

DOMICILIARY CARE IN KENT

**A Review by a Select Committee
appointed by the
Social Care and Community Health
Policy Overview Committee**

Parts I and II

Chairman: Mrs M E Featherstone

March 2003



FOREWORD TO THE SELECT COMMITTEE REPORT ON DOMICILIARY CARE

On behalf of the Select Committee I am pleased to present the final report on Domiciliary Care. This report follows that on Nursing Care. Some issues are shared, but the Domiciliary Care Service has a different role.

Recent Government initiatives encourage and support service developments which give people what most of them want – to remain in their own home for as long as possible. The key service which enables this to be realised is the Domiciliary Care service – care in the home.

Domiciliary Care has developed far beyond the days of the old 'Home Help'. Now Domiciliary Care enables very frail people to stay in their own home, providing very personal care and supporting their independence. This care postpones the day when residential care may be needed. Recent developments in the service enable people to leave hospital earlier and give them the confidence to continue to live independently.

This report shows a service in transition – from a part time casual job to a professional service. As the skills demanded of carers have become more complex, public awareness and esteem have not kept pace. Amongst our key recommendations are a new name for care workers, and encouragement for the development of a proper career structure.

Demographic trends show that pressure will rapidly increase on all the services which care for the elderly. Domiciliary Care has potentially a huge contribution to make to the quality of life of elderly people. It is vital that we get it right now. I hope that the recommendations made by the Committee will help in the development of carework as a recognized and valued career.

Finally, I would like to thank my colleagues on the committee, the staff who so ably supported the work, and particularly all those who gave up their time to come and give evidence.

Margaret Featherstone, Chairman of Select Committee

CONTENTS

PART 1

Executive Summary page 1

PART 2

Chapter One - Introduction to the Social Care and Community Health Policy Overview Committee and the Policy Overview Process page 5

Chapter Two - What is Domiciliary Care? page 7

Chapter Three - National and Local Policy Context page 10

Chapter Four - Demographics page 15

Chapter Five - Meeting Changing Needs page 18

Chapter Six - Different Settings of Domiciliary Care page 20

Chapter Seven - The Contracting Process page 27

Chapter Eight - The National Minimum Standards page 29

Chapter Nine - Domiciliary Care Providers page 35

Chapter Ten - Domiciliary Care Workers page 43

Chapter Eleven - The Commissioners of Domiciliary Care page 49

Chapter Twelve - Experience of Service Users page 52

Chapter Thirteen - Services for Minority Ethnic Communities page 57

Chapter Fourteen - Informal Carers page 61

Chapter Fifteen - Direct Payments page 66

Chapter Sixteen - The Cost of Care: Financial Implications for Domiciliary Care page 72

Appendices page 75

Glossary of terms page 85

References page 88

Part 3

Evidence: minutes of Select Committee meetings (separate document).

DOMICILIARY CARE TOPIC REVIEW – EXECUTIVE SUMMARY

This topic review was chosen by cross party agreement in light of two issues. Firstly Domiciliary Care is playing an increasingly important role in delivering needs-led community care services. A structured Domiciliary Care service tailored to the needs of its clients is central to the successful implementation of national and local Community Care policies in meeting the needs of an increasing ageing population. Secondly, Domiciliary Care is currently going through a radical transition period. The transition is due to the impending implementation of the National Minimum Standards and the regulation of the profession, set in a climate of increasing difficulties in the recruitment and retention of care staff carrying out more complex tasks than ever before.

The terms of reference of the Select Committee were:

To consider the capacity of, and the trends in costs and quality of Domiciliary Care Services in Kent, with particular reference to the projected needs of public sector purchasers and the influence of central government on supply.

The Select Committee, chaired by Mrs M E Featherstone was established in March 2002. The membership comprised of Mrs A D Allen, Mr J Beynon, Mr J D Kirby and Mr M V Snelling (for the conservative group), Mrs J E Butcher and Mrs M Newell (for the Labour Group) and Mrs M E Featherstone (the Liberal Democrat spokesperson).

There were 14 evidence gathering meetings involving 53 witnesses: involving a diagonal slice of staff within the Social services Directorate and from a broad range of stakeholders. In addition individual or small groups of members undertook 3 site visits to Age Concern, Guru Nanak Centre and a care provider and conducted semi structured interviews. To arrive at their findings and recommendations the Select Committee met on 23, 28 and 30 January 2003. Subsequent development of the text and refinements to the recommendations were achieved through email consultations.

The Committee identified five main issues. These are the levels of resources available, the changing role of the service, the quality of care provided, the commissioning/contracting of care and staffing issues. Within the staffing issue there are several important elements. These include the difficulties in the recruitment and retention of staff; the low status of care workers; poor pay and conditions; lack of a career path and job satisfaction. The main body of the report is divided in to 16 Chapters (see contents page). The recommendations to the Council are:

POLICY/OPERATIONAL ISSUES

Recommendation 6.2.1: The Select Committee supports the Cluster Care initiative and recommends that the provision of such care be extended where possible.

Recommendation 6.2.2: SSD explore the possibilities of expanding Cluster Care to clients receiving Domiciliary Care living in close geographical proximity areas (other than in sheltered housing schemes).

Recommendation 6.3: SSD examine carefully the Cluster Care Scheme's impact on the lack of choice of care workers for the users.

Recommendation 9.3: SSD to investigate the benefits of flexible transport arrangements, and consider a pilot scheme.

STRATEGY/POLICY

Recommendation 6.4: The Select Committee endorses the SSD links with the Health Service in the setting up of innovative Intermediate Care Schemes across parts of the county.

Recommendation 6.5: SSD in partnership with Health make every effort to expand the Intermediate Care schemes where relevant, especially, bearing in mind needs of rural areas.

Recommendation 6.6: The SSD identify key medical conditions that would benefit from Intermediate Care provided countywide, in partnership with the health service.

OPERATIONS

Recommendation 7.1: SSD make arrangements to monitor that clients receive the total amount of care time allocated to them.

Recommendation 9.4: SSD consider ways of aiding the development of a defined career structure through the commissioning process.

Recommendation 14.1: SSD to conduct a survey in partnership with a carer organisation on the concerns highlighted by informal carers.

Recommendation 15.1: The issue of Direct Payments needs to be introduced early in the assessment process for consideration by the client and/or their family.

Recommendation 15.2: KCC adopt a well resourced independent advisory scheme to provide independent support and follow up for elder persons considering and using Direct Payments.

Recommendation 15.3: SSD conduct a study of the potential impact of the Direct Payment Scheme on the contracting processes, and of the financial support functions that will need to be put in place.

Recommendation 6.7: SSD revise and provide information for Care Managers on where and how low level preventative care can be accessed.

EXTERNAL POLICY

Recommendation 8.1: KCC liaise with voluntary Domiciliary Care providers to explore with the National Care Standards Commission whether Voluntary providers could be offered concessions towards the payment of registration and inspection fees.

Recommendation 9.1: KCC encourage service providers to consider a move to salaried staff.

Recommendation 9.7: KCC lobby Central Government to demonstrate adequate resourcing of Domiciliary Care.

Recommendation 10.3: KCC liaise with and encourage District Councils to enable care workers to park in controlled parking zones in and around town centres.

COMMUNICATIONS/PR

Recommendation 6.1: SSD make interim arrangements for clients and carers to be made aware of how and where community equipment can be accessed quickly.

Recommendation 9.2: SSD in partnership with Domiciliary Care providers explore the possibility of a publicity campaign to publicise a career as a Domiciliary Carer.

Recommendation 12.1: SSD establish regular and local joint meetings between providers, purchasers, older people and elected members.

Recommendation 12.2: SSD lead a review of information currently available to publicise Domiciliary Care and related services, and how and when service users access such information.

Recommendation 12.3: SSD to disseminate good practice with regards to accessible information.

Recommendation 12.4: SSD to revise and rename the complaints leaflet.

Recommendation 13.1: KCC in liaison with voluntary bodies identify the Domiciliary Care needs of ethnic minority older people.

Recommendation 13.2: SSD publicise the Domiciliary Care service to all sections of the community.

Recommendation 13.3: The Select Committee welcomes the production of the document “Culturally Competent Care” and recommend that it be publicised and made widely available to the preferred Domiciliary Care providers both in-house and in the independent sector.

Recommendation 13.4: The Culturally Competent Care Guide and the interactive CD Rom be included in the training of carers.

Recommendation 14.2: County Benefits Unit provide information/leaflets for clients and Care managers, detailing how and where to find help to fill in benefit claim forms.

Recommendation 14.3: SSD in liaison with carer organisations ensure carers are aware of the current opportunities for Respite Care provision in Kent.

TRAINING/RESOURCES

Recommendation 9.5: SSD work in conjunction with the Care Provider organisations (UKDCA and KCCA) and the Skills Sector Council to make links with colleges and schools offering work experience practice placements.

Recommendation 9.6: SSD with care provider organisations (UKDCA and KCCA) explore ways of widening recruitment of carers.

Recommendation 10.4: The National Care Standards Commission be encouraged to inspect the training given to Domiciliary Care workers.

Recommendation 10.1: KCC to lobby the Department of Health to find ways to raise the status of Domiciliary Care workers.

Recommendation 10.2: KCC introduce a new name for Domiciliary Care workers.

Recommendation 10.5: The Select Committee endorse the SSD Professional and Social Care Training Sections' role in enabling and facilitating the exchange of information and access to funding opportunities in training for the Domiciliary Care sector. It is recommended that this continue

CHAPTER 1: INTRODUCTION TO THE SOCIAL CARE AND COMMUNITY HEALTH POLICY OVERVIEW COMMITTEE AND THE POLICY OVERVIEW PROCESS

1.1 Kent County Council is the democratically elected strategic authority for Kent. It has the broad power to promote and improve the social, economic and environmental well being of the area and has the statutory responsibility for the provision of a range of services. The Local Government Act 2000 laid out new procedures for the reform and modernising of local government. One of its main aims was to increase openness and accountability within local government, with local people playing a greater part in shaping and receiving better services. On 1st September 2001 Kent County Council adopted a new Constitution introducing a new political structure with a Leader and a single-party Cabinet taking most of the decisions previously taken by all-party service committees.

1.2 Under the new Constitution elected Members outside the Cabinet can contribute to the development of policy through the appointment of Policy Overview Committees, which focus on different services provided by the County Council. The three Policy Overview Committees help and advise the Council, the Leader and the Cabinet on the development of the Council's policies and review the Council's performance compared with objectives and targets.

1.3 The Policy Overview Committees have the power to set up smaller Select Committees to look in depth and review particular policy issues by way of topic reviews. The all party Select Committees are made up of Members from the different political parties proportional to the number of Council seats held by each party.

1.4 The Social Care and Community Health Policy Overview Committee (SCCH POC), considers various functions related to those managed by the Strategic Director of the Social Services Directorate. These may be issues relating to the introduction of new legislation, policies, or specific services that the SCCH POC consider need to be looked into at depth. In March 2002, the SCCH POC set up a seven Member Select Committee to carry out a review of Domiciliary Care. The Members of this Select Committee were Mrs M E Featherstone (Chair); Mrs A D Allen; Mr J Beynon; Mr J D Kirby; Mr M V Snelling; Mrs J E Butcher and Mrs M Newell.

1.5 The Terms of Reference for the Select Committee were:

“To consider the capacity of, and the trends in costs and quality of Domiciliary Care Services in Kent, with particular reference to the projected needs of public sector purchasers and the influence of central government on supply.”

1.6 The reasons for carrying out a review of Domiciliary Care are two fold. First of all, Domiciliary Care is playing an increasingly important role in delivering efficient, needs-led community care services to a large number of Adult Services' clients within the Social Services Directorate. A structured Domiciliary Care service tailored to the needs of its clients is central to the successful implementation of national and local Community Care policies in meeting the needs of an increasing ageing population. Secondly, Domiciliary Care is currently going through a radical transition

period. The transition is due to the impending implementation of the National Minimum Standards and the regulation of the profession, set in a climate of increasing difficulties in the recruitment and retention of care staff carrying out more complex tasks than ever before.

1.7 The Select Committee heard evidence from a number of witnesses. These included officers from the Social Services Directorate; users of Domiciliary Care services; Care Providers from the in-house and independent sector; Informal Carers, together with other individuals and organisations involved in the delivery or receipt of Domiciliary Care services. A complete list of the witnesses who gave evidence to the Select Committee is shown in Appendix I. The Select Committee took evidence from March to August 2002.

CHAPTER 2: WHAT IS DOMICILIARY CARE?

2.1 This Chapter explains what Domiciliary Care is and details some of the tasks that are carried out by care workers. It also details the aspects of Domiciliary Care that this review will focus on, and looks at how the service has changed from the former 'homehelp' service.

2.2 Domiciliary Care can be broadly defined as *'Help and services provided in a person's own home to improve their quality of life and enable them to maintain their independence.'* (Strategic Briefing, 27.03.02). These can include a range of different services: home care, meals on wheels, and visits by Occupational Therapists, Social Workers or District Nurses.

2.3 With greater numbers of older persons now maintaining their independence longer by moving to semi-independent living such as Sheltered Housing, it has meant that Domiciliary Care is now provided in a number of different environments. These can include a person's home, sheltered accommodation, or a health setting such as a community hospital in the provision of recuperative care (see Chapter 6).

2.4 Domiciliary Care can be provided for a range of different clients including:

- older people
- people with physical incapacity
- people with sensory loss including dual sensory impairments
- people with mental health difficulties
- people with learning difficulties
- children and their families
- personal or family carers

2.5 For the purposes of this review the Select Committee focussed primarily on Domiciliary Care commissioned, (and in some circumstances also provided) by the County Council's Social Services Directorate (SSD). It also includes Domiciliary Care provided to clients under joint initiatives with Primary Care Trusts such as the various Intermediate Care arrangements across the county.

2.6 With the emphasis on caring for more people with complex health and personal care needs living in their own homes instead of in residential or nursing homes or long stay hospitals, the provision of personal Domiciliary Care services is changing rapidly. This change also reflects changes at the interface between health and social care with the development of Intermediate Care policies designed to prevent clients from being admitted to hospital and enable early discharge from hospital. An article in 'Community Care' (March 2002), said:

'Far from its traditional image of unskilled workers doing a bit of cleaning and shopping for older clients, home care is mutating. Spurred on partly by the government's investment in intermediate care, Domiciliary Care is moving up a gear, to the extent that people who 10 years ago would have been in residential care are now able to stay at home with packages of care which may include significant medical or skilled tasks performed by home care staff'

2.7 Greater demands on Domiciliary Care as a result of government policies promoting independent living; the increasingly ageing population; coupled with budgetary constraints on SSDs, has meant a gradual increase in the 'eligibility criteria' for Domiciliary Care tasks that can be commissioned and provided by KCC. This has resulted in packages of care being more intensive with higher dependency needs now being catered for.

2.8 Since the 1980's the trend has been for SSD to gradually reduce or withdraw the homehelp service, which provided a large number of older people with domestic help. This has been replaced with a more intensive home care service providing primarily 'personal care', but for fewer people (Clark et al, 1998). Targeting of services was always an explicit objective of the Community Care reforms of the early 1990s. This was to ensure that priorities were applied to maximise 'the chances that those most in need would receive due care, and that eliminated the possibility of low priority need being met while higher priorities were neglected' (Griffiths, 1988). Some argue that 'it is clear that this targeting has now become rationing of care for many people' (Phelps, 1997). It must be noted that assistance with shopping and other domestic tasks is still provided to clients assessed by KCC Social Services Directorate as needing this support, but only as part of a wider package of care. The SSD no longer provides domestic home help as the only service to clients.

2.9 This review focuses primarily on the personal care element of Domiciliary Care provided to older people and adults with disabilities. However throughout the review process the Select Committee acknowledged the importance of 'low level' preventative and supervisory services. These encompass services that may not entitle a client for a SSD Domiciliary Care service on their own. These include services such as help with medication; supervision checks; and domestic home-help services such as cleaning and help with shopping. Supervision is a type of close personal care/support for the elderly and is as important as the physical care of clients e.g. checking food in fridge is safe to eat and clean clothes are worn. The importance of 'low-level' services in both enhancing the quality of life for older people and helping them maintain their independence has been documented (Clark et al (1998) and Raynes et al (2001)). The work of Clark et al suggests the need for a national strategy for the development of low level services which takes on board the voices of older people themselves. It concludes that services, which enhance quality of life and social engagement, have a central role in helping older people to remain in their homes with dignity and independence. Financial constraints have led to the tightening of the SSD eligibility criteria. The need for low level or supervisory services may no longer qualify for receipt of services. The Committee expressed their concerns that in tightening the eligibility criteria the need for low-level or supervisory services may not be identified.

2.10 Personal care can be defined as:

'Undertaking any activity which requires a degree of close personal and physical contact with a person, regardless of age who, for reasons associated with disability, frailty, illness or personal physical capacity are unable to provide it themselves without assistance.'

(DoH 2001a)

These activities include for example:

- Assisting the person to get up, get dressed or undressed and to go to bed
- Helping the person to have a wash, shower or bath including hair washing, shaving and oral hygiene
- Assisting the person with their toilet requirements
- Helping the person eat their food or take a drink
- Assisting the person with their medication or health related tasks in accordance with the local agreed policy
- Assisting a person to get in or out of a chair
- Personal support of a confidential, sensitive or specialist nature

(DoH 2001)

(A distinction must be made between Domiciliary Care and 'Community Support Services', which are more 'enabling' services for people with mental health needs or learning/physical disability. This review did not include Community Support Services.)

2.11 It is clear that Domiciliary Care has changed significantly in the last ten years with the services bearing little, if any, resemblance to the former 'home-help' service which catered for less intense low level needs. With a greater number of older persons retaining their independence in their own homes for longer, Domiciliary Care entails a greater intensive level of care with carers having to perform more skilled tasks than previously. These tasks include for example checking prescribed medication is taken and caring for people with special needs. However despite this greater professionalism the service has been unable to shed its image from the home-help days as a semi-formal service, which has implications for the profession as later Chapters will detail.

2.12 This Chapter has defined what Domiciliary Care is, detailed the various tasks that it encompasses and the different client groups that benefit from it. It has also detailed how Domiciliary Care has evolved from the simple tasks (such as cleaning and shopping) of the former 'homehelp' service to include a far greater professional service meeting complex health and personal care needs of clients who previously may have been cared for in residential settings.

CHAPTER 3: NATIONAL AND LOCAL POLICY CONTEXT

3.1 This Chapter considers the history of Community Care, and the increasing importance of Domiciliary Care as an integral part of service provision.

3.2 The National Context:

There is no one statute dedicated to governing the provision of domiciliary services. The statutory framework treats care services either as residential, or non-residential. Thus the legal framework for domiciliary services (which can be anything from personal care to night sitting, shopping, cleaning, benefits collection, etc) applies also to day care, social work advice and support, and any other non-residential service.

3.3 Public funds can be used to provide services under five different pieces of legislation: The Chronically Sick and Disabled Persons Act; The National Assistance Act 1948; The Health Services and Public Health Act; The Mental Health Act and the National Health Service Act 1977 Schedule 8. In all cases, eligibility for services depends on two things; that the client comes within the definition of the persons intended to benefit from the statute in question, and the client is assessed by the authority as 'needing' its assistance. The latter is determined by local authority 'eligibility criteria', which are discussed later in the Chapter.

3.4 Various policy documents have led to the development of Domiciliary Care being at the core of community care policy. (*Community Care* refers to the 'services and support to help anyone with care needs to live as independently as possible in their home, wherever that may be').

3.5 In 1981 the DHSS published the '*Report of a study on Community Care*' which found that there had been little identifiable shift in the balance of care for those elderly people on the margin between institutional and community-based care. The 1986 Audit Commission Report, '*Making a reality of Community Care*' suggested that it was too easy for people to go into homes with public support, and this was discouraging the development of effective services for people in their own homes. Furthermore it added that it would often cost less to help people to remain in their homes. Following this report the Government commissioned Sir Roy Griffiths to look at the organisation and funding of community care services. The Griffiths report '*Community Care: Agenda for Action*' identified obstacles to the effective planning and delivery of community care services. It concluded that people should be helped 'to stay in their own homes for as long as possible, or in as near a domestic environment as possible, so that residential, nursing home and hospital care is reserved for those whose needs cannot be met in any other way' (p.28). Griffiths also identified the need for local authorities to prioritise different client needs, and recommended that professionals acting for the local authority should adopt a care management role: assessing the client's needs, defining a package of care and purchasing services on behalf of the service user or carer.

3.6 The White Paper '*Caring for People*' (HMSO1989) incorporated some of the recommendations identified by Griffiths and set out the framework for the community care reforms. The White Paper outlined six key objectives. The four objectives that relate to Domiciliary Care are:

- Services for people at home:
To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible...In future the Government will encourage the targeting of home-based services on those people whose need for them is greatest.
- Services for carers
To ensure that service providers make practical support for carers a high priority.
- Assessments of care
To make proper assessment of need and good case management the cornerstone of high quality care. Packages of care should then be designed in line with individual needs and preferences.
- Better value for taxpayers' money
To secure better value for taxpayers' money by introducing a new funding structure for social care.... social security provisions should not... provide any incentive in favour of residential and nursing home care.

3.7 The National Health Service and Community Care Act 1990 put Domiciliary Care at the heart of community care provision. The community care reforms introduced new procedures for arranging and paying for state-funded care. The NHS and Community Care Act 1990 emerged due to three significant factors. Firstly Government policy throughout the 1980s encouraged the mixed economy of care in the public sector. Secondly the need to improve joint planning in light of demographic projections of older people was being recognised (Audit Commission 1986). Thirdly in the 1980's many older people were able to enter private residential homes through a system of social security financing separate from that of local and health authorities. This policy effectively channeled public sector funds into the private institutional sector while leaving the domiciliary sector chronically under resourced – undermining the commitment to community-based services (Powell, 2001).

3.8 The intent of the NHS and Community Care Act (fully implemented 1993) was to:

- encourage change in the balance of care from institutional to community care, discouraging long-term hospital provision and residential and nursing home placements;
- engineer a move away from supply-led towards needs-led decisions and service arrangements;
- enhance the role of both the private and voluntary sectors through the deployment of contractual and quasi-contractual agreements, and through the creation of “not-for-profit” providers to manage floated off services formerly directly run by local authorities; and
- move much more responsibility for community care decision making and funding to local authorities, away from central government, from whom funds were transferred in annual tranches

(Wistow et al 1994)

3.9 The NHS Plan for England was launched in July 2000 and set out the government's development of the NHS over a ten-year period (DoH 2000). Its vision is 'a health and care system focused on the service user, not around those delivering

the services'. It details achieving this by the provision of preventive services; support for self-care; social care; primary care; intermediate care; and hospital care.

3.10 Domiciliary Care has a key role, with the NHS Plan detailing a £900 million package of new intermediate care services to allow older people to live more independent lives (see Chapter 6). The NHS Plan also sets national standards for caring for older people to ensure that ageism in the provision of services is not tolerated.

3.11 This is further developed in the National Service Framework for Older People (DoH 2001), which is a comprehensive strategy setting national standards to ensure fair, high quality, integrated health and social care services for older people. The Framework sets out eight standards covering four themes. These are respecting the individual; Intermediate Care; providing evidence-based specialist care and promoting an active, healthy life. All services offered to older people should encompass these standards.

3.12 The standard which is particularly relevant to the delivery of Domiciliary Care is Standard Three covering Intermediate Care which it states should generally be provided in service users' own homes. It states older people will have access to a new range of intermediate care services at home or in designated care settings to:

- promote their independence by providing enhanced services from the NHS and councils
- enable early discharge from hospital
- prevent premature or unnecessary admission to long-term residential care

As Chapter 6 will show Domiciliary Care plays a crucial role in this strategy.

3.13 In recent years there has been an increased emphasis on joint working between Social Service Departments and the Health Service. An area to receive greatest publicity has been the issue of 'delayed discharge' from Hospital. Figures from the DoH suggest that at the end of April 2002, 6% of all acute beds in English Hospitals were taken up by people who could have been discharged. For Kent and Medway in March 2002 this was 4.5% of acute beds (SERO 2002). In March 2002, 8% of patients in acute and geriatric beds had their discharges delayed due to waiting for arrangements to be made for care, equipment or adaptations, which would have allowed them to return to their own home. The current figure for KCC residents of patients delayed awaiting Domiciliary Care, equipment or adaptations is 5.7% (which equates to 9 delays).

3.14 In the document 'Delivering the NHS Plan' (DoH 2002) the government introduced the idea of making local authorities responsible for the costs of delayed discharges from hospital. It states 'Councils will need to use the extra resources [detailed in the 2002 Budget], to expand care at home and to ensure that all older people are able to leave hospital once their treatment is completed and it is safe for them to do so. Achieving this is dependent on the presence of well co-ordinated Domiciliary Care services. A Consultation paper on the proposals to introduce a system of reimbursement around discharge from Hospital was issued in July 2002. Implementation of this scheme is due to be introduced in April 2003.

3.15 The 'Modernising Social Services' agenda details the need for Social Services to promote people's independence (DoH 1998). Similarly other related government initiatives, namely 'Promoting Independence' initiative and the 'Social Services Modernisation Fund' have shifted the emphasis of service provision to promoting independence. They too detail greater joint SSD/Health Services initiatives providing users with services in the home.

3.16 The Modernising Government White Paper (1999) set out some key objectives for the overall approach public services should be taking in the future. These include organising public services around the needs of users of services rather than around providers; listening to people's concerns, reflecting their real lives, and involving them in decisions about how services should be provided. It is interesting to note that the White Paper uses a diagrammatic representation of the number of organisations a person needing long-term Domiciliary Care may have to deal with, to illustrate the practical problems facing people when they use public services.

3.17 **The Local Context:**

Domiciliary Care's role is at the centre of Kent SSD's policies in delivering community care services. It is laid out in the following policy documents:

3.18 '**Active Care – A new look at Social Care in Kent**' was presented to the Social Services Committee in September 2000 and set out a number of commitments and targets for social care in Kent over a ten-year period (KCC 2000). With regards to Older People it details several services with Domiciliary Care at the core of this provision. These are detailed in Appendix II.

3.19 '**Kent – The Next Four Years**' sets out Kent County Council's priorities and targets for the next four years to 2005 (KCC 2002). It details several priorities with regards to Domiciliary Care, (which are detailed in Appendix III), in order to increase by 20% the number of people receiving intensive home care, and reduce by 10% the number of emergency admissions of older people to hospital.

3.20 '**Vision for Kent**', the community strategy document is about improving the economic, environmental and social wellbeing of the county of Kent over the next 20 years. It details some social and health care services involving Domiciliary Care that will be developed. These are detailed in Appendix IV.

3.21 In 2001 the Government introduced the concept of Public Service Agreements for local authorities. These involve a local authority committing itself to achieving targets agreed with local people and partners. As an incentive to better performance locally, central government offers financial reward to the local authority for achieving its targets after three years. Two of Kent County Council's Public Service Agreements relate to older people. The two targets are:

- *to reduce delays in moving people over 75 from hospital*
- *to reduce numbers of people over 65 moving into residential and nursing care*

If the targets are to be achieved, efficient and professional Domiciliary Care services are essential.

3.22 The **‘Social Care Eligibility – Standardising Assessed Needs to Indicate Entitlement to Services’** sets the criteria for those eligible for help from Kent Social Services Directorate (SSD). Form CM6 sets this out and is shown in Appendix V. An assessment of need is carried out and compared against ‘service entitlements’ to identify the band of service options to which a person may be entitled to. A person must be assessed as having a ‘Moderate’ level of need for temporary or low level Domiciliary Care, and a ‘High’ or ‘Very High’ level of need in order to be entitled to a Domiciliary Care package. Certain legal principles have been established through litigation regarding Domiciliary Care. A current care package cannot be cut back without a reassessment regardless of any financial crises a local authority may have.

3.23 The SSD recommends the service(s) that they consider to best suit the individual assessed as needing care e.g. residential/nursing home care. Clients do however have the right to challenge an outcome and a right to choose to remain in their own home. Although client and carer views are taken into account, this needs to be balanced with available resources and capacity. The level of care needed may be beyond the available resources of SSD or the capacity available, for example if a client requires 24hour care but SSD are unable to find carers to cover this. There may also be increased issues of risk if a person remains at home if this is not thought to be the most appropriate setting to meet the assessed needs. Clients wishes are therefore met as far as possible.

3.24 From the various policies highlighted above both at a national and local level, it is clear that Domiciliary Care has a crucial role in the provision of successful community care services. With a greater emphasis placed on supporting higher need clients in the community within their own homes; increased joint Social Services Directorate/Health Services initiatives, coupled with increased resource allocation dependent upon meeting targets, the need for a professional Domiciliary Care service has never been greater.

3.25 This Chapter has looked at the history of Community Care, and the increasing importance of Domiciliary Care as an integral part of service provision.

CHAPTER 4: DEMOGRAPHICS

4.1 This Chapter considers the change in demographics for an increasing ageing population both in terms of age groups and numbers nationally and locally, and the consequences this will have for Domiciliary Care.

4.2 The National Picture:

The importance of an efficient and adequate Domiciliary Care service to care for an ever-increasing ageing population is emphasised by population predictions.

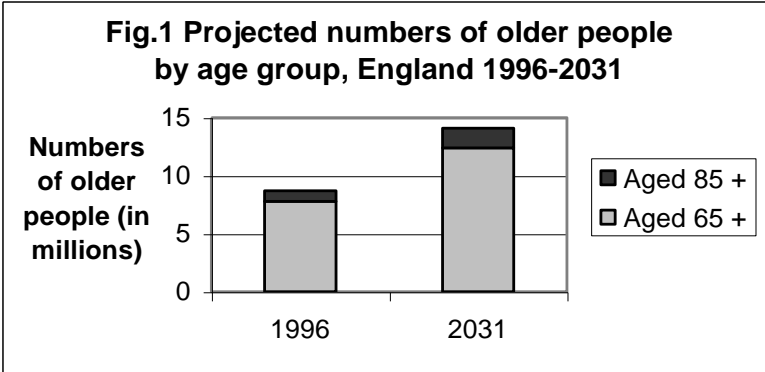
Number of people over age 65
 1996 2031
7.8 million >> 60% increase >> 12.4 million

4.3 The demand for Domiciliary Care is expected to rise in the future placing a greater significance on the need for a well co-ordinated and good quality service. Demographic studies predict sharp increases in the numbers of older persons who will be requiring Domiciliary Care in the future. Initial analyses from the 2002 Census show that nationally:

- people aged 60+ (21%) form a larger part of the population than children under 16 (20 %)
- there has been an increase in the number of people aged 85+, now over 1.1 million (1.9% of the population)

(ONS 2002)

4.4 The above statistics further exacerbate the care situation for the future. There is an increasing ageing population and the number of potential carers (be they professional or informal) is decreasing. Figure 1 illustrates the projected numbers of older people.



4.5 The Government’s Actuary’s Department (GAD) projects that the number of people in England aged 65 and over will rise by 4.6 million from 1996 to 2031, an increase of 60 per cent. The number of very elderly people (aged 85 and over) will rise even more rapidly, by 88 per cent, from 0.9 million in 1996 to 1.7 million in 2031 (Office for National Statistics, 2000).

4.6 Long-term care services for older people need to expand to keep pace with demographic pressures. The Personal Social Services Research Unit estimates that

'the number of home care hours would need to increase by around 48 percent between 1996 and 2031 (PSSRU, 2001).

4.7 The extent of the financial pressures arising from the demographic changes has been well documented. A review of the long term needs affecting the Health Service in the UK highlights the pressures on social care:

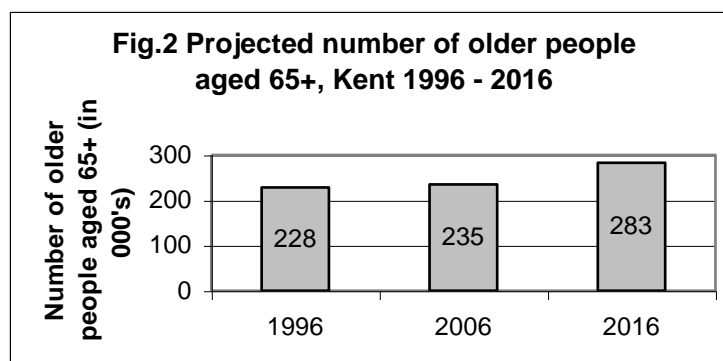
'projections of spending on the elderly and on adults with mental health problems and physical and learning disabilities show it rising from £6.4 billion in 2002/3 to between £10.0 - £11.0 billion in 2022/23. This confirms the finding that demographic change and, in particular, the ageing of the population is a more important cost pressure for social care than for health care...These figures do not include estimates of any additional increase in the level of resources required to deliver high quality social care or more imaginative planning of the whole of social care. The figures quoted are therefore under estimates of the additional resources that will be required.'

(HMT 2002)

4.8 **The Kent Picture:**

The final analysis of the population statistics for Kent has not been published at the time of writing this report. However from the Registrar General's Mid Year Population Estimates for 2001 (which are based on the 2001 Population Census) and those for 1991, there has been a 0.3% increase in the number of people in the 65-84 age range over this period. The increase in the number of people aged 85 and over has been more dramatic with an increase of 19.8%.

4.9 A survey by Laing and Buisson carried out in January 2000 commissioned by KCC SSD, indicates increases in Kent's elderly population, and the subsequent need for Domiciliary Care to cater for these needs. Kent's population of people aged over 65 is set to increase by 55,000 between 1996 to 2016 - an increase of 24 %. Figure 2 illustrates this.



4.10 The number of people aged 85 is also set to increase steadily (although a slight drop is predicted in 2003/4 owing to the low birth rate in 1917/18). This increase is significant as people aged 85+ are four times more likely to require long-term care than those between the ages of 75-84, and twenty times more likely than people aged 65-74. The predictions of the ageing population outlined above, clearly show the importance and need for an efficient and capable Domiciliary Care service.

4.11 This Chapter shows that demographic studies predict sharp increases in the number of older people. *As a result the demand for Domiciliary Care will rise as more older people maintain their independence in their homes for longer.*

CHAPTER 5: MEETING CHANGING NEEDS

5.1 This Chapter looks at the impact of changes in community care policies on Domiciliary Care in recent years, and the greater needs that it caters for now.

5.2 Domiciliary Care has changed in recent years. It is provided in a different policy context, and the type of tasks that are carried out have changed. Previously Domiciliary Care workers performed domestic tasks around a client's home such as help with housework and shopping. However as the eligibility criteria for the provision of local authority commissioned Domiciliary Care have gone up these low-level (preventative) services have become less common. In the last decade it has become increasingly geared towards personal care rather than domestic support.

5.3 Nationally low-level preventative services provided by local authorities are being reduced as resources are becoming stretched. The implications of this trend for the provision of preventative services are potentially concerning and were recognised by the Health Select Committee in 1996 three years into the community care reforms. 'Help with housework is not seen as life-threatening nor as being a deciding factor as to whether or not people stay at home or go into residential care' (Clark et al, 1998). The reduction in low-level preventative services has left a vacuum in terms of those older people who have lower levels of need and thus cannot meet the eligibility criteria for social services support. The committee believes that this apparent gap should be addressed, to ensure any longer term risks are identified.

5.4 Since the implementation of the NHS and Community Care Act 1993, there has been a progressive shift away from institutional care in care homes, towards care provided in people's own homes in the community. The development of Domiciliary Care has been central in enabling this. This has taken place at the same time as the reduction of nursing homes and residential homes for older people. In the five years to April 2001 there have been significant nursing home bed reductions for older people (including terminal care) in the two health authority areas in Kent. For example:

- from 2354 beds to 2117 for West Kent (including Medway), the loss of **10.07%**
- from 2189 beds to 1408 for East Kent, the loss of **35.68%**
(KCC SCCH POC '*Nursing Home Care in Kent*' Topic Review, 2002)

5.5 The reduction in residential care has contributed to an increased demand for Domiciliary Care, and a service which has had to develop and cater for a client group with increasingly greater care needs and higher dependency that previously may have been met in a residential setting.

5.6 The most recent statistics show that demand for home care services is rising and especially for more intensive care. Community Care Statistics on home care services purchased or provided by Local Authorities in England, estimate that 2.88 million contact hours were provided to around 381,200 households in 2001. Compared with the previous year this represents an increase of contact hours of 3%. (Since the DoH began recording these statistics in 1992 the number of hours has

increased by 71%). The DoH statistics for 2001 also show that the number of households receiving intensive home care (defined as more than 10 contact hours and 6 or more visits during the week) has increased (DoH March 2002). In 2001 around 76,400 households received intensive home care representing a 6% increase on the figure for 2000. This indicates that Domiciliary Care now caters for more intense client care needs than previously.

5.7 Serving people with higher needs and the recent developments in joint SSD/Health Intermediate Care schemes have placed more demands on Domiciliary Care workers. Increasingly, their tasks include offering care that may include a significant medical element to it, or other more skilled tasks than were being performed previously. These accelerated demands coupled with poor rates of pay and working conditions have contributed to the difficulties of recruitment and retention of care staff experienced by many Domiciliary Care providers.

5.8 The impending implementation of the National Minimum Standards for Domiciliary Care will provide much needed regulation to the Domiciliary Care profession and offer protection and safeguards to some of the most vulnerable clients of Social Services Departments. The Standards will also aid in generating a sense of professionalism within Domiciliary Care - still regarded as unskilled work as was the previously less skilled homehelp service - through the requirement for training and supervision. However in the short-term implementing the standards will pose new challenges to care providers and care workers, (see Chapters 9 and 10), and the way local authorities commission care from care providers (see Chapter 11).

5.9 Recent policy initiatives further place Domiciliary Care at the hub of achieving successful community care provision. These include policies to reduce bed-blocking within hospitals, (as detailed in the proposed measures to charge local authorities for delays in hospital discharges); and achieving KCC's Public Service Agreement targets. The government has stated that by 2006 an extra £1 billion a year will be spent on social services for older people and "as a result of the investment...by 2005 there will be twice as many older people receiving the intensive help they need to live at home than there were in 1995." (DoH 23 July 2002)

5.10 This Chapter has looked at the changes in policies which have resulted in both an increased demand for Domiciliary Care, and a service which has developed to cater for a client group with greater care needs and higher dependency levels than previously. Recent initiatives such as intermediate care has meant that Domiciliary Care tasks may now include a medical element and/or other more skilled tasks than were carried out previously.

CHAPTER 6: DIFFERENT SETTINGS OF DOMICILIARY CARE

6.1 This Chapter looks at the referral and assessment process and the provision of aids and adaptations in order to assist the provision of Domiciliary Care in a client's home. It will look at the different situations and environments in which Domiciliary Care is provided. The impacts of the Supporting People Initiative on Domiciliary Care are discussed.

6.2 Domiciliary Care can be provided in a number of different settings. It is not solely in a client's own home. The different settings include: a client's own home, a sheltered housing environment, or as part of an Intermediate care package (such as recuperative care) in a community hospital setting.

6.3 Referrals and Assessment:

When a client living in the community in their own home is referred to the SSD seeking support with Domiciliary Care, the SSD makes an assessment as to whether a service is to be provided. The request for a service can be from anyone who knows the client. This could be a professional working with the client, a friend, a relative, a carer or the person seeking the service themselves. Ninety percent of requests are made by telephone. As of June 2002 all initial contacts are made to the County Duty Service by telephone. Here it is determined whether the request can be best dealt with by forwarding it to another agency or whether it is appropriate for it to be forwarded to the relevant local Social Services Adult Services Care Management Team.

6.4 The Care Management Team then determines the level of urgency. This usually involves contacting other professionals involved and seeking their views. Depending on the urgency of the matter the case is allocated to a Care Manager and an assessment of need is carried out. Clients who receive a service from KCC are assessed under a care management model. (Care Management involves three key tasks. Firstly finding out what a client's needs are (assessment), care planning (looking at what services can be offered to meet the identified needs), and then reviewing the service).

6.5 The assessment may take 2/3 visits to complete and involves speaking to the client, their carer(s) and liaising with other professionals who may be involved with them.

6.6 The assessed need is then matched against the Kent SSD eligibility criteria, (Appendix V 'Social care Eligibility – Standardising Assessed Needs to Indicate Entitlement to Services'), to determine whether the needs can be met with a service provided by KCC SSD, and the level of the services. This is then agreed with the service user.

6.7 Over recent years with the increasing demand on public sector resources, the eligibility criteria for Domiciliary Care have been tightened both nationally and in Kent. As mentioned in previous Chapters this has meant that fewer people now receive Domiciliary Care. However those receiving it receive a more intensive service.

6.8 If the assessed need meets the eligibility criteria then arrangements are made for the care to be provided by a Care Provider. This may be the KCHS in-house provider or an independent care agency, which holds a 'preferred provider' contract with KCC. The care provider to ensure the carer can work in a safe environment carries out a health and safety assessment. If need be a referral is made for any aids to be fitted that are required to assist the client to remain independent in their home. These aids (known as community equipment) include 'home nursing equipment' such as pressure relief mattresses and commodes; 'equipment for daily living' such as shower rails, raised toilet seats, teapot tippers and liquid level indicators and 'minor adaptations' such as grab rails, lever taps. (From the 'Guide to Integrating Community Equipment Services' DoH 2001) At present these aids are available from either Social Services or the Health Service. (Aids and adaptations are discussed further in section 6.10).

6.9 If a person who has contacted the County Duty Service is not assessed as needing care (i.e. they do not meet the eligibility criteria) they are directed to providers/organisations who might be able to provide the support they need. The Select Committee are concerned that these people are then in effect 'lost to the system' and might not receive the care they need in the future or return to the County Duty Service should their needs change. The Committee discussed the introduction of named nurses within the NHS and believe this to be a good idea. The Committee suggested that people who are not assessed as needing care need a named contact for future reference should their needs change. A possible solution is the introduction of a follow-up card with details of a named person and/or service contact details.

6.10 Aids and Adaptations:

In March 2000, the Audit Commission published 'Fully Equipped', a report on the provision of community equipment to older and disabled people by the NHS or Social Services. It showed that the current organisation of services was a recipe for confusion, inequality and inefficiency. The NHS Plan included the Government's intention to achieve a single, integrated community equipment service by 2004. It set out targets to increase by 50 per cent the number of people benefiting from these services and to improve the quality of equipment issued. Standard 2 of the National Service Framework requires that 'NHS and social care services treat older people as individuals and enable them to make choices about their care. This is achieved through...integrated provision of services, including community equipment and continence services.'

6.11 Kent and Medway Councils together with the various health organisations across Kent and Medway have come together to form the 'Equipped for the Future – Working towards integrated community equipment services by 2004' Project Team. There was a public consultation between 18th June – 31st August 2002. Work is now under way to produce an action plan on how the Government milestones will be met. This will include looking at best ways of organising services, providing information and advice, setting up one or more demonstration areas and generally improving standards and user satisfaction.

6.12 The Select Committee has heard from carers that a delay in the provision of aids and adaptations can hold up the provision of Domiciliary Care. In addition

informal carers have expressed confusion as to how and where community equipment can be accessed.

Recommendation 6.1: SSD make interim arrangements for clients and carers to be made aware of how and where community equipment can be accessed quickly.

6.13 Sheltered Housing - Cluster Care:

As the demands on Domiciliary Care increase, Kent Social Services have had to explore innovative ways of providing care so as to overcome difficulties in the recruitment of carers and the provision of care in hard to reach areas such as rural communities. Cluster Care is one such initiative which seeks to overcome these problems by providing care to a number of clients living close to each other, using the same care provider.

6.14 Cluster care was first proposed as a cost saving exercise. It also represented better use of limited resources in terms of time management and logistics. Traditionally Domiciliary Care is purchased by 'time and task' booking individual timed (half hour) visits to each client, cluster care charges in 'blocks of hours' per unit rather than per person.

6.15 In Kent cluster care pilot schemes have been established in Edenbridge, Wrotham, Snodland and Sevenoaks. The schemes which have been set up cover clients in sheltered housing units where a natural cluster of clients requiring Domiciliary Care exist. All the care delivered to the cluster is by one (or at a maximum two), care providers. Timetabling of care for each individual client is agreed with a flexible approach of the carer carrying out a particular task and then moving onto another client before returning to the previous client – as opposed to being there all the time as care in a person's home.

6.16 The advantages of cluster care are: flexibility, reliability, continuity, increased security for the client and the carer, a sense of belonging, guaranteed work for care workers, and a reduction in travel time and costs. Cluster care also poses a few difficulties, which arise as a result of carers visiting several clients in close proximity. These include potential issues of confidentiality arising from innocent remarks by the carer leading to a neighbour becoming aware of the problems or care needs of another client. Strict hygiene procedures also need to be observed to avoid any chances of cross infection. Another problem may arise with the expansion of the Direct Payments Scheme (see Chapter 15). This will mean that clients within a cluster could choose care providers other than the ones providing the care to the cluster.

Recommendation 6.2.1: The Select Committee supports the Cluster Care initiative and recommends that the provision of such care be extended where possible.

Recommendation 6.2.2: SSD explore the possibilities of expanding Cluster Care to clients receiving Domiciliary Care living in close geographical proximity areas (other than in sheltered housing schemes).

Recommendation 6.3: SSD examine carefully the Cluster Care Scheme's impact on the lack of choice of care workers for the users.

6.17 Intermediate Care:

Domiciliary Care is playing an increasingly crucial role in keeping patients out of hospital. This has meant greater emphasis on joint working between Social Services and the Health Service. In recent years the issue of reducing bed-blocking in hospitals has received regular publicity especially in the winter months when pressures on geriatric wards are the greatest. When older persons are admitted to hospital be they for a planned routine admission, or an unexpected admission such as following a fall, they may lose confidence and need extra support to enable them to regain their independence. Intermediate Care 'is a range of services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living' (DoH 2002). Intermediate care is usually a range of short-term treatment or rehabilitation services designed to promote independence.

6.18 The National Beds Inquiry Consultation, the NHS Plan and the National Service Framework for Older People have signaled a clear policy direction and have provided impetus for the development of Intermediate Care. The NHS Plan details a number of preventative services one of which is 'intermediate care'. Here Domiciliary Care has a key role. It details a £900 million package of new intermediate care services to allow older people to live more independent lives. In July 2002 the Health Secretary reinforced the governments drive to expand intermediate care. He said:-

"To enable local councils to provide more rehabilitation services we will earmark resources to ensure an extra 70,000 older people a year get these services to avoid them going into hospital unnecessarily or to help them leave hospital speedily when it is safe to do so. I intend to legislate to ensure that these and all intermediate care services will be free whether they are provided by the health service or by Social services. "

(DoH Press Release 23 July 2002).

6.19 Intermediate care will play a major role in Kent SSD achieving its Public Service Agreements. These are targets agreed by KCC with local people and agencies. As an incentive to better performance locally, central government offers financial rewards to local authorities for achieving its targets. Two of KCC's Public Service Agreements relate to intermediate care:

- *to reduce delays in moving people over 75 from hospital*
- *to reduce numbers of people over 65 moving into residential and nursing care.'*

6.20 The Select Committee heard details of some joint intermediate care initiatives between Social Services and various health trusts. These can include Primary Care Trusts, Hospital Trusts, Community Trusts and the voluntary sector. Intermediate Care is a short-term input of services and usually provided for a maximum of six weeks). These have been going since 1997 when a 'Generic Worker Scheme' was set up. Other schemes in Kent include 'Community Assessment and Rehabilitation Team' CART which is rehabilitation service at home including occupational therapy and physiotherapy. 'Day Hospital' scheme which provides quick assessment and consultant access. 'Recuperative Care' providing rehabilitation in a twenty-four hour setting. 'Rapid Response Teams' which offer twenty-four hour intervention in acute

episodes. Another project set up by Social Services, Maidstone and Tunbridge Wells NHS Trust, South West Kent PCT and High Weald Housing to enable elderly people who might go into residential care to return home from hospital.

6.21 These services have been developed and monitored through multi-agency working groups. Intermediate Care entails joint funding between Health Trusts and SSD. Recently there has been a move to pooled budgets for Intermediate Care.

Recommendation 6.4: The Select Committee endorses the SSD links with the Health Service in the setting up of innovative Intermediate Care Schemes across parts of the County.

Recommendation 6.5: SSD in partnership with Health make every effort to expand the Intermediate Care Schemes where relevant, bearing in mind needs of rural areas.

6.22 The Select Committee recognises that the different Intermediate Care Schemes in different parts of the county have developed based on the needs and opportunities within their particular localities. The Committee is of the opinion that some schemes catering for key conditions such as stroke rehabilitation teams warrant expansion across the county.

Recommendation 6.6: SSD identify key medical conditions that would benefit from Intermediate Care provided countywide, in partnership with the Health Service.

6.23 Domiciliary Care plays a central role in intermediate care together with health professionals such as speech therapists, occupational therapists. There are two types of care. 'Step down care' is aimed at freeing up hospital beds by giving patients intermediate care at home and phasing this out gradually as their health improves and their confidence grows. 'Step-up care' seeks to keep patients out of hospital for as long as possible by increasing the care delivered at home.

6.24 Although the Select Committee heard that CART Schemes experience difficulties in the recruitment of rehabilitation care workers, this is only in some localised areas. Rehabilitation workers are mainly full-time and are paid at a higher rate than Domiciliary Care workers. They also tend to be seen as having a higher status as the job is seen as more skilled. This tends to attract staff away from Domiciliary Care agencies.

6.25 In contrast Generic Workers are employed by Domiciliary Care agencies and can be difficult to recruit. Cover for rural areas is a particular problem.

6.26 Although many of the schemes have not been thoroughly evaluated as they have only been in operation for a short period of time the Select Committee heard of some of the successes. Some users of the Recuperative Care Scheme, who had previously had a care package before entering hospital had been discharged from it no longer needing one. This, however, highlighted another problem. For people living alone, a Domiciliary Carer is often the only social contact they had in the day. When they ceased to require a care package, the Domiciliary Carer is no longer

allocated to them and these visits cease. They will then need some other way of alleviating their social isolation. If housebound, isolation could lead to Mental and Physical Health problems. It was heard that there is a need in this sort of scenario for a “checking” service, for example, someone not to administer or supervise medication but simply to check daily that the client had taken it. Hence there is a need for a lower level of care - supervision rather than personal care.

6.27 The Committee heard that the Recuperative Care Scheme had identified gaps in care not previously shown up (for example, the low-level supervision needs highlighted above). The Eligibility Criteria are very tight and such needs simply do not register. The challenge is to meet these needs without making the client dependent on Social Services. Properly planned community schemes could fill this gap. A suggested idea was using GNVQ and Key Training students to make check-up calls. The Committee feel this is not appropriate unless within a properly structured scheme.

Recommendation 6.7: SSD revise and provide information for Care Managers on where and how low level preventative care can be accessed.

6.28 Supporting People Initiative

The Supporting People (SP) programme offers vulnerable people the opportunity to improve their quality of life by providing services which enable them to have greater independence and control in making choices within their lives (DETR January 2001). SP promotes housing related support services and for example, will help older people remain living independently at home. Both Domiciliary Care and SP seek to maintain clients in the community for as long as possible. The SP programme will be delivered by a partnership of Local Government, the NHS, the national Probation Service, service users and support agencies. The Committee heard that the main objective of Supporting People was to streamline and simplify funding and charging for housing-related support.

6.29 The SSD Supporting People receives administrative funding from the DTLR. There are two areas of funding available: Supported Housing Management Grant (SHMG) and the Transitional Housing Benefit (THB). THB pays for housing-related support, for example the extra help needed to maintain tenancy, saving residents from losing their homes (such as cleaning services). Some of the tasks covered by this Benefit would have been covered by Domiciliary Care provision before the SSD eligibility criteria tightened.

6.30 The impact of the Supporting People Initiative upon the elderly population will mainly be on those people in warden accommodation and sheltered housing. The main SP issue that affects Domiciliary Care provision is the hourly rate payable by clients for housing-related support compared to that paid for personal care. The Committee heard that there are currently no regulations to restrict hourly rates for housing-related support. If providers can charge more for housing-related support, this service may be provided in preference to Domiciliary Care. Consequently better hourly rates may attract care workers and some providers away from providing Domiciliary Care. A further issue is that the same or different providers can provide housing-related support and/or Domiciliary Care. Service users could find this confusing.

6.31 This Chapter has looked at the different environments in which Domiciliary Care is provided. These include in the client's own home, a sheltered housing scheme or in a community hospital setting as in some aspects of intermediate care. The latter includes various joint SSD and Health initiatives across the county where a range of services are provided to promote faster recovery from illness or prevent unnecessary acute hospital admission and hence maximise independent living. It has been seen that Domiciliary Care plays a central role in the provision of intermediate care. The Chapter has also detailed the current Kent and Medway project looking at the provision of community equipment to assist clients to remain in their homes.

CHAPTER 7: THE CONTRACTING PROCESS

7.1 This Chapter looks at the way KCC contracts with Domiciliary Care providers, and the two types of contracts that are used.

7.2 As previous Chapters have detailed, Domiciliary Care for older people has changed significantly over the past two decades. The implementation of the NHS and Community Care Act 1990 established for local authority Social Service Departments the mixed economy of care. This meant that an increased volume of services is purchased from the independent sector through a framework of flexible contracts (such as Call off and rates of volume). This Chapter will detail how this process is carried out in Kent SSD. Although there has been no national regulation, Domiciliary Care providers are currently assessed and registered by the Inspection Units of KCC as 'preferred providers' from who the SSD purchases care.

7.3 The mixed economy of care has resulted in a major change in the balance of provision of Domiciliary Care between the public, private and voluntary sectors. In 2001 three fifths of the total contact hours of home care were provided by the independent sector (DoH March 2002). This reflects the increase in the amount of home care commissioned by local authorities from the independent sector. Between September 1992 and September 2001 the proportion of contact hours provided by the independent sector has increased from 2% to 60%. The number of contact hours provided directly by local authorities fell by 6% last year. Local authorities now directly provide 40% of the total contact hours of home care compared with 98% in 1992.

7.4 In 1998 KCC invited independent sector homecare providers to tender for the provision of its local authority funded homecare contracts. These were initially to run for 33 months from July 1998 to March 2001. Two types of contract were awarded by KCC, 'Cost and Volume' and 'Call-Off'. KCC pioneered 'Cost and Volume' contracts. Cost and Volume contracts guarantee a block purchase of hours plus a negotiable option to purchase further hours of service. 'Call-Off' contracts refer to contracts where a price per hour is specified in advance and paid when a service is provided. The contract re-let in 1998 aimed to raise the standards of care provided. KCC set minimum standards which providers awarded contracts have to meet. If a provider is unable to meet these standards they are not awarded a contract. KCC were the first Local Authority to take this step. All providers who were successful in securing contracts became 'preferred Domiciliary Care providers' from whom all KCC commissioned care is purchased. In July/August 2000 KCC offered to re-let the contracts by inviting all contracted providers to extend their contracts for a further two years from April 2001 to March 2003.

7.5 About 40% of Domiciliary Care purchased by KCC is via C&V contracts, where a price is set for a fixed volume of business (that is, a stated number of hours which could be anywhere between 25,000–200,000 hours per annum). One of the benefits of a C&V contract for a care provider company is that it is able to guarantee its workers an agreed number of hours employment and a constant pay level, rather than calling on them as and when they were required. The remaining 60% of care purchased by KCC is by Call-Off contracts.

7.6 The Kent Community Care Association (KCCA) was formed in 1999 to enable better liaison between commissioners and care providers, and to input the industry's point of view into the contracting process. 85% of 'preferred providers' in Kent are members of the KCCA.

7.7 The Select Committee has heard from a small care provider, new to the market. They heard about some of the difficulties that the owner encountered in starting off despite thorough knowledge and experience of the Domiciliary Care sector. One of the issues that has been raised has been the difficulties this small provider experienced without the business of a large purchaser of care such as KCC. The Select Committee has heard that small providers are essential in providing personalised care, and there is a need for encouraging new providers into the market.

7.8 Another issue to come to the fore throughout this review has been Domiciliary Carers using part of the time allotted for client care for travel between clients. This appears to have arisen as Care providers cover travel time and travel costs from the packages of care they serve. This needs to be closely monitored to ensure that such practices are eradicated. The Select Committee is aware that this may have repercussions on the costs charged to clients however this practice which reduces time with clients (already at a minimum) needs to be prevented. This issue is further expanded upon in Chapters 9 and 10.

Recommendation 7.1: SSD make arrangements to monitor that clients receive the total amount of care time allocated to them.

7.9 The scale of purchasing agency staff across the Domiciliary Care sector is substantial (as it is in the residential care market). Subsequent to the gathering of evidence the SSD Strategic Director has proposed that KCC set up its own agency through Commercial Services. This would offer agency staff at competitive rates to both KCC and the independent sector. This should have the benefit of reducing unit costs thus making it possible to translate savings into better conditions for care staff. The proposal has been accepted by the County Council. Commercial Services are in the process of researching the market and developing an action plan to implement this recommendation.

7.10 This Chapter has looked at the current contractual arrangements that KCC has with Domiciliary Care providers. Although up to now there has been no national regulation, Domiciliary Care providers are registered by the Contracts Team of KCC and awarded 'preferred provider status'. All 'preferred' providers hold either a 'Cost and Volume' or a 'Call Off' contract with KCC. It is only these providers from which SSD can commission Domiciliary Care. In exceptional circumstances a non-preferred provider may be used, this is however very infrequent.

CHAPTER 8: THE NATIONAL MINIMUM STANDARDS

8.1 This Chapter discusses the New National Minimum Standards for Domiciliary Care which are due to be implemented from 1 April 2003, and the benefits that regulation will bring to the profession. The Chapter also assesses the impact on care providers of implementing the various requirements.

8.2 As yet there are no national regulation requirements for Domiciliary Care providers. This potentially places some of society's most dependent and vulnerable individuals in dangerous situations especially as Domiciliary Care can be of an intimate nature carried out behind closed doors in clients' homes. There is substantial variation in the quality of Domiciliary Care services, and it is believed that the absence of any registration and inspection system is a major contributory factor.

8.3 The implementation of the Care Standards Act 2000 requires that for the first time national minimum standards will be introduced for Domiciliary Care providers. The draft standards were produced earlier in the year and they were due to be implemented in July 2002. This has now been delayed to January 2003. The standards will be compulsory for all Domiciliary Care providers delivering personal care services, except where the provider is a sole individual working alone. The reason for this exception is that the government's intention is not to intervene unnecessarily in personal, informal or low-key personal care arrangements between neighbours, friends or relatives. The standards are intended to achieve a uniform and minimum standard of care in the personal Domiciliary Care sector. This will ensure that registered providers of personal Domiciliary Care meet a reasonable standard. Below this level, they will not be able to operate as a registered provider.

8.4 Comprehensive levels of skill and competence will be required under legislation. At present there are only minimal requirements for Domiciliary Care providers. Currently, two bodies in Kent require a certain standard from Domiciliary Care providers. These are KCC Contracting, and Kent Community Care Association (KCCA). KCC contracting teams monitor those who have preferred provider status contracts with KCC. The preferred providers are monitored by a questionnaire sent every six months, (unless a need arises for greater investigation at any other time). At present no charges are levied on the providers. The other requirements that some providers are subjected to in Kent are for those who are members of the Kent Community Care Association (KCCA). Approximately 80% of all Domiciliary Care hours purchased by KCC is provided by providers who are members of the KCCA, a company limited by guarantee and controlled by its members. This association is forum based and at present has 38 members. It is self-monitoring and has an independent assessor to ensure that all members meet the Code of Conduct. The Code of Conduct covers issues such as the requirement for complaints procedures; appropriate insurance and working to ensure clients and employees are not discriminated against.

8.5 A number of risks are apparent to clients in an unregulated care market. These include:

- Inconsistency between agencies in quality and reliability of service
- Lack of training amongst careworkers
- Lack of supervision of careworkers

- Inconsistency in checks made on suitability of staff and managers seeking employment. This also applies to owners of agencies
- Inadequate arrangements around confidentiality, security, wellbeing and safety for users receiving personal Domiciliary Care services

8.6 Compulsory regulation brings clear benefits to users. It will ensure consistency, coherence and comprehensiveness. It will be clearer and safer for users. It will also be fairer to providers in that they will operate on a level playing field. All providers, private, voluntary and the KCC in-house service, Kent Home Care Service (KHCS) will be regulated. It is hoped that the new regulatory framework will improve the quality of care services by addressing the risk of abuse and neglect for clients. The new framework will impose new standards on training, recruitment and supervision. The local offices of the National Care Standards Commission will undertake implementation of the national minimum standards. It will be an offence to provide a personal Domiciliary Care service when not registered.

8.7 The consultation on the Draft Minimum Standards closed on 31 January 2002, with an original implementation date of July 2002. However following complex issues resulting from the consultation process, the date of implementation has been delayed to January 2003. At the point of writing this report the final version of the National Minimum Standards has yet to be published by the DoH. The National Care Standards Commission (NCSC) will inspect, register and regulate providers. It will be funded by full cost recovery through charging providers fees. The fee levels for Domiciliary Care are £1,100 for registration (a one off fee) and an annual fee of £750. For small agencies (which means an agency with no more than two members of staff, including registered persons, but excluding someone employed solely as a receptionist) the registration fee is £300 and the annual fee is £375.

8.8 Implications for Care Providers:

Although the care providers welcome the benefits the National Minimum Standards will bring, they have expressed concerns about the cost implications of compliance on their organisations. Costs are due to accrue from:

- The fees and charges payable to the NCSC
- Organisations that offer both nursing and Domiciliary Care will incur additional costs from the requirement that Nursing and Domiciliary Agencies must be accommodated, managed and accounted for separately. The costs of registration will also be duplicated.
- The draft standards require at least four supervision sessions for carers. The Standards suggest that each supervision will cost approximately £60.
- Pre-inspection schedules, which will put additional pressures on record-keeping
- Training – including increased provision of NVQ and the implementation of an approved care worker induction programme
- The introduction of quality assurance systems
- Rewriting policies and training staff in their implementation
- Criminal Records Bureau checks, including a significant cost for retrospective checks on the existing workforce.

- GP reports on managers
- Provision of documentation, ID cards etc in multiple languages
(Community Care Research and Consultancy, 2002)

8.9 The requirement for care workers to be trained to NVQ Level 2 not only poses a major cost but also a care worker resource issue. The Partial Regulatory Impact Assessment published with the draft Standards estimates that the cost of training a care worker to NVQ level 2 and a manager to level 4 (excluding the cost of staff substitution) is £1300. Another issue that may be key is the difficulty in achieving the training targets by the specified timescales. This is made more acute by the high current turnover of staff quoted to be at 27%.

8.10 The additional costs that will be incurred by care providers in implementing the standards have been estimated to be up to an extra £2.77 per hour of care. Appendix VI shows an assessment by The United Kingdom Home Care Association (UKHCA) of the compliance costs based on the draft standards and regulations for Domiciliary Care. It details an increased charge to clients of approximately £2.27 per hour, for the independent sector. (In addition, there are various proposed requirements that apply only to providers operating more than one branch, or to providers whose operations are integrated with complementary services. The extra costs to these organisations have been put around £2.77 per hour).

8.11 The Association of Directors of Social Services (ADSS) response to the Consultation on the Domiciliary Care Standards states 'the cost of compliance is high and has been under-estimated in the Regulatory Impact Assessment.' It details the estimated cost increases of two care providers, one independent and one in-house at £1.65 and £0.40 respectively for every hour of care provided (ADSS 2002).

8.12 Implications for Voluntary Care Providers:

The National Minimum Standards will also apply to providers in the voluntary sector. They are likely to have a comprehensive impact on Voluntary organisations. Where a national voluntary organisation has a number of affiliated branches, each of which is separately registered with the Charity Commission, each will be treated as a separate agency for the purposes of registration and regulation.

8.13 Community care and health reforms in the last two decades have led to an explosion in the number of voluntary organisations. This trend is likely to continue with the government placing increasing emphasis on partnerships between the voluntary, private and public sector. The voluntary and community sector is a key partner in delivering government policies. In 2000-01 local authorities allocated a total of £1.1 billion to Voluntary Community Organisations in England, with social services being the most significant service area (HMT (2002). Since the introduction of the mixed economy of care following the NHS and Community Care Act, there has been a changing balance of the provision of Domiciliary Care between the public, private and voluntary sectors. Nationally around 60% of all contact hours in 2001 were provided by the independent sector, which includes the private and the voluntary sectors (DoH 2002).

8.14 Voluntary care providers play a key role in the provision of Domiciliary Care commissioned by KCC. Currently Kent Social Services Department has contracts with 62 preferred Domiciliary Care providers, 11 of which are voluntary 'not for profit'

organisations (excluding the in-house service). These make up 18% of all preferred providers, and provide 6,858 hours of care per year, which constitutes 10.1% of all Domiciliary Care provided by KCC. The impact of implementing the Standards may well affect both the financial viability and the type of Domiciliary Care services that voluntary and charitable care providers are able to provide. In the draft Standards there are no concessions for these providers paying the registration and inspection fees. This will impact on their ability to continue to provide a service in a profession where care providers are already operating at minimal profit margins.

8.15 In its response to the DoH Consultation on the Minimum Standards, 'Age Concern England' highlights the following potential difficulties with regulation:

- Difficulties in applying standards to services, particularly those provided by the voluntary sector, which may provide a holistic service which combines Domiciliary Care with other forms of assistance. For example some Age Concern projects include specialist services for people with dementia aimed at promoting independence and preventing deterioration.
- Small specialised projects may be adversely affected as they will not be able to achieve the economies of scale needed to support the managerial arrangements required by the standards. It is debatable whether it is appropriate to apply the full range of standards to a specialised service, which provides for example, help with bathing or toenail clipping.
- Projects providing specialised services to members of minority ethnic communities might be particularly affected, as they come into the above categories.

8.16 The Manager of the Faversham Age Concern care service saw the main concern of compliance for her as being the initial registration and annual inspection fees as well as the ongoing costs of training carers to the required NVQ levels. In addition recruiting and retaining appropriately qualified staff at the required quotas was also seen as being potentially difficult.

8.17 The Director of Operations, 'Crossroads Caring for Carers' has highlighted the following difficulties for this organisation:

"The cost implications for service delivery are difficult to ascertain at the moment and the decisions about unit cost will rest with the individual Boards of Trustees. Clearly the Trustees will have to cover training and registration costs and these are likely to be reflected in costs of care."

Other difficulties she highlights include:

- The registration and inspection fees are a key concern. Nationally 'Crossroads' has 191 schemes across England and Wales. The majority of these are independent charities in their own right managed by a Board of Trustees. The national estimated total cost of meeting these fees is £250,000 in the first year.

- With regards to training a number of schemes across the country are well engaged with the NVQ programme and are being encouraged to access funding from the Learning Skills Councils and the Training Organisation for Personal Social Services (TOPSS) to support training costs. However this process can be complex and there is no guarantee of success.
- Concerns have also been expressed about the requirements for the 'responsible individual' in terms of how these relate to a voluntary sector structure where a Board of Trustees are jointly responsible for the governance of the organisation.

8.18 Another potential issue for voluntary care providers will be persuading and motivating volunteers to undertake the required training. The minimum standards require that a manager is on call at all times when a service is being provided. This will impose additional costs

8.19 It is clear that complying with the minimum standards will potentially pose challenges for voluntary care providers. In the light of the volume of care that is commissioned from them by KCC, and the nature of the specialised services offered by some voluntary schemes, it is essential that they are able to meet the challenges of regulation and remain viable.

Recommendation 8.1: KCC liaise with voluntary Domiciliary Care providers to explore with the National Care Standards Commission whether voluntary providers could be offered concessions towards the payment of registration and inspection fees.

8.20 Implications for Commissioners and Clients:

The Full Regulatory Impact Assessment makes it clear that the above implementation costs are the direct costs on providers. It adds it is expected that providers may absorb 10% of the additional costs but will pass on the rest to service users. The document states that the 'Government has compensated local authorities by £4m and health authorities by £0.5m so that their commissioning ability remains unaffected. With increasing pressures on Social Services spending, and the difficulties expressed by Care Providers in maintaining a viable business, concerns are raised as to who and how these costs will be met.

8.21 The ADSS in their response to the Consultation on Domiciliary Care standards (Jan 2002) state 'The cost of compliance is high and has been under-estimated in the Regulatory Impact Assessment.' It further adds 'Social Services authorities are not funded to absorb this increase.'

8.22 In a response letter to a query raised by a KCC Councillor about voluntary providers paying NCSC fees in April 2002, Jacqui Smith, Minister of State at the Department of Health responded:

"It is the Department's view that Local councils as commissioners of services should be taking account of the increased costs of regulation to providers they contract with through the fee levels they pay. The resources provided for personal social services are increasing by, on

average 3.4% per annum in real terms over the next three years and councils are funded to meet these additional costs.”

8.23 This Chapter has detailed the various benefits to clients that regulation of care providers will bring by the implementation of the National Minimum Standards which are due to be implemented on 1 April this year. Despite the benefits care providers have expressed concerns at the cost implications of compliance with the regulations. As well as the financial costs concerns have been raised about meeting deadlines for training of care workers to the required levels. The implications for voluntary/charitable providers is likely to be considerable and could affect their ability to continue providing a service.

CHAPTER 9: DOMICILIARY CARE PROVIDERS

9.1 This Chapter looks at different types of Domiciliary Care providers and highlights some of the difficulties currently affecting the profession.

9.2 Kent County Council Social Services Directorate purchases Domiciliary Care from a number of different providers. These include the in-house provider and the independent (private and voluntary) sector. At both a local and national level the independent sector provides a greater proportion of the Domiciliary Care purchased by local authorities. Between 1992 and 2001 the proportion of Domiciliary Care commissioned from the independent sector by local authorities has increased from 2% to 60% (DoH March 2002).

9.3 The Select Committee heard evidence from a number of different providers. These included the Kent Home Care Service (the in-house provider), and independent providers. For business confidentiality purposes members of the press and public were excluded from these hearings.

9.4 The In-House Provider:

Kent Home Care Service (KHCS) is the KCC in-house Domiciliary Care provider. It exists as a discrete business unit within the County Council. It provides care for a range of County Council client groups. These include the physically and mentally frail as well as younger disabled clients. Ninety percent (90%) of its clients are over 65 with the remaining being younger physically disabled people. Currently there are 1100 service users receiving a total of 40,000 visits per month. The KHCS service users are referred to the service by Care Managers and social workers (from the Social Services Department).

9.5 The KHC Service Manager has lead responsibility for KHCS for the whole county. The team includes three area managers, eight locality organisers, twelve supervisors and twenty part-time administrators. It is distributed across the county. The team match client needs to services. The Home Care Supervisors provide support and guidance to care workers. They ensure that health and safety risk assessments are carried out and a contact book recording daily visits is kept. Supervisors also carry out three monthly quality control visits to clients. They are also trained trainers and assessors in 'moving and handling' client techniques.

9.6 KHCS care staff work a shift pattern between 6.30am and 10.30pm from Monday to Friday, evenings, weekends and Sundays. An 'out of hours' team based in Mid-Kent covers the whole county from 6.30am to 9am and 5pm to 9pm Monday to Friday, and 6.30am-9pm on weekends and Bank Holidays. The committee heard that cover is difficult to find for evening and weekend shifts.

9.7 The in-house service, unlike commercial companies is not run for profit. It needs only to break even by balancing its costs with the prices charged. The main difference between the commercial and in-house providers is the rate paid to care workers. KHCS care workers are paid for travel time between visits. There are mileage rates for cars, motorcycles, bicycles and pedestrians. The rate paid is lower than that paid to other KCC staff.

9.8 The annual staff turnover is currently 15-20%. The reasons given for this include the low status of the job and the very limited blocks of concentrated hours. These are limited to 7-9.30am and 8-10.30pm. Domiciliary Care work is therefore often not convenient as a main job as the shift patterns can be disruptive to family life. KHCS are unable to offer carers contracts with more than 15 hours work per week, however, when cover for sickness and training is taken into account the average weekly hours worked amount to 25 hours. The Committee heard that the service experiences difficulty in recruiting care staff, particularly men. Men do apply for jobs but frequently do not accept the posts as full time work is not guaranteed. Out of 342 care staff there were currently only three men – less than 1%.

9.9 Newly recruited care workers undertake one and a half day's induction training. This covers KCC policies and procedures, personal care and medical conditions. They are then required to shadow more experienced carers for six weeks to learn good practices and gain experience of working with clients. Before carers are permitted to move clients they must also attend and pass a 'moving and handling' course.

9.10 The KHCS is also involved in a number of new initiatives and projects, for example Care Force Teams. These are teams of two carers, which provide care to rural areas across the county. Another pilot scheme is the 'Home-from-Hospital' scheme run jointly by the SSD and the Health Authority in Tunbridge Wells.

9.11 A Joint Review of Kent Social Services was carried out on behalf of the Audit Commission and the Department of Health between January and February 2001 (SSI 2001). The Joint Review identified 5 key themes. These summarise the challenges facing Kent County Council in continuing to improve the quality and effectiveness of social care in Kent. For example one theme was to 'review the role and management of in-house provider services'. This included a specific review to 'Develop a commissioning specification for a revised role for the in-house Domiciliary Care service'. The Joint Review Implementation Plan outlines the actions that will be needed in order to carry out the review recommendations.

9.12 The KHCS Review Group is jointly chaired by the Assistant Director (County Services) and Assistant Director (Performance Management). The group held its first meeting in September 2001. The Review Group has explored several options for future service delivery, modelled on the following four themes:

- Facilitating hospital discharge/avoiding hospital admissions
- Working with Care Management as part of an extended assessment process, particularly for complex new cases with KHCS being the initial provider
- Recuperative Care at home
- Provision of 'Double-Handed' Home Care

9.13 In December 2002 it was agreed that a differentiated approach to 'Active Care', which commissioners would individually determine would be put in place. The Active Care service is for older people who have been clinically assessed as ready for discharge from hospital into the community, and meet the SSD eligibility criteria for older people for social care. The select Committee welcomed this review taking place. At the time of writing this report the Committee have not had access to the

final review of KHCS and therefore are unable to make recommendations at this point in time.

9.14 Having heard from different care providers it is clear that due to KHCS's close links with KCC they are able to utilise some resources and therefore offer better pay and employment conditions than most other providers. This greater staff stability means KHCS is in a better position than others to explore new innovative projects, offer specialist Domiciliary Care or care in hard to service rural areas.

9.15 The Direct Payments Scheme, discussed at length in Chapter 14, allows clients assessed as having a need for Domiciliary Care to receive a payment to purchase their own care. The document '*Kent – The Next Four Years*' sets out KCC's priorities and targets for the next four years. One priority is to extend Direct Payments to enable a greater number of clients who need care to choose who looks after them. The in-house team cannot offer services to Direct Payment users. This is because the national scheme has been set up in a way which prohibits this. This will have implications for KHCS. As Direct Payments expands the care commissioned from them will reduce.

9.16 **Independent Sector Providers:**

The Select Committee heard from a number of independent Domiciliary Care providers. These were selected on the types of contracts they held with KCC; the number of hours they provided; the type of care offered; and geographical locality. The care providers were:

- Safe Hands Community Carers Ltd
- Ashford Homecare
- Age Concern- Faversham
- Carewatch Care Services
- Nurses Direct

These hearings were held in closed sessions. The Press and Public were excluded on the grounds that the information provided by the companies could be beneficial to their competitors.

9.17 **Care Worker Employment Conditions:**

It was noted that the different companies offered different conditions of employment and salaries to their care staff. These included different pay scales. Basic rates of pay ranged between £4.10 to £5.70 per hour. Most agencies paid extra for unsociable hours at weekends and Bank Holidays. It was universally accepted by the care agencies that pay scales were poor for the complex and demanding nature of the work. One manager referred to the parity in pay with other less demanding professions as a reason for difficulties in recruitment and retention.

9.18 Some providers offer holiday pay and a pension scheme. (However most only offered a Stakeholder Pension Scheme with no contributions being made by the Care Provider Company). The Committee heard no evidence of employers offering contractual sick pay above the statutory minimum. Similarly there were differences in care workers being paid travel time and costs. This ranges from no payment, a fixed 40p for every half-hour visit, to a mileage allowance of 22p per mile (see also travel time and expenses page 33).

9.19 Employee contracts also varied with most companies only able to offer temporary contracts and unable to offer a guaranteed minimum number of hours per week to their care workers. Care workers are mostly on zero hour contracts. They are dependent on a variable income based on the fluctuating number of work hours available. To encourage loyalty and improve recruitment and retention (discussed below) care worker employment conditions need to improve. There is a need for consistency and standardisation. The Committee heard that domiciliary providers could employ salaried staff with formal contracts and a guaranteed number of hours. If staff are salaried, providers will improve stability of the workforce. Improved conditions will help to maintain staff loyalty and develop a better team ethos.

Recommendation 9.1: KCC encourage service providers to consider a move to salaried staff.

9.20 **Increased Workload:**

There was recognition by the care providers that care workers were now expected to do more tasks (some more complex) in shorter visit times. One provider quoted that each of its carers was now doing 50% more work than 18 months ago. They relied heavily on their goodwill and their loyalty in remaining in their jobs.

9.21 **Training:**

Different care providers varied in the amount and type of training that was made available to their care workers. This ranged from one large company having its own training department; a provider (part of a national franchise) utilising training from its central office, to another being able to provide only minimal training to carers. One of the difficulties highlighted was accessing appropriate training. It was felt that the NVQ training available was more relevant to staff working in nursing homes or hospitals. Trainers did not seem to understand Domiciliary Care as a discrete subject. This resulted in staff spending valuable time on inappropriate training. Training increases the pressures on staff, as there are limited numbers of staff available to cover those on training.

9.22 **Staff Recruitment and Retention:**

The Committee heard that staff turnover within the Domiciliary Care profession is as high as 27% (Strategic Briefing 27.03.2002). The reasons for this include the poor status of careworkers as the profession still has an image of the former home-help service; the availability of limited blocks of concentrated work hours outside peak hours; poor wages; and the lack of a career structure. This high staff turnover poses difficulties for both care provider agencies and their clients. The care providers have to invest considerable time and funds in recruiting and training new staff. The reduced staff numbers creates a further strain on the care providers' ability to maintain a quality service to existing clients. For service users a high staff turnover means a disruption to their continuity of care – seen as one of the valued attributes of a quality Domiciliary Care service by service users (see Chapter 12).

9.23 The domiciliary agencies are in competition to attract staff to work for them. The care agencies told the Committee of the 'Blewater effect'. This refers to the Domiciliary Care sector competing for employees with the retail sector, which offers similar rates of pay, convenient hours of work and less individual responsibility and stress for its employees.

9.24 The Committee heard that in addition to the general difficulties in recruiting and retaining staff, both male carers and young carers are more difficult to recruit. The care agencies said that of the carers they employed only a very small proportion are men, if any at all. For example the carers of one particular care agency are all women aged between 40-65. The reasons for this include the lack of full time hours which makes the job unsuitable as a profession. A snapshot of users of Domiciliary Care in May 2002 indicated that 73% of them were female. Whilst it has been indicated that most clients prefer female carers (KCCA), there are nevertheless very few male carers should some clients request them. The benefits of working as a carer need to be promoted to help attract more carers to the profession.

Recommendation 9.2: SSD in partnership with Domiciliary Care providers explore the possibility of a publicity campaign to publicise a career as a Domiciliary Carer.

9.25 Profit Margins:

The Kent Community Care Association (KCCA) membership includes 85% of the care providers from whom KCC commissions Domiciliary Care. The KCCA told the Committee that providers are operating at minimal returns. They have quoted that the average profit margins are around 7%.

9.26 One of the 'preferred providers', kindly allowed the Select Committee to view its annual accounts. The accounts examined showed that the annual profit return for the period 15.04.01 to 14.04.02 was 4-5% of the total turnover. It was noted that the margin would be lower for a provider who only provided Domiciliary Care. The provider examined is a subsidiary of a wider organisation providing residential and nursing care. This means that they are able to take advantage of management consultancy and other business functions from within the wider organisation. It was also noted that they are able to retain carers whose clients are admitted to hospital in other parts of the group, rather than having to let them go and then recruit a carer when the client returned home and needed care. This prevents some of the difficulties in recruiting and the costs associated with it. For the client it means the continuity of carer after their break in care is resumed. In order to expand the business the Directors of this company have agreed to only draw their tax liabilities and plough the remaining profits back into the company.

9.27 The Select Committee also interviewed a manager of a care agency who was a franchisee of a larger national company. This offered some benefits such as training resources; and policies and some procedures being accessed from the parent company. In return the franchisee contributed a percentage of the agency's profits to the parent company. The franchisee stated that the company was just about managing to turn around a profit.

9.28 Most care providers stated that they experienced difficulty in meeting care needs within the prices agreed in their contracts with KCC. SSD had however increased payments by more than the rate of inflation for this period. Care providers reported that their overheads had increased since the prices had been set. These include the need to pay higher salaries to attract and retain experienced quality care staff. In 2002 the KCCA commissioned a study by an independent agency, *Community Care Research and Consultancy* to identify and quantify the factors that

had affected care providers since the KCC contracts had been awarded. The report concluded that:

“By November 2001 further uplifts from KCC brought the total cumulative increase to 17.1 percent, leaving a shortfall of 6 percent against the 23.1 percent increases in costs already met by KCCA members. The 23.1 percent represents quantifiable increased costs already met by home care providers. At least a further 8.4 percent of quantifiable increases in costs is likely in the near future....”

9.29 Travel Time and Expenses:

An important issue throughout the review has been carers having to take time from clients' allotted care for travel. Many care providers pay care workers little, if anything for their travel costs or travel time between client visits. One provider paid a combined rate of £1 per hour for travel time and expenses. Other providers pay a fixed rate of 40p, 22p mileage only or nothing at all. In contrast KHCS pay carers the minimum wage for travel time. The expense and travelling time make home care considerably less attractive for staff than a fixed-location job paying the same wage. It also means that time allocated and paid for by KCC for a client's care is cut short. Providers have stated that this is due to the lack of money in the system, i.e. the rates paid to them by KCC prevent them from paying for travel time and costs. This is an important issue that has wide ranging ramifications for clients. Rather than receiving their full-assessed amount of care, carers are arriving late and leaving early in order to compensate for the lack of travel expenses or travel time. For example if a carer arrives 5 minutes late and leaves 5 minutes early, on a half hour visit the client loses 1/3 of their care time. This in turn means carers are rushed in their tasks and rather than enabling clients to help themselves they 'do care to' the client and thus potentially increase the client's dependency. The Select Committee sees this as a critical issue and one that should be prevented from occurring in the future (see Recommendation 7.1).

9.30 Carers who do not drive or who do not have access to a vehicle can only work in their immediate area. This restricts the number of visits that they can cover and often limits recruitment of carers to drivers with transport. The Select Committee was particularly impressed by one provider's attempts to overcome the problem of mobility of/transport for carers. They have produced a business plan advocating a mixture of an in-house taxi service and the availability of fleet cars for their care workers (i.e. Project Motorway). 'Project Motorway' could widen recruitment to non-drivers or to drivers without transport. The financial projections suggest that the costs could outweigh the advantages. (At the time of gathering evidence this had not yet been put before the senior management team). This approach has a number of advantages but also disadvantages. It may be worth SSD to consider flexible transport arrangements, such as 'Project Motorway' and the benefits these might bring.

Recommendation 9:3: SSD to investigate the benefits of flexible transport arrangements and consider a pilot scheme.
--

9.31 Voluntary/Charitable Providers:

Voluntary care providers play a key role in the provision of Domiciliary Care commissioned by KCC. Currently Kent SSD has contracts with 62 preferred

Domiciliary Care providers. Eleven are voluntary 'not for profit' organisations (excluding the in-house service). These make up 18% of all preferred providers, and provide 6,858 hours of care per year i.e. 10.1% of all Domiciliary Care provided by KCC. Voluntary providers are particularly important as they offer services to clients whose needs may not be seen as economically viable to provide by larger private agencies. This includes services for clients with special needs or for members from minority ethnic communities.

9.32 Chapter 8 details the difficulties that providers will experience in implementing the National Minimum Standards from 1 April 2003. The Select Committee is concerned that efforts must be made to ensure that they are able to overcome the challenges that face them.

9.33 The Select Committee heard from the manager of the Faversham branch of Age Concern. Voluntary/Charitable providers sometimes have different experiences of the Domiciliary Care market to those of private profit making agencies. It was heard that due to their charitable status their principle focus was giving care rather than running a business. In addition their staff retention is generally good and many of their staff have been employed for 10 years or more. 80% of its recruitment is by word of mouth. It was quoted that when asked, 50% of their current staff had said that they would not work for another agency.

9.34 **Specialist Care Providers:**

There is a need for specialist carers to care for clients who have disabilities. These include clients who are disabled physically, have learning difficulties or suffer from dementia. The Select Committee heard that Domiciliary Care workers who provide care to this client group need additional skills. Care workers need to be aware of the client's disability and the limitations that it places on them. For example some conditions have changing effects on different days. This is discussed in greater detail in Chapter 12. In addition carers need good interpersonal skills to be able to communicate with clients who may have communication difficulties due to their disability. There is also a need for specialist providers to cater for the assessed needs of minority ethnic communities. This is discussed in Chapter 15.

9.35 **Changes Required to Address the Difficulties:**

The following issues have been identified by agencies as either important or changes that need to take place to address some of the difficulties in the provision of Domiciliary Care.

9.36 The **profile and status** of the Domiciliary Care profession needs to be raised to make it more attractive to new and current care staff. A new name would help to raise the profile of the job. It will alter the perception of potential employees and the public have of Domiciliary Care being the same as the previous Home-Help service. Alternative names that have been suggested include 'Community Care Assistants' and 'Community Health Assistant'. In addition a formal career structure with a defined career path from 'homehelp' to qualified carer needs to be put into place. This will be aided by stipulating at the point of commissioning the level of qualified/experienced carer that is required for the task(s).

Recommendation 9.4: SSD consider ways of aiding the development of a defined career structure through the commissioning process.

(For example the tasks requiring a higher skilled input, such as administering medication or working with a client with disability, and those requiring a more basic standard of care). This could be supported by a differentiated pay scale. Such a system would also provide an extra incentive for care providers to secure training for their carers.

9.37 A defined career structure would also make the profession more attractive to younger carers. A possible route may be to introduce younger people to the profession via Colleges and schemes such as the Key Training Scheme. There is also a lack of male carers in the profession (see section 9.8). Ways need to be found to attract more carers to the profession.

Recommendation 9.5: SSD work in conjunction with the Care Provider organisations (UKDCA and KCCA), and the Skills Sector Council to make links with colleges and schools offering work experience practice placements.

Recommendation 9.6: SSD in liaison with UKDCA and KCCA explore ways of widening recruitment of carers.

9.38 Another issue is increasing **rewards** for staff that would better recognise their contribution. This is a crucial point. In reality the continued budgetary constraints on the SSD make any sizeable increases very difficult to fund. In addition there will need to be a mechanism in place to ensure that any increases intended for care workers are not used by agencies to increase their profits.

Recommendation 9.7: KCC lobby Central Government to demonstrate adequate resourcing of Domiciliary Care.

9.39 This Chapter has considered the agencies that provide Domiciliary Care. These include the KCC in-house service; private providers of varying sizes and with different types of contracts with KCC; franchisee care providers; and voluntary/charitable providers operating on a not-for-profit basis. A number of difficulties experienced by agencies have been identified. These include recruitment and retention of staff; poor working conditions; rewards for care staff; and operating at low profit returns. It has been shown that these issues need to be overcome in order to increase the profession's status, attract new staff and reduce staff turnover.

CHAPTER 10: DOMICILIARY CARE WORKERS

10.1 This Chapter will look at the role and experiences of Domiciliary Care workers. It will also highlight some of the difficulties that contribute to the difficulties the profession experiences with regards to recruitment and retention of staff.

10.2 An efficient and reliable Domiciliary Care service is dependent upon care workers who are competent; well trained; have a high morale (enhanced by terms and conditions of employment), and have a sense of achievement in their roles. The latter is made more pertinent by the nature of the job - working in isolation in clients' homes - carrying out demanding and at times stressful tasks. The Committee heard evidence relating to the provision of Domiciliary Care, including from service users, commissioners of care and the care agencies. The Select Committee felt it imperative to hear also from a number of Domiciliary Care workers – working day to day with clients.

10.3 As Domiciliary Care has been unregulated up to now, the exact numbers of agencies and organisations existing are unknown and therefore the exact numbers of the total workforce in the independent sector are also unknown. Estimates have placed it at 185,000 individuals. The Employer's Organisation estimate that nationally that for local authority staff, there are 6,017 full time home care staff and 63, 961 part time care workers.

10.4 The type of work that Domiciliary Care workers are expected to carry out has changed over the last ten years:

“...the industry is no longer characterised by casual domestic workers. The work is equivalent now to long-stay geriatric hospital care, yet relies on a workforce still geared largely to the old domestic 'Home Help' type work. Hence the workforce needed to make up a lot of ground very quickly.”

(Mr Temple, United Kingdom Home Care Association UKHCA)

10.5 The care workers who were invited to give evidence were from a range of different care providers, which included those from the KCC in-house service, private, and voluntary sector. For the purposes of confidentiality members of the press and public were excluded from this evidence gathering session.

10.6 The carers detailed the terms and conditions they were employed under, the various tasks they performed, and highlighted some of the difficulties as well as the positive aspects of their roles.

10.7 **Status of the Profession:**

One of the carers commented that caring was seen as a 'last resort' by many people, however to do it well it required a special sort of person. Some of the key issues raised by carers are:

- The poor status of Domiciliary Care. Domiciliary Care is seen as Home Help despite their role as Domiciliary Care workers having greater responsibility.

- The lack of a formal career structure and path for professional development. Carers suggested that the recruitment of new carers would benefit if the profile of the role is raised e.g. by changing the name of the service. There is a general consensus that 'Community Nursing Auxiliary' or 'Health Care Assistant' is more appropriate names for Domiciliary Carers.
- Responsibilities of the job have increased with clients having higher dependencies than ever before. For example one carer stated she is doing a job that 10-20 years ago would have been done by a District Nurse, and that Domiciliary Carers had to be as thorough and observant as any nurse or doctor.

Recommendation 10.1: KCC to lobby the Department of Health to find ways to raise the status of Domiciliary Care workers.

Recommendation 10.2: KCC introduce a new name for Domiciliary Care workers.

The introduction of a new name for Domiciliary Care workers should be incorporated in all of the SSD forms, procedures and correspondence with clients and care providers.

10.8 Working Conditions and Pay:

The carers detailed several concerns with current working conditions and pay. These include a lack of guaranteed minimum number of hours work; low pay and that most companies do not pay carers for travel time and expenses incurred during visits.

10.9 Working in isolation also raises a number of difficulties for carers. Such as the issues of personal safety when making evening visits alone; travelling long distances between clients especially in rural areas; and issues of responsibility should an emergency arise whilst working with a client in their home.

10.10 Another important issue related to car parking facilities near clients' homes. There is a major difficulty in and around town centres where there are often car-parking restrictions. For example one carer stated that she received a parking ticket while making a thirty-minute visit to a client. To avoid this happening again, the carer has resorted to changing the time of the client visit(s) to a time when parking restrictions are more relaxed.

10.11 In light of low rates of pay, a parking fine represents a significant part of a carer's weekly income. A few of the care workers detailed that despite having 'on-call' stickers clearly displayed in their cars, these are often ignored by traffic wardens resulting in them receiving parking penalties. The scope of this problem was highlighted in the '*Gravesend Express*'. One Care Agency Co-ordinator states:

"We will not be able to provide the service in town centre areas if we keep having to pay these fines, and the community will suffer as a result. Four of the carers have had parking tickets this week alone. It's a continuing problem and it is getting worse. We have enough trouble

getting staff as it is, without the constant threat of them getting parking tickets.”

(Gravesend Express 28.08.2002).

10.12 The Committee heard that both finding and parking in a car park, and parking where there are no restrictions meant that carers had further to walk. This increases the length of time that the carers are not paid for. In addition this raises personal safety concerns especially having to walk long distances from the car at night or in secluded areas.

10.13 Carers pointed out that they needed to get from one client to another quickly as there was only so much time allocated to each client. The turn around time was very tight and some agencies included travel time and parking between each call in this time.

Recommendation 10.3: KCC liaise with and encourage District Councils to enable care workers to park in controlled parking zones in and around town centres.

10.14 Carers also raised the issue of shorter visits. The changes in the commissioning process have meant that the length of visits has shortened. Mr Wade from the Kent Community Care Association (KCCA), pointed out that:

“...carers who were used to taking their time with clients felt pressurised to fit the visit into a 30 minute slot. They did not have the scope to spend longer one day with a particular client that needed it. The old Home Help service did not have such rigid time pressures.”

10.15 Carers reported that this impacts on promoting client independence. Carers told the Committee that if they had more time they would be able to ‘**do tasks with**’ rather than ‘**do tasks to**’ clients. Whilst it was acknowledged that clients did not fall into such easily definable groups, as any client could be experience a bad day and require more assistance, it was agreed that the latter, ‘doing tasks to’ took away the clients independence.

10.16 Another consequence of shorter visit times is that there is no or little time to chat sociably to a client. One carer said that she sometimes felt guilty leaving a client at the end of a visit and sometimes stayed on in her own time to finish a conversation.

10.17 Recruitment and Retention of Staff:

The turnover of Domiciliary Care staff has been put at 27%. This poses difficulties for employers in increased recruitment activity and costs, and the constant need to train new staff. In addition a constantly changing workforce disrupts continuity of care that clients’ receive. The major factor causing difficulties in recruiting care workers is low pay and competition from other service industry jobs all paying at around National Minimum Wage levels. In particular, many retail and catering outlets offer more flexibility and better pay for less demanding and less stressful work. Other contributory factors include unattractive terms and conditions of employment, the low status, menial perception of the work, and the lack of prospects and career progression.

10.18 As well as the poor terms and conditions of employment, commissioning procedures which lead to variation in demand can have adverse consequences on the workforce. The independent sector's response to managing these and the associated cost pressures has been to operate flexibly, to keep wages low and to limit training to a minimum. Such an approach will encourage the development of a low paid casual workforce, lacking job security and regular guaranteed work. Workforces of this type attract transient, temporary workers and have relatively high staff turnover.

10.19 Other factors which contribute to difficulties in staff retention include the stressful and demanding nature of the work, anti-social hours, lack of career development opportunities, isolation of the work and the constraints placed by shorter visit times.

10.20 Training:

Historically the Domiciliary Care service has been a part of the social care workforce that has received little attention in terms of training and qualification. Information regarding this workforce is sparse and quantified only for the statutory sector. What is clear is that the workforce is large, diverse, mostly part-time, and that most staff have not had access to substantial training and that most of the direct staff have no qualification (TOPSS 1999).

10.21 A survey carried out in 1998 by the Training Organisation for the Personal Social Services (TOPSS), found that about 96% of home careworkers had no relevant qualification. The survey also found that 65% of assistant home care organisers and 56% of home care organisers have no relevant qualification. Thus not only are the front line staff mainly without qualification but so also are a substantial number of their first and second tier managers.

10.22 At present there is no statutory requirement on the qualifications or training that carers must have prior to working. However this is due to change when the National Minimum Standards for Domiciliary Care are introduced in April 2003. These regulations will require that 50% of the home careworkers, providing personal care are trained to NVQ level 2 by April 2007, and managers to NVQ Level 4.

10.23 Training of care workers will feature prominently for care provider agencies in the forthcoming years to meet both the Care Standards and equipping the workforce to meet the demands of the future. Initiatives such as Intermediate Care, which place Domiciliary Care at the centre of community care policy places a need for carers who are competent in critical and complex care and possibly working at the social care/nursing care cross-over point.

10.24 The training experiences of the care workers interviewed by the Select Committee varied across the different care providers. These ranged from agencies having their own trainers to others who purchased training from other providers/outside organisations. One of the carers stated that some training was compulsory, as it was part of the contract specification. She also added that a carer would not be offered any work if they were not trained in manual handling. This is in contrast to practices in another agency where it was heard that newly recruited carers are required to make calls before they are fully trained. This is often during times of staff shortage, for example during sickness and staff annual holidays. A

common issue raised is the difficulty in covering workloads when other carers are training, and also for carers to find time to attend training.

10.25 For the service to move effectively to meet future demands there has to be an improvement in status of careworkers. This may in turn require adjustments in pay related to the development of skills, competencies and the complexity of tasks undertaken. Care staff need both support and incentives in order to encourage and undertake training. Many carers are not reimbursed for the time it takes to train or rewarded on the successful completion of training.

10.26 The Committee heard from providers that advancements in qualifications, training and skills could not be matched with pay rates or rewards. The committee discussed that increases in KCC contract prices should result in increases in care staff salaries. There is a view that such increases would be invested in salaries hence increasing recruitment and attracting higher skilled staff to the service. It was however acknowledged that some providers could use this to improve profit margins. There is a need for purchasers and providers of Domiciliary Care to recognise the skills attained.

10.27 A survey carried out by the UKHCA, found that care providers were concerned about the difficulties they have in training their carers because of the pressures to reduce the cost of their services (UKHCA, 2000). The committee is of the view that any process adopted by the NCSC needs to be thorough. This needs to extend beyond employers satisfying the NCSC by written evidence of an employee's attendance on a course.

Recommendation: 10.4: The National Care Standards Commission (NCSC) be encouraged to inspect the training given to Domiciliary Care workers.

10.28 Some care staff may feel threatened by the thought of studying for qualifications, especially if they have literacy problems. For some experienced carers who have performed the job for many years, or who are not ambitious or seeking a career, qualifications may seem irrelevant. They may see training as placing unnecessary demands in terms of the time taken, and conflict with personal commitments and cost.

10.29 One of the key issues for the Domiciliary Care sector will be accessing the relevant training and ensuring its uptake by a workforce already stretched in covering staff absences. In the last year KCC SSD Training Section has been at the centre of developing and promoting joint initiatives within the industry linking together external funding bodies to support the Social Care Market. KCC is playing an enabling role in facilitating the exchange of information and access to funding opportunities for training within the Domiciliary Care (and the residential) sector.

10.30 The Training Section has been actively working with TOPSS, and has built strong relationships with the 'Learning Skills Council' (LSC), and with 'Business Link Kent' (BLK). TOPSS receive funding to help the workforce development in line with the Care Standards Act. In March 2002 the DoH announced that £15 million funding is to be directed through TOPSS England for qualifications for the private and voluntary social care sector. Three separate bids to the LSC for local initiative

funding have been brought together in one project facilitated by SSD Training Unit. These are:

- SSD led project (supported by Strategic Planning) to provide at least 100 NVQ's at levels 2, 3 and 4 to Residential and Domiciliary businesses in Kent, and to research the issues relating to the provision of NVQ training for the Domiciliary Care sector.
- A regional Unison led project (supported by TOPPS and Worker Education Association - WEA) to focus on issues for non-traditional learners and provide basic training and NVQ level 2 provision.
- A Kent Community Housing Trust and MCCH project to support and mentor people (over 45's) into social care work.

10.31 The Business Link Kent (BLK) funds a Health and Social Care Sector Group as an employers' forum. The Group focuses on action to support the sector, particularly in relation to business development skills and process, ensuring employers are involved in the development of their workforce. BLK and Kent Community Care association are working jointly on a 'Consortium Training and Business Development Initiative. Through this initiative BLK fund a person to visit KCCA members and identify and support the development and review of training and business needs. Funding of £50K has been allocated towards the funding of solutions of identified needs.

10.32 KCC has also been supporting the private sector to access funding from various bodies such as South-East England Development Agency, the Learning Skills Council and the European Union.

Recommendation: 10.5: The Select Committee endorse the SSD Professional and Social Care Training Sections' role in enabling and facilitating the exchange of information and access to funding opportunities in training for the Domiciliary Care sector. It is recommended that this continue.

10.33 It is important to note that despite the difficulties detailed above some carers also detailed positive aspects of their roles. For example one carer informed the Committee that she had worked as a carer for 9 years and is now an area manager in the company. Another carer was pleased that she is able to work flexible hours that fit around the care of her children. Other positives included the satisfaction that carers receive from seeing the clients' smiles and their gratitude, and the opportunity to build good working relationships with their clients and colleagues. The Committee heard that carers valued feeling that they had made a difference to clients' lives.

10.34 This Chapter has focussed on the Domiciliary Care workers highlighting some of the difficulties they encounter in the delivering of care on a daily basis. The matter is exacerbated by the low status of the profession; the limited opportunities for training; and the lack of a clear career pathway for care workers who would like to progress within the profession. With the types of tasks carers are expected to carry out becoming more complex and intensive, commissioners, care agencies and training organisations will be required to work together to achieve a skilled workforce to meet these needs.

CHAPTER 11: THE COMMISSIONERS OF DOMICILIARY CARE

11.1 This Chapter considers the commissioning of care. This is the planning and purchasing of care by Care managers or individuals with Direct Payments (see Chapter 15). The benefits of the new County Duty Service will be outlined and issues raised. These include the importance of and difficulties in collecting information from service users. The Chapter also considers the care management process and the forms used.

11.2 *Future Imperfect* stated that 'most commissioning and contracting of care and support services (both in house and external) is unsophisticated, poorly related to outcomes and has little regard for levers that might raise service quality. The relationships between purchasers and providers are too often adversarial. Many have restrictive contracts that allow little flexibility or response to changing needs'. *Future Imperfect* recommended greater support and guidance for commissioners of care and support services. The aim is to increase commissioning capacity and skills in order to develop 'high – quality, innovative and responsive services and to achieve a better balance between cost and quality.' (Kings Fund: Nov 2002). It highlights the need for best practice guidance on commissioning of care.

11.3 A central commissioning group has now been established at the Department of Health. They will focus on identifying more effective ways for Local Authorities to commission and contract care services from independent providers.

11.4 *Unfinished Business* reported that there are no signs that this will result in commissioning which focuses on improved quality and better outcomes for users. For example there are no 'visible signs that Local Authorities are taking note of challenges in recruitment and retention of care staff by commissioning to ensure job satisfaction' i.e. by changing from contracts that specify work in terms of tasks and time.

11.5 Both *Future Imperfect* and *Unfinished Business* (Kings Fund 2001 and 2002) stated that there is a clear need to support the training requirements for care managers. If Kent is to rise to the challenge, our care managers will need support.

11.6 **County Duty Service**

The new County Duty Service based at Kroner House became operational on 7 May 2002. The new systems' aim is to achieve uniformity across all areas dealing with new contacts from clients. Kent County Council previously had 65 separate systems across 12 geographic areas to deal with new contacts from clients. These systems had different records and access arrangements e.g. different hours of opening. All telephone calls to the system are now routed to the County Duty Service team at Kroner House.

11.7 The systems receive some 90,000 new contacts per year. These are either completely new clients or clients being re-referred. Re-referrals often come from third parties e.g. a client's family or carer. The County Duty Service can be contacted by telephone, letter, fax or email. Of the 90,000 new client contacts 93% are made by telephone.

11.8 The main benefits of the new County Duty Service are:

- greater equality of access
- uniform opening hours (8.30 am – 5pm)
- all calls to the system are charged at a local call rate only
- callers are now only transferred once from initial contact to a Duty Officer
- the system automatically seeks an available duty officer to accept and deal with the call
- identifies the number of calls waiting (maximum of 20) and number of abandoned calls
- initial contact officers are more qualified to appraise situation
- support of the translation service to assist ethnic minority clients to access the service

11.9 The select committee heard that keeping the County Duty Service fully staffed is crucial. Many of the telephone operators are part time. Some of the part –time staff have the scope to increase their hours (at short notice) to cover absences. It is estimated that on each day of the operation the system is short of 30 staff hours. The shortage is due to usual staff annual leave and sickness.

11.10 Care management Process

On receipt of a call the Initial Contact Officer gathers information relating to the condition and needs of the Client. This involves talking with the client and sometimes the referrer. The information is recorded on form CM2. This form gives the Care Management Team the maximum information available on which to base an appraisal of the necessary care and formulate a response.

11.11 Referrals for urgent assistance are passed to the Care management team within 72 hours. The team will respond by telephoning back to the client or visiting the client in person. For non-urgent cases a deadline is not set, but dealt with as soon as possible by the District teams. The Initial Contact Officer can not make a judgement on urgency but can ask the referrers opinion. Data is not currently available to confirm that the 72-hour deadline is being met.

11.12 The Care managers assess the referrals against the eligibility Criteria and decide which service(s) are appropriate. Some referrals may not receive a service e.g. those with supervisory needs rather than personal care needs. People not eligible to receive services are referred to agencies/voluntary organisations that offer help appropriate to the clients needs. The County Duty Service does not reassess a client once a package of care has been put in place. The clients' care manager carries out the reassessment/review of the care provided.

11.13 The committee heard that the SSD DMT was considering the format a review of the County Duty Service should take. The County Duty Service Manager said that review and assessment of the system was an ongoing process, as the system could produce regular statistics on request.

11.14 There are numerous forms used within the care management process. In brief these are Referral Form (SS1), Screening Form (CM2), Core Assessment Form (CM3), Care plan (CM7), Adult Services Domiciliary Care Review (CM11) and additional assessment forms for clients with physical and Learning disabilities.

11.15 Care Managers can have difficulty in assessing the actual level of need. The committee heard that older people aged 65-80 still attach some stigma to dealing with Social Services. Clients may be unable or unwilling to identify or articulate their problems and needs. Assessors need to be skilled to gather the information. Similarly carers might also be unable or unwilling to identify or articulate their problems and needs when a Carers Assessment is completed.

11.16 Some comments indicated that people found the assessment process intrusive, but the committee heard that the intrusiveness of the process is dependent on the skill of staff and their sensitivity to a client's condition. For example MS sufferers' may become tired after a short time. Some assessments can take 2-3 visits to gather all the information needed. It was also important to consult other parties involved (relative, carer, GP etc.).

11.17 The Adult Services Domiciliary Review Form (CM 11) is the first form within the process to mention Direct Payments. Direct Payments can be considered as an option when a client's care package is reviewed. The issue of Direct Payments could be raised when the care package is formulated. As Direct Payments expand more clients will become commissioners of care. (Direct Payments are discussed further in Chapter 15).

11.18 The time span between referral and delivery of service could vary from 3 hours to 3 months. Informal carers (Chapter 14) highlighted that delays in decision making caused delays in relatives receiving care.

11.19 Cases and situations can be complex so the information gathering needs to be thorough. The care management forms examined by the Select Committee were generally considered to be the most efficient way of collating the information needed. It was noted that the forms studied were not completed by care recipients but by trained, experienced professionals.

11.20 This Chapter has discussed the important role of care managers in the commissioning of care to develop a high-quality and innovative service, that is responsive and able to achieve a balance between cost and quality. The benefits of the County Duty Service were outlined - the key benefits being greater equality and uniformity. It was clear that for the system to be fully effective it needs to be staffed at full capacity. The care management process was discussed. Some of the issues highlighted include difficulties in obtaining information and the time span between referral and delivery of the service.

CHAPTER 12: EXPERIENCE OF SERVICE USERS

12.1 This Chapter explores the experiences of service users and the important role they can play in shaping an effective service. The experiences of disabled users of Domiciliary Care services received are considered.

12.2 Empowerment and involvement of service users is a key theme in the future provision of Domiciliary Care services. Services provided can be strengthened by the involvement of service users in their own care (e.g. by widening opportunities to take up Direct Payments – see Chapter 15) and the extent to which users are involved in service monitoring and staff training.

12.3 '*Hearing the voice of service users*' (Huntingford, P 2000) quoted research by Morris:

“User involvement is not an end in itself but is instead a means of enabling people to assert choices and have control over their daily lives.”

(Morris 1995 p5)

“extend the forms of choice and control by working in partnership with older people.”

(Morris 97 p57)

12.4 '*Hearing the voice of service users*' aimed to involve Kent “service users in the contracting process for the purchase of Domiciliary Care”. It enabled service users to inform SSD of their views on the service received (KCC 2000). The research highlighted a hierarchy of service attributes valued by service users. The attributes most valued by users were:

- having the same careworker – reliable, trustworthy and courteous
- that careworkers stay for allocated time

The research stated that the ‘high value placed by service users on continuity of care worker(s) may need to be weighed against the economic benefit of securing cheaper services from another provider (which is likely to result in discontinuity of care worker)’.

12.5 '*Quality at home for older people*' reported that older people have clear views on what characterises quality in Domiciliary Care services (Raynes, Temple, Glenister, Coulthard, JRF 2001). Some of the characteristics identified are:

- 7 Key attributes of quality. These include:-
 - Continuity of carers, to build up trust and save time
 - Notice of any changes in carers or carers activities.
 - Flexibility of service, and ability to respond to needs
 - Trained carers – in the tasks to be undertaken and listening to clients
 - Aids and adaptations
 - Services to enable older people to get out of their homes
 - Provision of help to keep home clean

- Safe transport and improved health care services to promote independence
- A service which involves users in quality assessment and monitoring
- Provision of company

12.6 Some comments to the Committee supported the view that user involvement in the quality assessment and monitoring of services is a key factor of quality. Service users in Kent are formally involved in consultation regarding changes to the domiciliary charging policy. The Public Involvement Team intends to conduct the 'Personal Social Services (PSS) Elderly Home Care Survey' of older users of Domiciliary Care aged 65+, from mid February to end of March 2003. This will provide the Department of Health with information for two Performance Assessment Framework/Best Value performance indicators. The survey may include the carer and/or service provider (for relevant issues and subject to client confidentiality). To work in partnership with older people there needs to be routine auditing of users' experience of the services delivered and good communication between providers and service users.

Recommendation 12.1: SSD establish regular and local joint meetings between providers, purchasers, older people and elected members.

12.7 **Access to information** enables users to gain a greater of understanding of services available, increases their ability to choose and can encourage participation in the continuous development of the service. The Committee heard that limited access to information can affect service user involvement. Some of the barriers to accessing information are bureaucracy, length, jargon and overall format. The Committee heard that for older people from ethnic minority groups language and cultural norms also present barriers to accessing information. Information about domiciliary (and related) services needs to be tailored to clients. It also needs to be provided in a variety of formats and locations. Research has suggested that improvements to access might be possible through:

- information in users own language (what is available and where from)
- putting information in locally accessible places within communities
(Raynes, Temple, Glenister, Coulthard, JRF 2001)

The Committee is of the opinion that examples of good practice should be highlighted and promoted.

Recommendation 12.2: SSD lead a review information currently available to publicise Domiciliary Care services, including when and how users access such information.

Recommendation 12.3: SSD to disseminate good practice with regards to accessible information.

12.8 Services for Disabled Users

Many of Kent's service users are disabled. For example in 1991 there were 21,540 dementia sufferers in Kent, 700,000 nation-wide. In Kent Alzheimer's affects 1 in 1000 people under 65; 4 or 5 in every 100 between 65-80; and 1 in 5 over the age of

80. The key concerns of disabled service users in Kent of the Domiciliary Care services received are summarised below.

Service Users with MS

- Little assistance and poor communication with providers – if liaison between agencies improved the service to carers would improve
- Lifestyle tailored to fit around care package

Service Users with Alzheimer's

- Frequent changes of care assistant - The same worker at each visit avoids confusion, the distress of seeing an unfamiliar person and loss of continuity
- Often carers do not take advantage of Respite care. For those with Alzheimer's respite care at home is often preferential to going away as changes of setting can be distressing and disorientating. No extra care is available to take account of this impact
- Vital services for people with Alzheimer's are not counted as Personal care (e.g. feeding, company, stimulation and accompanied outings) –there are some Voluntary Support networks (e.g. in Tunbridge Wells, funded by the Health Authority and KCC)

All Disabled Service Users

- Inadequately trained agency/provider staff
- Need to 'do with' which enables rather than 'do care to'
- Staff shortages by provider on any given day meant further reduction in time allocated for visits, increasing 'doing to' clients rather than 'with'
- More respite time, 2hrs per week was insufficient
- Difficulties with Care Assessments – changing effects of disability
- Infrequent Care assessments

12.9 The **changing effects of disability** on different days can affect assessment and the person's service needs. Fluctuating conditions therefore impact not only on the assessment of care but also on the provision of the service.

12.10 For example clients with MS may have differing needs depending on the type of MS. The Committee heard that MS in its early stages may not require Domiciliary Care but relapsing/remissive clients will require a highly flexible and responsive service. A person who usually does not require Domiciliary Care might relapse and need to access care quickly. The Committee heard that this was not easy within the current organisation of the service.

12.11 As the nature of some disabilities such as MS causes people to experience 'good' and 'bad' days, **assessments for care** are more difficult. Fluctuating needs make it difficult to have a care package that is the same for every day every week. Care plans need to reflect the fluctuating needs. The Select Committee heard from Service Users that the awareness and understanding of MS is limited within both Social Services and the Domiciliary Care industry, with those in charge of designing care packages not fully understanding the nature of MS or the difficulty in defining a person's fluctuating needs. Assessments may take two to three visits to complete. (see also section 6.4 and 6.5).

12.12 Similarly, Domiciliary Care needs for a person with Alzheimer's depend on the stage of the illness (and the age of the person). Dementia is a debilitating disease. Sufferers lose their ability to remember and also other abilities such as speech, movement, and reason. The Vice Chairman of Maidstone and Rural Communities Alzheimer's Society advised the Select Committee that symptoms of Alzheimer's can be disguised (unwittingly or otherwise) for short periods of time - an hour or so. Care packages therefore would not always be geared to the needs of Alzheimer's sufferer. People with Alzheimer's lose their abilities at different times. Needs often become priorities in unpredictable timescales. Service users reported that reviews of care packages were infrequent - sometimes not even once in 12 months. The suitability of the care package relies on reviews to reflect changing needs, without which suitability becomes increasingly reliant on notification of changes in condition from carers, GPs, family etc.

12.13 Both those people receiving care and care staff recognised the current **lack of knowledge** and the need to understand the different stages and progression of dementias, MS and other conditions in order to improve care. Service users reported that specialist charities often gave better service than agencies, because of their better understanding of the condition(s). Care staff need a comprehensive understanding of the conditions of the people receiving care, and the training to notice behavioural changes or drop in clients morale and potential medical problems arising from this. Thus empowering the care staff to notify the Care Manager, family or GP of changes in condition. There is a need for trained specialist carers with an approved training package. Currently care staff who undertake specialist training do not automatically access increased pay or status. This applies to staff training to deal with dementia, in the same way as for anyone learning languages, hence there is little or no incentive to learn new skills.

12.14 The Committee heard that any assessment and care delivery causes some intrusion into a person's life. For some clients the difficulties with the official process and assessments necessary to access care in addition to dealing with an illness makes it difficult for clients to ask for care. This presents a barrier to clients entering the assessment process to receive the care they need.

12.15 The Committee heard that once a person with MS had been assessed, they currently had little influence over the services received. In some instances the care package governed the recipient's life rather than fitting around it. Good quality of life is key. Given good care and support clients can achieve rewarding employment and a life with flexibility and real choices. The reluctance of providers to provide 'out of hours' late night care (after 10.30 pm) further limits a clients independence. Direct Payments (Chapter 15) were supported by disabled service users as a positive step to address these issues, giving clients control over their own package of care.

12.16 KCC has restricted funds. Pressures on these funds include the increasing costs of care and an aging population. To balance the numbers needing care and the funding available, the **length of visits** is reduced. A provider reported private visits were normally for an hour compared to half an hour for a KCC client. A carer needs to complete the visit and tasks within a limited time slot. 'Time pressure' causes a scenario where care is 'done to' rather than 'with' the client.

12.17 The more people do for themselves the longer they remain capable. This can be supported by the provision of 'enabling rather than doing to' services. The Select Committee heard that shorter task focussed visits potentially increase the dependence of people receiving care. For example people with MS need physiotherapy and regular exercise to remain as active as possible for as long as possible. The less clients do, the more quickly their muscles' waste away and their physical condition deteriorates and ultimately more care is needed. Similarly people with Alzheimer's can complete tasks, but they need time and space (e.g. laying out the clothes and letting the client dress themselves or cutting up food and letting the client feed himself/herself). With time restricted visits this is not possible. Clients need 'enabling' care.

12.18 Visits are often shortened due to late arrival and early departure of care staff. If 5 minutes are lost at the beginning and end of each half hour visit, a 1/3 of the client's care time is lost. This impacts on the care delivered, with more care being 'done to rather than enabling'. Recuperative care is geared to enabling people to cope on their own, keeping independence for as long as possible. If 'enabling' care was available earlier in the process, people might be able to remain at home longer.

12.19 Some care recipients have become very passive and are reluctant to complain about the care received. There is a fear that complaining will result in the withdrawal of future care provision. *'Hearing the voice of service users'* supports this finding, highlighting **passive acceptance of care** amongst some service users. It states that "Many older people remain with a sense of gratitude for the services they receive and have a fear that 'speaking out' will result in their withdrawal" (KCC Huntingford 2000).

12.20 A client information pack containing a "how to complain" leaflet is given to all clients when they are first visited for them to read at leisure. This contains a "*How to complain*" leaflet. Users need to continue to be encouraged and empowered to use their voice to assist in the delivery of an effective and responsive service to meet their needs. The Committee are of the opinion that the image of complaining can appear negative, but this could be referred to more positively as 'problem solving' or 'putting things right'.

Recommendation 12.4: SSD to revise and rename the complaints leaflet.
--

12.21 This Chapter has discussed the experiences of service users. The value of user involvement in shaping the services provided and developing a service that is responsive and innovative should not be underestimated. It has raised the key concerns of service users with regards to service provision. These include the importance of information to encourage the take-up of services and participation in service development; inadequately trained care staff; the need for 'enabling' care; the changing effects of disability; the length of care visits; and the passive acceptance of care.

CHAPTER 13: SERVICES FOR MINORITY ETHNIC COMMUNITIES

13.1 This Chapter considers the experiences of service users from minority ethnic communities in Kent.

13.2 The Community Care Act 1990 sought to promote services for individuals based on respect for differing cultures. The race relations (amendment) Act 2000 states that racial equality should be at the heart of services provided and those commissioning care should aim to achieve the best fit possible.

13.3 *Future Imperfect* highlights concern that “services that are culturally responsive to diverse needs of black and minority Ethnic Communities are poorly developed”, and that groups (both users and providers) are significantly disadvantaged. Two quotes illustrate this:-

“Too often in the past, people from black and ethnic minority communities have found their needs were not adequately met within the mainstream of our services.”

(The Secretary of State, Alan Milburn)

“Too often black and minority ethnic older people have lacked access to care services and, despite the efforts and hard work of many staff, have received inappropriate assessments and been faced with services that do not adequately reflect their way of life and aspirations.”

(Department of Health, Barry Mussenden)

13.4 The Committee recognised the creative thinking of care staff in making the ‘best fit’ of care for ethnic minority clients. It was suggested that the ideal is to strike a balance between pragmatism and flexibility and use care resources creatively. For example services need to be sensitive to dietary requirements:

A Chinese grandmother living in a private residential home would not eat, simply because the English food on offer was unfamiliar and unpalatable to her. With creative thinking the home could have discovered the grandmother’s preferences and served an acceptable alternative, perhaps by making arrangements with a local Chinese restaurant.

KCC Community Services Manager

13.5 *Future Imperfect* (Kings Fund 2001) emphasises the need for commissioners of care to “encourage the development of services to meet diverse needs of different communities”. Legislation and good care practice state that “a person’s language, culture and religious identity should be key factors in the assessment and design of personal services”. Ideally services should be available as a matter of course through mainstream provision, creating a service able to respond appropriately to needs of service users from all cultural backgrounds.

13.6 Social trends have shown increasing cultural diversity coupled with an aging society. Age Concern (2001) have said that:

The numbers of people in minority ethnic communities who are aged over 60 will multiply ten fold over the next 15 years, from around 175,000 people today to nearly 1.8 million in 2016.

13.7 Kent reflects this trend with increasing numbers of Black and minority ethnic older people. In Kent the largest minority ethnic community resides in the Dartford and Gravesham areas. Out of c15,000 people of minority ethnic background approximately 80% are estimated to be of Punjabi Sikh origin. Other black and minority ethnic communities in Kent include: African Caribbean, Muslim, Chinese, Hindu, Jewish, Mauritian, Turkish and Greek Cypriot. The care needs of older Asian clients have only recently been recognised. The generations of workers who came to the UK and were recruited in Kent in the 50's and 60's are now reaching the age when they may need care.

13.8 The take up of services or advice currently available is limited. The Committee heard that research by SSD shows that people from multi-cultural groups generally did not take-up services offered from outside agencies. For example, in Dartford and Gravesham some 160 people attend Day centres regularly but only a very small proportion take up any other service. Take up is restricted for many reasons. For example, within the Asian culture barriers to accepting care services include:

- The acceptance that the extended family cares for young and old. 'Family' is often a whole village community.
- Idea of self-sufficient communities.
- Stigma within community of receiving services as this informs outsiders either that the family are incapable of looking after relatives or that the person is particularly 'difficult'.
- Independence and stubbornness of elderly when faced with change (all cultures).

13.9 There is a need to ensure that services are accessible and provided in culturally appropriate ways. Services also need to address the needs of users for whom English might not be the first language or where community lifestyle does not fit with traditional Domiciliary Care provision.

Recommendation 13.1: KCC in liaison with voluntary bodies identify the Domiciliary Care needs of ethnic minority older people.

Recommendation 13.2: SSD publicise the Domiciliary Care service to all sections of the community.

13.10 Nationally there are 'glimmers of change' to improve the cultural responsiveness of care services. The Department of Health have developed a new audit tool for social service departments to monitor progress in improving the cultural responsiveness of local services. It is unclear how widespread the use of this tool is or if the benefits of good practice developments for minority ethnic communities are being promoted (Kings Fund Nov 2002).

13.11 In July 2002 Kent County Council published a **Race Equality Scheme 2002-2005** with a three-year action Plan of how racial equality issues within Kent services might be addressed. There are five levels of equality standards for local authorities. Kent is assessed at level 2. The Chief Executive has made a commitment to a phased programme of improvement to reach level 5.

13.12 The Committee heard many care staff had unjustifiable fears of working with people who were 'different' and that there was a genuine lack of understanding of the diverse needs of black and minority ethnic communities. Attitudes can affect behaviour, impacting on the quality of care and the cultural responsiveness of the service. Care Managers have a responsibility to ensure that personal stereotypes, assumptions and prejudices do not affect their attitude and the provision of quality services. Although there is a need to respect the wishes of both the client and the carer regarding whom they wish to work with, it is however necessary to strike a balance between wishes and care needs. The training of care staff in cultural aspects of care delivery is essential if the service is to become more culturally responsive.

13.13 Care workers could be encouraged to learn new skills. For example at the Guru Nanak Centre the staff team are required to be bi-lingual in Punjabi and English. Although good facilities exist for interpretation and translation support countywide, it is desirable that all teams providing care within minority ethnic communities have some bi-lingual staff. Care staff who have specialist training (including languages) do not automatically access increased pay or status. There is therefore little or no incentive for care staff to gain new skills.

13.14 **Culturally Competent Care** provides valuable cultural information and brings together information and knowledge about good practice. Chris Pond, Member of Parliament for Gravesham said that Culturally Competent Care is "an excellent guide to best practice in the improved provision of culturally appropriate services in both the health and social care sector". Kent in partnership with the DoH produced this guide to help to improve quality of care services for black and minority ethnic people within Kent, and help achieve national improvements in practice.

13.15 An interactive CD ROM of Culturally Competent Care has been commissioned by Kent SSD to aid the training and development of staff. This guide is the first step to understanding different cultures, targeted primarily to help front line practitioners, followed closely by a need for culturally competent practitioners to inform and enlighten services commissioned for Kent.

13.16 In developing 'Culturally Competent Care' it was recognised that few of the county's 450 residential homes were equipped to cater for ethnic minorities. KCC are now taking action to develop support for 20 preferred residential providers. The number of Domiciliary Care providers able to cater for ethnic minorities within Kent is uncertain. The development of 'provider support' could extend to domiciliary preferred providers or specialist providers, although this is more complex than for residential care.

Recommendation 13.3: The select committee welcomes the production of 'Culturally Competent Care' and recommend that it be publicised and made widely available to the preferred Domiciliary Care providers both in-house and in the independent sector.

Recommendation 13.4: The 'Culturally Competent Care Guide and interactive CD ROM be included in the training of carers.

13.17 Difficulties have been experienced recruiting staff from ethnic minorities. Section 11 Home Office Grants are no longer available to help ethnic minority recruitment. KCC and Kent's care providers could be more proactive in recruiting and retaining a more diverse workforce that better reflects Kent's population. The example below demonstrates how effective non-traditional recruitment methods can be:

When a Punjabi speaking receptionist was needed, the usual newspaper advertisement produced only a very poor response. However, making an announcement at the local Gurdwara (Sikh Temple) had produced a good response with 35 good candidates.

(KCC Community Services Manager)

13.18 In promoting care facilities to ethnic communities there are two considerations, how best to 'go out and reach communities' and how best to 'guide communities to reach' us. It was suggested that

- Staff who spoke the languages of the Asian communities could link with community groups to publicise the services. If individuals are aware of services available, they might pursue the provision services if the need for care arises.
- The joint review encouraged greater use of paid advocates to aid families in need to access services and work to create more appropriate services. A pilot scheme is planned for Gravesend Older Persons' Team.
- Information should be tailored to clients in both format and location.

13.19 This Chapter has considered the experiences of minority ethnic communities of care services received. It identifies some of the barriers to service take-up amongst ethnic minority communities. The need of support for both care workers and the minority ethnic community is highlighted. Support is needed to promote access to care and the delivery of quality culturally responsive services.

CHAPTER 14: INFORMAL CARERS

14.1 In this Chapter we consider the role played by informal carers, the impact of caring upon them and the importance of Respite Care.

14.2 Nationally there are an estimated 6 million informal carers (Community Care Aug 2002), some giving in excess of 50 hours of care per week (estimated 30%). Key facts from research:

- The number caring for a relative for the equivalent of 2 ½ working days rose by 7% during the 1990's.
- As we live longer 2 out of 3 women and more than half of men will spend at least 20 hours a week looking after spouses or family members.
- Many children start taking on the responsibility of looking after a sick or frail parent between their mid 30's and their mid 50's.

(Daily Mail 7/02: Research by Dr Hirst)

14.3 Informal carers include younger people caring for an older person; a parent caring for a disabled child; husbands or wives caring for elderly or disabled spouse; older adult children caring for parents and friend, neighbour or other relative carers. *Caring in later life: reviewing the role of older carers* (Help the Aged 2002) found that a change in household composition and an emphasis on community based care has resulted in larger numbers of frail elders remaining at home, supported by older relatives. Increasingly large proportions of the total number of carers are older carers – a third are aged 60+. Not only is there a significant increase in the numbers of older people living at home with a chronic illness or disability but many older carers have their own health problems. The research states that 31% of older carers offer 'personal care' and nearly a third of carers aged 75+ provide 50+ hours of care per week.

14.4 Informal carers save the country an estimated £57 billion a year (Community Care 22-28 August 2002). Alan Milburn, Health secretary said that:

"Many older people rely on more informal care from their family, friends and neighbours. Without the millions of carers in our country the services provided by the NHS or local councils simply could not do their job. The whole country owes ...carers an enormous debt of gratitude."

(DoH July 2002)

Andrew Cozens (ADSS spokesperson on carers' issues and ADSS junior Vice president) supports this view. He said that:

"Funds devoted to helping with some of the pressures on carers can transform lives ... and often prove wise investments in terms of taking pressures away from other services."

(ADSS April 2002)

It is important therefore that carers receive the support they need to enable them to continue caring. Some support is available through Respite Care. Respite Care offers carers a break from caring.

14.5 The Carers Grant, introduced in 1999 was aimed to make it easier for carers to take breaks. The introduction of the grant has led to a dramatic increase in the number of short, respite breaks for carers (ADSS April 2002). The scheme was funded for 5 years and has recently been extended. It is Alan Milburn's intention that the Carers Grant will more than double to £185 million by 2006. The anticipated result is 130,000 additional carers will get help not just with shortbreaks through respite care, but with extended care they themselves need so they can continue caring (DoH July 2002).

14.6 The government intends the additional funding to be targeted towards carers receiving the care they need to enable them to continue caring. Alison Thompson (Chief Executive for Crossroads – caring for carers) has estimated that this equates to £142 per carer per year, buying approximately 1 hour per month (Community Care August 2002).

14.7 Within West Kent alone it is estimated there are currently 26,000 informal carers (Carers First). As a result of raised eligibility criteria and reductions in low level preventative services the County relies on the efforts of informal carers to give the remainder of care needed.

14.8 Becoming an informal carer often shapes the carers' life. Caring can impact on the carer financially, socially and in health terms. The Select Committee heard (based on evidence from 2 carers and 1 carers organisation) that within Kent informal carers could experience limited freedom; a reduced social life; the need to cancel or give up work; feelings of isolation; conflicting demands but also some satisfaction and reward. Conflicting demands upon informal carers for example could include work, caring for the family and caring for the person needing care.

14.9 *Caring in later life: Reviewing the role of Older carers* reports that:

- Older carers are one of the poorest groups in UK society – carers tend to have reduced incomes and fund the additional costs related to caring.
- Older carers are at increased risk of experiencing a range of health problems with over half having a long-standing disability or illness.
- Carers of people with dementia become detached from their social networks.

(Help the Aged and University of Kent 2002)

14.10 Informal Carers receive support from a wide range of services. These include Respite Care and Day care to improve carer well being; Home care and community nursing to offer practical advice, emotional support and guidance; carers groups to provide advice, information and support; and specialist services to help carers care for people with particular conditions e.g. Alzheimer's. Respite care offers a break from caring and an opportunity to make a difference to the carers' own quality of life. It can enable a carer to continue caring.

14.11 'Carers First' is funded by Kent County Council (via a service level agreement), donations from the Health Authority, other trusts and donations. Carers First provide a respite service (6-7000 hours/year) and 3 specialist projects for carer groups. The Committee heard that although there are some support groups and specialist groups (e.g. for carers of people with Alzheimer's) within Kent, few were geared solely to the needs of the carer rather than the client. Under the Carers and Disabled Children Act (2000) carers are also entitled to Direct Payments to support them in their caring role.

14.12 Key concerns highlighted by informal carers and/or carer organisations in Kent include:

- lack of good quality respite care
- uncertain how to find out 'reliably' which homes were good, a 'minefield' to find the right people
- often carers do not take advantage of Respite care - If clients are unhappy with the services currently provided the carer is less likely to use them
- more respite care of 1-2 hours at a time
- if respite care is provided within the home, carers need the reassurance of knowing the carer and confidence that privacy will be respected
- unavailability of a care facility for younger people to attend to free partner to care for family unit
- difficult to approach SSD directly, carers often need moral support to do so
- difficulty in claiming benefits
- paperwork and administrative aspects were 'horrific' and a 'nightmare', deterring carers from accessing support
- delays in decisions, causing delays in relatives receiving care
- maximum choice allows each individual to achieve from the service what suited them best.
- inadequate provision of care

Recommendation 14.1: SSD to conduct a survey in partnership with a carer organisation on the concerns highlighted by informal carers.

14.13 One of the concerns highlighted is the limited use (by some carers) of Respite Care currently provided. The Committee heard from carers that carers are less likely to use Respite Care if clients are unhappy with the services provided. For example for those with Alzheimer's having respite care at home is preferential to going to a centre as changes of setting can be distressing and disorientating (as discussed in Chapter 12). Similarly although experiences of respite care varied for people with MS, some users found respite centres depressing and therefore preferred not to use them. Carers said that respite care needs to be tailored to the different client groups who use it.

14.14 The Carers and Disabled Children Act 2000 put into legislation key aspects of the National Strategy for Carers (1999). This Act gave Carers a right to an assessment, in addition to an assessment of the person they cared for. A survey carried out by the Association of Directors of Social Services suggests that the impact of the Act has been 'seriously blunted by a shortage of funds needed to carry out assessments of carers'. Less than 20% of English Local Authorities are in a

position to fund the new services envisaged under the Act in 2002-2003, beyond those supported by the ring fenced Carers Grant (ADSS April 2002).

14.15 Kent County Council SSD is operating a pilot scheme with 'Carers First' on carers assessments. The aim is to assist carers in securing an assessment and to help carers plan how they can access the support they need. The scheme raises awareness of carers rights, the benefits available to them, and help available to them from Social Services and the community.

14.16 The struggle to claim and achieve benefits discourages some clients and their carers from claiming their entitlements e.g. attendance allowance, Invalid Carers allowance. Carers referred to the forms and process to claim benefits as 'difficult' and assessing eligibility as 'bureaucratic'. 'Carers First', (who provide advice on benefits and assist with forms) told the committee that forms can take 2-3 hours to complete per client. It is important that carers are encouraged and supported in claiming entitlements. Carers acknowledged the helpfulness of the County Benefits Unit, although their time is limited.

Recommendation 14.2: County Benefits Unit provide information for Care managers, detailing how and where clients can find help to fill in benefit claim forms.

14.17 In order for carers to continue caring they need support. Many carers are unaware of support services currently provided, with details of support often discovered 'out of the blue' or by chance. Carers also require support to access these services, as often carers rely on/need the moral support of carer organisations before contacting Social Services. Also some carer groups have particular needs to take into consideration, as highlighted in *Caring in Later Life: Reviewing the role of Older Carers*:

- Studies have shown that linguistic, economic and cultural factors can adversely affect the take-up of health and social care services by ethnic minority carers despite a high level of need. Assumptions about ethnic minority families 'looking after their own' are often inaccurate.
- Rural areas are identified as 'hard to reach'. They are isolated and receive few services. The voluntary sector tends to provide services in rural areas.
(Help the Aged and University of Kent 2002)

14.18 An opportunity exists to widen carers and users choices through raising awareness of services currently provided. This could be achieved partly by increasing awareness of carers, ensuring information on the support available is accessible and how this can be accessed. This might be a matter of approach rather than additional services.

Recommendation 14.3: SSD in liaison with carer organisations ensure carers are aware of the current opportunities for Respite Care provision in Kent.

14.19 In this Chapter we have outlined the important role played by informal carers in the provision of care. In order for carers to continue caring and relieving pressures from other services there is a need for ongoing support, both with day to day care

and respite care giving carers a break and time for themselves. The profile of carers highlighted key issues that will impact on the type and levels of support needed. For example there are more older carers and a third of carers aged 75+ provide more than 50 hours of care.

CHAPTER 15: DIRECT PAYMENTS

15.1 This Chapter discusses the benefits of Direct Payments and the provision of support to encourage their take-up with service users. Direct Payments enable users to receive money to pay for their own services, giving users greater control over their own lives.

15.2 *Future Imperfect* (Kings Fund 2001) reported that many service users fail to experience any significant choice or control over the services they receive. Many users have to fit in with service routines rather than having their individual needs met. Direct payments empower the service user to have greater choice and control over the care they receive.

15.3 The Community Care (Direct Payments) Act 1996 was given royal assent in 1996 and was implemented in 1997. Prior to this amendment it was technically illegal to provide cash in lieu of services. In April 2002 the Secretary of State placed a duty on Local Authorities to widen opportunities of Direct Payment Schemes to older people assessed as needing care (Help the Aged, Jan 2002).

15.4 The committee heard that the key benefits of Direct Payments are:

- Increased choice and control for the client assessed as needing care services
- Improved self image
- Self assessment processes enable older people to think about when they require help, what they require and who their assistant will be.
- Offers alternative to traditional service, tailored to individual needs
- Flexibility to adjust times of care provision to suit lifestyle, 'out of hours care'

15.5 KCC SSD have taken a proactive role in the development of a Direct Payment Scheme. The Kent System was initially available to clients aged 20–50 with physical disabilities. In 2000 KCC removed these restrictions, extending the Kent Direct Payment Scheme to include older people. The current Kent scheme ('I decide') enables disabled and older people receive money to pay for their own services, giving users greater control over their own lives, and services that suit their individual needs and lifestyle.

15.6 'I decide' enables service users to choose either a direct service or to receive direct cash payments, which can be used to buy the care or equipment that suits them. Clients can spend Direct Payments in two ways, either to employ a personal assistant to support them or to arrange and purchase services with other service providers (agencies etc) to meet assessed needs (stated within the service users' Care plan). 'By controlling who provides the assistance needed clients have control of their own lives, deciding who works for them, how and when' (HCC). As these quotes illustrate:

"My care package does **not** govern my life – my care package most definitely fits around me."

DPS User, Kent

“I used to go into a residential home while my wife went off to visit relatives...They call where I went ‘Respite Care’. Since having a Direct Payment, my wife and I are deciding where we go together on holiday and I am taking a personal assistant with me. It will be far more like the holidays we used to enjoy.”

(Help the Aged January 2002)

15.7 The Committee discussed that Direct Payments could be useful for people in remote areas. Direct Payments could resolve issues of carers travel time and carers pay for travel and the difficulties in finding carers to cover remote areas, for example by employing someone locally.

15.8 To be eligible for Direct Payments clients need to have an assessment of need carried out by the Care Manager, be able to manage the scheme (alone or with assistance) and be assessed for any financial contribution.

15.9 Although Direct Payments give increased choice and control there are additional responsibilities placed on the scheme user, and the ability to manage these form part of the eligibility criteria of the scheme. This is the outline of the scheme from a user’s perspective:-

Process:

- Receive care plan
- Set up a separate bank account
- Keep records on how the money is spent (can spend up to 20% on administration costs, insurance, advertising)
- Sign ‘letter of agreement’ with Council
- Accept responsibilities in arranging/employing staff

Responsibilities:

- Recruit and pay staff, or arrange alternative services
- Manage the financial resources allocated
- Ensure staff are not at risk of injury due to poor Health and Safety procedures/ provide a safe place to work in.

Additional responsibilities if staff are employed directly

- Need to be a responsible employer – provide job description and contract of employment
- Inform the local tax office of the employment
- Pay National Insurance contributions to the inland revenue
- Ensure adequate Employers Liability Insurance and Public Liability Insurance is in place

15.10 The **Next Four Years** sets a target to extend the Direct Payment Scheme to enable 5000 people, who need a care service, to choose who looks after them. In May 2002 uptake of Direct Payments was reported as 64 Direct Payment users in Kent and approximately 90 potential users. (Potential users are clients who have expressed an interest in using DPS and have been referred to a Personal Access Advisor). By December 2002 further take up of Direct Payments remained fairly limited, with an increase to 80 users. In contrast Hampshire County Council

achieved a 10% take up of Direct payments using an agency to administer the scheme. 5,000 users is more than half of Kent's clients (53%) to be in receipt of Direct Payments.

15.11 Out of 9,500 Kent clients currently receiving a care package, the majority are elderly, many of whom are unlikely to become Direct Payment users. To achieve the 5000 target all Direct Payment user groups will need to have a good take up of Direct Payments, both by elderly and disabled clients. SSD view the target set as "genuinely challenging". There is a view that uptake could be rapidly increased with clients with disability or mental Health needs. Realistically the percentage of elderly clients able to use the scheme is questionable if the scheme is not managed on the users behalf. The Select Committee are of the opinion that Kent are unlikely to achieve this.

15.12 Feedback received from DPS users supports the view that many older people would not be confident in managing Direct Payments, finding the process daunting. Users describe the scheme's paperwork as 'bureaucratic' and difficult to follow. This poses a major barrier for take up of the scheme and for clients to access the potential benefits offered through its' use. Unfinished Business (Kings fund 2002) states the number of older people who decide to take up this option is uncertain as take up will be limited if resources for support services are insufficient. The Health Secretary Alan Milburn has announced the intention to channel £9m into older people's organisations and other voluntary bodies "to make a reality of Direct Payments". The additional funding of £9m may be a drop in the ocean as nationally there are only about 4000 disabled people receiving Direct Payments and more than 11 million older people in the UK (Community Care Nov 2002).

15.13 To increase accessibility of Direct Payments to users it is important that barriers to take-up are minimised. Although some older people may be unwilling to take up the Direct Payment Scheme, family members could take on the responsibility on their behalf. The Committee heard that to achieve this a client would ideally require family willing to take on the scheme and located sufficiently near to enable checks that care visits to their relatives did occur as invoiced. It was felt that this could be operated remotely but it would be more difficult to check care invoiced is actually received. Clients using DPS highlighted that invoices from providers were often incorrect.

15.14 Many users have limited or no experience with contracts, job specifications, National Insurance etc. **Support schemes** therefore play a vital and essential role helping people with these technicalities and in empowering the user to manage the scheme. Scheme users have emphasised the importance of advice and guidance on procedures and forms through home visits and help-lines. Both current and potential users will require support and guidance on managing the scheme. The take-up of Direct Payments might dramatically increase if support services helping people to use them were better resourced (Community Care Nov 2002). The continued development of the Direct Payment Scheme needs to be both actively promoted and fully supported by KCC.

15.15 Assistance is currently provided to scheme users through a variety of sources for example, the care manager, Personal access advisors and literature explaining

the system and how to manage its administration. A new team of Direct Payment Support Officers is also due to be established. These will be discussed in turn.

15.16 The role of the **care manager** is vital in introducing clients to the option of Direct Payments, as an alternative to the traditional system. The evidence highlights attitudes of care managers are resistant towards Direct Payments, founded in the belief that control over the quality of care delivered might be compromised. The committee heard that currently there is no formal training on Direct Payments for care managers. Care managers need to be enthused about how Direct Payments can enable clients to lead an independent life; and they need training and support to successfully meet the demands of a changing culture. Users of Direct Payments require the support of staff equipped with the skills to address problems that users might encounter when either purchasing services or employing staff directly. Training required for both client and care manager will include the purpose of Direct Payments, form filling and giving service users the skills they need to become their own commissioners. Form CM 11 (Adult Services Domiciliary Care Review) is the first form to mention Direct Payments and yet is the last in the assessment process.

Recommendation 15.1: The issue of Direct Payments needs to be introduced early in the assessment process for consideration by the client and/or their family.

15.17 Kent County Council fund the **Personal Access Advisor** (PAA) support scheme. Currently this is provided by MENCAP on Kent's behalf. The PAA provides detailed information and guidance to service users. They give support to the user throughout the time the user is involved with the scheme. The PAA could help tailor the scheme to the maximum number of users who could benefit from it. The promotion of Direct Payments could coincide with the expansion of the Personal Access Advisor role.

15.18 Kent SSD have responded to the need for support and guidance by establishing a new **Direct Payments team**. The team will include a Co-ordinator and 6 support workers (including the PAA). The primary focus will be the promotion of choice and control over how people direct the support they receive. The team will be able to assist with managing the scheme on behalf of elderly or vulnerable users who do not feel they could manage the scheme on their own. It is envisaged that this group of staff will initially be employed and managed within SSD. The aim is eventually to have a 'Centre for Independent Living' that will have a contract to manage the support scheme for Direct Payments. These staff will then be transferred to that organisation.

15.19 To maximise Direct Payment take-up it is important that information and guidance is accessible and tailored to the client in a variety of formats and locations¹. An Independent Living scheme can help here. **The National Centre for Independent living** (NCIL) is part of the British Council of Disabled People (BCODP). It is funded by the government to give information and advice on Direct Payments. The NCIL aims to assist all disabled people (including older people, people with learning difficulties, young people, people who use mental health services, people from minority ethnic backgrounds) to live independently and take responsibility for their own lives by having more choice and control over the services they receive (NCIL 2002).

15.20 The NCIL assists groups of people to develop their own solutions to independent living and encourages access to Direct Payments. It researches and promotes best practice in relation to Direct Payments and provides consultants to work with local Authorities to get 'Personal Assistance Support' (PAS) schemes established (e.g. Centres for Independent Living).

15.21 Personal Assistance support schemes have numerous names. For example Living Support schemes, Self operated Care schemes or **Centre for Independent Living** (CIL). These organisations provide information, advocacy, peer support and training to people who want to employ their own personal assistants⁷. Both Southampton County Council and Hampshire County Council reported the benefits of a Centre for Independent Living (CIL) in promoting and facilitating the take up of Direct Payments. A Centre for Independent Living steering Group of service users has been established in Kent and is managed by and accountable to people with disabilities. This is yet to set aims/framework. As mentioned previously it is envisaged that the Directs Payment team will transfer to the CIL and operate the Direct Payments scheme.

Recommendation 15.2: KCC adopt a well resourced independent advisory scheme to provide independent support and follow up for elder persons considering and using Direct Payments.

15.22 Increases in the number of Direct Payment Clients will affect the SSD finance processing sections and also the contracting process in the following ways:-

- If many users have their own assistants this would affect the quantity of care purchased by KCC from care provider companies.
- The SSD would need to forecast and project the ongoing consequences of the scheme on the care provider from whom Domiciliary Care was purchased.
- Extending Direct Payments to older people represents a significant change in the way services are provided – clients opting to use this service will require support throughout their involvement with the scheme (financial and audit processes).

Recommendation 15.3: SSD conduct a study of the potential impact of the Direct Payment Scheme on the contracting processes, and of the financial support functions that will need to be put in place.

15.23 The in house team cannot offer services to Direct Payment Users. This is because the national scheme has been set up in such a way as to prohibit this. Service users unwilling or unable to make use of Direct Payments will need other provision (such as care planning) to ensure that real choices and control are built into use of care and support services.

15.24 Subsequent to the evidence gathering, there are developments taking place in SSD within the framework of 'e-commerce'. SSD in partnership with a clearing bank aim to offer charge cards (Visa) with cash ceilings for Direct Payments. These would

be offered to both users and carers as a way of reducing transactional costs and offering a simplified way of accessing services when the general public choose this way of managing their care. SSD hopes to have a pilot running during the Summer 2003 with the aim of rolling out this service before the end of the next financial year (April 2004).

15.25 This Chapter considered the role of Direct Payments in empowering the user to have greater choice and control. It highlighted that although Direct Payments have many benefits there are several barriers to their take-up. These barriers will affect the achievement of targets within 'The next Four years'. They include the process itself, the personnel and financial management aspects; and dealing directly with providers. The importance of support schemes was underlined as key to encourage take-up and the assistance needed by service users.

CHAPTER 16: THE COST OF CARE: FINANCIAL IMPLICATIONS FOR DOMICILIARY CARE

16.1 This Chapter considers some of the financial implications that are raised for the future financing of Domiciliary Care if it is to continue to meet increasing client demands, and to have a central role in supporting wider community care policies.

16.2 Future Imperfect stated that:

“The conclusion is inescapable that Social services is under resourced ... Pressures on services to deliver within tighter and tighter financial constraints has had direct effects on the nature of care and support provided. Support is increasingly reduced to a series of tasks and interventions, rather than the provision of supportive, flexible and responsive individualised care.”

(Kings Fund 2001)

16.3 The Local Government Association state that 7 out of ten Councils have tightened (or propose to) the way they ration care in order to control spending pressures (LGA 2002). The National Association of Citizens Advice Bureau state

“Excessive targeting of scarce resources on those greatest in need is leading to inadequate preventative measures in terms of support services ... for both carers and care users, which may result in more costly institutional remedies becoming necessary”

(NACAB 1997)

The National perspective and eligibility criteria are discussed further in Chapter 3

16.4 There are a number of factors that, if implemented, will place additional spending pressures on Domiciliary Care provision.

16.5 The demand for the quantity of Domiciliary Care is expected to rise in the future due to **demographic changes** in the population. Demographic studies predict sharp increases in the numbers of older persons. Nationally the number of people over the age of 65 is expected to rise by over 60% in the period 1996 to 2031. Similarly the number of very elderly people (aged 85 and over) will increase by 88% (ONS 1998). It is estimated that ‘the number of home care hours would need to increase by around 48 percent between 1996 and 2031’ (PSSRU 2001).

16.6 The extent of the financial pressures on social care arising from the demographic changes was highlighted by a review of the long-term needs affecting the Health Service. Projections of spending show a rise from £6billion in 2002/3 to £11 billion in 2022/23 (HMT 2002). These figures are viewed as an underestimate as they do not reflect increases in the level of resources required to deliver high quality social care. The demographic impact is discussed in detail in Chapter 4.

16.7 Implementation of the **National Minimum Care Standards** will bring added cost implications for care provider organisations. These additional costs are estimated to be up to an extra £2.77 per hour of care (UKHCA). The DoH Full Regulatory Impact Assessment makes it clear that these costs are the direct costs on

providers. It is expected that providers may absorb 10% of the additional costs but 90% will pass on to service users/commissioners. As a commissioner of care this will have serious implications for KCC. The Association of Directors of Social Services (ADSS 11/01/02) state that 'The cost of compliance is high and has been underestimated in the Regulatory Impact Assessment...Social Services authorities are not funded to absorb this increase'. This is however contrary to the statement by Jackie Smith, Director of State DoH. The impact of the National Care Minimum Standards is discussed in detail in Chapter 8. Support to providers of care is available through organisations such as Business Link Kent, TOPSS, Learning Skills Council (see Chapter 10).

16.8 The turnover of **Domiciliary Care staff** has been put as high as 27%. With high vacancy and turnover rates, recruitment and retention of staff are both a major problem for care providers, and a serious obstacle to delivering high quality care. Two of the factors causing difficulties in recruiting care workers are low levels of pay and competition from other service industry jobs, such as the retail sector. The retail sector and catering outlets offer more flexibility, better pay, less demanding work, and generally more attractive terms and conditions of employment. Improving pay rates that better reflect the demanding and complex nature of domiciliary work are essential in order to attract quality staff. However this will mean increased costs for KCC. The recruitment and retention of care staff is discussed in Chapters 9 and 10.

16.9 A recurrent theme throughout the review has been the **poor status of the Domiciliary Care profession**. Any publicity campaign(s) to promote and attract quality staff to the profession will entail costs to the whole sector. Also any increases in pay to care staff will either have to be absorbed by care providers and ultimately will be passed on to the commissioners of care. Similarly if care staff are to be paid for travel time this will lead to additional costs to providers and commissioners of care. These issues are discussed further in Chapters 9 and 10.

16.10 The expansion of the **Direct Payments** Scheme will introduce new administration and financial costs to promote and publicise it to potential service users; advice users and for finance/admin staff to process the extra paperwork generated. Direct Payments are discussed in Chapter 15.

16.11 Recent legislative changes mean that Domiciliary Care provision will need to address the cultural and linguistic needs of service users for whom English is not a first language.

16.12 The possible future introduction of new technology will provide benefits, both in terms of aids and adaptations available to help clients, and computer technology, e.g. smart cards to aid invoicing and payment processes. As with any automation process these would entail high start up costs.

16.13 As discussed in Chapter 3, **delayed hospital discharges** could have a cost implication for Social Services. There are numerous reasons for delays, including awaiting Care Home placement, assessment and some due to awaiting Domiciliary Care provision (currently 5.7% i.e. 9 delays).

16.14 These additional financial pressures for Domiciliary Care can be summarised into two distinct categories - increased Quantity and Quality of care. This is demonstrated below.

Units of Care x rate of care (£) = Cost

Quantity of Care

Increases due to:

Demographics	}	↑ units x rate(£) = COST INCREASE
Better publicity will require more care	}	
e.g. to members of minority ethnic communities)		

Quality of Care

Increased rates (£) due to:

Raising the status and profile of carers	}	units x ↑ rate(£) = COST INCREASE
Better training	}	
Implementation of care standards	}	
Recruitment initiatives	}	
Career structure	}	
Better rates of pay	}	

16.15 The issues detailed above highlight the areas that will create additional costs for commissioners, clients and care providers. Despite the constraints on budgets, additional funding for Domiciliary Care is essential if the service is to continue to meet the increasing demands placed on it.

LIST OF APPENDICES

- Appendix I: List of Witnesses**
- Appendix II: 'Active Care – A new look at social care in Kent'**
- Appendix III: Kent - The Next Four Years**
- Appendix IV: 'Vision for Kent'**
- Appendix V: Social Care Eligibility – Standardising Assessed Needs to Indicate Entitlement to Services (Form CM6)**
- Appendix VI: An assessment by the United Kingdom Home Care Association of the compliance costs based on the draft National Minimum Standards for Domiciliary Care**

APPENDIX I

LIST OF WITNESSES

Meeting Date	Witness/es Attending (or Visited)	Subject Covered
27 March 2002	Oliver Mills Pat Huntingford Chris Belton	Introduction and Overview of Dorr Care
4 April 2002	Christine Collinder	Cluster Care
	Keith Wyncoll	Culturally Competent Care
10 April 2002	David Wade, UKHCA Norman Temple, KCCA	Role of National and Regional Associations
	Claire Martin	Supporting People
17 April 2002	Dave Holman Pam McGregor Bob Perfect Carol Gooderson Lorna Savage Tim Liggins Liz Gibson Richard Brabbin Bob Ditchburn	Role of Managers and Practitioners in Older Persons' and Adult Disability Teams
22 April 2002	Elaine Buxton Sue Smith Andrew Saunders Paula Owen Lynette Jarman Janice Drain	In House Provider External Care Provider Companies
29 April 2002	Linda Cooper, Carers First Richard Killick, Carer	Experience of Carers
	Vicci Chittenden	Experience of Disabled User
	Vic Codling, Ursula Hagen Alzheimer's Society	Experience of people with Alzheimers
30 April 2002	Colin Holman	Experience of Direct Payments
8 May 2002	Visit to Age Concern, Dartford	Provision of ancillary services, experiences of Domiciliary Care
9 May 2002	Mary Stewart	Generic Worker, CART,

Meeting Date	Witness/es Attending (or Visited)	Subject Covered
	Anne Tidmarsh	Rapid Response Team
	Chris Cogdell Jerry Wilson Maggie Pauling	Recuperative Care Scheme
	Lynne Selman	Role of Health/Intermediate Care
17 May 2002	Visit to Guru Nanak Centre, Gravesend	Cultural Care Issues
17 May 2002	7 Care Workers employed by providers interviewed on 22 April	Experience of the job
	Sheila Harrison , Carer	Experiences of Former Health Worker Carer, caring for elderly parent
20 May 2002	Keith Lyon	Duty Screening System
	Martyn Ayre	Direct Payments System
22 May 2002	Oliver Mills Andrew Ireland	Sharing of issues so far
	John Cunningham , Mencap	Role of Access Advisor
	Caroline Highwood	Finance Issues, Member Questions
	Pat Huntingford Lauretta Kavanagh	Contracting Service, Member Questions
	Elaine Buxton	In-house Service, Member Questions
28 May 2002	Richard Brabbin	Forms and their uses

APPENDIX II

'Active Care – A new look at Social Care in Kent' was presented to the Social Services Committee in September 2000 and set out a number of commitments and targets for social care in Kent over a ten-year period. With regards to Older People it details several services with Domiciliary Care at the core of this provision. These are detailed below:

'Commitment: *in ten years we will ensure that older people have the support to stay in their home or community if this is what they (and their carer) want.*

Measure: *Increase the number of older people supported in their own homes*

Increase the proportion of older people supported in their own home relative to the number of local authority supported older people in nursing or residential care

Increase the proportion of people receiving intensive home care as a proportion of those who receive intensive home care and residential care

Targets: *Provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible, by reducing preventable hospitalisation and ensuring year on year reductions in delays in moving people over 75 on from hospital.*

How we will do it:

- *Reinstate preventative Domiciliary Care services (i.e.. early intervention) as soon as the national statutory guidance on charging has been made clear and resources allow;*
- *Develop rehabilitation and recuperative care services in people's homes; using both in-house and independent Domiciliary Care providers;*
- *Provide more intensive home care;*
- *Promote and support training and development for the large numbers of Domiciliary Care staff throughout Kent to help improve the supply of good quality services.'*

APPENDIX III

'Kent – The Next Four Years' sets out KCC's priorities and targets for the next four years to 2005. It details the following with respect to 'Independence and better care for older people':

- *'develop care services for people in their own homes so that 20% more people who would benefit from intensive home care, and who want to live at home, can do so.*
- *Increase the range of care and nursing support services in communities and reduce the number of emergency admissions of older people to hospital by 10%.'*

Another priority which is relevant to Domiciliary Care is that of Direct Payments. (The Direct Payment Scheme is detailed in Chapter 14).

- *We will extend our Direct Payments scheme to enable 5,000 people, who need a care service, to choose who looks after them.*

APPENDIX IV

The Community Strategy document '***Vision for Kent***' is about improving the economic, environmental and social wellbeing of the county of Kent over the next 20 years. It details the following social and health care services involving Domiciliary Care that will be developed:

- *'enables the elderly to remain in their own homes*
- *enables people to take greater control of their lives and live safely and independently in their own communities, through engagement with KCC and its social care partners*
- *develops a range of options for older people, so they have a choice in how they are looked after between leaving hospital and returning home.'*

APPENDIX V
SOCIAL CARE ELIGIBILITY

APPENDIX VI

ASSESSMENT OF THE UNITED HOME CARE ASSOCIATION OF THE COMPLIANCE COSTS BASED ON THE DRAFT NATIONAL MINIMUM STANDARDS FOR DOMICILIARY CARE.

GLOSSARY OF TERMS

ASSESSMENT (NEEDS ASSESSMENT):

The process of defining needs and determining the eligibility for assistance. It is a continuing process which should involve the service user, carers, and all organisations involved in the provision of care for that person.

BED-BLOCKING: A bed occupied by a patient who in the consultant's opinion no longer requires the services provided for that bed, but who cannot be discharged or transferred to more suitable accommodation.

BLOCK CONTRACT: Is a contract which guarantees a given volume of business for the provider.

CALL-OFF CONTRACTS: Refer to contracts where a price per hour is specified in advance and paid when a service is provided.

CARE MANAGEMENT: A process which involves identifying a person's needs (see assessment), drawing up a care plan and arranging provision of the services required. Services may be purchased from social services, health or the independent (private and voluntary) sector

CARE MANAGER: The member of staff (usually, but not always, from Social Services) responsible for assessment, producing a care package and monitoring and adjusting, as necessary, care arrangements.

CARE PACKAGE: A combination of services arranged by a Care Manager to meet the needs of an individual.

CART: Community Assessment and Rehabilitation Team.

COMMISSIONING: The means by which the local authority (and health authority) plan, organise and purchase services for people.

COMMUNITY CARE: Services and support to help anyone with care needs to live as independently as possible in their home, wherever that is.

COMMUNITY CARE REFORMS: The reforms introduced by the White Paper *Caring for People*, and by the NHS and Community Care Act 1990.

COMPLAINTS PROCEDURE: The process which every social services department must have for listening and responding to comments and complaints from users of services.

CONTRACTING: The process through which local authorities purchase services from care providers.

COST AND VOLUME CONTRACTS: Refer to contracts that guarantee a block purchase of hours plus a negotiable option to purchase further hours of service.

DEMENTIA: Progressive impairment of a person's mental processes.

DOMICILIARY CARE: Help and services provided in a person's own home to improve their quality of life and enable them to maintain their independence. This can include home care, meals on wheels, and

visits by the occupational therapist and/or district nurse.

ELDERLY MENTALLY INFIRM (EMI): Older person(s) with mental frailty e.g. due to dementia.

ELIGIBILITY CRITERIA: The 'rules' which determine whether a person is entitled to a particular service e.g. Care Management. The criteria are used so that those with the greatest needs are given priority.

ETHNIC MINORITY COMMUNITIES: Relates to all sub-groups of the population not indigenous to the UK whose cultural traditions and values derived, at least in part, from their countries of origin.

GRIFFITHS REPORT *Community Care: Agenda for action*, by Sir Roy Griffiths, was published in 1988 and paved the way for the community care reforms.

HOME CARE: Is a Social Services Department's most extensive service. Since community care, home care has increasingly provided personal care; whilst housework and other domestic tasks have become marginalised. It has also developed into a more intensive support service targeted at more dependent people at risk of admission to residential or nursing care.

INDEPENDENT SECTOR: A range of non-statutory organisations involved in social and health care provision, including both private and voluntary/charitable organisations.

INTERMEDIATE CARE: Is a range of services to promote faster

recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living.

JOINT COMMISSIONING: Where more than one statutory agency join together to commission or purchase new or existing services.

JOINT FUNDING: A funding arrangement which includes two or more funders.

MCCH: Maidstone Care in the Community Housing.

MULTI-DISCIPLINARY (Multi-Agency): The involvement of people from different agencies or professions, combining their specialist skills and knowledge to work towards a common goal.

PERSONAL CARE: Is care which involves support with bathing, washing, dressing, going to the toilet, help with getting in and out of bed, walking and getting up and down stairs

PRIMARY CARE: Care provided through the traditional family practitioner services i.e. general practice services, pharmacists, optometrists and dentists.

PRIMARY CARE TRUSTS: Bring together all the GP practices and their staff in a geographical patch to provide the range of primary care services and to commission other services.

PROJECT MOTORWAY: A scheme proposed by a care provider to overcome transport difficulties. The scheme suggests

using an in-house taxi service and fleet cars.

PROVIDERS: Any person, group or organisation supplying a community care service.

REFERRAL: A request for action may be initiated by an individual or by a professional e.g. their GP.

RESPITE CARE: May take several forms, e.g. a short stay in residential care or care in the home to give carers a break from their usual caring activities.

SERVICE USER: Anyone using services provided by Social Services. Other terms frequently used are 'clients', 'customers', 'consumers' or, in the NHS, 'patients'.

SHELTERED HOUSING: Specially designed housing with varying levels of support, available to rent from district councils or housing associations, or to buy privately.

SOCIAL SERVICES INSPECTORATE (SSI): A section of the Department of Health responsible for monitoring the performance of local authority social services departments.

STEP-DOWN CARE: A way of organising care aimed at freeing up hospital beds by giving patients intensive care at home and phasing this out gradually as their health improves and confidence grows.

STEP-UP CARE: Increased level of care delivered at home to keep clients out of hospital as long as possible.

TOPSS: The National Training Organisation for Personal Social services.

VOLUNTARY SECTOR: A range of non-statutory organisations which include self-help groups, consumer forums, umbrella organisations, users and carers groups, lobbying groups as well as organisations providing services for certain groups of people. Voluntary sector organisations may employ volunteers, paid staff or both and are usually controlled by an unpaid management committee or trustees. Funding may be received from a variety of sources including grants, donations, fund-raising, legacies and sponsorship.

REFERENCES

- ADSS (24 April 2002) Carers would benefit from Extra resources
- ADSS (11/01/02) Response to Consultation on Domiciliary Care Standards
- Audit Commission (1986) Making a Reality of Community Care. London
- Audit Commission (2000) Fully Equipped: the provisions of equipment to older or disabled people by the WHS and Social Services in England and Wales. London: Audit Commission Publication London
- Cabinet Office (1999) Modernising Government. London
- Clark H, Dyer S & Horwood J (1998) That bit of help: The high value of low level preventative services for older people. The Policy Press.
- Community Care (22-28 Aug 2002) Give me a break. Katie Leason
- Community Care (21-27 November 2002) The right to choose wrongly. Philpott T
- Community Care (7 March 2002) Where better to care?
- Community Care Research and Consultancy (Nov 2000). Estimation of the Increase in the Cost of Providing Home Care under the Kent County Council Contract, for the Kent County Care Association. KCC.
- Community Care Research and Consultancy (March 2002). Estimation of the Increase in the Cost of Providing Home Care under the Kent County Council Contract, for the Kent County Care Association Updated Report to Oct. 2001. KCC.
- Daily Mail (19/7/02) Research by Dr Hirst, York University, published in the Journal of Epidemiology and Community Health (based on a long term study of 10,000 people)
- DETR (Jan 2001) Supporting People: Policy into practice. London
- DoH (1998) Modernising Social Services. Department of Health.
- DoH (2000) The NHS Plan: A plan for investment A plan for reform". The Stationery Office
- DoH (2001a) Consultation on National Minimum Standards for Domiciliary Care Agencies. Department of Health
- DoH (2001) Guide to Integrating Community Equipment Services. Department of Health.
- DoH (2001) National Service Framework for Older People. Department of Health.
- DoH (March 2002) Community Care Statistics 2001: Home Care Service for Adults, England. Department of Health.

DoH (2002) Delivering the NHS Plan: next steps on investment next steps on reform. Department of Health.

DoH (2002) National Service Framework for Older People Supporting Implementation – Intermediate Care : Moving Forward. Department of Health.

DoH (23 July 2002) Expanded Services and Increased Choices for Older People. Press Release. Department of Health.

Griffiths R (1988) An Agenda for Action on Community Care. HMSO.

HCC (2002) Direct Payments scheme. Hampshire County Council.

Help the Aged (2002) Nothing Personal: Rationing Care for Older People. Help the Aged.

Help the Aged (Jan 2002) Direct Payments direct control: enabling older people to manage their own care

Help the Aged and University Of Kent (2002) Caring in later life: reviewing the role of older carers.

HM Government (March 1999) Report of the consultative conference on a national strategy for carers.

HMT (2002) The Role of the Voluntary and County Sector in Service Delivery. HM Treasury

HMT (2002) Wanless, D Securing our Future Health : Taking a Long-term View. HM Treasury

HMSO (1989) Caring for People and Community Care in the next decade and beyond HMSO, London White Paper

Housing 21 (1999) Citizens and Services for Older Age: The Strategic Role of very Sheltered Housing. Peter Fletcher Associates.

KCC (2000) Huntingford, P Hearing the voice of service users, Kent County Council.

KCC (2000) Active Care – A new look at Social Care in Kent. Kent County Council.

KCC (2002) Culturally Competent Care. Kent County Council.

KCC (July 2002) Race Equality Scheme. Kent County Council.

KCC (2002) Kent – The Next Four Years. Kent County Council.

KCC (2001) Vision for Kent. Kent Partnership. Kent County Council.

KCC SCCH POC (2002) Nursing Home Care in Kent. Topic Review.

Kings Fund (June 2001) Henwood M, Future Imperfect? Report of the King's Fund Care and Support Inquiry. Kings Fund.

Kings Fund (Nov 2002), Robinson J. Unfinished Business. Is a crisis in care still looming? King's Fund.

LGA (Feb 2002) Local authority Social services Budget survey. Local Government Association.

Lindlow, V and Morris, J (1995) Service User Involvement: synthesis of findings and experience in the field of community care. York. York University Press.

Milne A, Hatzidimitriadou E, Chyssanthopoulou C, Owen T. Caring in later life: Reviewing the role of older carers. Help the Aged and University of Kent.

Morris, J (1997) Community Care: Working in Partnership with Service Users. Birmingham. Venture Press.

NACAB (March 1997) - Phelps L, Rationing Community care: CAB client's experience of home care services. National Association of Citizens Advice Bureau.

NCIL (2002) Promoting personal assistance to enable independent living. National Centre For Independent Living.

ONS (2000) Office for National Statistics. National population projection : 1998-based. Office for National Statistics TSO London.

ONS (2002) Census 2001: First Results: total Population by age and Gender. Office for National Statistics.

Phelps L (1997) Rationing Community Care – CAB clients' experience of home care services. National Association of Citizens Advice Bureau.

Powell J L (2001) The NHS and Community Care Act (1990) in the United Kingdom; A Critical Review. Centre for Social Science, Liverpool John Moores University.

PSSRU (2001) Demand for Long-term Care for Older People in England to 2031. The Personal Social Services Research Unit.

Raynes N, Temple B, Glenister C, Coulthard L (2001) Quality at home for older people; Involving service users in defining home care specifications. Joseph Rowntree Foundation. The Policy Press

SERO (April 2002) Building Care Capacity Grant process. DoH South East Regional Office.

SSI & AC (Jan – Feb 2001) A report of the Joint Review of Social Services in Kent. Social Services Inspectorate and Audit Commission.

Strategic Briefing (27/03/02) Briefing to the Select Committee by Oliver Mills, Pat Huntingford and Christ Belton. Kent County Council.

TOPPS (1999) Modernising the Social Care Workforce – the first national training strategy for England. Supplementary report on Domiciliary Care.

UKHCA (2000) Dinah Mathew (2000) Who Cares? A profile of the Independent Sector Home Care Workforce in England.

Wistow G, Knapp M, Hardy B and Allen C (1994) Social Care in a Mixed Economy. Open University Press