INSPECTION OF SOCIAL CARE SUPPORT SERVICES FOR CARERS OF OLDER PEOPLE

HOMEFIRST COMMUNITY HEALTH & SOCIAL SERVICES TRUST
NORTHERN HEALTH AND SOCIAL SERVICES BOARD

Fieldwork Inspection: 3 March 2006 – 16 March 2006

Final Report March 2007
INSPECTION OF SOCIAL CARE SUPPORT SERVICES FOR CARERS OF OLDER PEOPLE

HOMEFIRST COMMUNITY
HEALTH AND SOCIAL SERVICES TRUST
NORTHERN HEALTH AND SOCIAL SERVICES BOARD

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INSPECTION OF SOCIAL CARE SUPPORT SERVICES FOR CARERS OF OLDER PEOPLE

PREFACE

This report on the Inspection of Social Care Support Services for Carers of Older People in Homefirst Community Health and Social Services Trust is one of four separate inspection reports on the inspection fieldwork to be conducted in one Trust in each of the four Health and Social Services Board areas.

The field work Inspection took place between 3 March 2006 to 16 March 2006 inclusive.

In addition to the individual Trust reports, an Overview Report will be produced, covering key features emerging during the course of the inspection and outlining the recommendations, which will have common application to all Trusts.

Copies of the publications referred to above can be accessed as they become available on the Social Services Inspectorate website http://www.dhsspsni.gov.uk/hss/ssi/pubs.asp. Printed copies can be obtained by contacting the Social Services Inspectorate, Telephone (028) 9052 0729.

The Department can make this document available in Irish, Chinese, audio cassette, Braille and in large type. The Department will also consider requests for translations in other ethnic minority languages. If needed, please contact the Social Services Inspectorate, Telephone no. (028) 9052 0729.
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<td>Care manager</td>
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<td>Care package</td>
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<td>Care plan</td>
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<td>Care worker</td>
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<td>Review</td>
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<td>Specialist assessment</td>
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1. INTRODUCTION

1.1 The Social Services Inspectorate’s (SSI) roll-forward inspection programme for 2002/2005 identified an inspection of the social care support services for carers of older people as an area for the development of draft standards and consequent inspection. It was considered that an inspection would be timely, given:

- the publication of Valuing Carers\(^1\) and subsequent developments in support services for carers;
- the introduction of the Carers and Direct Payments Act\(^2\), which extends the provision of direct payments to include, among others, carers and came into effect in April 2004; and
- the ongoing work in developing a Strategy for Carers under the auspices of the Programme for Social Inclusion.

1.2 The aim of the Inspection was to inspect social care support services for carers of older people. Full details of the background to the Inspection will be found in the Inspection Brief (Appendix 1).

1.3 The aim of the Inspection was achieved by:

- convening a Reference Group with representatives from carer groups, including carers, the 4 Health and Social Services (HSS) Boards, 4 HSS Trusts providing social care services, voluntary organisations and academic interests;
- developing and agreeing a set of draft standards (Appendix 2) in consultation with the Reference Group and a subsequent wider consultation with a number of key organisations in the voluntary, statutory, private and education sectors. Consultation covered the needs of carers in general and ethnic minorities in particular;
- conducting an inspection of carers’ services against the agreed draft standards;
- meeting with carers and cared for persons;
- meeting with key partnership agencies and service user representative groups;
- interviewing a range of staff in the health and social services and other agencies regarding the provision of social care to carers of older people;
- developing and distributing a questionnaire (Appendix 3) to all 11 HSS Trusts providing social care services, which was designed to collect data on organisational structures, staffing levels, workloads and services to carers; and
- analysing data received from questionnaires.

\(^1\) Valuing Carers – Proposals for a Strategy for Carers in Northern Ireland, DHSSPS April 2002

\(^2\) The Carers and Direct Payments Act (Northern Ireland) 2002
1.4 The fieldwork inspection of social care support services for carers of older people in Homefirst Community Health and Social Services Trust (the Trust) was undertaken from 3 March 2006 to 16 March 2006 inclusive. The Trust is located within the area of the Northern Health and Social Services Board (NHSSB).

Demography
The NHSSB

1.5 The NHSSB is the second largest of the 4 HSS Boards in terms of population. Just over 430,500\(^3\) people live within the NHSSB area (Table 1). The Board’s area covers the borough and district councils of:

- Antrim;
- Ballymena;
- Ballymoney;
- Carrickfergus;
- Coleraine;
- Cookstown;
- Larne;
- Magherafelt;
- Moyle; and
- Newtownabbey.

1.6 The NHSSB has responsibility for assessing need, planning, commissioning, monitoring and development of new services to meet the health and social care needs of the population within its geographical area. The NHSSB commissions services on behalf of its population through service agreements for care services from HSS Trusts, voluntary organisations and organisations in the private sector. The main providers of care are HSS Trusts.

Table 1

\(^{3}\) www.nhssb.n-i.uk
The Trust

1.7 The Trust delivers a range of community health and social care services to approximately 327,823 people of whom 44,500 are aged 65 and over. The Trust covers the council areas of Antrim, Ballymena, Carrickfergus, Cookstown, Larne, Magherafelt and Newtownabbey. It is the largest Community Trust in Northern Ireland employing over 5,200 staff. The Trust provides services to large urban areas, rural areas and areas of considerable rural isolation. It also provides hospital social work services to Antrim, Braid Valley, Mid Ulster, Moyle and Whiteabbey Hospitals as part of an agreement with United Hospitals Trust.

Profile of Carers in the Trust and NHSSB area

1.8 There are, according to the 2001 Census, 34,695 people in the Trust area who perceive themselves to be carers. This is just over 78% of carers living in the NHSSB area.

1.9 There are significantly more female, almost 60% more than male carers. The higher percentage of female carers may reflect the traditional assumption that caring is perceived as a role for females in the family.

1.10 Some 38% of carers identified themselves as providing 20 or more hours of care per week.

1.11 Carers come from all age ranges with the largest numbers being in the 25-44 years age band (37%) and 44-65 years age band (42%). A significant minority of carers were reported in the 0-15 age band (991 i.e. almost 3%).

1.12 A considerable number of carers 20% have a limiting long term illness and are therefore likely to find the caring role particularly difficult and potentially need high levels of support to allow them to continue their caring role.

1.13 At the time of the census there were very few people from a minority ethnic background reported as involved in caring – less than 2.85% of the total. However, Trust staff informed the Inspectors that since the Census in 2001 there has been a considerable increase in the number of migrant workers, other migrants and their families living and working in the Trust area. Therefore, it is anticipated that figures for minority ethnic group carers are likely to rise in the future. A profile of carers in the NHSSB is set out in table 2 and for the Trust in table 3 below.

---

4 Census 2001
<table>
<thead>
<tr>
<th>NHSSB</th>
<th>All persons</th>
<th>Carers</th>
<th>Provides care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 – 19 hours</td>
</tr>
<tr>
<td>All persons</td>
<td>426,965</td>
<td>44,259</td>
<td>27,193</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>209,098</td>
<td>17,802</td>
<td>11,462</td>
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<tr>
<td>Females</td>
<td>217,867</td>
<td>26,457</td>
<td>15,731</td>
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<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 15</td>
<td>98,610</td>
<td>1,229</td>
<td>1,020</td>
</tr>
<tr>
<td>16 to 24</td>
<td>50,870</td>
<td>2,861</td>
<td>2,233</td>
</tr>
<tr>
<td>25 to 44</td>
<td>125,266</td>
<td>16,303</td>
<td>10,541</td>
</tr>
<tr>
<td>45 to 64</td>
<td>95,578</td>
<td>18,633</td>
<td>11,268</td>
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<tr>
<td>65 and over</td>
<td>56,641</td>
<td>5,233</td>
<td>2,131</td>
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<tr>
<td><strong>Ethnic Group</strong></td>
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<tr>
<td>White</td>
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<td>44,069</td>
<td>27,083</td>
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<tr>
<td>Mixed</td>
<td>770</td>
<td>34</td>
<td>23</td>
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<tr>
<td>Asian</td>
<td>626</td>
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<td>Black</td>
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<td>Chinese or other</td>
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<td>8,948</td>
<td>4,272</td>
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<table>
<thead>
<tr>
<th>Homefirst</th>
<th>All persons</th>
<th>Carers</th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1 – 19 hours</td>
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<tr>
<td>All persons</td>
<td>327,823</td>
<td>34,695</td>
<td>21,439</td>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
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<tr>
<td>Males</td>
<td>161,067</td>
<td>14,066</td>
<td>9,068</td>
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<tr>
<td>Females</td>
<td>166,756</td>
<td>20,629</td>
<td>12,371</td>
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<tr>
<td><strong>Age</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0 to 15</td>
<td>75,882</td>
<td>991</td>
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<td>16 to 24</td>
<td>38,642</td>
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<td>1,767</td>
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<tr>
<td>25 to 44</td>
<td>97,387</td>
<td>12,853</td>
<td>8,393</td>
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<tr>
<td>45 to 64</td>
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<td>65 and over</td>
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<td>3,982</td>
<td>1,600</td>
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<td><strong>Ethnic Group</strong></td>
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<td>White</td>
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<tr>
<td>Mixed</td>
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<tr>
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</tr>
<tr>
<td>Black</td>
<td>145</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Chinese or other</td>
<td>968</td>
<td>55</td>
<td>39</td>
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<tr>
<td><strong>Has a limiting long-term illness</strong></td>
<td>61,731</td>
<td>7,000</td>
<td>3,335</td>
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</table>

Table 3

5 www.nisra.gov.uk/census/excel/theme - tables
1.14 The Trust is concerned that there is an increasing elderly population within its area and predictions indicate that the number of over 65s within the area will have increased by 33.5% by 2013.

1.15 Trust Officers report that the current level of elderly population combined with a greater emphasis of providing care in the community is placing pressures on existing let alone future resources. At present the Trust has identified that there is severe underfunding within elder care services in the region of £9m per annum. Discussions with the NHSSB indicate that this is currently being addressed.

Management of the Trust

1.16 The aim of the Trust is:

“to work together with the community to provide the best care we can, so that people use our services with confidence and can make informed choices which promote their health and well being”.

1.17 The Trust is managed by a Trust board. The Trust board consists of the Non-Executive Chairman, 5 Non-Executive Members, the Chief Executive and 4 Executive Members.

1.18 The Trust board is responsible for the overall strategic direction and corporate governance of the Trust. The Chief Executive, who is answerable to the Trust board, has overall day-to-day responsibility for the management of the Trust’s activities. The Chief Executive is supported by the Trust’s Senior Management Team in managing this process.

1.19 The Trust’s Senior Management Team consists of the following personnel:

- the Chief Executive;
- the Executive Director – Finance;
- the Executive Director – Nursing, Dental and Governance;
- the Executive Director – Medical;
- the Executive Director – Social Work (also Director – Child Care Services);
- the Director Mental Health Services;
- the Director Social Care and Disability Services;
- the Director Child Health and Allied Health Services;
- the Director Planning and Information; and
- the Director Human Resources.

*Denotes Executive Member of the Trust board also.
Line Management Arrangements

1.20 The Director of Social Care and Disability Services, who comes from a planning and information background, has the main responsibility for services for carers of older people. In relation to services for older people, the Director is supported by 2 Assistant Directors for Social Care. Each Assistant Director has responsibility for a number of locality fieldwork areas and a range of specialist services.

**Director of Social Care and Disability Services**

↓

**Assistant Director**

↓

**Principal Officer**
Larne/Carrickfergus Locality Fieldwork Team

**Principal Officer**
Newtownabbey Locality Fieldwork Team

**Principal Officer**
Dementia Services

**Investigating Officer**
Investigations

**Services Improvement Manager**
Service improvements

↓

**Assistant Director**

↓

**Principal Officer**
Antrim/Ballymena Locality Fieldwork Team

**Principal Officer**
Magherafelt/ Cookstown Locality Fieldwork Team

**Principal Officer**
Domiciliary Care

**Manager**
Permanent Care

**Manager**
Bed co-ordination
1.21 Principal Officers have responsibility for all services within their geographical area. So, for example, the Principal Officer for Magherafelt/Cookstown has the following line management structure. This structure is reflected throughout the Trust where, except for specialist teams, each Principal Officer has management for all the key teams within their geographical patch.

\[\text{Director} \downarrow\]
\[\text{Assistant Director} \downarrow\]
\[\text{Principal Officer} \downarrow\]
\[\text{Senior Social Workers x 2} \downarrow \text{Heads of Unit x 3} \downarrow \text{Manager}\]

Senior Social Workers x 2
Fieldwork Offices at Cookstown and Magherafelt

Heads of Unit x 3
Day Centres at Maghera/Magherafelt/Cookstown

Manager
Westlands Old Peoples Home

1.22 Each locality team within the Trust is managed by a Senior Social Worker who in turn is managed by the appropriate Principal Officer. All of the Principal Officers are qualified social workers. Both of the Assistant Directors are also social work trained so the career progress path and professional development route within social work is strong.

1.23 Each team comprises a number of social workers depending on the size of its catchment area. The number of social workers range from 6.5 in the largest team to 3.5 in the smallest team. In addition, each team has one Community Care Support Worker; a post which is similar to Social Work Assistant grade.

1.24 Social workers carry out all initial assessments when a new referral is made. If the case is a complex one remains on the social worker’s caseload. Less complex cases, which are generally those with limited practical care support needs, are managed by the Community Care Support Workers. Cases with exclusive domiciliary care needs are passed to the Home Care service.

1.25 Caseloads are high across the Trust, they are generally in the region of 50-55 per social worker and 100 per community care support worker. There are no waiting lists for assessments but at the time of inspection there are considerable waiting lists for services. Trust staff report there are considerable demands on community services.

1.26 In addition to the fieldwork teams, there are a number of specialist teams in the Trust which support families and carers.
Dementia Team

1.27 There are 2 Trust-wide dementia teams with particular responsibility for the delivery of dementia services. These are managed by social workers and comprise 4 social workers and 2-3 community care support workers. These Teams have responsibility for providing support to those individuals and families who have specific needs related to dementia and so are likely to have complex care and support needs. There are considerable links between these Teams and mental health services as well as with the locality fieldwork teams.

Permanent Care Review Team

1.28 The Permanent Care Review Team, set up in 2004, reviews all permanent nursing and residential care placements in the Trust. The Team is managed by a Manager from a social work background and is made up of 2 social workers, 2.5 district nurses, a community psychiatric nurse and a community learning disability nurse.

1.29 The Team receives referrals from community-based teams after an individual has been in residential care for over 3 months and is deemed to be a ‘settled placement’. The aim of the Team is to review all permanent care placements, in both statutory and independent residential care, initially at 6 months and thereafter on an annual basis as a minimum.

1.30 The review is to ensure that all individuals being supported by the Trust are receiving the appropriate level of care and that their needs are being identified and met through an appropriate care planning process. This is a major development in the management of reviews and as such the Trust should be commended on this initiative.

1.31 Carers are invited to the reviews by a standard letter to relatives informing them that the review is taking place. Staff reported that some of the relatives and carers invited to these reviews have other caring roles and therefore have limited opportunities to participate in the reviews. These reviews form the main point of contact for carers who have family members in residential care as locality fieldwork social work teams no longer have a role once the referral to the permanent care review team is made.

Recommendation

The Trust should consider how to increase the engagement with carers and families who have other caring commitments to ensure that permanent care reviews take place at a time and place that suits them. In addition, consideration should be given to providing additional practical support which ensure the carer can attend reviews without placing extra stress on other members of the family.

Community Rehabilitation Service

1.32 The multi-disciplinary Community Rehabilitation Teams, which comprise the Community Rehabilitation Service, provide a high level of care from a range of professionals over a 6 or 12 week period, according to assessed need, to facilitate discharge from hospital to the community. The aim of the Teams are to provide a comprehensive support system for patients leaving hospital which will aid their
recovery. The Teams also seek to prevent avoidable admissions to hospital and/or nursing or residential care. The individuals usually referred are those who have suffered strokes or similar debilitating illnesses. Potential referrals to the service are screened by a team member and then discussed within the Teams. If the referral is deemed appropriate then a service is put in place with co-ordinated professional input from across the range of health and social care disciplines. The aim is to ensure that individuals can be safely maintained in their own homes.

1.33 There are 3 Teams located throughout the Trust. The Teams consist of different disciplines, although numbers may fluctuate, which include:

- the senior social worker;
- social workers;
- occupational therapists;
- physiotherapists;
- community rehabilitation assistants;
- community nurses;
- speech and language therapists;
- podiatrists; and
- dieticians.

Managers of the 3 Teams are respectively from social work, occupational therapy and podiatry backgrounds.

1.34 When agreeing a package of care for the patient being discharged the needs of the family and the primary carers are taken into consideration. The staff in the Team informed Inspectors that, on occasion, discharges had been delayed when carers felt that they were not ready to undertake the caring role in the community.

1.35 Initial screening and assessment can be undertaken by any team member. This is then discussed at team meetings and clearly defined roles with outcomes are agreed, for example, a social worker will always carry out the carer assessment.

1.36 At the end of the 6 or 12 week period the service user and the carer are referred back to the locality fieldwork team for ongoing support, if required.

1.37 At each stage of the process the family and carers are engaged in consultation over need and the rehabilitation plan. This relatively new service has successfully allowed people, requiring intensive time limited support, to return to the community.

1.38 As part of the support mechanism for the discharge from hospital the Community Rehabilitation Team have ring fenced home care support and can at short notice call on home care hours. While this allows an immediate service to these Teams, it means that other services such as locality fieldwork teams have fewer hours available for ongoing support. The Trust points to the underfunding of elder care services (para 1.15) as the primary constraints in relation to the provision of domiciliary care. However, it will need to continue to work with the NHSSB to ensure that this is addressed and that there is equity of provision.
**Integrated Care of Elderly People Team**

1.39 This is a new co-ordinated approach by a range of disciplines and services, including community rehabilitation, community nursing and social care services initiative linked to clusters of GP practices. This Team targets older people who are frequently admitted to hospital and seeks to help develop alternative support infrastructures within the community for them. This team too has access to ringfenced home care hours. When there is a need for social care support for either the service user and/or the carer referral is made to a social worker. Each locality fieldwork team will have a social worker designated to work in partnership with the Integrated Care of Elderly People Team. However, these social workers continue to be line-managed and supported professionally from within their locality fieldwork team.

**FIELDWORK**

**The Trust**

1.40 The Inspection was undertaken against an explicit set of draft standards and criteria, which were drawn up prior to the Inspection. The Standards were derived from legislation, policy and practice guidance, relevant literature and other appropriate standards developed by the SSI or adapted from similar work elsewhere in the United Kingdom. The Standards were based on current best practice and they were developed and refined in collaboration with the Reference Group and in consultation with the HSS Boards, HSS Trusts and other key agencies. This Report outlines the Trust’s performance against the criteria for each of the 6 standards:

1. Planning, Commissioning, Delivery and Review of Social Care Services;
2. Assessment, Care Planning and Review;
3. Support Services;
4. Information for Service Users;
5. Workforce Planning, Workforce Management, Training, Supervision and Support; and

1.41 Following the completion of the inspection in the 4 HSS Board and 4 HSS Trust areas, the draft standards will be reviewed and refined in the light of the inspection findings. These will then be issued by SSI as an agreed set of standards for the provision of social care support services to carers. The Standards will set out what carers can reasonably expect from services and provide a benchmark against which providers of social care services can undertake self-audit. The Standards will be subject to continuous review in the light of best practice emerging.

1.42 During the inspection period, the Inspection Team analysed the Trust questionnaire and examined a range of Trust policy documents. A number of carers were identified from 36 randomly selected case files, 6 of these files were followed through in detail including, interviews with carers and, where possible, cared for people. In addition a series of interviews and meetings were conducted with carers’ groups, Trust managers, Trust professional staff and representatives of key organisations in contact with carers including:
• Director – Social Care and Disability Services;
• Assistant Director Social Care and Disability Services x 2;
• Director of Planning and Information;
• Director – Children’s Services;
• Social Worker – Integrated Care of Elderly People Team;
• Manager – Permanent Care Review Team;
• Members of the Intermediate Care Team;
• Members of the Dementia Team;
• Social Work Seniors x 5;
• Social Workers x 7;
• 2 APSWS – Area Social Services Training Department;
• Principal Officer Nursing;
• Hospital Social Workers, (Antrim, Braid Valley, Whiteabbey, Mid Ulster and Moyle Hospital) - 1 APSW, 2 SSWs and 3 SWs;
• Acting Principal Officer Community Nursing Learning Disability;
• Community Psychiatric Nurse – Team Leader (Antrim/Ballymena, Cookstown/Magherafelt);
• Manager – Clanmil Housing Association, Voluntary Residential Unit (Marriott House, Magherafelt);
• Manager & Nursing Care Assistant – Milesian Manor Private Nursing Home (Magherafelt);
• Acting Manager – Westlands Statutory Residential Home (Cookstown);
• Manager – Cookstown Day Centre;
• Centre Manager – Antrim Day Centre;
• Manager – Moylinney Elderly Mentally Infirm (EMI) Residential Care Home; Moylinney EMI Day Care Centre;
• Deputy Manager – Inniscoole Day Centre;
• Equality Manager;
• Complaints Officer;
• Director (NI) and Outreach Worker (Larne/Ballyclare) – Alzheimer’s Society;
• Operations Manager (NI) and Locality Manager (Homefirst) – Home Care NI;
• Business Development Officer – Fold Telecare;
• Director – Carers NI, Information and Development Workers x 2;
• Chief Executive – Crossroads Care; and
• Director, Office Manager & Project Worker - Relatives Association.

1.43 The Inspection Team also spoke to Carers facilitated by following groups:

• Manager – Home Care;
• Older People’s Support Group – facilitate by Age Concern, Cookstown;
• Dementia Carers Support Group – Antrim/Mid Ulster facilitated by Extra Care;
• Dementia Carers Support Group – Larne/Carrickfergus facilitated by Extra Care; and
• Carer’s Support Group representatives from Ballyclare, Ballymena, Larne – facilitated by Carers NI.
The Trust and NHSSB also provided a range of written materials on all aspects of their services and practice, which are referred to throughout the report, where appropriate.

NHSSB

The Inspection Team held 3 meetings with representatives of the NHSSB. This included a preliminary meeting with key personnel to outline the Inspection Brief and afford the NHSSB the opportunity to present their commissioning, planning and monitoring arrangements with particular regard to carers of older people. This was followed up by a meeting to explore these areas more fully and finally by a general feedback meeting on the key themes emerging from the fieldwork element of the Inspection in the NHSSB and the Trust. The Inspection Team held discussions with the:

- Acting Assistant Director of Social Services (Adult Services); and
- Principle Social Worker (Adult Services).

The NHSSB also provided a number of written documents. These included:

- Implementation of Valuing Carer’s Progress Report May 2004;
- Public Involvement Policy – 27 June 2001;
- Public Involvement Activity – Annual Review April 2004;
- Extra Care Family Carer Training Pilot Project – Final Evaluation Report;
- Carers NI/NHSSB Carers Initiative Report on Activity – April 2003;
- Breakdown of funding for Voluntary/Community Sector – 2006;
- Corporate Plan – 2005-2006 and 2006-2007; and
- SSI Inspection of Social Care Support Services for Carers of Older People response document.

Questionnaires

Prior to the Inspection period, the Trust completed a pre-inspection questionnaire, providing details of services (including their location), management arrangements, staff levels, training, quality assurance activities, complaints procedures and information and communications technology arrangements.

The Trust also disseminated 50 questionnaires directly to carers of older people with whom the Trust was in contact. Further questionnaires were distributed through Advice NI, a local welfare rights network agency who sought to access further carers in the Trust area who are not in receipt of services. These questionnaires will be analysed by the Inspection Team and form part of the evidence for the overview report.
SUMMARY OF RECOMMENDATIONS – CHAPTER 1

• The Trust should consider how to increase the engagement with carers and families who have other caring commitments to ensure that permanent care reviews take place at a time and place that suits them. In addition, consideration should be given to providing additional practical support which ensure the carer can attend reviews without placing extra stress on other members of the family (Para. 1.31).
2. PLANNING, COMMISSIONING, DELIVERY AND REVIEW OF SOCIAL CARE SERVICES

<table>
<thead>
<tr>
<th>Standard for planning, commissioning, delivery and review of social care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers and/or carers’ representative organisations are actively involved in the planning, commissioning and review of social care services</td>
</tr>
</tbody>
</table>

**NHSSB**

2.1 The NHSSB has a number of initiatives in place which promote consultation with its resident population. There are 2 key consultation databases both of which include carers or carers’ representatives. These are:

- a voluntary and community database; and
- a public consultation database.

**Voluntary and Community Database**

2.2 This is a database of 549 voluntary and community groups whose work is in the NHSSB area. The database includes groups local to the NHSSB area and larger organisations with a regional remit.

2.3 This database is consulted on a range of topics by the NHSSB including Equality Impact Assessments, development of new services and review of or change to existing services. Consultation can be with the entire database, or, where appropriate, with specific organisations on the database where the topic may be of special interest to them.

2.4 There are a number of carers organisations and organisations with an interest in caring on the database including:

- Carers Northern Ireland (Carers NI);
- the Relatives Association;
- Age Concern;
- Rethink; and
- Crossroads Caring for Carers.

**Public Consultation Database**

2.5 In order to reach a wider public for consultation beyond the voluntary and community organisations, the NHSSB developed a public involvement policy in 2001. The principles underpinning this policy are that:

- marginalised people need to be involved in consultation;
• members of the public will be viewed as equal partners to professional staff on committees and project teams; and
• particular efforts will be made to engage with representatives of the 9 categories of people identified under Section 75 of the Northern Ireland Act 1998.

2.6 NHSSB recognises that while the voluntary and community sector are a key part of consultation there is a need to seek a wide ranging consultation and interaction with the general public. In order to facilitate this wider engagement 2,000 letters were sent out in October 2003 to members of the general public selected at random from General Practitioner lists held by the Central Services Agency. Because of a limited take up, a further 3,975 letters were sent out early in 2004. This has resulted in a total of 521 active panel members who work with the NHSSB on a range of consultations and other developments. The 521 active panel members are spread across all of the council areas within the NHSSB area.

2.7 The public involvement policy is reviewed every year and it is intended that the range of interests represented by panel members will be reviewed every 3 years.

2.8 Panel Members have been involved in a range of activities and meetings with regard to:

• consultation on cancer prevention;
• consultation on community involvement;
• review of privacy and dignity for patients;
• review of regional transport services;
• cervical screening;
• investment in neurology;
• cardiac rehabilitation;
• stroke strategy review;
• review of privacy and dignity for patients/clients in the community; and
• the NHSSB response to standards development work undertaken by the Department.

2.9 The NHSSB has devised a training programme which is delivered to all panel members who have been involved in its work or in the work of the Local Health and Social Care Groups (LHSCGs).

2.10 The NHSSB is to be commended on its approach to public and carer involvement and in particular for the training and support provided to panel members.
Consultation with Carers

2.11  NHSSB has ensured that carer’s voices are heard as part of the overall consultation process within its area. A total of 147 of the 521 Panel Members are carers. These are broken down as follows:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-19 years old</td>
<td>11</td>
</tr>
<tr>
<td>20-29 years old</td>
<td>26</td>
</tr>
<tr>
<td>30-39 years old</td>
<td>35</td>
</tr>
<tr>
<td>40-49 years old</td>
<td>42</td>
</tr>
<tr>
<td>50-59 years old</td>
<td>21</td>
</tr>
<tr>
<td>60-69 years old</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147</strong></td>
</tr>
</tbody>
</table>

There are 104 female and 43 male carers in this group.

2.12  These carers are part of the wide range of ongoing consultation and review processes undertaken by NHSSB but are also consulted specifically on areas of work which may be of specific interest or significant to carers. These include:

- the ongoing consultation linked to the Carers Strategy which the Board has developed in response to “Valuing Carers – Proposals for a Strategy for Carers in Northern Ireland”;
- a mental health forum;
- public health project teams; and
- a stroke strategy review group.

2.13  The NHSSB has also developed a “Caring for Carers Strategy Implementation Group”. This group consists of local carers, representatives of the NHSSB and the Trusts and representation from carers group. This is a relatively new group set up to respond to the recommendations contained in “Caring for Carers, Recognising, Valuing and Supporting the Carer Role” (DHSSPS January 2006).

2.14  In addition, the NHSSB has a Service Level Agreement (SLA) with Carers NI. As part of this agreement Carers NI has developed a number of local carers’ groups across the Trust area which act as a further conduit for consultation between NHSSB and both local carers groups and individual carers. Further information on this agreement is contained in Paras. 2.29-2.53.

The Trust

2.15  One of the Trust’s stated core objectives is “to involve users and communities” in a meaningful way when planning and reviewing services or developing policies. This is undertaken through a number of processes. An example of this is the Trust’s Disability Consultation Panel which was established as a forum to actively involve service users and carers in the planning and monitoring of services.
2.16 The Trust has a contact list of voluntary and community organisation which provide support and information within their area. This includes a wide range of organisations from local area/community based organisations to organisations such as Age Concern NI which not only have services at a local level but also have a regional remit.

2.17 Carers and users have been extensively involved in the development of “A Better Age”, the Trust’s Strategy for Services to Older People. This was facilitated through consultation with local carers groups, the LHSCGs and consultation with individual carers identified by Carers NI.

2.18 The Trust has also developed an interesting approach to consultation via front line professional staff to further access service users’ views. So, for example, each social worker in the relevant programmes of care was asked to gather views from a minimum of 3 service users during the development of the strategy for services to older people. This meant that there was a considerable input from service users. The Trust is to be commended on this widespread focus on consultation.

2.19 There are, some concerns over the level of consultation between the Trusts and carers groups. In particular there is limited contact between the Trust and Carers NI who provide a key link to local carers group in the Trust area. This contact is explored further in Paras 2.29-2.53.

Commissioning Arrangements

2.20 Each year the NHSSB sets out its commissioning priorities and spending plans. This process is informed by Priorities for Action (DHSSPS), Programme for Government, local service pressures, development priorities and the management of acute pressures. The Trust is required to respond to the priorities and spending plans by developing annual delivery plans.

2.21 Commissioning arrangements for carers and support and planning of services for carers are developed and informed by further factors including:

- “Valuing Carers” and the subsequent Carers Strategy;
- Carers and Direct Payment Act;
- information about population and needs;
- the focus on developing community based services;
- improving the quality of life and encouraging choice; and
- value for money.

2.22 Information on need is collected from the Trust who have regular meetings with the NHSSB. The issue of the identification of need is explored in Paras 3.2 and 3.3.

2.23 The NHSSB sets up Project Boards which oversee particular projects or areas of work. These are normally internal working groups consisting of relevant officers from within the NHSSB. So, for example, the Project Board which oversaw the development of ‘Ringing the Changes’ a Strategy for Older People 2002 was chaired by the Chief Executive and had a range of representation including the Directors of:
• social work;
• medicine;
• nursing;
• finance; and
• strategic planning and commissioning.

It also included members of the LHSCGs within the NHSSB area.

2.24 The Project Board then puts in place a Project Team which will have responsibility for taking the work forward. This Team is NHSSB-led and contains Commissioning Officers and Senior Managers across the range of appropriate disciplines as well as inviting representatives of other interested parties which may include GPs and Trust personnel such as social workers and allied health professionals depending on the remit of the project.

2.25 The Project Team and Board are further supported by a Project Advisory Panel. This comprises a wider range of stakeholders, including Trust representatives, and representation from:
• social security;
• the voluntary sector;
• hospital and community based nursing;
• NI Housing Executive; and
• consultants from a range of hospitals.

Again the representation will depend on the remit of the project and decisions on team membership are the responsibility of the Project Board.

2.26 The process is inclusive of a wide range of stakeholders within the statutory, voluntary and community sectors and is time limited to develop appropriate strategies. These strategies then form the basis of further planning, development, commissioning and review of services.

2.27 The Commissioning Team for older people meets internally on a weekly basis and with the Trust on a monthly basis. It is chaired by the Senior Nurse Advisor, NHSSB. The meetings examine progress in meeting Priorities for Action targets, identify pressures and identify unmet needs. These meetings will take place with the appropriate staff from the programme of care within the Trust.

2.28 In addition to the monthly meetings at which the Trust will prepare a monthly report on key areas of activity, the Trust is also expected to provide an annual report on delegated statutory functions. This monthly and annual cycle forms the basis of ongoing monitoring, evaluation and identification of need. Issues around identification of need are further explored in Paras 3.1 and 3.3.

Support for Carers

2.29 NHSSB has been involved in the development of services for carers and has demonstrated that commitment through the pilot support for carers programme established in 2000. This pilot demonstrates the NHSSB’s long standing commitment to carer support.
2.30 This programme was a partnership between NHSSB and Carers NI to identify and meet the information and support needs of carers in the NHSSB area regardless of whether they were known to the Trust(s) or not. It is the Board’s experience that many carers may not use or wish to use Trust services and that a voluntary sector provider makes additional resources available which carers may access. This pilot has now evolved into a wider support programme for carers, provided through a service level agreement, funded by money from the Department. Consequently, the Trust does not have a carers co-ordinator as recommended by “Valuing Carers”.

2.31 The NHSSB has allocated £66,000 per annum to Carers NI to provide services which are directly focused on supporting carers. In addition, the Trust has a funding support programme which provides either grant aid or has service level agreements with a range of voluntary providers including:

- Alzheimer’s Society;
- Chest Heart and Stroke Society; and
- the Relatives Association.

All of whom provide direct support services to carers.

2.32 Two Information and Development Workers (IDWs) are based in the NHSSB area. The posts are based on the localities of the LHSCGs as follows:

<table>
<thead>
<tr>
<th>LHSCG</th>
<th>Council Areas Covered</th>
<th>IDW</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Antrim</td>
<td>Carrickfergus, Larne and Newtownabbey</td>
<td>1</td>
</tr>
<tr>
<td>Antrim/Ballymena</td>
<td>Antrim and Ballymena</td>
<td></td>
</tr>
<tr>
<td>Causeway and Mid-Ulster</td>
<td>Coleraine, Ballymoney, Magherafelt and Cookstown</td>
<td>1</td>
</tr>
</tbody>
</table>

The decision to allocate the IDWs in this way was taken with the view that the LHSCGs would have a major part in identifying need and allocating resources for Carers’ Services. The outcome is that one worker has a full-time remit in the Trust’s area while the other covers the Magherafelt/Cookstown area of the Trust for approximately half of the time while the rest of their time is spent in promoting activities in Causeway HSS Trust.

2.33 The service level agreement between the Board and Carers NI sets out a number of key objectives. These are:

- development and support of local carers’ groups;
- production and distribution of a local A-Z information guide of services for carers;
- enquiry service to advise on individual needs;
- Information Outreach Service;
- creating networking opportunities amongst agencies;
- training and support for mentors to support carers in raising complaints; and
- support for the involvement of carers in service planning and development.
Development and Support for Local Carers’ Groups

2.34 There are a number of local carers’ groups in the Trust area. These are as follows:

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>Current average attendance</th>
<th>Total membership in the past 3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Ulster</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Antrim</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Larne</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Whitehead</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>Carrickfergus</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Whiteabbey</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>Ballymena</td>
<td>30</td>
<td>40</td>
</tr>
</tbody>
</table>

2.35 The Antrim group is a reconstituted group where the previous group had largely folded in 2003. With support from the IDW the group was successfully relaunched in September 2005. The Whitehead group has recently ceased due to poor attendance. However the IDW is working closely with a local social worker to revive the group. A key part of the work has been in maintaining and reinvigorating existing groups. There has been little emphasis on the development of new groups over the last 2 years. Work is going on in Ballyclare to develop a group there. This is the only new group in the Trust area in the last 3 years.

Recommendation

The Trust, in partnership with Carers NI, should identify where there is most need for support and concentrate on setting up new groups in those locations, as well as continuing the support for existing groups.

2.36 Support to the existing local carers’ groups includes:

- funding advice;
- help with funding applications;
- management advice;
- information on new initiatives;
- facilitating consultation;
- highlighting issues to the Trust and Board;
- negotiating with external agencies e.g. benefits;
- signposting to other services; and
- facilitating external speakers.

2.37 During the Inspection discussions took place with representatives of 4 of the local carers’ groups. They found the support and services offered by the IDWs to be of considerable value in supporting them in the practical development and maintenance of the groups and in the access to information. A number of individual carers commented on the support that they had received in accessing benefits and in corresponding with the Trust in order to get appropriate services.
2.38 The groups are meant to be a support for carers and also act as a conduit for exchange for information between the Board, the Trust and carers on many topics such as, for example, Carers’ Assessments and Direct Payments. Information sessions which are normally led by Carers NI or external speakers brought in to talk to the groups do provide a range of practical information but there is little evidence of direct dialogue between the groups and either Trust or NHSSB personnel.

2.39 For example, information on the groups did not appear to be readily available to Trust staff and was therefore not passed on to carers. Consequently opportunities to join groups appeared to be limited. The Inspection Team spoke to 5 different carers, identified through Trust files, and none of these were aware of carers’ groups operating in their area. In addition, none of the file recordings had indicated that any carers had been referred to group support within the community by Trust staff.

**Recommendation**

*The Trust and Carers NI need to consider ways in which information on carers’ groups is developed and circulated to Trust staff so that it can be passed on to all existing carers and to new carers as they are identified.*

2.40 There was no evidence of any information regarding carers’ groups or the role of Carers NI on display at any of the Trust premises visited as part of the Inspection. Carers NI did not have an overall plan on how information could be distributed and maintained at key points throughout the Trust. Carers NI representatives informed the Inspection Team that they did however distribute information at public locations such as GP surgeries and public libraries and that there was an agreement that the Trust would circulate information through their internal mail system.

**Recommendation**

*The NHSSB, the Trust and Carers’ NI should begin discussions on how information on carers’ groups and other general information of value to carers is distributed and maintained in the Trust’s key locations.*

**Referral Systems**

2.41 Carers NI has developed postcards which are intended to be distributed to carers by Trust staff. The postcards have a prepaid “tear-off” section which the carer can fill in and send to Carers NI. The carer will then be contacted by the IDW who will, if this is agreed by the carer, visit to provide further information and signpost on to other potential support.

2.42 The Inspection Team found that the vast majority of Trust staff, at team and management level, interviewed had neither heard of nor seen these postcards. In addition, those staff who had heard of the IDWs had little or no understanding of their role. A significant proportion of staff interviewed had not heard of the IDWs and had no idea that Carers NI were providing support services to carers within their Trust.
2.43 This lack of information flow is significant and creates limited opportunities for carers to be signposted to the appropriate services. Only 2 of the 8 social work teams indicated that they had had any contact with the IDWs and on both occasions this was at the request of the Team Leader. The Director of Carers NI had written to all of the teams to introduce the IDWs. The IDWs have indicated that they have had meetings with 9 field teams across the programmes of care as well as day centre and hospital social work staff. There is, however, little evidence of any proactive partnerships between Trust staff and IDWs to promote the needs of carers.

**Recommendation**

*The NHSSB, the Trust and Carers NI urgently need to review the process of promoting the work of the IDWs so as to ensure that they have regular and meaningful dialogue with Trust staff in order to better promote support systems for carers.*

2.44 Equally there is little indication that the Trust has promoted or co-ordinated work with Carers NI or attempted to develop strategies which would promote greater integration of services to carers or put mechanisms in place to raise awareness of or promote ownership of carers’ issues within the Trust.

**Recommendation**

*The Trust needs to ensure that awareness of and ownership of carers’ issues is placed on the agenda by senior officers who can promote partnerships and co-ordinated work which will benefit carers.*

**Social Work Referrals**

2.45 Even where social work personnel were aware of some or all of the range of support services available for carers in the voluntary and community sectors, the Inspection Team noted that there was a reluctance among some staff to refer carers to these sources of support. Social work staff on different occasions indicated to Inspectors that they saw the role of carers’ support as primarily theirs. They did not see this as something other agencies should or could undertake as it needed a professional social work input.

2.46 This view is a matter of concern as it means that on occasions social workers may be unwilling or reluctant to refer to other supports which are available to carers. This does not allow carers to make decisions about their own lives. It also deprives them of the opportunity to receive support from a range of organisations which can provide additional and alternative services to those that the Trust with its stretched resources can supply. In addition, it raises concerns over the benefits arising from increased community development processes within the Trust. If these community development initiatives are to be successful then staff need to recognise their value and use them appropriately.
**Recommendation**

*The Trust should put systems in place which will monitor and assess the referrals to external supports which complement Trust services. Individual carer’s care plans should reflect consideration of the range of resources available and recording clearly show where these have been offered to carers.*

**Monitoring of Referrals**

2.47 The commissioning arrangement between the NHSSB and Carers NI contains limited monitoring of activity and in particular monitoring of referrals from Trust personnel. This means that there is no effective way of evaluating the impact that the project is having in promoting appropriate referrals. At present evaluation appears to largely rely on a cycle of bi-annual meetings and an annual report presented by Carers NI to the NHSSB.

**Recommendation**

*The NHSSB needs to further develop its monitoring and reporting systems with Carers NI to ensure that action plan targets are clear and are being met. In addition the NHSSB and Carers NI need to begin a process of engagement with the Trust to ensure that appropriate structures are put in place which allow for greater monitoring of referrals.*

**Planning and Delivery**

2.48 The NHSSB and Carers NI partnership arrangement to provide a range of services for carers, in effect, has left the Trust peripheral to the planning process and less than engaged in viewing Carers NI as a source of support for carers in its area. This is evidenced by the most recent agreement for delivery of services by Carers NI which has been agreed with the NHSSB and an outline 3 year strategy which was put in place without any consultation with the Trust. This is a matter of concern as the Trust’s participation in and informing of any planning is vital to its success.

**Recommendation**

*The NHSSB and Carers NI needs to reconsider the outline plan for the next 3 years and begin a process of in-depth consultation with the Trust. This will help ensure that the Trust fully engages with the plan.*

2.49 Overall Inspectors were concerned that the Trust has not been consistently involved with the development and monitoring of services for carers commissioned by the NHSSB over the past 3 years. This limits any impact that support services to carers may have had in the Trust area.
Recommendation

The NHSSB and Trust need to work cojointly to drive forward the carers’ agenda within the Trust. It may also be appropriate to include the Causeway HSS Trust in these discussions as the process of carers’ support is similar there.

The basis for these discussions should reflect changes in the HSS structure in the wake of the Review of Public Administration and the Carer’s Strategy issued by the Department in January 2006. In particular, attention should be paid to the recommendation which states that “the potential for change is maximised where the carer co-ordinator is located in the Trust”.

2.50 Notwithstanding the issues that have arisen about communication and commissioning arrangements it is important to reflect that the NHSSB has given a high level of commitment to the support of carers. This has included support to a range of local community organisations as well as regional organisations who have a carers remit (Para 2.31). There is also a range of consultation processes in place at both Trust and NHSSB level as previously indicated.

“Hidden Carers”

2.51 Carers NI have been involved in a number of initiatives to focus on the needs of carers, raise awareness and try to target hidden carers. Examples of events over the last 3 years include:-

- awareness displays at Whiteabbey Hospital, Cullybackey Health Centre, and contributing to The Relatives Association information day;
- participation in health and community information days at the Townhall in Coleraine, the Arts Centre in Cookstown and the Cookstown networking event;
- talks to social work teams and other voluntary/community organisations such as PAPA (support autism) and Parkinson’s Disease Support Group;
- organising events for Carers’ Week such as displays in libraries, GP practices; and
- awareness raising activities to promote Carers’ Rights Day on the first Friday in December each year.

2.52 There is little evidence of the Trust developing their own strategy to identify and target “hidden carers” within its area or to undertake activities linked to Carers’ Week.

2.53 The Trust’s partnership with Carers NI is extremely limited and is largely confined to a 6-monthly meeting between the Director of Carers NI and the Assistant Director for Social Care. This is, by and large, an exchange of information and does little to inform the strategic focus of work with carers in the Trust area.

Recommendation

The Trust needs to develop a fuller more meaningful partnership with Carers NI which creates an environment of real partnership and joint working based on needs identified by both organisations.
SUMMARY OF RECOMMENDATIONS - CHAPTER 2

- The Trust, in partnership with Carers NI, should identify where there is most need for support and concentrate on setting up new groups in those locations, as well as continuing the support for existing groups (Para. 2.35).

- The Trust and Carers NI need to consider ways in which information on carers’ groups is developed and circulated to Trust staff so that it can be passed on to all existing carers and to new carers as they are identified (Para. 2.39).

- The NHSSB, the Trust and Carers’ NI should begin discussions on how information on carers’ groups and other general information of value to carers is distributed and maintained in the Trust’s key locations (Para. 2.40).

- The NHSSB, the Trust and Carers NI urgently need to review the process of promoting the work of the IDWs so as to ensure that they have regular and meaningful dialogue with Trust staff in order to better promote support systems for carers (Para. 2.43).

- The Trust needs to ensure that awareness of and ownership of carers’ issues is placed on the agenda by senior officers who can promote partnerships and co-ordinated work which will benefit carers (Para. 2.44).

- The Trust should put systems in place which will monitor and assess the referrals to external supports which complement Trust services. Individual carer’s care plans should reflect consideration of the range of resources available and recording clearly show where these have been offered to carers (Para. 2.46).

- The NHSSB needs to further develop its monitoring and reporting systems with Carers NI to ensure that action plan targets are clear and are being met. In addition, the NHSSB and Carers NI need to begin a process of engagement with the Trust to ensure that appropriate structures are put in place which allow for greater monitoring of referrals (Para. 2.47).

- The NHSSB and Carers NI needs to reconsider the outline plan for the next 3 years and begin a process of in-depth consultation with the Trust. This will help ensure that the Trust fully engages with the plan (Para. 2.48).

- The NHSSB and Trust need to work cojointly to drive forward the Carers’ agenda within the Trust. It may also be appropriate to include the Causeway HSS Trust in these discussions as the process of carers’ support is similar there.

The basis for these discussions should reflect changes in the HSS structure in the wake of the Review of Public Administration and the Carer’s Strategy issued by the Department in January 2006. In particular, attention should be paid to the recommendation which states that “the potential for change is maximised where the carer co-ordinator is located in the Trust” (Para. 2.49).
• The Trust needs to develop a fuller more meaningful partnership with Carers NI which creates an environment of real partnership and joint working based on needs identified by both organisations (Para. 2.53).
3. ASSESSMENT, CARE PLANNING AND REVIEW

<table>
<thead>
<tr>
<th>Standard for assessment, care planning and review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers benefit from convenient, easy to use services through effective person-centred assessment, care planning and review arrangements</td>
</tr>
</tbody>
</table>

**Carers Assessments**

3.1 There is evidence from the files examined that most cases contain a carer’s assessment. The Trust has encouraged social workers to complete carer’s assessment but some social workers report that they are inhibited by the lack of resources which tended to turn the process into ‘a paperwork exercise’. Social workers acknowledge that training has been made available for completion of carer’s assessments but indicated that there needed to be more resources to offer real support for carers. Several staff referred to the need for a ring-fenced budget for support for carers, in order to respond realistically to the needs identified in carer’s assessments. In particular, many staff commented that a sitting service was a frequently identified need, but it was rarely possible to meet this. For example, the Trust has an upper limit of 27 hours per week in relation to care support, which can only be extended in exceptional cases, such as emergencies and assessments tend to reflect this boundary.

3.2 This means that unmet need is not being fully explored by staff not recorded which has ramifications at both Trust and NHSSB level in that it limits the amount of information available to inform the commissioning and planning of services. The impact of the 27 hours ceiling is further discussed in Paras. 4.42-4.44.

3.3 It also suggests that the assessment process is being driven by the availability of resources rather than the assessed needs of individuals, which runs counter to the core objectives of care management.

**Recommendation**

*The Trust needs to ensure that staff adhere to the principle that assessment is needs-based rather than resource driven and that all unmet need identified through holistic assessment is properly recorded and identified for planning purposes.*

3.4 Some staff referred to the length of the carer’s assessment process, which could take up to 3 hours. This was viewed as a reason for not actively promoting carers’ assessment. A further reason given was concern about raising expectations, among carers, that they would receive services and support which the Trust could not provide given budgetary restraints. However, several staff commented on the “therapeutic” value to a carer when an assessment was completed, as it provided an opportunity to allow the carer to reflect on what they had achieved. It was commented that completion of an assessment often required considerable social work skills. The Inspection Team interviewed several carers who had been offered carer assessments and there was general appreciation of the value of completing this exercise regardless of whether this resulted in further service provision.
3.5 The Trust is currently delivering training to all key staff on Carer’s Assessment. At the time of Inspection 109 staff had received training on carrying out carers assessments. It is anticipated by the Trust that the process of training will increase the number of assessments being offered and being carried out.

**Recommendation**

*The Trust should review its training on Carer Assessment to reinforce the understanding that appropriate professional assessment is a support in itself as well as a tool for identifying and meeting need.*

**Assessment, Care Planning and Review**

3.6 There was evidence from the files randomly selected for examination by Inspectors of a consistent system which produced an assessment, a care plan and a review for the cared for person. There was evidence from the files of the carer’s contribution to the assessment of the cared for person and numerous forms were signed by the carer and by the service user. There were no separate files for carers; all of the information relating to carers is contained in the service user’s file. This information was often threaded through the service user’s file. It would be easier to access and allow more effective monitoring of the carer’s needs over time if it were kept separate.

**Recommendation**

*The Trust should ensure that specific information regarding carers, the carer’s assessment and other pertinent information is kept as a separate record. Files should be cross referenced to ensure that the carer and the service user files are linked.*

3.7 The standard of recording in the files inspected was consistently high and there was a useful range of forms including initial assessments, care plans and reviews. There were frequent indications that carers had been advised of Complaints Procedures and Direct Payments. Several files contained a useful File Audit proforma which included a Recording Standards Quality Assurance proforma and a Care Planning Quality Assurance proforma. Several files contained copies of unmet need reports and in one instance the assessed need for an urgent sitting service was exceptionally met.

3.8 Assessments for social care services are carried out by professional staff from a social work background. Assessments are thorough and case files have generally clear action plans based on the assessment.

3.9 Staff reported that there is an emphasis on practical support and that high caseloads often meant that care planning had a focus on practical intervention. However the Inspection Team found in their sampling of files ample evidence of emotional support.
3.10 Services were responsive to carers needs, for example, one case showed that special arrangements had been made to allow a carer to attend a family wedding in the USA. Files were not solely focused on service provision and many recognised the emotional needs of carers as their role evolved. For example, there was an acknowledgement in one file of a daughter’s difficulty that she could no longer care for her mother at home. She continued to receive support from the Trust to work through this.

3.11 Nursing staff were aware of the carer’s assessment process and one nurse recently completed a dissertation on caring for carers. Nurses generally referred carers to social workers if a carer’s assessment was required. It was accepted that the decision to refer was usually left to the professional judgement of the individual nurse and that a more systematic consideration of this option could be achieved by including a prompt for a carer’s assessment in the nurses’ initial assessment form.

**Recommendation**

*The Trust should consider putting in a prompt into all assessment processes used by all professionals in all settings which will ensure that Carer Assessment referral is given a more central focus.*

3.12 The Inspection Team found a number of files where it appeared that needed follow-up action had not been taken by the Trust. In one example, it was noted that a complaint had been lodged by a carer regarding the breakdown in domiciliary care provision. From the case record it appeared that the complaint had not been responded to by the Trust. In another instance it appeared that, on the death of a service user, the file was simply closed with no further contact with the carer beyond a phone call advising them to contact Cruise, a voluntary organisation providing counselling for those who have suffered a bereavement.

3.13 Upon further investigation and discussion with the key personnel involved in both cases it became clear that both situations were responded to more effectively than the case file had suggested.

3.14 The complaint had been fully investigated by the Trust’s Home Care Manager and had been resolved to the satisfaction of the carer. Information on this was available in a file held by the Home Care Manager. It had not been cross-referenced back to the case file.

3.15 In the case where the carer had experienced a bereavement, the social worker had in fact spent a considerable amount of time working through issues with the carer. This was such a positive process, at a particularly difficult time, that the carer had written to the Trust to compliment the social worker for her support. The social worker had been informed of this correspondence. Again the recording was limited and no cross reference had been made to the case file from the Trust’s compliments process.
Recommendation

The Trust should ensure that staff fully record activity in case files to make sure that an accurate picture of outcomes is available. In addition, the Trust should ensure that mechanisms are in place to ensure that the outcomes from complaints and compliments processes are available, where appropriate in the main service user/carer file.

Caseload Management/Case Plans/Case Reviews

3.16 All cases are formally reviewed annually or more often if this is seen by the Team Leader to be appropriate and/or the case is particularly complex. In addition, service users can request a case review and are made aware of this.

3.17 Each member of staff is expected to receive formal supervision on a 6 weekly basis. Staff and Trust Management are clear that this cycle is normally adhered to unless there are exceptional circumstances such as illness or annual leave.

3.18 The Trust has procedures on the opening, reviewing and closing of cases, but these are not written down in any clear policy.

Recommendation

The Trust should produce a clear written policy on all aspects of case management from screening to closing of cases and ensure that it is consistently applied by staff and managers.

Effective Communication between Carers and Care Workers

3.19 The Trust is currently developing the information exchange document which is the client held record. This will allow the range of care workers, family carers and other staff, such as social workers, GPs and other health professionals to record their visits and any pertinent information and observations which they feel would be of help to others in their caring role. This development is currently at draft discussion stage among Trust staff. At the time of Inspection carers had not been consulted with regard to this potential information process nor had cared for people.

Recommendation

The Trust should ensure that the draft information exchange document changes are discussed with both carers and cared for people to ensure that it meets their needs and takes account of their sensitivities.
Onward Referral

3.20 The Inspection Team found little evidence of onward referral to either generic carers groups or specific organisations such as Carers NI, Chest Heart and Stroke Society or the Alzheimer’s Society carers’ support groups. A number of reasons were given for this which included:-

- lack of knowledge of carers’ groups;
- lack of knowledge of the role of Carers NI; and
- judgements made that carers did not wish to have or need this support.

In addition, some social work staff indicated to Inspectors that they were the main support for carers and so did not always refer on to other organisations. This lack of communication with carers’ support networks has already been discussed in Paras. 2.45-2.46.

3.21 This is a cause of some concern in that it would appear that carers are not being given informed choice and options. While there is a responsibility on Carers NI and local carers’ groups to provide information to the Trust there is equally a responsibility on the Trust to ensure that its staff are aware of the range of services available to carers. For example, it is unclear as to how widely the Carers’ A-Z commissioned by NHSSB has been distributed.

Recommendation

The Trust, in partnership with the various carers’ local support groups and regional organisations, needs to develop a proactive approach to engagement with and circulation of information on the range of support that can be made available to individual carers. This is directly to carers as and when they are identified by Trust staff as well as ensuring that information (as already recommended in Paras. 2.39 and 2.40) is available at appropriate Trust offices.
SUMMARY OF RECOMMENDATIONS – CHAPTER 3

• The Trust needs to ensure that staff adhere to the principle that assessment is needs-based rather than resource driven and that all unmet need identified through holistic assessment is properly recorded and identified for planning purposes (Para. 3.3).

• The Trust should review its training on Carer Assessment to reinforce the understanding that appropriate professional assessment is a support in itself as well as a tool for identifying and meeting need (Para. 3.5).

• The Trust should ensure that specific information regarding carers, the carer’s assessment and other pertinent information is kept as a separate record. Files should be cross referenced to ensure that the carer and the service user files are linked (Para. 3.6).

• The Trust should consider putting in a prompt into all assessment processes used by all professionals in all settings which will ensure that carer assessment referral is given a more central focus (Para. 3.11).

• The Trust should ensure that staff fully record activity in case files to make sure that an accurate picture of outcomes is available. In addition, the Trust should ensure that mechanisms are in place to ensure that the outcomes from complaints and compliments processes are available, where appropriate in the main service user/carer file (Para. 3.15).

• The Trust should produce a clear written policy on all aspects of case management from screening to closing of cases and ensure that it is consistently applied by staff and managers (Para. 3.18).

• The Trust should ensure that the draft information exchange document changes are discussed with both carers and cared for people to ensure that it meets their needs and takes account of their sensitivities (Para. 3.19).

• The Trust, in partnership with the various carers’ local support groups and regional organisations, needs to develop a proactive approach to engagement with and circulation of information on the range of support that can be made available to individual carers. This is directly to carers as and when they are identified by Trust staff as well as ensuring that information (as already recommended in Paras. 2.39 and 2.40) is available at appropriate Trust offices (Para. 3.21).
4. SUPPORT SERVICES

Standard for support services

Carers have access to a range of quality services that meet their identified need.

4.1 The Trust has a range of services which help to meet the assessed needs of carers and the cared for person. These include:

- day care;
- residential respite care;
- domiciliary care, including night care; and
- emergency help lines.

Day Care

4.2 Day care for older people, where there is an assessed need is provided in statutory day care facilities and at some statutory residential homes across the Trust. There is a small provision of Day Care provided by the independent sector. Trust Day Care facilities are located in:

- Antrim;
- Ballymena;
- Cookstown;
- Larne;
- Maghera;
- Magherafelt;
- Newtownabbey; and
- Rathcoole.

There had also been a Day Centre in Carrickfergus but this has now closed due to the disrepair of the building.

4.3 The number of day care places in Centres varies across the Trust. There are between 30 and 60 day care places per day in each centre. Referrals come from a range of sources such as, social work staff, occupational therapists and community psychiatric nurses.

4.4 The Inspection Team visited 2 Centres at Cookstown and Rathcoole. The Centres, because of their size, can provide support to a number of people with diverse needs. So, for example, within the Rathcoole Day Centre support is provided to individuals of all ages with needs arising from:

- dementia;
- learning disability;
- physical disability;
- mental health;
- old age; and/or
- sensory impairment.

4.5 After initial referral, staff from the Centre will visit the individual, and his/her family where appropriate, to make an initial assessment of need and agree a contract with expected outcomes. This is followed up by a pre-admission visit which allows the individual and their family to look around the Centre and meet key staff before they
make any final decisions. At this stage a primary Care Worker is allocated to the individual and this Care Worker is the main source of contact between the individual, the carer and the referral agent.

4.6 After 10 weeks an initial review is carried out which includes as key participants:

- the service user;
- the carer(s);
- the Day Care Manager;
- the referral agent; and
- the primary care worker.

4.7 Carers/families are encouraged to attend and do so in most cases. After this initial review, cases are reviewed on an annual basis. However this can be more frequent, according to need, and at the request of any of the key participants.

4.8 Close links are kept with carers through the formal review mechanisms and informal day-to-day contact. For example, through care assistants who accompany individuals where the Trust provides transport.

4.9 Carers spoken to, as part of the Inspection, had a positive attitude toward the Day Centre provision. They considered it was supportive and while resources were perceived as limited, staff were said to be flexible within these limitations.

4.10 Because of the large geographic area which it covers and the fact that the Carrickfergus Day Centre has closed, there are long waiting lists for placements in the Centre in Rathcoole. At present there are 30 people on a waiting list across all Programmes of Care. This is the largest number waiting for any of the Trust’s Day Care facilities all of which have waiting lists. New ways of working such as those being developed by the Community Development Worker are one of the Trusts responses to these waiting lists. This is further explored in Paras. 4.17-4.22.

4.11 Trust staff indicated that a further restriction on referral is the availability of appropriate transport. Spaces are limited on transport and there are limitations on how long it is appropriate to have an individual travelling on a bus. In addition, many of the potential referrals are people with physical disabilities who use wheelchairs and appropriate transport to accommodate them is limited.

Recommendation

*The Trust should investigate ways in which it can remedy the limitations in transport so that all potential day care users have equal opportunity to access the service.*

4.12 However even in the context of waiting lists and full attendance all of the Day Centres are sufficiently flexible to be able to cater for short term emergencies. These can be triggered by a family crisis or where temporary attendance is needed to provide support while permanent residential support is accessed.
4.13 In addition to agreed contract hours with the service user, Centres will provide an added element of flexibility to support carers, often at short notice. Centres often take individuals to allow carers to attend other appointments for example, with the dentist. This is an example of flexible, supportive work with carers and the Trust and Day Centre staff are to be commended on this approach.

4.14 At the time of the Inspection, one Day Centre was planning to set up a short-term sitting service, which would be available to carers on an ongoing basis. Carers would be able to telephone the Centre requesting support to enable them to respond to unforeseen or routine domestic demands. Staff anticipate that this service could be provided at nil cost, as there would be sufficient staff available in the Centre to deal with this modest increase in attendance. It is envisaged that up to 3 people per day could be catered for, depending on their individual requirements. Clients could come for a morning, afternoon or all day, depending on the individual need of the carer. This is a regular service reflecting a more formal approach to sudden emergencies or smaller time-bound demands that carers may encounter. The Inspection Team commended the Centre for this imaginative approach.

**Recommendation**

*The Trust should encourage all statutory Day Centres to examine the possibility of setting up a short term sitting service, accessible to carers on a short notice basis.*

4.15 The Day Centres visited provided a wide range of activities, including some specialist programmes, for example, one designed to engage dementia sufferers by stimulating their senses of touch, taste and sound. The service users present during the Inspection visit spoke positively about the service offered by the Centre.

4.16 The Trust is developing new services and approaches which will decrease waiting lists engaging local communities to provide local solutions rather than being dependent on existing day care provision. An example of this is work currently going on in Ballyclare. Through a partnership with the local group of the Alzheimer’s Society the Trust has been engaged in the development of a new community centre. The Trust is supporting the Alzheimer’s Society to facilitate a local group where people with lower levels of dependency and lower levels of supervision need can come on a regular basis. This will not only allow for a more localised support for carers but will provide a safe, stimulating environment for individuals with dementia.

**User Involvement**

4.17 Most of the Day Centres have service user “councils”. These “councils” are elected on an annual basis from the day centre users and form part of the planning processes of the Centre. The “councils” are involved in identifying issues and concerns as well as being part of the decision-making process for activities, meals, celebrations and expenditure. The pre-admission visit noted in Para. 4.5 is, in part, managed by members of the “council”. This is an excellent example of good practice which, however, is not taking place in all of the Day Centres.
**Recommendation**

*The Trust should build on the good practice available with regard to user involvement in some Day Centres and ensure that similar models are available at all Trust day centres. Consideration should also be given as to how this model might be used in other appropriate Trust day and residential services.*

**Community Development Project Elderly Care**

4.18 The Trust also created a Community Development Project Worker (CDPW) in April 2004. The CDPW post was created in response to concerns that day centre provision in the Trust was increasingly being used to meet the needs of older people with complex needs and as a result, many older people were not getting access to day centre provision.

4.19 The role of the CDPW is primarily to identify and support existing community infrastructure which could provide support to older people within their own communities rather than at designated Day Centres.

4.20 The main aim of the project is to use and utilise to best effect existing resources so as well as links to community organisations. The CDPW has developed links with a range of other support organisations such as:

- Carers NI;
- Alzheimer’s Society;
- Chest Heart and Stroke Society; and
- the Indian Community.

4.21 To date a mapping exercise of potential support has been carried out, largely in the Newtownabbey area, and a number of initiatives put in place. Among these are the development of a new support group in Ballyclare which offers luncheon club and social outings to a number of isolated older people in the area.

4.22 A particularly significant development has been a partnership between older people in Bawnmore and Whitehouse who now share facilities in a local church. There was no provision in this area 2 years ago for either community. The particular significance of this development is that it is cross-community in an area known traditionally for its high sectarian tensions.

4.23 There are just 2 examples of the work being promoted. The CDPW holds public consultations and targets carers through carers organisations and the Trust. Carers are also consulted on an individual basis about family members needs where this is appropriate. The Trust is to be commended on this initiative and exploring ways in which the role could be expanded to provide alternatives to day care, thereby relieving some of the pressure described in Paras. 4.10-4.11.
Assistive Technology

4.24 The Trust is also investigating the potential for increasing the use of technology to provide support for people in their own homes. This assistive technology is provided by Telecare.

4.25 Telecare is part of Fold Housing. Telecare provides assistive technology to enable people to stay at home and give assurance to their carers. A phone line is essential for this service. There are a range of different supports such as:

- bed sensor strips programmed, for example, for 15 minutes to detect if the individual has not returned to bed;
- sensors around the front and rear doors programmed to detect wandering behaviour;
- pull cords in bathrooms;
- smoke detectors;
- heat sensor above cookers; and
- voice reminder set to tell the individuals to take medication at set times.

4.26 Where a particular sensor is triggered the alarm will go off in a central unit. The advisor will then alert the main carer to the potential issue. This technology has been welcomed by relatives and carers as a further support and a way of monitoring without them needing to physically call all the time.

4.27 The Trust and the Board are to be commended on the development of these new initiatives.

Residential Respite Care

4.28 Respite care is provided at the Trust statutory homes and by private providers across the Trust area. The Trust provided some 7,323 bed days in statutory respite accommodation in 2004 (Homefirst Annual Report 2004-05).

4.29 The Trust purchases additional respite care from the independent sector to complement their own provision. However, it is reported that independent providers are not willing to have bed space which is potentially empty for periods of time as this could lead to loss of revenue. In addition, the Trust has found that independent providers are reluctant to provide this service as it is more disruptive than having long-term residents with whom staff can build up relationships and whose needs are known and can be addressed as part of staff daily routines.

4.30 The consequence of this is that the Trust has increasingly to depend on its own residential facilities to provide this service. These facilities are limited with the result that there are waiting lists for residential respite care. For example, there are only 2 beds available for respite in Moylinney, a specialist EMI home, and at the time of Inspection the home was already fully booked until October 2006.
4.31 The Trust has made efforts to address this issue. If residential beds do become free at short notice field work teams are informed and can access these beds quickly if individuals and families wish to avail of them. While this is not an ideal solution, it is an attempt to address a severe demand on resources.

4.32 Residential respite care is a key support for carers and the limits on the availability of this service are a concern.

**Recommendation**

*The NHSSB and the Trust need to address the issues with regard to limits to residential respite care and develop a strategy on how this can be addressed as quickly as possible.*

**Domiciliary Care**

4.33 Care in the home is provided by both the Trust’s own Home Care Service and by a number of independent sector providers.

4.34 There are currently 3,200 people in the Trust area receiving home care services. According to the 2004-05 Annual Report the Trust provided 1,731,315 hours of home care in the previous year of which just under 22% was provided by the independent sector as follows:

- Extra Care (142,000 hours);
- Crossroads (37,500 hours); and
- Home Care NI (200,000 hours).

4.35 Domiciliary care provision is managed by a Principal Officer who is a qualified social worker. The Principal Officer has overall co-ordination responsibility for both statutory and voluntary sector provision.

4.36 This is a relatively new structure (2004). The new structure is felt to be more cohesive as previously the home care service was organised within local social work teams and management and supervision processes differed from location to location.

4.37 There are 4 Home Care Managers who work on a full-time basis who have responsibility for the day to day allocation of cases to Home care officers who in turn allocate cases to and monitor the Home Care Workers in their areas.

4.38 The structure for dealing with the Trusts home care cases is set out as follows:
4.39 The Trust is making progress toward ensuring that all home care workers receive mandatory training on moving and handling, infection control and food hygiene and are working to achieve this. The Trust is also in the process of developing further training for home care staff in areas such as confidentiality and communications to enhance their skills and to make the post more appealing to potential recruits. This is further explored in Paras. 6.8-6.10.

4.40 There are waiting lists for domiciliary care and these vary throughout the Trust’s area. However, a wait of 2 weeks to a month is not unusual. This is a cause of some concern and the waiting lists put extra pressure on both service users and their carers.

4.41 The waiting lists may be exacerbated by the Trust’s policy of ‘ring fencing’ domiciliary care services for some of the specialist teams operating in the Trust’s area. These include:

- Community rehabilitation service (Para 1.32-1.38); and
- Integrated care of elderly people team (Para 1.39)

**Recommendation**

*The NHSSB and the Trust should review the provision of domiciliary care services to ensure that waiting lists are decreased and set targets to achieve this.*

4.42 The Trust operates a ceiling on domiciliary care. This is set at 27 hours per week and it is only in exceptional circumstances such as very complex needs or emergencies that the ceiling is breached. While this may be necessary to remain within budgets it has the effect of placing extra burdens on carers who are expected to provide the additional support.

4.43 The Trust has recently carried out a survey on the main reasons as to why people are admitted to full-time residential care. It emerged that the key reason was the breakdown in the caring role. The limited level of domiciliary care provision is likely to be a contributory factor to this breakdown.
4.44 The Trust therefore finds itself in the position of having limited resources targeted specifically at carers. Consequently the potential for carer breakdown increases in which case the cared for person is admitted into residential care which may be the most costly option of all.

**Recommendation**

*The Trust needs to urgently review the level of service provision directed to carers in order to ensure that lack of support does not lead to carer breakdown and ultimately an increase in otherwise avoidable admission to long term residential care.*

**Emergency Cover**

4.45 The onus is on Home Care workers to contact another member of staff who will cover for them. According to the Trust this process works quite well and the number of instances where cover is not provided is limited. However the Trust does not keep statistics on this.

4.46 There is no formal mechanism for provision of out-of-hours cover in the event of a service breakdown. For example, the number of the Duty Social Worker Service is not provided by home care staff. There is an expectation that the social worker who has made the initial referral will have provided this information. However, it is not clear what intervention aimed at helping the service user could be made if contact were made out-of-hours.

4.47 While the Inspection Team did not encounter any instances where the system had broken down there is a concern that this is quite possible. If a home care worker cannot or does not contact a colleague through the current scheme then potentially vulnerable people can be left unsupported.

**Recommendation**

*The Trust should put in place a central contact point which ensures that cover is provided whenever the Home Care service breaks down.*

**Nightruns & Night Sitting**

4.48 The Trust contracts with independent providers to provide domiciliary support throughout the night. There are night runs which can occur at any stage between 10pm and 9am to support identified need. There is also a night sitting service although this is not used on a widespread basis. All of these services reflect identified need. The Trust keeps these services to a minimum where possible as they are particularly expensive to provide. There are 6 monthly review meetings with providers to discuss issues.
Training for Carers

4.49 In response to “Valuing Carers”, the NHSSB, in partnership with the Trust, Causeway HSS Trust and Extra Care, developed a training project for carers. The initial pilot included 23 carers from across the NHSSB to receive focused support which would help them to develop and maintain their caring role. The training was developed and delivered by Extra Care. The overall process was managed by a Steering Group consisting of representatives from:

- NHSSB;
- the Trust;
- Causeway HSS Trust;
- Extra Care; and
- Carers NI.

4.50 The training covered a range of topics which included:

- moving and handling;
- stress management;
- back care;
- relaxation;
- challenging behaviour; and
- dementia.

4.51 The training was evaluated by Carers NI and 80% of the respondents reported that, overall, the training had made a positive difference to them as a carer. As well as the practical help carers thought that the training made them feel cared for, listened to and valued. In addition, it encouraged carers to seek support elsewhere and a number have subsequently joined local carers groups.

4.52 After this initial pilot the training is now being rolled out on an annual basis in both Community Trusts in the NHSSB area by Extra Care on an ongoing basis.

4.53 Protocols were developed to cover the legal implications of training carers to work alongside paid staff from the voluntary or statutory sectors. Referrals of carers for training are made by voluntary staff and by Trust staff. This means that carers work alongside paid staff to undertake tasks such as moving and handling. However, it was reported to one of the Inspectors that CPNs were not making referrals as they were concerned about possible infringement of role. They reported that either they did not need a carer’s help or else they could provide training themselves to carers in the home if this was appropriate.

4.54 The NHSSB, the Trusts and Extra Care are to be commended on this initiative which provides a level of support to carers and which has been well received. This project has recently won a national (UK) training award.

4.55 Some of the voluntary organisations such as local carers groups visited by the Inspection team were unaware of the carers training scheme. This highlighted a lack of communication between the Trust and some of its voluntary service providers.
**Recommendation**

*The Trust should ensure that the Carers’ Training Project and its value are promoted among all Trust staff and other voluntary sector service providers.*

**Dementia Video**

4.56 In 2002 the Trust produced a video “Coping with Maggie - Caring for Margaret”. This promotes a person-centred approach to caring for people with dementia. It follows Margaret who strives to maintain her dignity and composure as her world begins to disintegrate through the onset of dementia. As well as showing her struggles it also shows well intentioned but often unthinking care delivered in a non-sensitive manner.

4.57 Aimed particularly at carers to enhance the quality of life for people with dementia. It is distributed to all carers in the Trust area who have a family member or friend suffering from dementia. It is also a useful tool for home care and social care staff training. In this regard the video has been widely promoted in the Trust to social care and home care staff.

4.58 The video has also been distributed widely to other HSS Trusts and Boards across Northern Ireland with over 500 having been bought by Trusts and Boards.

4.59 Feedback on the video was received from a number of carers as part of the Inspection who found it helpful and useful in considering ways in which to deal with their own issues, respond appropriately to the person with dementia and seek appropriate support.

**Partnership Approaches**

4.60 The Trust has a range of partnerships in place which provide support for carers. The work with Extra Care is one example of this approach. The Trust is also engaged in the development of new technology which will help to support carers and maintain vulnerable individuals in their homes (Paras. 4.23-4.26).

4.61 The development of this technology can have a considerable impact on carers as it allows them to leave the person they care for alone in the house and still be assured that an individual is being monitored.

4.62 In addition, the Trust provides “one-off” grants to a range of voluntary organisations which provide services to service users and/or carers. At the end of January 2006 this amounted to just over £10,700.

4.63 Grant aid recipients included:

- Greenisland 99 Luncheon Club for pensioners;
- Toome and District Senior Citizens Clubs;
- Still Active Club (St Patricks Church) Ballymena; and
- Mossley Senior Citizen Club.
Independent Sector Service Providers

4.64 The Trust had contracts with 3 main independent sector providers, Extra Care, Home Care NI and Crossroads Caring for Carers. Between them, the organisations provided a comprehensive range of services that complement Trust services and provided respite for carers, for example: domiciliary care – including feeding and toileting, a mobile night service where care workers could call throughout the night to toilet an individual, tracheotomy and stoma care, rehabilitation and a dementia sitting service. However, the lack of sitting services was cited as a major gap in provision that could provide respite for carers.

4.65 The 3 organisations reported good relationships with Trust staff and felt that in general they worked well in partnership. There are monitoring meetings between independent domiciliary care providers and the Trust which include Trust Finance, Planning and Information staff and the Assistant Director Social Care and Disability Services.

4.66 Some concerns were raised with the Inspection team. One organisation said that contracts could be difficult to fulfil, particularly in rural areas. An example was given where the contract was for 4 hours care, but travel could take 2 hours of this so only 2 hours direct care were delivered. Trust managers indicate that this should not be occurring and that all SLAs with independent providers should include both the travel time and direct contact time as part of the overall contract. The example cited raises concern about the level of care actually being provided. Another example was given where 3 or 4 clients could be in hospital, so the hours contracted would not be met. This meant that staff were not paid and so had their hours shortened at short notice.

4.67 One organisation reported that the Trust often gave them the “difficult cases half way up a mountain” when the Trust could not get its own staff to provide the service. This organisation complained that the Trust withdrew cases from it for no apparent reason, to the detriment of the service user and the carer. These experiences led the organisation to feel that the Trust used them as a stopgap. This organisation also stated that their contract price was not increased in line with annual inflation, which left them with a shortfall to make up from their own funds and limited their ability to pay their staff a cost of living allowance.

4.68 With regard to pricing, the Trust indicates that it invites all providers, on an annual basis, to indicate the hourly rate the provider believes it can provide the service for. It is the Trust’s view that it is up to the provider to accurately cost its provision to reflect such issues.

Recommendation

The Trust should ensure that its engagement with its independent providers demonstrates clarity about the content of contracts and notice of variations to ensure that there is no room for misinterpretation of service level agreements.
4.69 All providers, independent and statutory reported recruitment problems, which they attributed largely to low rates of pay. Independent organisations compete with the Trust to recruit from a decreasing pool of workers. Trust employed staff have regionally agreed rates of pay. These are often not reflected in the Independent Sector making recruitment potentially more difficult.

**Addressing Carers Needs Further**

4.70 The Trust with support from the NHSSB, is undertaking a number of new initiatives to address support for carers and those they care for in the community.

**Supported Housing**

4.71 The Trust, in 2005, appointed a Supported Housing Development Officer (SHDO). The SHDO is currently looking at the role of supported housing schemes to maintain people in the community who might otherwise be placed in residential accommodation. The role of the SHDO is to work with a range of stakeholders such as housing associations, and the Housing Executive to develop new supported housing stock through the Supporting People initiative. At present one scheme comprising of self-contained flats which will accommodate 26 individuals is being developed in Carrickfergus. This is in partnership with the Fold Housing Association.

4.72 While focused largely on older people, the flats will also contain some accommodation for carers so that they can stay on a temporary or permanent basis with the person they are caring for.

4.73 This is one of a number of proposed new initiatives in supported housing. Further developments in Cookstown and Magherafelt are planned over the next 3 years.

4.74 A key part of this approach is consultation with a range of key stakeholders including carers and those service users may use this type of sheltered accommodation to see what they want and need. This consultation is also taking place with other key agencies, for example, the Police Service for Northern Ireland (PSNI) is being consulted over personal safety for older people.

4.75 Other key stakeholders are Trust personnel in other support services, such as day centres and local communities where sheltered housing is being developed. The aim is to have integrated safe supported housing which are complemented by Trust and community led-support services.

**Direct Payments**

4.76 The Trust is currently undertaking a process of cascade training with regard to informing staff about the process of Direct Payments. Managers are aware that there needs to be a considerable increase in the use of Direct Payments and anticipate that with appropriate training the uptake should increase.
At the end of 2005 there were 32 people in the Trust receiving Direct Payments in the Trust. The numbers have increased year on year as is demonstrated by the table below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>2000</td>
<td>2</td>
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<td>2001</td>
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<td>2004</td>
<td>20</td>
</tr>
<tr>
<td>2005</td>
<td>32</td>
</tr>
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</table>

**Charging Policy**

4.77 Information is available to carers on the Trust’s charging policy. This sets out the cost of services. It is anticipated by managers that social workers and other appropriate Trust staff will explain charging policy to service users and their carers when appropriate.

**End of the Caring Role**

4.78 The Trust continues, within resources, to support people at the end of the caring role. Referrals are made to other appropriate agencies such as Cruse and the Relatives Association. In the one instance where the Inspectors identified a file where the caring role had finished the carer had reported that this has been well supported by Trust staff.
SUMMARY OF RECOMMENDATIONS – CHAPTER 4

• The Trust should investigate ways in which it can remedy the limitations in transport so that all potential day care users have equal opportunity to access the service (Para. 4.11).

• The Trust should encourage all statutory Day Centres to examine the possibility of setting up a short term sitting service, accessible to carers on a short notice basis (Para. 4.14).

• The Trust should build on the good practice available with regard to user involvement in some Day Centres and ensure that similar models are available at all Trust day centres. Consideration should also be given as to how this model might be used in other appropriate Trust day and residential services (Para. 4.17).

• The NHSSB and the Trust need to address the issues with regard to limits to residential respite care and develop a strategy on how this can be addressed as quickly as possible (Para. 4.32).

• The NHSSB and the Trust should review the provision of domiciliary care services to ensure that waiting lists are decreased and set targets to achieve this (Para. 4.41).

• The Trust needs to urgently review the level of service provision directed to carers in order to ensure that lack of support does not lead to carer breakdown and ultimately an increase in otherwise avoidable admission to long term residential care (Para. 4.44).

• The Trust should put in place a central contact point which ensures that cover is provided whenever the Home Care service breaks down (Para. 4.47).

• The Trust should ensure that the Carers’ Training Project and its value are promoted among all Trust staff and other voluntary sector service providers (Para. 4.55).

• The Trust should ensure that its engagement with its independent providers demonstrates clarity about the content of contracts and notice of variations to ensure that there is no room for misinterpretation of service level agreements (Para. 4.68).
5. INFORMATION FOR SERVICE USERS

Standard for Information for Service Users

Carers receive up to date comprehensive published information about social care services and other relevant information from the Trust.

General Information for Service Users

5.1 The Trust provides a range of information on all of its services. Information about services was provided in hard copy and a limited amount of information was also available on the Trust’s website. Information was provided in standard format English. It was also available in a number of other formats, on request.

5.2 The Trust also provides a range of information on other organisations, largely from the voluntary sector, potentially of benefit to carers. This includes information on services and support from organisations such as:

- Chest Heart and Stroke Society;
- Alzheimer’s Society; and
- Age Concern NI.

5.3 Inspectors noted that information was not always available publicly at all the offices and other Trust properties visited. There was some general information on the Trust as well as more specific information on topics such as its:

- comments and complaints procedures;
- ranges of services; and
- annual reports.

Recommendation

The Trust should develop an information development and dissemination strategy which will ensure that information about its services and other relevant information is readily available at key strategic points in the Trust’s own premises.

5.4 There is an A-Z available of services produced by Carers NI which may be of value to carers, voluntary organisations and Trust personnel. It lists local carers branches and support groups as well as other relevant groups such as:

- Action MS;
- Alzheimers Society;
- Disability Action;
- Mencap; and
- Speech matters.

5.5 The A-Z gives a contact name, contact details and a brief description of each organisation.
5.6 However, there are gaps in the information and some local key contacts for support are not included. For example, there is no information on Age Concern NI who have a number of support projects in the Trust area.

**Recommendation**

_The Trust needs to work closely with Carers NI to ensure that information that is developed within the Trust area is detailed, inclusive, accurate and updated regularly._

5.7 Only one team was aware of the Carers NI postcard scheme (Paras. 2.41-2.43) and this was one of only two teams that had invited Carers NI to come and give a talk to the staff.

5.8 A further key piece of information which is available to carers to help them as their caring role ceases is entitled ‘After Caring’. For many carers this time immediately after the caring role had finished left a vacuum both in terms of their time and also created a range of emotional issues. The leaflet documents some of the issues, highlights support and provides practical suggestions as to how to manage.

5.9 This after care leaflet was developed by Carers NI in response to requests from both carers and social care staff as to what was appropriate after the caring role had finished. Again, as with other materials, it is difficult to ascertain how this leaflet has been distributed and what impact it has had.

**Other information**

5.10 At the time of Inspection, the NHSSB and the Relatives Association are in the process of developing a practical guide to support carers when the person they care for has moved into residential care. It is intended that this will be widely promoted throughout the Trusts in the NHSSB area.

5.11 Both the guide on aftercare and on changes when someone is admitted to residential or hospital care have been developed in partnership with carers.

**SUMMARY OF RECOMMENDATIONS – CHAPTER 5**

- The Trust should develop an information development and dissemination strategy which will ensure that information about its services and other relevant information is readily available at key strategic points in the Trust’s own premises (Para. 5.3).

- The Trust needs to work closely with Carers NI to ensure that information that is developed within the Trust area is detailed, inclusive, accurate and updated regularly (Para. 5.6).
6. WORKFORCE PLANNING, WORKFORCE MANAGEMENT, TRAINING, SUPERVISION AND SUPPORT

**Standard for workforce planning, workforce management, training, supervision and support**

The Trust has a strategy in place to recruit, retain, support and develop sufficient numbers of appropriately qualified and competent staff with the knowledge and expertise to deliver services to carers.

**Workforce Planning**

6.1 The Trust has a Human Resources (HR) Department which has a key role in the support of staff.

6.2 There is not a specific Workforce Strategy. However, components and sections of workforce planning are contained in the Corporate Plan and the Trust’s delivery plan.

6.3 There are a number of Codes of Practice and policies which promote staff support and workforce management. These are identified through internal need and by external legislation, guidance and good practice demands. For example, all policies and procedures are proofed in relation to equality legislation. Within social work the HR Department promotes and monitors work against the Northern Ireland Social Care Council (NISCC) requirements to support the registration process, to promote best practice and compliance with NISSC’s codes of practice.

6.4 There are a range of policies covering all aspects of support and management. These include:

- recruitment;
- job specifications;
- harassment;
- violence and aggression;
- disciplinary procedures; and
- complaints procedures.

**Valuing and Caring for Staff**

6.5 The Trust is continuing to develop policies and practices to support the needs of different staff within the organisation. These include:

- time-in-lieu
- job sharing;
- career breaks;
- flexible working hours;
- adoption leave;
- parental leave; and
- time off for dependants.
While there is no specific policy on supporting carers in the workplace the HR Department indicated that where possible the short-term needs of staff who are carers are responded to on an individual emergency needs basis and longer-term needs through flexible working hours and career breaks. Inspectors met with a number of staff who were or who had availed of these flexible working arrangements. Some of these staff indicated that these arrangements were not always easy to access and that a lot depended on work demands in particular teams or locations.

6.6 At present the Trust does not monitor the impact of these more flexible supportive arrangements and so it is unclear how user-friendly and accessible to staff they are.

**Recommendation**

*The Trust should continue to build on its commitment to a range of flexible and staff friendly policies and practices and actively monitor these to ensure that they are making a positive difference.*

6.7 All policies are developed in partnership with staff side representatives so that no policies are introduced without relevant staff being consulted. In addition, there is a consultation and negotiation forum between management and staff representative groups which meets on a regular basis to discuss developments and deal with any issues which may arise.

6.8 The Trust has begun an initiative to further develop training for home care staff. This is for a number of reasons. Firstly, to promote home care as a career path with appropriate qualifications and so attract potentially more recruits to the work. Traditionally it is reported home care staff are hard to recruit because of poor terms and conditions and the poor perception the public have of the job.

6.9 The Trust also views accredited qualifications as part of an initiative to retain staff through providing better terms and conditions and by adding to their sense of value by committing training and resources to what was traditionally seen as low paid and undervalued work.

6.10 Primarily, however, more comprehensive training allows staff to provide a more professional service to individuals and their carers. This training will provide an opportunity to look at areas such as:

- confidentiality;
- communication;
- respect; and
- adult protection.

The Trust is to be commended on the development of this process of training and support for a part of the staff team which has perhaps been traditionally under-recognised and given limited support.
6.11 The Trust has also undertaken a proactive approach to the identified high sickness and absenteeism among staff in domiciliary care. This approach includes a more immediate intervention where absenteeism is identified as an issue as well as identifying appropriate support to ensure a supported and timely return to work.

6.12 This has resulted in a considerable reduction in absenteeism which coupled with the training strategy has developed a workforce within domiciliary care who are better supported and trained.

6.13 The Trust has also moved to providing contracted hours for domiciliary staff. Previously staff were paid by the hour and contracted for work with specific people. However, this could often have major financial issues for the staff member. For example, if a service user was an emergency hospital admission then the domiciliary care worker simply, with no notice, lost the hours of payment they would have received for this work. The Trust is in the process of providing all domiciliary staff with full-time Terms and Conditions and at the time of Inspection approximately one-third of all domiciliary staff had moved to this system. In so doing anomalies in relation to Service Level Agreements with Independent Sector providers of domiciliary care have been identified (Para. 4.66-4.69).

6.14 The move to providing contracted hours has allowed the Trust to take a much more flexible approach to domiciliary care as staff are increasingly no longer assigned to particular service users but operate on flexible rotas to meet need as and where it arises.

6.15 The Trust is currently developing standards, performance and practice which it is anticipated will lead to the awarding of Investors in People for the whole Trust.

Training

6.16 Individual training need is identified through supervision. In addition, Team Managers are responsible for highlighting team training need. This information is collated in each Programme of Care and supplied to the Training Unit. The Training Unit will then identify key areas for development and either provide or source the appropriate training. A further identification of training is through the Trust’s need to adhere to legislation or statutory requirements; for example, training on equality issues. This legislative or statutory obligation training is normally compulsory for key staff in the organisation.

6.17 Training is delivered internally by the Trusts own Social Services Training Unit or by the Management Development Training Unit (MDTU).

6.18 MDTU and the Social Services Training Department provide training and consultancy services within the NHSSB and work in partnership with the Board and Trusts.

6.19 Training is categorised into 2 broad areas ‘compulsory’ and ‘developmental’. Compulsory training covers areas such as protection of children and vulnerable adults, health and safety, equality and other legislative requirements. Other developmental training is available on a wide range of topics such as:
• management;
• continued professional development;
• health promotion;
• corporate governance; and
• community development.

In addition the Social Services Training Department offers a range of training opportunities from NVQ to PQ for staff.

**Performance and Quality**

6.20 The Trust has a framework for accountability with regard to clinical and social care governance. While the Trust board has overall responsibility the Chief Executive has day to day responsibility for all aspects of the Trust’s strategy and operational performance and corporate governance.

6.21 The Director of Nursing, Dental and Governance has a particular responsibility and leads the Trust in relation to clinical and social care government arrangements.

6.22 The Director chairs a bi-monthly Clinical and Social Care Governance Group which consists of:

• the Executive Director of Medicine;
• the Executive Director of Social Work;
• Director of Social Care and Disability Services (or their Directorate lead for governance);
• Director of Child and Allied Health;
• Director of Mental Health;
• Director of Human Resources; and
• Head of Governance.

This group is responsible for advising the Senior Management Team on Clinical and Social Care Governance and developing policy and best practice.

6.23 Each directorate in turn has a directorate governance team consisting of both managers and practitioners which promotes the integration of clinical and social care governance into each area of their business. They liaise with the Clinical and Social Care Governance Group to highlight issues developments and initiatives. The Clinical and Social Care Governance Group also monitors complaints, implement policy and guidelines and ensure all staff receive both information on governance and risk assessment.

6.24 The Trust also has a professional Social Work Forum which meets on a bi-monthly basis to consider professional issues and development.

6.25 The Trust provides an annual report to the NHSSB which outlines the Trust’s progress throughout the year of the pressures and proposed actions to address these. This forms part of the framework for future commissioning along with, for example, Departmental priorities and NHSSB targets.
Supervision

6.26 Organisational roles are clear throughout the Trust and the management structure promote accountability, supervision, support and appraisal. All staff interviewed were clear about their roles and responsibilities. The Trust expectation is that supervision for social work staff is on a monthly cycle and fortnightly for newly qualified staff for the first 6 months. Evidence from files and discussions with staff indicated that supervision took place on a regular basis.

6.27 Supervision focused on both the cases carried by the social worker but also their own personal development needs.

6.28 There was evidence in the inspection of files of supervision of cases and Team Managers “signing off” on a regular basis.

SUMMARY OF RECOMMENDATIONS – CHAPTER 6

- The Trust should continue to build on its commitment to a range of flexible and staff friendly policies and practices and actively monitor these to ensure that they are making a positive difference (Para. 6.6).
7. **HUMAN RIGHTS AND EQUALITY**

<table>
<thead>
<tr>
<th>Standards for human rights and equality</th>
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</thead>
<tbody>
<tr>
<td>Boards and Trusts are fulfilling their statutory duties in respect of the requirements of the human rights and equality legislation and these principles are integrated into practice within all aspects of social care services for carers</td>
</tr>
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</table>

**NHSSB**

7.1 The NHSSB is committed to ensuring that equality and human rights underpin its policies, procedures and ways of working. In line with obligations under Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998, the Board requires all new and revised policies to be screened so that any potential adverse impacts can be identified and mitigated, where possible.

7.2 The NHSSB works alongside local Trusts, other HSS Boards and agencies and the Department to ensure that good practice initiatives can be taken forward on a regional basis and to share learning across the HPSS. In addition, meetings with other statutory agencies take place on a periodic basis to progress those issues where a multi-agency approach would work best.

7.3 Some of the recent initiatives in which the NHSSB has been involved include:

- continuing work with local inter-agency minority ethnic steering groups to find out more about the health and social care needs of those communities to better inform and influence future decision-making;

- working with local GPs to highlight and promote the benefits of the new Regional Interpreting Service and to help ensure that migrant workers have timely and equitable access to general medical services;

- undertaking research to ascertain what barriers people with disabilities face when trying to access employment locally in the HPSS with a view to seeing how these impediments may be overcome; and

- engaging with representatives of the deaf community so as to make information and services more accessible and user-friendly to those who are deaf or hearing impaired.

7.4 The NHSSB has an Equality Officer who has had responsibility for ensuring that the Equality agenda is at the fore of policy development. This post is closely linked to training, user involvement and development of new services to reflect the changing population in the area.

**The Trust**

7.5 Trust has an Equality Scheme which highlights the commitment to equality across all areas of its work. All new and existing policies are equality screened by the Trust.
There are 5 key objectives to the Equality Scheme. These are:

- to make equality issues central to the whole range of policy decision making within the Trust;
- to assess, over the period of the scheme, how policies within each area can contribute to promoting equality of opportunity and good relations;
- to carry out impact assessments of policies in relevant areas using the principles laid down in the Equality Scheme;
- to monitor how the Equality Scheme works; and
- to review the Equality Scheme within 5 years of sending it to the Equality Commission.

Training on human rights and equality is mandatory for all staff. In the period from 2001-2004, which were the most recent statistics available, the following numbers of staff had received training:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality human rights and disability awareness</td>
<td>939</td>
</tr>
<tr>
<td>Diversity training</td>
<td>514</td>
</tr>
<tr>
<td>Disability training</td>
<td>747</td>
</tr>
</tbody>
</table>

The Trust has an Equality Manager who promotes and monitors equality issues and works closely with training, and senior managers to ensure equality is kept high on the Trust’s agenda.

Examples of good practice in relation to diversity and in particular to the increase in the number of economic migrants moving into the area include:

- leaflets in a number of different languages;
- partnership working with the Borough Council on a multi-national “Welcome to Ballymena” pack; and
- interpreting and translation services.

Engagement in the Human Rights and Equality agenda within the Trust, according to managers, is largely a compliance process with limited proactive review of services or assessment of changing populations being addressed by the Trust.

**Recommendation**

*The Trust needs to develop the Equality agenda to respond to the changing needs in the community. In particular responses may be needed to address the needs of new minority ethnic groups and individuals from minority ethnic backgrounds moving into the area.*
SUMMARY OF RECOMMENDATIONS – CHAPTER 7

- The Trust needs to develop the Equality agenda to respond to the changing needs in the community. In particular responses may be needed to address the needs of new minority ethnic groups and individuals from minority ethnic backgrounds moving into the area (Para. 7.10).
8. CONCLUSION

8.1 The Trust is geographically one of the largest in Northern Ireland. It is providing a range of services to people in both urban and isolated rural communities. With a staff of over 5,000 people the Trust has a wide range of services and support, including domiciliary day care, residential and night-time services which support individuals and their carers within the community.

8.2 There is a sizeable population of older people in the Trust area and this continues to grow with a current population of 44,500 over 65 years of age (NI Census 2001). This is projected to rise by 33.5% by 2013 (Trust’s own figures).

8.3 It is estimated that there are almost 35,000 unpaid carers within Homefirst, so the demand for support from carers is potentially great.

8.4 In order to deal with an increasing number of older people in the area the Trust has undertaken a range of new initiatives which help to support older people and their carers within the community. These have included specialist support teams on a range of services such as the Intermediate Care Team, the Dementia Team, community development initiatives and flexible responses to day care.

8.5 However, these have to be put against a backdrop of increasing need and demand for services. This has led to waiting lists and services which are not as flexible as service users and carers require them to be or as the Trust would wish them to be.

8.6 There is evidence of carers assessments being undertaken in the Trust and evidence of innovative practice in supporting carers to continue to provide their caring role. However, there is also evidence that the limitations of service availability has influenced the assessment process which means that unmet need is not fully identified, which in turn means that the need for support to carers is underestimated. Nor does there appear to be a consistent strategy to meet carers needs.

8.7 There is a Service Level Agreement (SLA) between the NHSSB and Carers NI which provides for direct support to carers. It is also intended to be a key link between carers and the Trust. This approach is based on previous work which the Carers NI and the NHSSB undertook before the Carers’ Strategy was developed.

8.8 This SLA provides a range of valuable support to carers at a local level and feedback from carers is very positive. There are useful publications such as a carers guide and on what happens to carers after the caring role has finished. However these would need updated and reviewed.

8.9 The nature and process of establishing the SLA has meant that the Trust has played a peripheral role in the development of these services. It is clear that all parties need to develop and maintain communication which feeds into a planning and development strategy. This will clarify roles and ensure carers needs are high on each organisations’ agenda.
8.10 However, the impact of the SLA has not been closely monitored and there has been a tendency to focus on existing groups and limited success in identifying new areas of need and promoting group activity to help meet these.

8.11 NHSSB and the Trust are also involved in a number of initiatives to support carers among which are:

- training for carers provided by Extra Care; and
- development of information for carers who have family in residential care with the Relatives Association.

8.12 There is considerable evidence of the NHSSB having a high level of commitment to carers. This is demonstrated through its longstanding funding to Carers NI and other groups supporting carers and to its commitment to user involvement as part of its consultation.

8.13 There is much going on which is of value to carers in the Trust but there is a clear sense of a lack of co-ordination and strategy around the needs of carers.

8.14 There is evidence, from files, from discussion with Trust staff and discussion with carers, of high quality professional social work support for carers and a willingness on staff to be flexible within the boundaries set down by the Trust. Staff within the Trust are to be commended on their commitment and hard work.

8.15 A number of recommendations have emerged from the Inspection and the NHSSB, the Trust and their key partners should now address these to further develop the current good practice evident in work with carers.
9. **SUMMARY OF RECOMMENDATIONS**

**Introduction – Chapter 1**

1. The Trust should consider how to increase the engagement with carers and families who have other caring commitments to ensure that permanent care reviews take place at a time and place that suits them. In addition, consideration should be given to providing additional practical support which ensure the carer can attend reviews without placing extra stress on other members of the family (Para. 1.31).

**Planning, Commissioning, Delivery and Review of Social Care Services – Chapter 2**

2. The Trust, in partnership with Carers NI, should identify where there is most need for support and concentrate on setting up new groups in those locations, as well as continuing the support for existing groups (Para. 2.35).

3. The Trust and Carers NI need to consider ways in which information on carers’ groups is developed and circulated to Trust staff so that it can be passed on to all existing carers and to new carers as they are identified (Para. 2.39).

4. The NHSSB, the Trust and Carers’ NI should begin discussions on how information on carers’ groups and other general information of value to carers is distributed and maintained in the Trust’s key locations (Para. 2.40).

5. The NHSSB, the Trust and Carers NI urgently need to review the process of promoting the work of the IDWs so as to ensure that they have regular and meaningful dialogue with Trust staff in order to better promote support systems for carers (Para 2.43).

6. The Trust needs to ensure that awareness of and ownership of carers’ issues is placed on the agenda by senior officers who can promote partnerships and co-ordinated work which will benefit carers (Para. 2.44).

7. The Trust should put systems in place which will monitor and assess the referrals to external supports which complement Trust services. Individual carer’s care plans should reflect consideration of the range of resources available and recording clearly show where these have been offered to carers (Para. 2.46).

8. The NHSSB needs to further develop its monitoring and reporting systems with Carers NI to ensure that action plan targets are clear and are being met. In addition the NHSSB and Carers NI need to begin a process of engagement with the Trust to ensure that appropriate structures are put in place which allow for greater monitoring of referrals (Para. 2.47).

9. The NHSSB and Carers NI needs to reconsider the outline plan for the next 3 years and begin a process of in-depth consultation with the Trust. This will help ensure that the Trust fully engages with the plan (Para. 2.48).

10. The NHSSB and Trust need to work cojointly to drive forward the Carers agenda within the Trust. It may also be appropriate to include the Causeway HSS Trust in these discussions as the process of carers’ support is similar there.
The basis for these discussions should reflect changes in the HSS structure in the wake of the Review of Public Administration and the Carers Strategy issued by the Department in January 2006. In particular, attention should be paid to the recommendation which states that “the potential for change is maximised where the carer co-ordinator is located in the Trust” (Para. 2.49).

11. The Trust needs to develop a fuller more meaningful partnership with Carers NI which creates an environment of real partnership and joint working based on needs identified by both organisations (Para. 2.53).

Assessment, Care Planning and Review – Chapter 3

12. The Trust needs to ensure that staff adhere to the principle that assessment is needs-based rather than resource driven and that all unmet need identified through holistic assessment is properly recorded and identified for planning purposes (Para. 3.3).

13. The Trust should review its training on Carer Assessment to reinforce the understanding that appropriate professional assessment is a support in itself as well as a tool for identifying and meeting need (Para. 3.5).

14. The Trust should ensure that specific information regarding carers, the carer’s assessment and other pertinent information is kept as a separate record. Files should be cross referenced to ensure that the carer and service user files are linked (Para. 3.6).

15. The Trust should consider putting in a prompt into all assessment processes used by all professionals in all settings which will ensure that carer assessment referral is given a more central focus (Para. 3.11).

16. The Trust should ensure that staff fully record activity in case files to ensure that an accurate picture of outcomes is available. In addition, the Trust should ensure that mechanisms are in place to ensure that the outcomes from complaints and compliments processes are available, where appropriate in the main service user/carer file (Para. 3.15).

17. The Trust should provide a clear written policy on all aspects of case management from screening to closing of cases and ensure that it is consistently applied by staff and managers (Para. 3.18).

18. The Trust should ensure that the draft information exchange document changes are discussed with both carers and cared for people to ensure that it meets their needs and takes account of their sensitivities (Para. 3.19).

19. The Trust, in partnership with the various carers’ local support groups and regional organisations, needs to develop a proactive approach to engagement with and circulation of information on the range of support that can be made available to individual carers. This is directly to carers as and when they are identified by Trust...
staff as well as ensuring that information (as already recommended in Paras. 2.39 and 2.40) is available at appropriate Trust offices (Para. 3.21).

Support Services – Chapter 4

20. The Trust should investigate ways in which it can remedy the limitations in transport so that all potential day care users have equal opportunity to access the service (Para. 4.11).

21. The Trust should encourage all statutory Day Centres to examine the possibility of setting up a short term sitting service, accessible to carers on a short notice basis (Para. 4.14).

22. The Trust should build on the good practice available with regard to user involvement in some Day Centres and ensure that similar models are available at all Trust day centres. Consideration should also be given as to how this model might be used in other appropriate day and residential Trust services (Para. 4.17).

25. The NHSSB and the Trust need to address the issues with regard to limits to residential respite care and develop a strategy on how this can be addressed as quickly as possible (Para. 4.32).

26. The NHSSB and the Trust should review the provision of domiciliary care services to ensure that waiting lists are decreased and set targets to achieve this (Para. 4.41).

27. The Trust needs to urgently review the level of service provision directed to carers in order to ensure that lack of support does not lead to carer breakdown and ultimately an increase in otherwise avoidable admission to long term residential care (Para. 4.44).

28. The Trust should put in place a central contact point which ensures that cover is provided whenever the Home Care service breaks down (Para. 4.47).

29. The Trust should ensure that the Carers’ Training Project and its value are promoted among all Trust staff and other voluntary sector service providers (Para. 4.55).

30. The Trust should ensure that its engagement with its independent providers demonstrates clarity about the content of contracts and notice of variation to ensure that there is no room for misinterpretation of service level agreements (Para. 4.68).

Information for Service Users – Chapter 5

31. The Trust should develop an information development and dissemination strategy which will ensure that information about its services and other relevant information is readily available at key strategic points in the Trust’s own premises (Para. 5.3).

32. The Trust needs to work closely with Carers NI to ensure that information that is developed within the Trust area is detailed, inclusive, accurate and updated regularly (Para. 5.6).
Workforce Planning, Workforce Management, Training, Supervision and Support – Chapter 6

33. The Trust should continue to build on its commitment to a range of flexible and staff friendly policies and practices to ensure that they are making a positive difference (Para. 6.6).

Human Rights and Equality – Chapter 7

34. The Trust needs to develop the Equality agenda to respond to the changing needs in the community. In particular responses may be needed to address the needs of minority ethnic groups and individuals from minority ethnic backgrounds moving into the area (Para. 7.10).
APPENDIX 1

INSPECTION BRIEF
1. Background to the Inspection

1.1 The need for an inspection of social care support services for carers of older people was identified during the consultation on the Social Services Inspectorate’s roll-forward inspection programme for 2002-2005. The inspection was considered timely given the work that is underway by the Promoting Social Inclusion Working Group on Carers in relation to progressing the recommendations of the Department of Health, Social Services and Public Safety report *Valuing Carers – Proposals for a Strategy for Carers in Northern Ireland*. This paper sets out the aim and objectives and purpose of the inspection, the inspection focus, the policy context, the timescale for the inspection, the scope and the locations to be inspected, the Inspection Team, co-ordinator brief, an outline of the Draft Standards developed, methodology, feedback arrangements and how the findings of the Inspection will be used. A separate literature review in relation to carers’ issues will also be published.

2. Aim and objectives of the Inspection

2.1 The aim of the inspection is to assess the extent to which social care services for carers of older people meet their needs and comply with the policy objectives of *People First: Community Care in Northern Ireland in the 1990s*, the recommendations of *Valuing Carers* and the requirements of the Carers and Direct Payments Act (Northern Ireland) 2002 in relation to a carer’s right to a separate assessment of his/her needs.

2.2 The main objectives of the inspection are to:

- establish the type, range and volume of current social care support services for carers of older people;
- consider the structure, organisation and management of social care support services for carers of older people in relation to assuring quality and managing the performance of these services;
- determine the extent to which Boards and Trusts are complying with the requirements of People First, the Carers and Direct Payments Act 2002 in relation to the carer’s right to a separate assessment of his/her need, and the recommendations of Valuing Carers in respect of social care support services for carers of older people in relation to:
  - identification, assessment of need, care planning and review;
  - provision of information and training;
  - provision of services that actively promote independence, respond to carers’ identified needs outcomes, which listen to and respect carers as partners in care giving and which are reliable, timely, flexible,

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1 *Valuing Carers – Proposals for a Strategy for Carers in Northern Ireland, DHSSPS, April 2002*
2 *People First - Community Care in Northern Ireland in the 1990s, DHSS, 1991.*
3 *Carers and Direct Payments Act (Northern Ireland) 2002.*
accessible, supportive and adaptable to changing need and circumstances; and
- promotion of choice, equality, social and life opportunities.

- consider how carers of older people are involved in decisions about the provision of services, individually and collectively and examining how services are organised and delivered;
- consider the resources currently allocated to this area of work and identify any areas of unmet need;
- identify and promote good practice; and
- provide a report and make recommendations as necessary.

2.3 This inspection will establish the nature, range and quality of social care support services for the carers of older people commissioned and provided by Boards and Trusts on a direct or partnership basis. This will be achieved by completing a review of the available literature, developing and agreeing a set of standards, establishing the type, range and volume of current service provision for carers of older people, conducting an audit of current service provision for carers of older people, to include the way in which carers of older people are involved in the provision of services, individually and collectively and examining how services are organised and delivered.

3. **Inspection Purpose**

3.1 The inspection will help refine issues for further examination, highlight good practice and provide the basis for self-audit by organisations providing social care services to the carers of older people. It will also make recommendations, which will guide commissioners and providers of social care support services in respect of areas requiring further development or change as well as informing Government policy. Finally, it will set out what carers can and should reasonably expect from social care support services and from the organisations commissioning and providing them.

4. **Inspection Focus**

4.1 The focus of the inspection is social care support services for carers of older people with a particular emphasis on the impact of these services on carers and the caring role. This includes reviews of the services and role – that is recognising the carer as a partner in the development and review of services. The Draft Standards developed will apply to any social care services that set out to support carers. Such services will include:

- information, advice and counselling;
- domiciliary care, including help with personal care and domestic tasks;
- respite/breaks in the home and in an appropriate residential setting;
- help with disablement equipment and home adaptations;
- meals;
- laundry;
- day care;
- help with transport;
- carer support groups and emotional support;
• rehabilitation;
• out-of-hours social work service response;
• help lines; and
• residential care.

4.2 There are three dimensions of social services interaction with carers. These are:

(a) as a person in receipt of services designed to support them in their caring role;

(b) as a key person to be consulted in relation to the needs of the cared for person and how services are designed and delivered to meet these needs; and

(c) as a recipient of social services in his/her own right as a client.

The inspection will focus on the first two of these dimensions.

While these standards focus on carers of older people, they will be relevant to other carers who use services.

5. Policy Context

5.1 People First continues to provide the policy focus for actions designed to ensure that all users of community care services, including carers, 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. A central objective of the Department’s community care policy is “to ensure that service providers make practical support for carers a high priority”.

A very large number of those people who receive community care services to help them to manage their own lives are dependent on the care and support of a carer. Government policies for community care depend in large part upon the continuing contribution of carers; indeed carers are increasingly seen as forming the backbone of caring for people in the community.

5.2 Valuing Carers, considered that “the most important and far-reaching improvements in the lives of carers will be brought about by changes in the way statutory agencies and other bodies view and treat carers”. The most fundamental conclusion was that carers “should be recognised as key partners in the provision of care”. Whilst many of the Report’s recommendations were considered possible without incurring significant costs, it was nevertheless considered “that it is vital to invest in improving services to support carers”.

5.3 The Carers (Recognition and Services) Act 1995, which came into force on 1 April 1996, gave carers in Great Britain a right on request (at the time the person they care for is assessed for community care services) to an assessment of their ability to care and to continue caring. Although that Act did not extend to Northern Ireland, Health and Social Services Boards and Trusts were required by the Department from 1 April 1996 to assess the needs of carers here, if so requested.
5.4 Subsequently, the Carers and Direct Payments Act (Northern Ireland) 2002 gave carers the right to a separate assessment of their needs and placed an obligation on the Trusts to identify and to provide information to carers. The Act also makes it possible for carers to receive services in their own right and allows them to be considered for receipt of Direct Payments as an alternative to direct service provision.

5.5 From April 2003 the Act imposed a duty on Trusts to identify carers, to provide them with information on services available and to offer assessment of their need for services. The aim is to promote an approach, which improves practice, not increasing bureaucracy but providing the opportunity for an assessment of carer need without an elaborate or bureaucratic procedure.

Early intervention individually tailored to the needs of the carer and the person being cared for can be crucial in avoiding breakdown in the caring situation and good assessment processes are key in developing appropriate and quality services for carers. The carer’s assessment should be focused on identifying what information, training or services is required to support the carer.

All carers providing or intending to provide care on a regular and substantial basis have a legal right to have their needs assessed and the results of the assessment should be recorded separately from that of the person being cared for.

6. Timescales for the Inspection

6.1 The following timescales have been established:

- formal consultation on draft standards with Boards/Trusts, the Voluntary Sector, Private Sector, Education and Training Sector and Community Organisations July 2004 – Feb 2005;
- development of methodology and initial planning for inspection November 2004 – May 2005;
- distribution, collection and analysis of questionnaires for carers of older people March/April 2005;
- distribution, collection and analysis of questionnaires to all eleven Health and Social Services Trusts April/May 2005;
- fieldwork/analysis of finding in each Trust selected for Inspection June 2005 – May 2006;
- collation of overview inspection report on the 4 sites and launch of the report October 2006; and
- dissemination of findings November 2006.
7. **Scope of the Inspection and locations to be inspected**

7.1 The fieldwork elements of the inspection will take place in one Trust each HSS Board areas and will focus on the nature, range and quality of social care support services for the carers of older people.

7.2 Inspectors will examine cases relating directly to carers and where appropriate cared for people to consider the work undertaken with carers for older people at each stage of their involvement with social services from initial referral through to closure.

7.3 The Trusts to be inspected, with proposed timescales, are:

- Down Lisburn Trust, 31 May – 10 June 2005;
- Sperrin Lakeland Trust, 12 September – 23 September 2005;
- Craigavon & Banbridge Trust, 14 November - 25 November 2005; and
- Homefirst Trust, 3 March – 16 March 2006.

7.4 While the fieldwork component of the inspection is focused on these four Trusts, all eleven Community Trusts will participate in the completion of questionnaires regarding their own services and facilitating access to carer’s to encourage them to complete a ‘carers questionnaire’. It is hoped to have 50 completed questionnaires from each Trust area. This will provide a regional background to the fieldwork inspection.

In addition to this, Advice N I are facilitating access to advice workers across the region who will help to identify carers who have little or no contact with Trusts so that their views can be sought. In excess of 400 questionnaires are being circulated through this process.

8. **Inspection Team**

8.1 A unidisciplinary team has been established to take forward the Inspection. The team consists of

Maire McMahon  -  Inspection Manager
Pat Newe  -  Lead Inspector
Joe Blake  -  Project Manager
John Park  -  Sessional Inspector
Ronnie Carser  -  Lay Assessor
Dr Patricia McDowell  -  Statistical Support

The Inspection team may also from time to time include other full or sessional staff from within SSI.

9. **Co-ordinator in each Trust**

9.1 The Trust undertaking the fieldwork element of the Inspection will be expected to have identified a Co-ordinator to facilitate the Inspection process. This Co-ordination process will include:
• collation of statistical information;
• completion of pre-inspection questionnaires;
• organisation of visits and meetings;
• temporary transfer of case files;
• facilitating access to staff, service users and other agencies/individuals; and
• generally facilitate contact between the Trust and the Inspection team.

9.2 The Project Manager will work with the Co-ordinator to draw up a programme for the Inspection and outline the methodology of the fieldwork.

9.3 To facilitate the Inspection an office will be required in each Trusts area as a base for the Inspection team. Inspectors will also require access to a desk, secure filing cabinet and a meeting room.

10. Draft Standards Social Care Support Services for Carers of Older People

10.1 The Inspection will consider practice against the agreed draft standards, which have already been issued, in relation to:

• planning, commissioning, delivery and review of social care services;
• assessment, care planning and review;
• support services;
• information to service users;
• workforce planning, workforce management, training, supervision and support; and
• human rights and equality.

11. Methodology

Inspection methods will include:

• the collation of specific data from all Health and Social Services Trusts;
• the collation of specific data from each of the four Trusts to be inspected;
• examination of relevant HSS Board and Trust information;
• a written survey of carers; and
• a written Survey of Trust Services, planning and processes.

11.1 Fieldwork will include:

• an examination of a random sample of referrals;
• an examination of carers’ own files;
• an examination of cared for persons files where this refers to carers’ needs;
• appropriate Trust policies and procedures; and
• an examination of literature/information available to carers.

11.2 The fieldwork will also include interviews with:

• carers;
• carers support groups;
• cared for people;
• Trust frontline staff;
• senior Board and Trust staff;
• key personnel from other involved disciplines; and
• key personnel from other involved agencies.

11.3 Samples will take account of Trust size and Trust population as well as reflecting key categories contained in section 75 of the Northern Ireland Act 1998.

12. Feedback

12.1 At the completion of the fieldwork, verbal headline feedback will be presented to senior managers in the Board and the Trust. A draft report will be issued for a factual accuracy check at the completion of the Inspection in keeping with Circular No. HSS(EC) 1/94. At the completion of the fieldwork in all four sites an overview report will be prepared and its findings widely disseminated.

13. Findings of the Inspection

13.1 The findings of the Inspection will be used to:

• improve support for carers of older people in the community;
• contribute to the development of social care services for carers of older people;
• contribute to enhancing professional practice, management and monitoring arrangements; and

• inform policy development.
APPENDIX 2

FINAL DRAFT STANDARDS FOR INSPECTION OF SOCIAL CARE SUPPORT SERVICES FOR CARERS OF OLDER PEOPLE

Key Standards, Criteria and Examples of Evidence
DRAFT STANDARDS

1. Planning, commissioning, delivery and review of social care services

**Standard**

Carers and/or carers’ representative organisations are actively involved in the planning, commissioning and review of social care services.

**Criteria**

1. Boards and Trusts have a clear written policy for promoting carer involvement and there is a commitment, and evidence of same, at every level in the organisation to ensure that carers are fully involved.

2. Carers are actively made aware of mechanisms in planning, commissioning and delivery of services and they and/or their representative organisations are actively involved in planning, and commissioning, decisions with regard to the range and type of services that would meet their needs.

3. Information collected by Trusts to identify and monitor unmet needs is informed by collating information from individual assessments, care plans and reviews. There is a mechanism to ensure that this information informs planning, service delivery and policy development at Trust, Board and Departmental level.

4. Carers are involved in identifying and assessing local needs.

5. Carers’ needs, views and aspirations are reflected in service standards and service activity.

6. Carers are encouraged and facilitated to develop and operate their own self-help services.

7. Carers and/or their representative organisations are actively involved in promoting service effectiveness and continuous improvement in all aspects of social care service provision.

8. Carers and/or their representative organisations are actively involved in reviews and evaluations of services in the Boards and Trusts areas.

9. Carers and/or their representative organisations receive appropriate support, training and information to assist their involvement in planning, commissioning, delivery and review of services.

10. The Boards and Trusts service planning processes promote an equitable pattern of community social care support services.

11. Boards and Trusts monitor and evaluate carer involvement and the outcomes of this involvement.

12. Public consultation is promoted and publicised widely to ensure the full participation of carers who have not yet been identified by the Board/Trust.
Examples of evidence

- Boards’ and Trusts’ policy statements.
- Boards’ monitoring of care services and uptake.
- Consultation planning meetings.
- Published information/media coverage.
- Boards’ and Trusts’ service planning process.
- Questionnaires/evaluation studies/audits.
- Records/minutes of meetings.
- Public consultation.
- Standards.
- Needs assessment/unmet need policy/procedures.
- Interviews with carers, staff and agencies.
2. **Assessment, Care Planning and Review**

*Standard*  
Carers benefit from convenient, easy to use services through effective person-centred assessment, care planning and review arrangements.

*Criteria*

1. **The Trust has policies and procedures in place, which support best practice in relation to:**
   - receiving, screening and opening cases;
   - assessment, care planning, review, and case closure;
   - establishing the main carer and dealing with the resolution of potential conflict between different carer interests;
   - record keeping and the management of records; and
   - the effective management of staff workloads.

2. **Carers’ independence and choice are promoted through person-centred assessment, care planning and review arrangements that:**
   - are carried out by appropriately qualified staff;
   - are timely, understandable and needs-led;
   - involve carers as active participants and contributors, and provide access to independent advocacy where appropriate;
   - effectively combine health and social care issues involving all relevant professionals;
   - minimise the need for carers to repeat basic information;
   - recognise the diversity of carers;
   - promote social inclusion;
   - screen for possible entitlement to social security benefits; and
   - are carried out in a time and place suited to the need of the carer.

3. **Assessment, care planning and review procedures take account of carers needs including risk assessment and identification of unmet need.**

4. **Assessment and care planning records cover main areas, such as carer’s role, breaks and social life, physical well being and personal safety, relationships and mental well being, accommodation, finances (including benefits maximisation), work, education and training, practical and emotional support, wider responsibilities, future caring role,**
emergencies/alternative arrangements, access to information, agreed outcomes, complaints and challenges, review and charging.

5. Care plans for carers are:
   
   - comprehensive and build on carers strengths, identify needs as well as addressing and clarifying eligibility for services;
   
   - clear about what is of value to carers in their lifestyle;
   
   - acknowledge and deal with tensions that may arise between the needs of the carer and the needs of the person cared for;
   
   - identify the elements of service required to support the carer and make clear the intended outcomes of each element; and
   
   - include service contact arrangements in and out-of-hours.

6. Trusts have explored ways (e.g. a care plan/information sheet/diary retained in the person’s home) having regard to confidentiality, which ensure effective day-to-day communication between different care workers, the carer and others as appropriate. This information should include:
   
   - who the care workers are;
   
   - what they are assigned to do and when, including levels of discretion if any; and
   
   - how they can be contacted.

7. Case records demonstrate carers’ involvement in their own assessment, planning and review of care e.g. care plans and reviews signed by carer and case worker, record of attendance at reviews, copies of care plans and reviews given to carer.

8. There is agreement with the carer about the involvement and contribution of other agencies and professionals to the process and about the sharing of personal information.

9. The carer is provided with a copy of the care plan and the agreed plan is implemented with review dates identified and the responsibilities of other agencies agreed and clearly assigned and the carer is provided with a copy of the plan and any review or update.

10. Monitoring and review arrangements are in place, which:

    - re-assess whether the type and volume of services are still maximising independence and providing the best outcomes for the carer; and

    - lead to revision/confirmation of the plan with carers and all appropriate agencies/staff/professionals.
11. There is a clear process whereby information from individual assessments, care plans and reviews, including unmet need, is collated, analysed and used to plan the delivery of services and policy at Trust, Board and Departmental level.

**Examples of evidence**

- Policies, procedures and guidance for staff, for example in relation to assessment, care planning and review, recording and workload management.
- Case records including care plans.
- Review records.
- Cared for person’s care plan takes account of carers needs.
- Advocacy arrangements.
- Systems in relation to unmet need.
- Interviews with carers, staff and agencies.
- Training on communication regarding record keeping and day-to-day communication.
3. **Support Services**

*Standard* Carers have access to a range of quality services that meet their identified need.

**Criteria**

1. The Trust works in partnership with carers to provide responsive and accessible support systems to meet their individual needs and ensure continuity of support.

2. Carers have the opportunity to choose from a range of services.

3. Carers have access to a range of approaches and range of services to be used by social care staff including individual support, counselling, community development and group work. This is based on person-centred approaches, which develop new opportunities and support for carers.

4. Appropriately skilled and competent staff deliver services and pre-employment checks are carried out.

5. Training for carers on areas such as hygiene, moving and handling, medical conditions and administration of medication is provided. Support to facilitate participation in training is given.

6. Direct Payments are used innovatively and up-to-date procedures and information for carers/service users are in place. Carers are provided with appropriate information and supported to enable them to make use of direct payments.

7. Carers have access to support services at times that best meet their needs including access to interpreters, facilitators and signers.

8. Carers have access to emergency support in and out of office hours.

9. Carers are made aware of any charge for care services in a timely fashion.

10. The system of charging for care services is transparent, fair and consistent and it avoids discrimination.

11. When carers want to comment about their service, there is an effective mechanism for listening to them and they know how to access it.

12. The complaints and comments systems work well for carers and are linked to mechanisms to support continuous service improvement.

13. Carers are provided with support at the end of the caring role or where caring responsibilities change (aftercare) including referrals to other agencies where appropriate.

**Examples of evidence**

- Information leaflets.
• Services available and provided.
• Charging policy.
• Direct Payment documentation and uptake.
• Case records.
• Training programme.
• Trust participation and research/audit/publications and quality awards.
• Access to counselling.
• Out-of-hours arrangements.
• Comments/feedback system.
• Complaints register.
• Interviews with carers, staff and agencies.
• Carer co-ordinator/advocate/care liaison services.
4. **Information for service users**

**Standard**  Carers receive up to date comprehensive published information about social care services and other relevant information from the Trust.

**Criteria**

1. Information is produced and distributed in consultation with carers and based on needs identified.

2. Information published covers the nature, range and types of services provided, including services commissioned from other providers, how to access them and includes, for example:
   - eligibility and prioritisation criteria;
   - response times and service standards;
   - charging policy, if any;
   - contact arrangements in and out-of-hours;
   - confidentiality and data protection; and
   - comments and compliments process.

3. The Trust has published and distributed information about the carer’s right to a separate assessment and the process involved.

4. Carers are provided with information in relation to the person cared for at appropriate stages e.g. at times of change in care needs, admission to and discharge from residential, nursing or hospital care.

5. Key information is produced, as necessary, in a range of user-friendly formats and languages to ensure equal access for carers.

6. A named member of staff is responsible for ensuring that information is accessible to carers. This includes:
   - developing a database of carers in the Trust area;
   - developing a profile of their preferred information formats, ensuring that information is produced in these preferred formats; and
   - distribution to appropriate outlets.

7. Published information about services and information delivery methods are regularly reviewed and updated as necessary to take account of new and flexible methods of communication.
8. Responsibility for review of information provided is clearly assigned and the process includes representation from carers.

9. Carers have access to information about complementary or alternative sources of help.

**Examples of evidence**

- Policies and procedures, for example in relation to access criteria, charging, confidentiality and data protection.
- Organisational service standards.
- Collaborative working/consultation arrangements with carers.
- Published information.
- Database of carers.
- Circulation lists and distribution points.
- Review/monitoring procedures/updating procedures.
- Audits/carer feedback arrangements.
- Interviews with carers, staff and agencies.
- Carers’ induction pack.
5. **Workforce planning, workforce management, training, supervision and support**

**Standard** The Trust has a strategy in place to recruit, retain, support and develop sufficient numbers of appropriately qualified and competent staff with the knowledge and expertise to deliver services to carers.

**Criteria**

1. There is a Workforce Strategy in place that ensures that:
   - there is a clear organisational structure and clarity of role and function of staff at all levels;
   - there are a sufficient number of staff employed to meet current and future service needs including sufficient administration staff to provide adequate back up; and
   - there is a defined career structure and opportunity for continued career development.

2. There is an effective workload management system and staff are regularly supervised in their work. This will include supervision of:
   - caseloads, including the application of case opening and closure policies;
   - casework intervention including line management agreeing interventions and signing of records; and
   - staff appraisal including identification of training needs, continuing professional development, promotion of evidence based practice and audit.

3. The Trust monitors the implementation of the Workforce Strategy and workload management policy and ensures that relevant information such as staffing levels and workloads inform planning and are acted upon.

4. There is an overarching training and development plan that ensures appropriate competence in the workforce including training provided on human rights and equality.

5. The Trust complies with the Northern Ireland Social Care Council employers code of conduct and support staff to comply with these.

6. All staff working with and making decisions about services for carers complete basic awareness training in the needs of carers.

7. The Trust ensures that social care workers are informed about government policy and guidance related to services for carers in the Trust’s area.

8. Carers are facilitated to contribute their experience of the caring role and of services to help train staff.
9. Boards and Trusts have an overall strategy for effective organisational audit, which involves the workforce, service planners and services deliverers.

**Examples of evidence**

- Organisational structure.
- Carer grade/senior practitioner.
- Workforce strategy, including recruitment and retention policy.
- Monitoring of staff who leave.
- Workload/caseload management policy and systems.
- Training development programme.
- Supervision policy/records and staff appraisal policy/records.
- Audit Reports.
- Interviews with carers, staff and agencies.
6. **Human Rights and Equality**

**Standard** Boards and Trusts are fulfilling their statutory duties in respect of the requirements of the human rights and equality legislation and these principles are integrated into practice within all aspects of social care services for carers.

**Criteria**

1. Boards and Trusts promote a culture, which respects and promotes the principles of human rights and equality.

2. The carer’s right to privacy and confidentiality is reflected in Trusts’ policies, procedures and practices in keeping with the Codes of Practice, The Department’s guidance on the Protection and Use of Patient and Client Information and the Human Rights Act 1998.

3. The dignity of the carer is respected and valued in accordance with the Codes of Practice for social care workers and employers of social care workers and the requirements of the Human Rights Act 1998.

4. All relevant policies have been screened and subject to appropriate consultation in accordance with Section 75 of the Northern Ireland Act 1998.

5. Awareness training on human rights, equality and appropriate legislation is provided to staff.

**Examples of evidence**

- Policy and procedures.
- Screening, impact assessment and publication schemes.
- Staff training records.
- Records and Audit Reports.
- Consultation arrangements and interviews with carers, staff and agencies.
APPENDIX 3

INDIVIDUAL TRUST PRE-INSPECTION QUESTIONNAIRE
A.  **PLANNING, COMMISSIONING AND REVIEW OF SERVICES.**

1. Does your Trust have a written policy for promoting carer involvement in planning, commissioning and review of services?  
   - Yes  
   - No  

   **If yes, please attach**

   If no, please describe the key ways in which carers participate in the planning, commissioning and review of services:

2. Are there any carer organisations operating in your area?  
   - Yes  
   - No  

2a) If yes, please list the key carer organisations operating in your area:

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<th>Organisation</th>
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3. How do you keep in contact with carer organisations regarding planning, commissioning and review of services? (please tick all that apply)

- Formal meetings
- Informal meetings
- Written communication
- Telephone conversations
- No communication
- Other (please specify below)

4. How frequently, on average, would your Trust be in touch with carer organisations regarding planning, commissioning and review of services?

- At least once a week
- At least once a month
- At least once every three months
- At least once every six months
- Less often than this
- Never

5. Does your Trust support these carer organisations in providing services for carers through…

- Yes
- No

- funding?
- support worker(s)?
- use of premises?
- information and advice?
- other ways?

(please specify below)

6. Are individual carers involved in…

- Yes
- No

- identifying need?
- monitoring services?
- helping to meet need, through e.g., training, advice and counselling?
- other roles or services? (please describe below)
7. **If yes,** are individual carers trained …
   - to identify need?
   - to monitor services?
   - to meet need, through e.g., training, advice, counselling?
   - in other roles in which they are involved? (please describe below)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

__________________________________________________________________________
__________________________________________________________________________

8. Is carer input to these processes monitored?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

9. **If yes,** which post-holder(s) have responsibility for monitoring carer input to these processes?

__________________________________________________________________________

B. **ASSESSMENT, CARE PLANNING AND REVIEW**

10. Does your Trust have a written policy which supports screening and opening of cases?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**If yes,** please attach

11. Does your Trust have a written policy which supports assessment, review and closure of cases?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**If yes,** please attach

12. Does your Trust have a written policy which supports establishing the primary carer?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**If yes,** please attach
13. Does your Trust have a written policy which supports dealing with conflict between carers?

Yes \[1\]  
No \[2\]

**If yes, please attach**

14. Does your Trust have a written policy which supports record keeping and management of records?

Yes \[1\]  
No \[2\]

**If yes, please attach**

15. Does your Trust have a written policy which supports management of staff workloads?

Yes \[1\]  
No \[2\]

**If yes, please attach**

16. Do all carers known to the Trust receive their own assessment?

Yes \[1\]  
No \[2\]

17. Which post-holder(s) have responsibility for carrying out individual carer assessments?

__________________________________________________________________
__________________________________________________________________

18. Are other professionals involved in the assessment?

Yes \[1\]  
No \[2\]

19. **If yes**, which other professional(s) are most likely to be involved?

(Please rank in order with those most likely to be involved ranked as 1 and so on)

1)_______________________________________________________________
2)_______________________________________________________________
3)_______________________________________________________________
4)_______________________________________________________________
5)_______________________________________________________________
20. Is the carer’s assessment linked with other assessments, such as that of the cared for person? |
Yes [1]  No [2]

21. Please give some key examples of how consideration is given to carers’ individual circumstances in terms of age, gender, religion, ethnicity, marital status, dependants, disability, income level and other issues.

22. Is information from individual cases collated to identify unmet need and inform future services? |
Yes [1]  No [2]

23. If yes, which post-holder(s) have responsibility for collating this information?

25. Do care plans (either for the carer or cared for person) …

<table>
<thead>
<tr>
<th>Acknowledge confidentiality?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look at information sharing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate the carer’s involvement in the care planning process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build on strengths?</td>
<td></td>
<td></td>
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<tr>
<td>Cover needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledge tensions between carers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify key workers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify contacts?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify emergency cover?</td>
<td></td>
<td></td>
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</tbody>
</table>

26. Does the primary carer receive a copy of care plans?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

27. What is the maximum period between reviews of care plans?

<table>
<thead>
<tr>
<th>One month</th>
<th>Three months</th>
<th>Six months</th>
<th>A year</th>
<th>Longer than this</th>
<th>Only at request of carer</th>
<th>Care plans are not reviewed</th>
</tr>
</thead>
</table>

C. ACCESS TO A RANGE OF SERVICES

28. Where appropriate, are carers offered …

<table>
<thead>
<tr>
<th>Counselling?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training in moving and handling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training in medicine management?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training in hygiene?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other training or services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If yes, please specify below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_____________________________________________________________________
_____________________________________________________________________
29. Do all carers receive information on the availability of direct payments?  
   Yes ☐  
   No ☐

30. What proportion of carers known to the Trust take up direct payments?  
   All ☐  
   More than half ☐  
   About half ☐  
   Less than half ☐  
   None ☐  
   Don’t Know ☐

31. Does your Trust charge for any services to carers?  
   Yes ☐  
   No ☐

   **If yes,**

   31a) which services does the Trust charge for?  
   _______________________________________________________________  
   _______________________________________________________________  
   _______________________________________________________________  
   _______________________________________________________________  
   _______________________________________________________________  
   _______________________________________________________________

   and

   31b). Do all carers receive written information on charging?  
   Yes ☐  
   No ☐
If yes, please include a copy of this information with your return.

32. Does your Trust have a register of carers? Yes ☐  No ☐

**If yes,**

32a) How many carers are on the register? ☐

33. If your Trust does not have a register, does it intend to establish one? Yes ☐  No ☐

**If yes,**

33a) When is this register likely to be compiled? ___________________________

General comments and complaints procedures:

34. Are there procedures for … complaints? Yes ☐  No ☒

35. **If yes,** are these monitored? Yes ☐  No ☐

36. **If yes,** which post-holder(s) have responsibility for monitoring? ___________________________

37. Are services or supports offered to the carer when their caring role ends? Yes ☒  No ☐
D. INFORMATION

38. Is information for carers made available in a range of formats and languages?  Yes ☐  No ☐ 

If yes, please attach

39. Is written information supplied on …  Yes ☐  No ☐

- eligibility for services?
- response time from referral to assessment?
- likely time from assessment to provision of services?
- contact arrangements?
- other aspects of services? (please specify below)

__________________________________________________________________
__________________________________________________________________

If yes, please attach

40. Is written information supplied to all carers who present on their rights to separate assessments?  Yes ☐  No ☐ 

If yes, please attach

41. Is there a designated person who develops, collates and reviews carer information?  Yes ☐  No ☐ 

42. If yes, which post-holder(s) have this responsibility?

__________________________________________________________________
__________________________________________________________________

E. WORKFORCE PLANNING

43. Is there a written workforce strategy?  Yes ☐  No ☐ 

If yes, please include a copy of this strategy with your return.
44. Is there regular supervision of all social care staff involved with carers?  
   Yes  
   No  
   **If yes**,  
   
44a) How often is this carried out?  
   At least once a month  
   At least once every three months  
   At least once every six months  
   Less often than this  
   
44b) Does supervision include a formal staff appraisal component?  
   Yes  
   No  
   
44c) Does this inform the Trust’s training plan?  
   Yes  
   No  
   
Please provide a copy of the Trust’s training plan with your return  
   
45. Is there regular monitoring of secondary providers, i.e. voluntary and private organisations?  
   Yes  
   No  
   **If no, please go to Q46**  
   
45a) Which post-holders have responsibility for this?  

_____________________________________________________________________
_____________________________________________________________________

_____________________________________________________________________

and

45b) How often is monitoring carried out?  
   At least once a month  
   At least once every three months  
   At least once every six months  
   Less often than this  
   
45c) What does this monitoring entail?  

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
45d). Are carers involved in this monitoring?  

Please include monitoring documentation with your return.

46. Are carers involved in staff training?  

**EQUALITY**

47. Does the Trust have written policies on equality?  

If yes, please include a copy of these with your return.

48. Is training provided on equality and human rights to all staff involved with carers?  

49. Are trust policies and procedures equality proofed?  

If no, please go to Q50

If yes

49a) Which post-holder(s) have responsibility for this proofing?

49b) How often is proofing carried out?  

At least once a month  
At least once every three months  
At least once every six months  
Less often than this
49c) Are carers involved in the proofing? 

Yes 1
No 2

50. Does your Trust monitor uptake of services for carers on an equality basis? 

Yes 1
No 2

If yes, please include documentation relating to this with your return

This is the end of the questionnaire.
Thank you for your cooperation.
APPENDIX 4

BOARD/TRUST RESPONSE TO REPORT
Since its establishment as a Commissioner of Health and Social Services in 1996, the Northern Board has been assessing the need for support to Carers. The population of Older People within the Board area is growing faster than anywhere else in Northern Ireland, yet in terms of our population and assessed needs, we are still under-funded in comparison with other Board areas by around £9 million.

Despite these challenges, significant funding has been made available to local Trusts to provide extra domiciliary support, additional respite care and a range of other services that will better support Carers. In addition, partnerships have been established with voluntary organisations to deliver new and innovative schemes including one which has recently achieved UK wide recognition for excellence through the presentation of a National Training Award in London.

The Inspection report has made some constructive recommendations about the way forward and the Board is committed to acting on these. We will establish a mechanism for ensuring that the recommendations are robustly implemented in pursuit of better support to Carers of Older People and indeed all Carers.
2 January 2007

Dear Mr Newe


The above report and its recommendations are broadly welcomed by Homefirst Trust.

As was shared with the team during the fieldwork visits, the Trust is significantly under-funded in terms of our population size and assessed needs and it is in this context that we continue to strive to support carers of older people.

Homefirst will incorporate the recommendations within the report within its Carers Strategy which is currently being developed, and we will work with the NHSSB to support carers of older people where we can.

Yours sincerely

Cathy McKillop
Chief Executive

Mr Patrick Newe
Assistant Chief Inspector
Social Services Inspectorate
Room C3.28
Castle Buildings
Stormont
BELFAST
BT4 3SQ