide a dedicated person to focus on particular discharge issues and allow other medical and nursing staff to carry on with their duties; and provide consistency of approach specifically in relation to resource allocation.

The review team had the opportunity to meet some of the personnel involved in these schemes. These staff are convinced of the merits of a single point of contact in the hospital and were able to demonstrate some of the benefits of ensuring a collaborative, patient-led approach to the assessment and care planning of patients in hospital settings. They were also able to demonstrate that the establishment of this service has served to promote a culture of joint working between the acute and community sector professionals in their area. While many of the schemes identified have not been independently evaluated in terms of the long-term benefits to the patient, this post would appear to be worth investing in to ensure that because of poor processes, or a lack of a co-ordinated approach, patients do not remain in hospital long after they are medically fit to go home.

39 Discharge Co-ordination Team: Ulster Community and Hospitals Trust

The Ulster Community and Hospitals Trust have taken the concept of discharge co-ordination a step further and established a discharge Team in the Ulster Hospital Dundonald. This team serves as a single contact point for referrals for patients with health and social care needs from the Ulster Community and Hospitals Trust and ensures an efficient and effective discharge process. All patients requiring health and social care should have this arranged through the Discharge Team, which is made up of 5 whole time equivalent nursing and social work staff. The care is arranged on the basis of assessed need and the services provided include:

- Home From Hospital Scheme (six week, time-limited rehabilitative service);
- Step down Services (for patients with less complex care needs) in residential, nursing home or community hospital settings for conditions such as patient rehydration and convalescence post fracture;
- Care Management Services;
- Intensive domiciliary services, and
- Nursing/residential placements.

The aims and key features of the discharge team are:

- To improve the channels of communication between hospital and community staff;
- To make the discharge process more efficient for the client and to safeguard service to clients already in the community;
- To decrease the delay days due to care arrangement process for those being placed in nursing/residential accommodation or those who require care managed domiciliary packages;
- To actively promote the use of current community rehabilitation options such as community hospital, step down facilities and fracture beds in statutory elderly persons' home, and
- The Discharge Team could also be a vehicle for developing the use of time limited domiciliary packages, more appropriate for people with less complex needs

An independent pre-discharge team and post-discharge team evaluation was carried out. On comparison of the pre- and post-discharge team evaluations it is evident that the team has had some success. It has improved communication between hospital and community staff, reduced the number of delay days for those awaiting placement into nursing or residential care, and has increased the number of clients being stepped down into community hospital, statutory homes and fracture beds. The Discharge Team also made effective use of time-limited, domiciliary packages, accessed through Home From Hospital. This focus on rehabilitation has eased the current care management workload, "freeing up" care managers in the community to give appropriate attention to current community clients. The evaluation also highlighted the positive opinions and feelings of the clients and carers that received a service. It concluded that there was a clear increase in satisfaction of information provided and services received.

(E) REHABILITATION APPROACHES

- 40 The review team heard concerns from a wide range of professionals and users that community care had developed into a service which "did things for users", rather than helping users achieve their potential in terms of independence. Many believe, and there is evidence to support the claim, that we have created a culture of dependence rather than independence. People are being given less rehabilitation and are therefore less able to make a full recovery, resulting in more demand for residential and nursing home provision. There is also evidence that even within the accommodation provision more users are requiring the higher dependency nursing home care.
- 41 There is strong evidence of the positive effects of rehabilitation in a variety of key areas. Examples include stroke rehabilitation and geriatric assessment of older people. The evidence suggests rehabilitation effects often exceed drug-assisted improvements. Assessment and appropriate rehabilitation reduces the risk of older people being readmitted to hospitals or placed in long-term care. It also improves survival rates and physical and cognitive functioning. It should therefore follow that investing in rehabilitation in the short to medium term will have considerable long-term benefits in terms of quality of life and cost of care. This is because a significant proportion of service users are ultimately able to make good recoveries and are consequently much less dependent on long-term services.

Recommendation

- 42 The next phase of the review will examine how we can develop a culture of rehabilitation within community care. One of the specific projects proposed is entitled “Enabling people to live in their own homes”. It is proposed that the review team will build upon the examples of good practice found during phase one and examine how people can be maintained in their own homes or other community setting. This project will involve an examination of a range of rehabilitation methods to determine whether it is an appropriate, person-centred and cost effective approach to addressing need. This project will not only focus upon best practice schemes here, but will research, and hopefully learn from rehabilitation schemes in the Republic of Ireland, Great Britain and further afield.

Immediate action

- 43 Trusts should begin to make the shift from the maintenance and accommodation model of community care to a more rehabilitative model. Trusts should revisit the vast wealth of experience, knowledge and skill within their own staff teams, to develop a culture where everyone involved in individual care planning and service delivery is focused on helping the user achieve maximum levels of independence. The overall objective must be to rehabilitate and therefore empower people to live for as long as possible in their own homes. The Project Board identified some initiatives which may prove useful models for Trusts wishing to develop specific rehabilitation schemes to meet their local needs. These schemes are based on the view that increased investment in care and therapeutic intervention in the short-term can be more beneficial to the user in the long-term, and is consequently more cost-effective.

44 **South and East Belfast Stroke Rehabilitation Scheme**

This Stroke Rehabilitation Scheme is a good example of the benefits of helping people achieve their potential after serious illness. This particular scheme has enabled 98 people to receive their acute rehabilitation at home and initial findings from a study carried out by Queens University Belfast suggest that people receiving community based rehabilitation spent on average 20 days less in hospital. The same findings indicate that carers in the community appeared to have a significantly lower level of self reported stress and strain.

Results also showed that users of the service expressed significantly higher levels of satisfaction, due to the fact they could be treated in their own home. The scheme, if funded recurrently, could make it possible for 50 people per year to receive their post stroke rehabilitation at home. In terms of cost, results show that on average this scheme costs £1,500 less per person than an equivalent hospital based service.

45 **South and East Belfast Community Rehabilitation Scheme**

This scheme offers older people meeting care management criteria (people with complex needs) the choice to have a combined intensive rehabilitation/care package for up to 13 weeks before making any decisions about their long-term care. Rehabilitation plans are developed using a person-centred goal setting approach. The scheme aims to maximise the patients potential thereby helping them become less dependent on care services. This pilot is currently being evaluated by researchers from Queens University Belfast. The initial findings are positive evidence that a rehabilitation model can offer realistic alternatives to intensive care management services. This evaluation will be ongoing during the next 3 years.

46 **North and West Belfast Community Fracture Rehabilitation Scheme**

This scheme was developed in response to the Eastern Board's guidelines for "Management of Elderly People with Fracture of the Proximal Femur". The scheme offers rehabilitation in the community for patients normally aged over 65 years, with any fracture, though younger patients are considered. A maximum of 10 patients on a 7-day a week basis can be treated at any one time. Suitable patients identified at ward level are referred by the fracture rehabilitation co-ordinator through to community rehabilitation team. The team comprises of 1 full time Occupational Therapist, 1 full time Physiotherapist, and 2 nursing home beds normally available for 2 weeks co-ordinated by the care manager. There are regular meetings between the Community Rehabilitation Team members and the Fracture Rehabilitation Co-ordinator to monitor the patient's progress and resolve any issues which may arise.

(F) INVOLVING USERS AND COMMUNITIES

47 Community/user participation is about involving people, most especially the disadvantaged, in making decisions about changes to their lives which they identify as important and which use and develop their skills, knowledge and experience. For community/user participation to have any real meaning in community care there requires to be a tremendous cultural shift from a service where traditionally the decisions about the allocation of scarce resources have been in the hands of expert professionals - where expectations about health improvements have been linked to inputs and outputs of services and where users are usually the passive recipients of treatments and services. Community development approaches are widely viewed as a more appropriate vehicle to deal with complex health and social service provision, where the

community/users are actively involved in the planning, design, provision and evaluation of services.

- 48 While many of the Trusts we visited were keen to tell us about their many user groups and consultation processes, the reality is that bottom up planning is limited. Most Trust resources are tied up in infrastructure, staff and buildings, therefore community care tends to be more service led rather than needs led. The community care review team, recognise that at this time of change there is an opportunity to actively involve communities in reshaping their community services.
- 49 The review team also recognize, for example, that the significant movement of acute care services into the community would require confidence building among the general public. To do so we need to involve the public in this process. The public need to be actively involved in the design and systematic evaluation of initiatives and schemes to demonstrate positive outcomes. This is a significant step beyond the consultation and information giving, which many public bodies currently engage in.

Recommendation

- 50 At the next stage of the review it is planned to involve users and their representatives in each of the projects proposed. In this way communities will have an active role to play in shaping the future of community care.

Immediate Action

51 Trusts need to:

- Actively listen to what users of the service are saying, and not assume that professionals, carers or advocates always speak on their behalf.
- Encourage capacity building, particularly with the older population, to enable them to participate more effectively.
- Think beyond the concept of a consultation group or forum to ensure the voice of older people is heard, particularly those users with complex needs.
- Take cognisance of the fact that activist users emerge who dominate every committee and perhaps actually limit the opportunity for other users to participate.
- Identify personnel within each programme of care to drive forward the user participation agenda.
- To ring fence resources to ensure adequate time is given to allow the process of community participation to progress.

During the consultation process the review team had the opportunity to meet a number of service users and learned of some of the methods Trusts are using to involve users in service design and evaluation. We have described a few of these initiatives as examples of how this agenda might be moved forward.

52 Sperrin Lakeland Senior Citizens Forum

This forum was established in partnership with Western Health and Social Services Board; Sperrin Lakeland Trust; Age Concern; the Western Health and Social Services Council and the Rank Foundation. The key aim of the consortium is to promote the interests of senior citizens in the Sperrin Lakeland Trust area.

Its main achievements are:

- Development of a partnership with voluntary, community and statutory organisations to improve the assessment of needs of older people;
- Participation in the setting up of a cross-party group of MLA's to promote issues affecting older people;
- Responding to policy initiatives; and
- Representing the views of older people to public agencies.

The Chairman of Sperrin Lakeland Trust has commented that he hopes to constructively use the infrastructure created by the establishment of the consortium and its cluster groups to consult with users and carers about the planning and provision of services.

53 Mid Ulster Commissioning Pilot - Elderly Needs Assessment

The aim of the pilot was to bring together primary care based professionals from GP practices and local H&SS Trusts to work in partnership with the NHSSB and the local community to plan how best to deliver services to that community. This exercise drew on existing information across the complete range of health and personal social services provision, including mental health services, district nursing, podiatry, home help service, occupational therapy, residential and nursing home care etc. A user involvement group was established to take on board the views of local older people and their carers. Improving care in the community for older people and supporting carers was identified as the top priority and a series of recommendations were made as to how improvements could best be made.

These included the:

- Provision of additional community based PAMs resources e.g. occupational therapy assessments;
- Enhancement of the home help service;
- Provision of additional specialist training for care providers, and
- Consideration of community-based services such as Hospital at Home and
- Intermediate Care beds

The report and recommendations went out for consultation and decisions will now be taken on how the NHSSB will take forward the recommendations specifically relating to health and personal social services.

54 Down Lisburn Trust Disability Network Scheme

This scheme was developed in response to the needs of people living in the Twinbrook and Poleglass areas of Belfast. It was developed as a response to local research which suggested many of those with a disability living in the area did not have access to, or wish to avail of, the traditional services on offer. The target group is doubly disadvantaged by living in an area that experiences marked social exclusion and poverty, as well as facing the typical barriers that confront all people with disabilities in accessing services, facilities and employment. Since it was first established in March 1997, the Disability Network Scheme has received over 207 referrals from people aged between 5 and 65 who have a physical, learning or sensory disability. The Disability Network Scheme's main areas of activity include:

- Research that highlights the needs of people with disabilities in the area;
- Provision of a one-to-one support service;
- Development of a number of self help support groups;
- Awareness raising activity;
- Development of a user forum;
- Advice and information giving;
- Extensive networking;
- Increasing access to training and employment, and
- Increasing access to facilities and services

The scheme has been independently evaluated as having a positive impact on peoples' lives. It was described by the evaluation team as

"at the leading edge of community development approaches to health and social care delivery".

(G) PROVIDING SUPPORT FOR CARERS

55 'People First' stated as one of its six key objectives

"To ensure that service providers make practical support for carers a high priority"

Clearly this objective has only been partially met and sadly, in some situations, not met at all. The users that the review team met expressed concern for their carers who they feel require more help. An increasing number of carers are also elderly and frail: this is worrying for users and carers who fear a crisis and the inevitable admission to care. Carers we met also expressed concern at the insecurity of their practical support which they claim is often cut back without warning. One 87 year old gentleman caring for his 85 year old wife had recently had his home help service reduced on the day following her discharge from hospital.

Recommendation

56 At the next phase of the community care review the review team will take full account of the proposals for a carers strategy and any plans in place to implement. This will ensure all the issues raised during the review are taken into consideration. One of the projects proposed is specifically aimed at developing a range of services which would provide practical support for carers. It will build upon the work carried out to produce the Carer's Strategy. It will examine the potential for developing an extensive range of community based services, e.g. respite services, sitting services etc in line with what is recognised as good practice here, in GB and the Republic of Ireland. It aims to establish whether existing schemes and initiatives are cost effective and if they are provided in the correct location. The desired outcome will be models of good practice that fall within a developed set of key principles for carers support.

Immediate action

57 Trusts need to make support for carers a high priority to ensure that the many valuable and over worked carers in the community are provided with the support they need to maintain their loved ones at home. Services such as respite and sitting services should be protected and developed to ensure carers have access to them at short notice and times of stress or illness. Regular respite should be built into care plans to ensure the carers have planned breaks at times appropriate to their needs. Personal care services, including home help services, should involve as few changes as possible to enable carers to plan the rest of their lives outside of their caring role. Trusts should also give

consideration to the development of a support group for carers. Such a group could have the potential for not only self help initiatives and mutual support but could develop into a carers lobby and advocacy group. Such groups require practical support to enable carers to participate fully.

There are many good examples of such groups within the disability programme. One example of note is:

58 **Down Lisburn Trust Learning Disability Carers Forum**

This forum has been in existence for ten years, providing a means for carers of people with a learning disability to make their voice heard. Although the Trust support the group financially, they also benefit from administrative support from Mencap. The Carers Forum is a very active group, lobbying on behalf of all carers in the Trust. They are also very much involved in helping carers with the task of caring through support, advice and education. They have recently been involved in organising an international conference which has given parents and carers access to the latest ideas and innovation in the world of learning disability.

(H) MEDICINES MANAGEMENT

59 Medicine-related illness is often an overlooked element of community care. In reality however, it is a significant problem, particularly in older people. Adverse drug reactions have been implicated in between 3% to 17% of hospital admissions (rates vary according to patient group), costing the health service well in excess of £13m annually. A significant proportion of these admissions could be prevented with effective medicines management systems. The need to provide support for targeted patients and their carers in taking and administering medicines is now acknowledged. The perceived benefits of such support include optimisation of treatment, minimisation of adverse events and a reduction in wastage. It is clear that one of the key issues is the patient's failure to take their medication appropriately. Research has shown that as many as 50% of older people may not be taking their medicines as intended. Older people and their carers need to be more involved in decisions about treatment and to receive more information than they currently do about the risks and benefits of treatment.

Recommendation

60 The next phase of the community care review does not have a specific project relating to the issue of medicine management. However, it will be an ongoing theme in the development of good practice, particularly within projects which are

reviewing assessment and care management processes and examination of prevention of admissions.

Immediate Action

61 There is a vast body of research and local knowledge on this subject available to Trusts. Trusts should make use of this research in partnership with their pharmacy colleagues to identify schemes and innovative initiatives which have been shown to have significant benefits to the patients. Trusts should ensure that:

- Community pharmacists are more involved in primary and community care systems;
- The issues around medicines management are brought to the attention of all community staff involved in the care of older people;
- A medicines review becomes a routine part of the care review process especially for older people and those in residential and nursing settings;
- Education and training is provided to carers on the safe use and administration of medicines; and
- patients and/or carers receive written information and advice on their medicines before leaving hospital.

Consideration should also be given to:

- increasing the current 3 day discharge prescribing period to enhance the convenience for people leaving hospital and their carers.

62 Many good practice initiatives were described during the consultation process. While in the main these may be at an early stage in their development and are not routinely available, they may provide Trusts with a template/guide to dealing with the significant medicine issues identified by this review.

63 Medication Review Schemes - "Managing your Medicines"

This is a new service, funded by the Department through the Boards, for a medicines management initiative delivered by community pharmacies. In this scheme eligible patients who are either taking multiple medicines, have a history of poor compliance, or recently discharged from hospital, can have their complete medication history (prescribed, OTC and complementary medicines) reviewed by their local pharmacist. During a one-to-one private consultation, the pharmacist reviews the suitability of each medicine for the patient and identifies any drug interactions or potential side effects. This also presents an opportunity to identify any particular needs a patient may have in managing their medicines, such as difficulties in self-administration, and the pharmacist is able to identify potential compliance problems and provide drug charts or other compliance aids where necessary. The service was launched over the winter period 2000-2001, with a target of 20% of pharmacies actively providing the service. The recruitment target for community pharmacy has since been exceeded, although only a minority of contractors have actually commenced patient reviews. These early adopters have however shown a high level of commitment and have been positive about the service, both in terms of the improvements in patient care and the professional rewards.

64. **Practice Based Medication Review - ABC Commissioning Pilot**

Pharmacists were employed to work with eight GP practices on a sessional basis. A detailed medication review of over 700 patients on multiple medication was undertaken. Suggested amendments to therapeutic regimes were discussed between the pharmacist and a nominated GP and actioned by administrative staff. Evaluation of the scheme indicated that following the review approximately 95% of patients screened had at least one change made to their medication. The quality of prescribing had improved, education of nursing home carers was extremely well received, pharmacists and GPs had collaborated well and ultimately the quality of patient care had improved. Overall cost implications for changes to individual patient's medication were not calculated, but savings resulting from the implementation of agreed therapeutic switches in those screened indicate the programme was cost effective, off-setting the employment costs of the pharmacists.

65 **Falls Prevention Initiative - Armagh Primary Care Commissioning Pilot**

This scheme was set up as part of a fall prevention initiative. A dedicated nurse undertook assessment of patients referred by local GPs, or through the A&E department, who were at risk of falls, or further falls. Those visited who were on 6 or more medications were referred to the Pilot's Prescribing Advisor for a medication review. This review entailed the identification of any potential side-effects of the patient's current drug therapy, drug-drug or drug-disease interactions, which placed the patient at increased risk of fall. Where appropriate, recommendations were made for changes to drug therapy to minimise such risks. In total, 29 (20%) of those screened were referred for a medication review. Outcomes from this scheme demonstrated that 52% of referrals assessed had actual or potential medicine associated problems and had resulted in a medical intervention. This initiative demonstrates clear patient care benefits.

66 Domiciliary Pharmaceutical Care for Elderly Housebound Patients

In 1998 NHSSB commissioned a project to determine the scale of pharmaceutical care issues occurring with elderly housebound patients and to examine whether domiciliary visits by a pharmacist would be of benefit to them. GPs from 5 practices referred 36 patients for enrolment, 21 of whom met the inclusion criteria and agreed to participate in the project. Results from the project indicated that some 90.5% of the enrolled patients had medication problems on assessment. These problems included:

- Compliance problems, 52.3%;
- Medication not synchronised, 52.3%;
- Inappropriate use of medication, 38.1%;
- Incorrect dosage, 23.8%;
- Adverse drug reaction, 23.8%, and
- Unable to open CRC, 23.8%.

Where compliance problems were identified, these were further classified as unintentional (65%), or intentional (35%): Management plans were produced for all patients (n=21) and implemented in 81% of cases (n=17). GPs approved 92% of proposed interventions. Pharmacists, GPs and patients all indicated high levels of satisfaction with the scheme and hoped that it would be rolled out in the future.

67 Medication Review in Nursing Homes

There have been a number of schemes set up across NI involving pharmacists undertaking medication review in Nursing Homes. All have been well evaluated and have demonstrated effectiveness in reducing the number of drugs taken by patients, identifying medicine-related problems and improving medication administration systems in the nursing homes. Examples of such schemes are found in Western Health and Social Services Board (projected annual cost saving of £2,300), Lisburn Commissioning Pilot (projected annual cost saving of £12,450) and Armagh Commissioning Pilot (projected annual cost saving of £12,671). This is a key target area for future development.

68 Schemes operating at the Hospital-Community Interface -Dedicated Interface Pharmacists

A recent study carried out in Antrim Area Hospital demonstrated that 61% of patients had an incomplete medication history on admission, 21% of patients who brought their own drugs were not dealt with appropriately and 33% of discharged patients had medication-related problems. The study also found that a Trust-based community liaison pharmacist produced benefits in terms of patient medication management, reduced readmission rates (by 2.4%) and reduced wastage of patients' own drugs. There is increased recognition that a dedicated interface role is necessary to achieve more pro-active liaison between all the relevant practitioners in primary and secondary care and so improve understanding, promote seamless care for patients and reduce risk. One such pharmacist has already been appointed in WHSSB as a result of concerns identified with the increased use of more specialised drugs in the community setting. Key tasks for this role include:

- Development of shared care protocols and clear guidelines on prescribing responsibility between primary and secondary care;
- Development of guidelines for the introduction of new drugs or existing drugs with major new indications;
- Providing guidance on the prescribing interface between hospital and primary care including the supply of medication to patients on discharge, return of medication brought into hospital and the development of communication links with hospital and primary care;

- Development of a single formulary, through integrating the current formularies, for use by the local GPs and provider units and primary care;
- Development of guidelines for improving patient compliance and understanding of medication;
- Development of guidelines for effective medication reviews, and
- Development of a means of liaising with the Local Medical Council; Area Medical Advisory Committee; Area pharmacy Committee, and other relevant agencies to help inform and shape local action plans

(I) INDEPENDENT SECTOR PROVISION

69 The private sector indicated that they were fast approaching a time when the residential and nursing home business would be no longer profitable. While there may be an argument that that this sector is over used, demand for this provision is still growing. Many of the staff consulted are deeply concerned about the decline in availability of all independent sector beds, with demand beginning to outstrip supply in some areas, and particular problems emerging in the supply of EMI beds. While staff accept that the use of nursing home and residential beds is still relatively high compared to usage elsewhere, there is some feeling that the difficulty here has arisen because there has been insufficient growth of alternatives to nursing home and residential care. While it is not clear why this situation has developed, there is a view within the voluntary sector that the contract culture has significantly damaged relationships and has resulted in less partnership working and joint planning.

Recommendation

70 "People First" Policy stated as one of its central objectives to

"Promote the development of a flourishing independent sector alongside good quality public services"

In the second phase of the Community Care Review a project is proposed which will carry out an examination of this objective. The project will review the potential for improved partnerships between the statutory, voluntary and independent sectors to ensure the development of a range of high quality services giving value for money. The aim is to review the effectiveness and efficiency of current partnerships to the benefit of the individual, the community and the service providers. It will also seek to identify solutions that meet everyone's needs in the short and long-term and which develops planning approaches that reflect all interests and are of mutual benefit for all parties. An aim of this review will be to ensure that there is an equal status between all

parties that builds and fosters trust and good relationships. The desired outcome is a set of recommendations that will create a stable and sustainable independent sector that works with the HPSS and which promotes innovative, diverse, flexible solutions, providing value for money and choice.

Immediate Action

- 71 An immediate resolution of the contract price issue is required if we are to ensure stability in the nursing and residential home sector in the short-term. This will allow space for more long-term planning in partnership with both the private and voluntary sector. This should reflect a desire to develop more appropriate levels of nursing home provision and domiciliary support.
- 72 Throughout the consultation process the review team heard many concerns expressed around the reduction in support type services. These services are often provided by the voluntary and community sector and grant aided by the Trusts. They include day centres, social clubs, meals on wheels etc., which are seen by users and carers as a means of respite and social inclusion. Trusts should seek to support and protect such services to ensure older people have access to the community and remain an active part of it.
- 73 During the consultation process the review team met with the voluntary sector to hear first hand some of the initiatives they are involved in. They were keen to share examples of good practice which they had direct experience of. Examples included:

Actively Ageing Well Project (Age Concern and The Health Promotion Agency)

This scheme is designed to allow older people to take part in social activities which will alleviate isolation and boredom both of which have a detrimental effect on people's lives.

Warm Home Scheme (Help the Aged)

For older people on income support, this scheme attempts to deal with the issue of older people currently waiting for heating.

Freephone Advice Service “Senior line” (Help the Aged)

This is a free welfare rights advice service for older people and their carers. The service offers advice or information about a wide range of issues including community and residential care, welfare/disability benefits and housing issues.

Preventative Adaptations Scheme (NIHE)

Which aims to prevent falls etc in older people

Assisted Living Schemes (Cedar Foundation)

Examples of which are in North and West Belfast and Ulster Hospitals Trusts.

Angel Watch Project (Partners in Care)

Provides personal and domestic care to older and disabled people in their own homes and at the same time provides support and relief for their carers. The service operates 24 hours a day throughout the year and the “Angel Watch” provides a special service in the clients home throughout the night.

(J) HUMAN RESOURCE PLANNING

- 74 Recruitment and retention of staff is an issue across all grades, with a particular lack of skilled staff in some areas to carry out assessment, treatment and rehabilitation. There is a widespread feeling that there needs to be improved long-term planning to tackle these issues, based on prediction of future staffing needs.
- 75 The review team's attention was also drawn to the very poor pay and conditions still experienced by many frontline care workers. As a result it is difficult to attract high quality committed staff. This situation has been further exacerbated by the growth within other sectors of the economy, for example, in the retail sector, with supermarkets often offering much better pay and conditions for easier, less stressful jobs. High turnover of staff means that there are often many workers involved with individual service users and it is difficult to provide high quality care with new inexperienced staff. The problem is often further complicated in rural areas where populations are less dense, leading to increased costs of travel and a smaller potential recruitment pool of staff. It was felt that the issue needs to be tackled urgently to improve the situation for care workers so that they are more highly valued and rewarded by employers and by society.

Recommendation

- 76 At the next phase of the community care review the review team will work alongside the Departmental working party who are currently developing the new Health and Social Services Workforce Plan. This will ensure all the issues raised during the review are taken into consideration.

Immediate action

- 77 Undoubtedly there is scope for improved efficiency in the area of providing skilled staff to carry out assessment, treatment and rehabilitation, particularly regarding the duplication of effort that occurs because of the complexity of systems and structures and lack of integration that are highlighted elsewhere in this report. There would appear to be room for improvement in skill mix and, in particular, with the better targeting and sharing of the time and expertise of skilled specialist staff. Almost all of the schemes and practice highlighted during the report are based on the principle of dedicated multi-disciplinary teams. Trusts should review their method of service delivery to identify scope for improved skill mix and multi-disciplinary working.
- 78 In relation to the issues of shortages of care staff Trusts need to begin to urgently address this issue. Trusts, in conjunction with staff representatives, need to develop policies and practice which begin to value the essential service provided by this group of staff. Policies which are family friendly, training intensive and which begin to develop career structures in this sector are urgently required. Best Practice – Best Care, the consultation paper which describes the Framework for Setting Standards, delivering services and improving, monitoring and regulation in the HPSS, offers Trusts a starting point for improvement in this area. The National Service Framework for Older People is a valuable source that could also be drawn on for further development of local standards.
- 79 Experienced staff generally feel that there needs to be an accepted degree of risk taking if older people are to be allowed a reasonable quality of life. However, many feel that they are working in a "blame culture", with an increasing likelihood of litigation if they get it wrong. There was a frequently expressed view that we need to find ways to allow older people to take risks, if that is what they desire to do in order to maintain a reasonable quality of life. There is a need to move from "blame" to "learning" or "educative" culture.

(K) EQUALITY

- 80 During the consultation process a number of issues were raised with regard to inequalities that exist within the present system. Many Trusts feel that the equity issue in funding arrangements between Trusts has not been fully addressed, leading to unacceptable differences in the range and level of services available across Trusts' areas. There is insufficient clarity around this issue to determine if this claim is legitimate and further work is therefore required. There was evidence, however, of different priorities and different eligibility criteria being applied in various Trusts. Evidence also emerged relating to levels of service in rural areas as well as increased costs due to travelling. Older people also face many attitudes which are negative or subject to ageism. This can lead to older people experiencing considerable social exclusion from everyday life.

Recommendation

- 81 The next phase of the community care review will consist of a number of projects which will provide a comprehensive review of the community care policy. All of these projects will be based on the premise that any new policy must be developed with regard to issues around equality, inclusion and anti-discrimination. They need to be based on the policy of targeting social need and promoting social inclusion as well as ensuring they are fully compliant with equality and human rights legislation. They must be based on the principle of promoting independence and helping users realise their potential. It is proposed that a particular project in the next phase will examine how community care is funded. This should help identify any inequalities which relate to different funding levels in different areas.

Immediate Action

- 82 Trusts need to ensure the eligibility criteria for service is applied equally and fairly across their entire service provision. Older people and their families need to be given clear information on their rights and responsibilities vis-a-vis community care provision. The Equality Officer in each Trust should be actively involved in the development and updating of all community care policies and systems to ensure equity and human rights issues are fully addressed.

SECTION 6

FUTURE WORK PROGRAMME

Introduction

- 1 "People First: Community Care in Northern Ireland in the 1990s" set out six central objectives. The Project Board has used each of these objectives as a framework for setting out the future work programme for the next phase of the community care review. It incorporates projects relating to each of the People First objectives, identifying the likely outcomes from each piece of work designed to produce practical solutions to the issues raised in phase one. Presented in this section is a short description of each project, its purpose and expected outcome.
- 2 The aim is to improve services to give users and carers real choice over the how, and where of service delivery to meet their needs. Attention will be paid to building a seamless service with proper linkages between primary, secondary and community care and which develops effective partnerships with other public sector bodies, government departments and the independent sectors who have unique contributions to make in addressing individual and community expectations. Account will also be taken of other programmes of care where there is the potential for learning or read across to improve the services for the benefit of users and carers. The overall goal is to develop a new vision that uses innovative and creative ways of working for the benefit of the community.

Second Phase Plans – Community Care Review

- 3 A number of projects will be taken forward based on the 'People First' objectives.

(People First - Objective 1)

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

Project 1 – Enabling people to live in their own homes

- 4 Building upon the examples of good practice found during phase one, this project will examine how people can be maintained in their own homes or other community setting. It will comprise 3 elements:
 - An examination of a range of rehabilitation methods to determine whether it is an appropriate and cost effective approach to addressing need. This project will not only focus upon best practice schemes in Northern Ireland but will identify how similar schemes are delivered in the Republic of Ireland, Great Britain and further afield.
 - A review to identify ways of preventing people from being inappropriately admitted to residential and nursing homes or hospital. This project will examine the range of preventative services and other innovative approaches to meeting the needs of the community before they become dependent on care management services. It will build upon the findings from phase one and consider best practice from other countries.
 - A review to identify the scope for developing a range of services in the community/service user's home which would previously be provided in an acute hospital setting. This will include an examination of existing schemes and schemes trawled from further afield.
- 5 All three elements will involve desk research, meetings with staff and consultation with users and carers (or their advocates), to obtain the information required to produce sound recommendations and actions that can be implemented. These actions will be based upon best practice principles for meeting people's needs using a range of well developed preventative, rehabilitative and other innovative schemes, (or by providing acute services where people feel more secure and less vulnerable in their own homes).

Project 2 – Spreading Best Practice

- 6 The aim of this review is to identify and propose effective methods to spread best practice across the Health and Personal Social Services. The findings from the phase one revealed that there is little or no sharing of best practice across Boards and Trusts. All too often good work that has been carried out in one place is not known about elsewhere, so similar work is redone and duplicated

throughout the HPSS. This review will identify the strengths and weaknesses of different dissemination techniques and how they need to be adjusted to suit the HPSS. Its outcome will be the development of effective knowledge management systems and a database for sharing best practice that reduces waste and transfers knowledge to the point where it is needed. The Review will use local and international research about knowledge management and, as necessary, will seek expert academic and operational advice to develop solutions. It will also utilise other pieces of research such as The Cabinet Office's research project: "The effectiveness of different mechanisms for spreading best practice" which contains examples of mechanisms currently in use in UK Health sectors.

(People First - Objective 2)

"To ensure that service providers make practical support for carers a high priority".

Project 3 – Developing services to provide practical support for carers

- 7 This project is aimed at developing a range of services which would provide practical support for carers. It builds upon the work carried out to produce the Carer's Strategy. It will examine the potential for developing an extensive range of community based services e.g. respite services, sitting services etc., in line with what is recognised as good practice appropriate to N.I. and establish if existing schemes and initiatives are cost effective and provided in the correct location. The desired outcome will be models of good practice that fall within a developed set of key principles for carers.

(People First - Objective 3)

"To make proper assessment of need and good case management the cornerstone of high quality care"

Project 4 – Care management processes and assessment tools

- 8 The purpose of this project is to identify the most effective and efficient care management process that enables sound operational and planning decisions to be taken for the benefit of the individual and the community as a whole. It will examine best practice multi-disciplinary models with a focus on the most appropriate skill mix and the possibility of developing a single assessment tool that can be used to meet all levels of need whether in the hospital or in the community setting. It will pay particular attention to the current processes, to identify weaknesses in how information is gathered, communicated and used, not only in the context of the individual, but also in the assessment of need within

the overall planning context in light of its implications on the financial and performance management of services.

(People First - Objective 4)

“To promote the development of a flourishing independent sector alongside good quality public services”

Project 5 – Promoting the development of a flourishing independent sector alongside good quality public services

9 This project will review the potential for partnership between the statutory, voluntary and private sectors to ensure the development of a range of high quality services and value for money. The aim is to review the effectiveness and efficiency of current partnerships to the benefit of:

- the individual
- the service user
- all other stakeholders

It will also seek to identify solutions that meet stakeholder needs in the short and long-term and which develops planning approaches that reflect all stakeholder interests and are of mutual benefit for all parties. An aim of this review will be to ensure that there is an equal status between all parties that builds and fosters trust and good relationships. The desired outcome is a set of recommendations that will create a stable and sustainable independent sector that works with the HPSS and which promotes innovative, diverse, flexible solutions that provide value for money and choice.

(People First - Objective 5)

“To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance”

Project 6 – Accountability of Agencies

10 The aim of this project is to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance. The review will identify how quality and standards are currently set, how and by whom they are monitored, and establish if the processes are in place to hold the various agencies to account if they are not continually improving performance, or are not focusing on the most appropriate measures to successfully run their business. The review aims to develop recommendations for monitoring performance and

give a greater clarity about roles, responsibilities and the processes that gives a greater focus on outcomes and continuous improvement.

(People First - Objective 6) –

“To secure better value for taxpayers' money by introducing a new funding structure for community care”

Project 7 – Funding Structure for Community Care

- 11 This review will examine the various funding streams for community care to ensure value for taxpayers' money. It will consider the key sources of funding, how it is spent, and whether funding levels are adequate to address need. To do this the reviewers will establish how funding is planned for, targeted and monitored to determine whether there is clarity about how HPSS funding objectives fit with each other and with wider Government objectives.
- 12 Recommendations should be made about the appropriateness of, and use of funds, and the adequacy and effectiveness of short and long-term planning and monitoring processes. Other recommendations should emerge, for example, around the possible need for redirecting funding, revised targets, and around the need to give greater attention to outcomes and value for money.

ANNEXE 1

COMMUNITY CARE REVIEW

PROJECT BOARD MEMBERS

Brian Coulter, Chief Executive, Fold Housing Association (Chair)

Les Allamby, Law Centre N.I.

Hazel Baird, Director of Nursing, Homefirst Community HSS Trust

Dominic Burke, Director of Social Work, Western HSS Board

Laura Collins, Carers National Association

Robert Ferguson, Chief Executive, South & East Belfast HSS Trust

Leslie Frew, Director, Child and Community Care Directorate, DHSSPS

Brian Grzymek, Director, Secondary Care Directorate, DHSSPS

Paul Martin, Chief Social Services Inspector, DHSSPS

John McGrath, Director, Planning and Performance Directorate, DHSSPS

Dr Brian Patterson, British Medical Association

ANNEXE 2

COMMUNITY CARE REVIEW

PROJECT TEAM MEMBERS

Bernie McNally, Project Team Leader, Down and Lisburn Trust (Project Team Leader)

Robbie Saulters, Policy Development and Review Unit, DHSSPS (Project Manager)

Charlie Bamford, Social Services Inspectorate, DHSSPS

Fergal Bradley, Regional Information Branch, DHSSPS

Greg Campbell, Economics Branch, DHSSPS

Dr Vanessa Chambers, Pharmaceutical Officer, DHSSPS

Peter Deazley, Elderly and Community Care Unit, DHSSPS

Gary Fair, Developments Unit, DHSSPS

Nuala McArdle, Officer for the Professions Allied to Medicine, DHSSPS

Dr Ian McMaster, Medical Officer, DHSSPS

John McKeown, Elderly and Community Care Unit, DHSSPS

Francis Rice, Nursing Officer, DHSSPS

Alan Urquhart, Policy Development and Review Unit, DHSSPS

ANNEXE 3

COMMUNITY CARE REVIEW

CONSULTATION PROCESS

The consultation process comprised:

- 1 A letter from the Project Board Chairman, Mr Brian Coulter, issued to all service staff on 14 May, to gather early views and comments on the review
- 2 Six workshops held at different locations throughout all Board Areas and attended by a range of professionals from all the Trusts, Boards and Health and Social Services Councils. Further workshops held specifically for the voluntary sector, Registered Homes Confederation and General Practitioners. Over 230 people attended this series of workshops.
- 3 A series of visits with the following Trusts to establish current practice and gain further views and suggestions:

Craigavon Hospitals HSS Trust.
Ulster Community Hospitals HSS Trust.
Craigavon and Banbridge Community HSS Trust.
Down Lisburn Trust HSS Trust.
Armagh and Dungannon HSS Trust.
- 4 Further meetings with:

Jane Graham, Eastern HSS Council.
Dr Brian Patterson, BMA Advisory
Committee of the Therapeutic Professions Allied to Medicine.
Royal College of Practitioners
- 5 Two focus groups with the North Belfast Community Forum for Elderly People and the Omagh Elderly Forum, arranged by the Health and Social Services Councils. The Northern HSS Council provided the Team with the results of a user satisfaction survey that they had recently carried out.
- 6 An advertisement placed in the following newspapers inviting comments and views from the general public:

Belfast Telegraph Irish News Belfast Newsletter
Coleraine Chronicle Ballymena Guardian CountyDown Spectator

Newtownards Chronicle	Larene/Carrickfergus/Newtownabbey Times	
Ulster Star	Down Recorder	Down Democrat
Newry Reporter	Portadown Times	Lurgan Mail
Impartial Reporter	Ulster Herald	Tyrone Constitution
Tyrone Courier	Dungannon Observer	Mid Ulster Mail
Mid Ulster Observer	Derry Journal	Londonderry Sentinel

- 7 An article in the following professional journals requesting a personal or professional opinion on current service delivery, possible improvements, examples of 'Good Practice' or more effective ways of working:

British Medical Journal	Community Care	Doctor
GP Magazine	GP Newspaper	Health Service Journal
Hospital Doctor	Northern Ireland Medical Review	
Northern Ireland Medicine Today	Nursing Standard	Nursing Times
Pulse Magazine		

- 8 A letter to all 1,080 General Practitioners and 77 Geriatricians and Pyscho-geriatricians giving them an opportunity to make their views known on what they see as the main issues in the delivery of community care services and to put forward suggestions for improvements in the service.

- 9 Alphabetical List of Organisations and Individuals Consulted

Advisory Committee of the Therapeutic Professions Allied to Medicine	
Age Concern	Altnagelvin Hospital HSS Trust
Armagh and Dungannon HSS Trust	Arthritis Care
Bangor Citizens Advice Bureau	Belfast City Hospital HSS Trust
British Medical Association	Bryson House
Causeway HSS Trust	Cedar Foundation
Church of Ireland Board for Social Responsibility	Laura Collins
Craigavon Area Hospital Group HSS Trust	
Craigavon and Banbridge Community HSS Trust	Crossroads
Down Lisburn HSS Trust	

Eastern Health and Social Services Board Eastern Health and Social Services Council	Extracare
Foyle HSS Trust	
(All) General Practitioners	Green Park Healthcare Trust
Homefirst Community HSS Trust	Help the Aged
Law Centre NI	
Mater Infirmorum HSS Trust	
Newry and Mourne HSS Trust	
North Belfast Community Forum for Elderly People	
North and West Belfast HSS Trust	
NI Federation of Housing Associations	
Northern Health and Social Services Board	
Northern Health and Social Services Council	
Northern Ireland Housing Executive	
Northern Ireland Public Service Alliance	
Omagh Elderly Forum	
Registered Homes Confederation	Royal College of GPs
Royal Group of Hospitals HSS Trust	RNIB
Simon Community Trust	South and East Belfast HSS
Southern Health and Social Services Board	
Southern Health and Social Services Council	Sperrin Lakeland HSS Trust
Triangle Housing Association	
Ulster Community and Hospitals HSS Trust	United Hospitals HSS Trust
Voluntary Service Belfast	
Western Health and Social Services Board Services Council	Western Health and Social Services Board

10 Submissions Received During Course Of Review

1. Mr J Compton, Deputy Chief Executive, Down Lisburn Trust.
2. Brian Dornan, Director of Community Services, Down Lisburn Trust.
3. Chris Williamson, Director, NI Federation of Housing Associations.
4. Dominic Burke, Western Health and Social Services Board.
5. Dr Jean McClune, Skegoneill Health Centre.
6. Christie Colhoun, Chief Executive, Homefirst HSS Trust.
7. Hilary Boyd, Chief Executive, Greenpark Healthcare Trust.
8. Dr M G Scott, Chief Pharmacist, Pharmacy Department, United Hospitals Trust.
9. Helen Creighton, Prescribing Advisor, Lisburn Commissioning Pilot.
10. Teresa O'Neill, Senior Manager, Social Care Services, Bryson House.
11. Dr B Farrell, Acting Primary Care Medical Adviser, Southern Health and Social Services Board.
12. John McGrath, Project Manager, Mid-Ulster Primary Care Commissioning Pilot.
13. Dr Paula Cobain, Senior Pharmaceutical Prescribing Advisor, NHSSB.
14. Dr Kathryn Booth, GP Unit, EHSSB
15. Emer McPhelimy, NHSSB.
16. Pat Haines, Director of Planning, Belfast City Hospital Trust.
17. Cavan Weir, Deputy Chief Executive, Extra Care.
18. Dr Michael Steele, GP Principal, Ballywalter Health Centre.
19. Marie Doherty, Primary Care Pharmacist, Boots the Chemist.
20. Stuart MacDonnell, Chief Executive, NHSSB
21. Fiona McConnell, NHSSB.
22. Dr Kevin McCoy, Social Services Inspectorate, Review of Care in the Community Report (February 2000).
23. Down Lisburn Trust/Lisburn Commissioning Pilot.
24. Stephen O' Brien, South and East Belfast HSS Trust.
25. Brian Coulter, Foldgroup, Notes from meeting of Pressure Group.
26. Mrs E Cavan, Director of Professions Allied to Medicine.
27. Dr D Boyd, Medical Adviser (Primary Care) NHSSB.
28. Joe Brogan, FPSU, WHSSB.
29. Age Concern NI.
30. Prof. James C. McElnay, President of the Pharmaceutical Society of NI.
31. J P Ferguson, Chief Executive, Ulster Community Hospitals Trust.
32. Dr Peter Beckett, Chair of the Armagh GP Forum.
33. Angela Costello, Fracture Rehabilitation Co-ordinator, Musgrave Park Hospital.
34. B P Cunningham, Chief Executive, SHSSB.
35. Brian Dornan, Research Report "Teamwork in Integrated Primary Health and Social Care Teams".
36. Irene Duddy, Director of Nursing, Altnagelvin Hospitals HSS Trust.
37. J P Loughrey, Director Child and Community Care, Causeway HSS Trust.
38. Dr H Curran, Chairman, South & East Belfast Primary Care Group.

39. Chris Williamson, Director, The Northern Ireland Federation of Housing Associations.
40. Fiona McConnell, Pilot Prescribing Adviser, Mid-Ulster Commissioning Pilot.
41. Dr D H Gilmore, Consultant Physician in Geriatric Medicine, The Royal Hospitals.
42. Dr Peter Flanagan, Consultant Geriatrician, Braid Valley Hospital.
43. Ricky Stewart, Project Manager, North & West Locality Consortium.
44. F G McCafferty, Consultant Psychiatrist, South & East Belfast Trust.
45. Gerard Finnegan, Training and Development Manager, S.T.E.E.R.
46. B J Hampson, Derry.
47. Liz Cuddy, Business Development Manager, Threshold.
48. Joanne Murphy, JCM Training Services, County Derry.
49. D & P Maguire, Ballycastle, County Antrim.
50. Eleanor Duff, Ballycastle, County Antrim.
51. Dr J S Burnham, Newtownards Health Centre.
52. Dr G M Crawford, Chairman GP Executive Ards and Bangor Community Hospitals.
53. Dr G D O'Neill, Springfield Road Surgery.
54. Dr Eamonn McMullan, Omagh Health Centre.
55. Dr I C Steele, Consultant Physician in Geriatric Medicine, Royal Hospitals.
56. Dr T R O Beringer, Dr DH Gilmore, Dr IC Steele, Dr MI Wiggam, Royal Hospitals.
57. Dr M A Jones, Consultant Physician, South Tyrone Hospital.
58. W H Moffatt, Greenisland.
59. M Dowse, Peterborough, Cambridgeshire.

ANNEXE 4

COMMUNITY CARE REVIEW

DEMOGRAPHIC AND OPERATIONAL PROFILE

Demographics

- 1 In the 1991 census the demographic picture showed that the elderly population accounted for 13.6 % of the total population in Northern Ireland, which then stood at 1.57 million. Of this 13%, 7.4% were between 65 and 74 and 5.2% were 75 or over. The mid year estimates for 1999 show that while the total population had grown to almost 1.70 million, the proportion of those between 65 and 74 had reduced by 0.21% and now made up 7.2% of the population. Conversely, those aged over 75 had increased by 0.6% and now accounted for 5.8% of the total population.

- 2 From our point of view, the most important demographic trend is that people are living longer. The generally accepted reasons for this are:

Improved living standards – housing, sanitation and environment;

Developments in medical technology leading to improved diagnosis and treatment; and

Increasing emphasis on health promotion and health education.

- 3 The direct consequence of people living longer is an increased demand on a range of both health and personal social services. As well as the direct effect of increased numbers, there are a number of other factors that are responsible for increasing demand. These are:

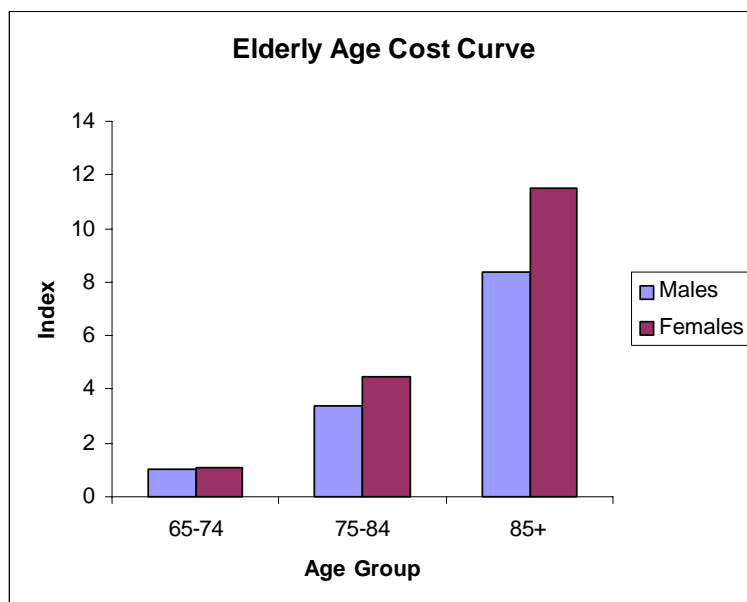
Higher expectations of the level and range of services which are available, increased by the high profile publicity surrounding all health and social care developments;

A reduction in community and family infrastructure support, forcing more people to depend on the support and intervention of the state, and

Increased public awareness of their rights to health and social services.

- 4 The following diagram illustrates how the cost of service provision increases with the age of the client.

Figure1: Age Cost Curve for Elderly Programme



Assessed and Met Need

- 5 Since the "People First" policy was first introduced in 1993, many people are now being maintained in their own homes who would otherwise have been in residential care or, perhaps, in a long stay hospital ward. The number of care packages in place to support these people can be taken as a direct measure of the success of the community care policy. There are three main types of care package – residential care, nursing care and domiciliary care. The following table shows the numbers of residential and domiciliary care packages in place for each of the years from 1995 to 2001.

Table 1: Numbers of Residential Care Packages 1995-2001

Year	1995	1996	1997	1998	1999	2000	2001
Total Care Packages	6849	9146	10027	10457	11067	11502	12622
Residential Care Packages*	3585	5011	5726	6498	6894	7179	7985
As % of Total Care Packages	52%	55%	57%	62%	62%	62%	63%
% Increase of Residential Care Packages Since 1995		40%	60%	81%	92%	100%	123%

(* Both residential homes and nursing homes)

Table 2 Numbers of Domiciliary Care Packages 1995-2001

	1995	1996	1997	1998	1999	2000	2001
Total Care Packages	6849	9146	10027	10457	11067	11502	12622
Domiciliary Care Packages	3264	4135	4501	3959	4173	4323	4637
As % of Total care Packages	48%	45%	45%	38%	38%	38%	37%
% Increase of Domiciliary Care Packages Since 1995		27%	38%	21%	28%	32%	42%

- 6 As can be seen, between 1995 and 2001 the numbers of residential care packages in effect increased by 123% whilst the numbers of domiciliary care packages increased by only 42%.

(NB: During the review staff from a number of Trusts argued there is a major incentive to place people in residential care since some of the costs are defrayed by access to Social Security benefits, while the costs of more expensive domiciliary care packages must be met in full by the Trusts themselves)

The view that more people are going into residential care than is necessary is supported by evidence of the comparative provision of community care.

Table 3: Comparative Provision of Community Care (1999)

Service Area	NUMBERS PER 1000 OF POPULATION OVER 75				
	N. Ireland	England	Scotland	Wales	R o I
Number Of Nursing Home Beds	99.5	54.9	68.1	49.2	35.6
Number Of Residential Places	71.4	93.7	70.7	72.9	62.8
Total Number Of Care Home Places	170.9	148.6	138.7	122.0	98.4
Numbers State Supported In Nursing Homes	51.9	19.9	35.5	22.1	N/a
% Of Care Home Places Provided In Residential Homes	58%	37%	49%	40%	36%
Numbers State Supported In Residential Homes	34.0	50.8	20.2	48.3	N/a
Total supported	85.9	70.8	55.8	70.4	N/a

Source: DHSSPS

- 7 In comparison to other areas, Northern Ireland has the highest number of residential care places in the UK. Of these places 58% are within a nursing home environment, compared to 37% in England, 49% in Scotland, 40% in Wales and 36% in the Republic of Ireland.

(NB: While these figures may seem to indicate a greater propensity to use nursing home accommodation we should be cautious with this explanation; the figures may simply reflect a greater level of need (for whatever reason) in Northern Ireland)

Assessed But Unmet Need

We are not clear about the relationship between our current service provision and potential, i.e., as yet unassessed need

(NB: work is currently being undertaken which may clarify this somewhat viz., the Needs and Effectiveness Working Group and the Review of Business Information Needs project).

Pressures on services are often measured only in terms of provision and met and unmet (identified) demands, whereas establishing the appropriate level of provision of health and social services would require the identification of total need, both met and unmet as well as all need in the community yet to be assessed. Since we lack direct and reliable data we have had to develop alternative ways to assess the appropriate level of provision. Hospital and community waiting list information and delayed discharge figures are therefore used as crude proxy measures.

Delayed Discharge

- 8 The number of patients remaining in hospital, after they have been deemed medically fit for discharge, has become the yardstick for measuring community care pressures. In July 2001, there were 365 patients who had had their discharge delayed. Of these, 91% were aged 65 or over and 77% were 75 or older. 66% of patients had had their discharge delayed by more than 3 weeks, 15% by more than 12 weeks and 2% by more than 6 months.

Table 4 identifies the numbers in each of the Board areas.

Table 4: Numbers With A Delayed Discharge At July 2001

	Total	Eastern HSS Board	Northern HSS Board	Southern HSS Board	Western HSS Board
July 2001	365	129	112	102	22

Source: Regional Information Branch, DHSSPS

- 9 Although a simple reading of Table 4 would seem to indicate a marked inequity between Board Areas, these figures require more detailed explanation. It would be necessary to look as well at the number of bed days lost, community waiting lists and the reporting criteria used. The straight figures are not meaningful unless examined within the context of the total services demands.

Table 5 below supports this, in particular by highlighting the significant numbers of people waiting outside for services outside the hospitals sector.

Table 5: Unmet Need in the Community (All Boards)

Number Of Adults Waiting At Home For A Nursing Home Placement	107
Number Of Adults Waiting At Home For A Residential Home Placement	174
Number Of Adults Waiting At Home For A Home Care Package	456
Number Of People (Adults Or Children) Awaiting At Home Specialist Equipment To Support Them Or Their Carers	907
Number Of People Waiting For Home Help Service	281
Number Of People Waiting For Day Care Provision	343
Number Of Adults Awaiting Hospital (As A Result Of Financial Deficits)	3
TOTAL	2271

10 Table 5 above shows the estimated numbers of people, in all of the relevant categories of assessed but unmet need, at October 2000

(NB: The table shows cases where no package is in place and does not account for cases where part of the assessed need is being met).

The 365 people identified as awaiting discharge in Table 4 will also require community care services but are not included in the Table 5 figures.

(NB: the numbers waiting in the community is therefore more than 6 times the number waiting in hospital for services to be provided).

Table 6 below provides information on the reasons why patients remain in hospital after they have been deemed medically fit for discharge.

Table 6: Reasons For Delayed Discharge

Reason for Delay	Number Delayed	% of Total Delayed
Hospital Process Not Complete	61	17%
Care Planning In Process	48	13%
Patient/Relative Choice Not Available	28	8%
No Funding Available	146	40%
No Provision Available For Place/Care Package	43	12%
Patient Self Funding	16	4%
Essential Equipment/Adaptations Not Available	13	4%
Other	10	3%
Not Specified	0	0%
TOTAL	365	100%

- 11 On these figures, a significant number (40%) are the result of a general lack of funding for community care services. While this means that the majority of delays are not primarily funding related, we have evidence that funding issues are much more complex problems to resolve.
- 12 Patients remaining in an acute hospital bed long after they have been deemed medically fit for discharge has a number of ramifications.
- Patient's human rights may be infringed as many would choose not to remain in hospital;
 - It increases risk, as vulnerable patients may be exposed to other contagious illness;

- Patient's recovery may be delayed as people tend to recover more quickly in their own homes;
- Patients may become more dependent and institutionalised;
- An acute hospital bed is the most expensive way of accommodating a person who does not require hospital treatment;
- Patient care in hospital is free therefore client contributions to accommodation are lost to service providers, and
- Inappropriate use of hospital beds results in a reduction in acute treatment capacity.

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Review of Community Care 'First Report' is also available on the Department's website:
www.dhsspsni.gov.uk

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