Independent Whole Systems Review
into Safeguarding and Care at Dunmurry Manor Care Home

EVIDENCE PAPER: 4

Assessment and Care Management

December 2020

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Section A: Introduction

Background

1. The Department of Health ("DH") of the Northern Ireland government commissioned CPEA Ltd ("CPEA") to undertake a "whole systems" review following the complaints of families concerning poor standards of care and support at Dunmurry Manor Care Home ("DMCH," owned by Runwood Homes Ltd).
2. Families approached the Commissioner for Older People in Northern Ireland ("COPNI") during December 2016, to express significant misgivings about the standards of care at the home. They reported that the care provider, the Regulation and Quality Improvement Authority ("RQIA"), the Health and Social Care Board ("HSCB"), the Health and Social Care Trusts ("HSCTs") and the Patient and Client Council ("PCC") had not addressed their complaints and they had nowhere else to go. In response, the COPNI used his investigation powers for the first time, requiring the DH, the HSCTs, RQIA and Runwood Homes to submit information for his consideration. He engaged an expert panel of three[1] to advise him.
3. *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* ["*Home Truths*"] was published in June 2018. The report cited poor and inadequate personal care and inadequate assessments in relation to older people's skin integrity, continence, nutrition, pain, falls and, more generally, concerning risks and anticipatory care needs.
4. The purpose of the whole systems review is to learn and change. An Evidence Paper is a way of soliciting comment to inform and advise those who are responsible for formulating and implementing change. Sources of information about assessment and care management are set out in Appendix A. This Evidence Paper considers (i) assessment and care management as a focus for action, most particularly as older people and their families seek support when considering care options, and (ii) the extent to which the People First documents of 1990s[2] and *Improving and Safeguarding Social Wellbeing 2012-2022*[3] have realised specific benefits.
5. Families with relatives at DMCH and other homes in Northern Ireland were unsparing in their descriptions of the assessment and care management processes and how they perceived the actions of HSCTs' employees. Most typically they described feelings of powerlessness. This paper sets out their experience and perceptions and those of professionals in the five HSCTs, in care homes and other organisations. Although the assessment of individual needs is a common process across all professions and agencies, to be most effective it requires information about the procedures to be freely and easily shared. The remit of individual professionals responsible for assessing older people should be understood and there should be clear arrangements for people whose circumstances are most pressing. Almost 20 years ago the *Review of Community Care – First Report*[4] confirmed the importance of making,

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[1] Eleanor Hayes, with expertise in nursing and care; Professor John Williams and Dr Robert Peat with expertise in safeguarding and human rights; regulation, inspection and commissioning respectively

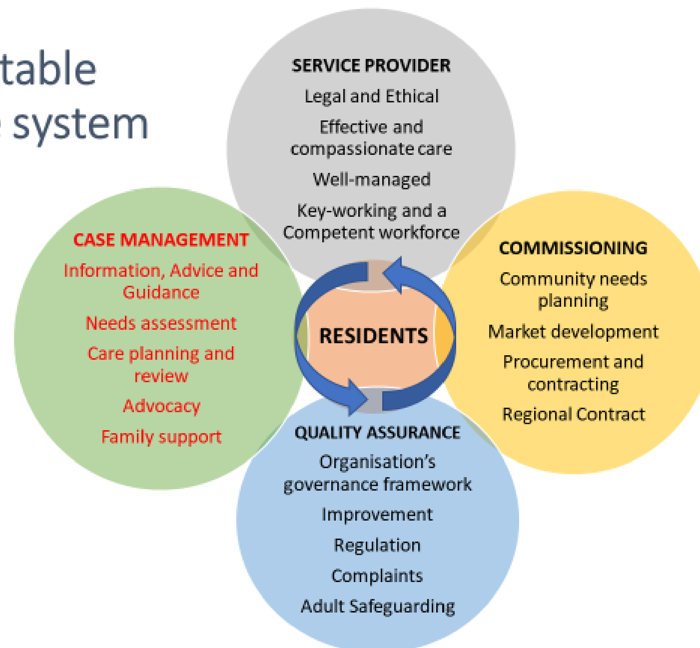
[2] See https://www.health-ni.gov.uk/publications/people-first-literature (accessed 10 February 2020)

[3] A Strategy for Social Work in Northern Ireland 2012-2022 sets out a framework for social work practice to deliver the vision for social work

[4] http://www.dhsspsni.gov.uk/review_of_community_care.pdf (accessed on 2 February 2020)

"proper assessment of need and good case management the cornerstone of high-quality care."

6. The position of assessment and care management in the context of the whole systems review is shown in the graphic below.



Methodology

7. The structure of the Evidence Paper seeks to demonstrate how case work, beginning with assessment, is essential to the whole system. How people seek help and support, how they are received, signposted and their needs evaluated are pivotal matters. So is the integrity of the role and remit of the professional undertaking the assessment. The Paper seeks to understand how different professionals – social workers, nurses and allied health professionals – maintain their identities.
8. The maintenance of professional practice values of, for example, self-determination is examined through dialogue and working sessions to evaluate how the system copes in the pressurised environment of hospital discharge or shortcomings in community support. Individual assessments are relevant to the pathways older people follow as they move into care homes. These pathways should correspond to Northern Ireland's policies and demonstrate their underpinning values in practice.
9. Personal stories, illustrative quotations from interviews and discussions during workshop events and meetings with individuals, families and groups are presented. Similarly, the invaluable contributions of professionals undertaking assessment and care management with older people are reflected in this Paper.
10. The CPEA Independent Review Team ("IRT") gave assurances that in sharing the experiences of individuals, their identities and those of their families would be protected.
11. Since residents' families have a compelling track record in specifying what needs to change to fulfil the support needs of their relatives, the paper begins with their experiences.

Subsequent sections offer a reality check into how well the systems are working and are equipped to achieve the aspirations of *Power to People*[5] in respect of self-control and personalised care navigation, for example. That report's use of the term "reboot" encapsulates what is necessary.

12. Throughout the Evidence Paper, sections are concluded with "POINTS TO CONSIDER." These reflect discussions about emergent learning and possibilities for change as well as discussions with professional and non-professional contributors. They reflect the "no surprises" approach of the IRT in providing and discussing professional challenges and best practice examples. Such discussions helped to shape the advice and proposals within the final section of this Paper.
13. There are several actions that ought to be taken and can be initiated without waiting for the perfect solution or the right time. The events at DMCH confirm the significance of ensuring that people's care and support needs are correctly assessed with the resulting interventions carefully planned. Assessment and care management should be concurrent, focussed on the individual and attentive to the importance of people controlling those aspects of their lives that remain within their gift.

A caveat

14. The families who approached the Independent Review Team were self-selected. That is, they initiated contact and/ or were encouraged to make contact by relatives who had been introduced and become known. Most of their experiences were bleak. The IRT does not take the view that these typify the experiences of all families with relatives in care homes in Northern Ireland. It encountered owners and managers of care homes who welcome family contact; who promote engagement with young people; and homes which play a part in supporting their immediate neighbourhoods, for example. It is possible that the families with relatives in such care homes did not make themselves known because their experiences were quite unlike those of the DMCH families whose stories received a great deal of media publicity in the wake of *Home Truths'* publication. Of the families who were met satisfaction was expressed by four with relatives in the residential care part of DMCH.

[5] Kelly, D, and Kennedy, J. (2017) *Power to People: Proposals to reboot adult social care and support in N.I. – Expert Advisory Panel on adult care and support* Belfast: Department of Health

Section B: Context

Family involvement and experiences

> *We have had to battle with most parts of the system.*
> *I have been made to feel that it is my fault.*
> *I feel very guilty* - Relatives of DMCH residents

15. The views, experiences and suggestions from and about older people and families are at the heart of this Review. Learning from them creates a compelling foundation for change. Several used terms such as "fighting" and "battling" to be heard by professionals, most particularly when a clinical decision was made that an older person was ready to be discharged from acute care. One family provided a clear window on the limitations of assessment and care management:

Dad was a proud man. He was always well turned out and as he worked on cars, he was always conscious of getting oil off his hands. After our Mummy died, he was so lost. A part of him had gone. With the help of all of us, he started to turn the corner. He had many friends and was always happy. I have brothers and a sister in England who came across regularly to go out and about with him. Then he started to fade away a bit and left the taps on and was not doing the washing. I was worried and took him to the GP who found nothing wrong. He thought he was "tired." A few weeks later I went around and Dad was hot and flustered and in a mess. I took him to the hospital and he had a water infection [so] *they kept him in. He had only been in hospital once before for a hernia when he was young. This time it was different. He recovered slowly and was sent home; he was sent home on tablets. When he was in hospital, I told them his memory was going but they said it was the infection. When he got home, he stopped eating. I visited with meals and still he still wasn't eating.*

Dad was losing weight and we were all worried. I rang the GP who said, "bring him in." We did and he was referred to the hospital. [At the out-patients' department] *I was asked to sit outside and when Dad went in, he was looking very fearful. He came out and was upset. Afterwards I took him to his favourite place for some tea. He didn't know what was going on and no one at the hospital told me what was happening. I got a call from someone at the hospital who said he had to go for another appointment. The following day he fell at home and fractured his hip. We were so upset. We were all at the hospital…After the operation they told us he had to go to a care home as he was too much of a risk at home. They handed us a list of them. We didn't know what to do and hadn't even started when they said he had to leave hospital and a home had visited and he was going there to start with. We couldn't do anything or say anything and he was just taken there. We did what we could. I told him he would be coming home in a few weeks, but he didn't. He just went from bad to worse and then it was less than a week when they called us to say he was dying. On the Sunday night when I was there and my sister was on her way over from England, he died. I never told him what was happening and he didn't know he was to be in a care home from then on. I can't stop thinking*

about it and what went wrong. They never asked us about him about what he liked or needed or where he wanted to be. Afterwards, I thought it can't be like this usually and read about assessments. We didn't have those or if they were there, we didn't see them. I hope others don't get this treatment.

16. Some families expressed distress about their relatives' experience of assessment and care management. They explained that professionals did not always involve them, listen to them or enable them to influence or change what was happening with their relatives. Professionals were said to be making life altering decisions through applying a single approach to practice across the HSCTs. It resulted in confusion, uncertainty and anxiety about why their relatives were being moved into care homes.
17. Pertinent questions which commonly arose: *What are the Trusts' legal duties and responsibilities? Why weren't we given the inspection reports when things were going wrong and of poor and failing homes so we could make sure we didn't put our Mum in there? Can they make her move into a care home? Why were we told she had to move into a care home?*
18. People's families, in contributing to the Review, reflected on the barriers to informed decision-making about a move into a care home. Families' contributions hinged on their lived experience of exclusion from the professional assessment and care management. Additional themes concerned the lack of choice and information. Relatives described:
    - [Information was] *non-existent about supporting families with someone moving into a care home. There is more information about a stay in hospital, but it is as if older people and care homes don't matter.*
    - *We did not know how it worked and no one told us.*
    - *I would have willingly assisted with an assessment but wasn't even told when it was happening.*
    - *My relative was in hospital and we were not told about a worker from a care home* [who] *visited her to carry out an assessment. We should have been involved. She was not well and depends on us as her family.*
    - *We have no voice. We were not listened to or involved.*
    - *My Mummy wanted to go home with extra support in her own home and we were told that could not happen because of the risks and because she may have probable dementia.*
    - *We felt it was rushed and the only option was a care home. We had planned with our Daddy that he would stay at home for the duration of his illness and we had purchased equipment to help with that such as a special chair. It was what he wanted and what we wanted but was never even discussed.*
19. With reference to care homes:
    - [They have] *lots of glossy brochures but no information about what was expected from families*.
    - [There was no] *information that explained what we could do to continue to support our relatives.*

- *…there was little information about our role as families and what was expected of us, it was as if we no longer mattered.*
- *We did not know who was who on the staff team and their duties* [were not known to us].
- *Never been informed by Runwood when the managers changed and, at DMCH, that was very frequent.*
- *There were several managers who we never even met.*
- *Some managers were always in the office and* [were] *rarely seen around the home. Is that right or wrong?*
- [Relationship with one HSCT was] *very fraught and frustrating as they would not listen and I was describing how concerned I was about the poor care and staffing levels at the home. I asked if I could have their work phone contact number and told that was not allowed. I asked if I could email them and told that was not allowed…*[I asked the care manager] *many questions. I never got an answer.* [The backstory was that] *when* [my relative] *had been ill at home and we asked for support, the care manager was great and easy to contact. Why is this not the norm?*
- *We did not have a six-week review or a first review. I was asked during a phone call how* [my relative] *was doing but never attended a meeting.*
- *Not being told about a change of care manager* [was described by several people as discourteous and distressing because their replacement had to be properly briefed about a person's life and current challenges].

20. None of the families had been offered a carer's assessment. At least ten families had asked for domiciliary care so that their relatives could return to their homes from hospital. Although they were willing to supplement domiciliary care, they were told that their relatives had to go into a care home.
21. Information from families about their perception of how HSCTs work was supported by care home managers. They questioned the adequacy of information about financial arrangements for care and arrangements to ensure that an individual's needs are being met. Typically, the only document signed was a 'top-up' agreement.[6] Several care home managers explained that it was not uncommon for care managers to undertake care reviews by telephone and that the home's staff were usually asked to complete the necessary forms. Regardless of the Northern Ireland Single Assessment Tool (NISAT), managers said that the five HSCTs had developed different assessment forms and supporting documents that they have to deal with.
22. A minority of families recalled being invited to be involved in the care of their relatives. Some older people were admitted to care homes from their own homes. In contrast with the experience of those discharged from hospital directly into care homes, these families acknowledged that they had some control over their situation because they were able to visit and consider the acceptability of certain care homes. However, they confirmed that there was

[6] See paragraph 142 for detail on 'top-up' arrangements.

no reliable information to address the distinction between a residential or nursing home "bed."

POINTS TO CONSIDER – LEARNING AND CHANGE

- ✓ The system of assessment and care management must explain the different roles of social work, social care, nursing and health professionals.
- ✓ Clinical staff in acute hospitals may be unaware of the community support available or have the time to consider the option[7] of support to people with complex needs in their own homes. Some HSCT staff may believe that long term health care needs can only be met in a nursing home.
- ✓ The combination of clinical case knowledge and personal knowledge – gathered from the older person and their relatives – should be central to decision-making about people's care and support needs.
- ✓ The quality of people's relationships with professionals is fundamental to the delivery of care and support.
- ✓ Working through the practical and emotional implications of entering a care home is associated with feelings of powerlessness and distress.
- ✓ If people's need for relevant information and advice is not met by professionals and services, it results in unrealised expectations.
- ✓ Older people and their families have a right to be actively involved in the process of assessment and discussing its implications.

Policy background

Overview

23. The enduring social care policy focus has been and largely remains on responses to the perceived needs of older people – as a consequence of their "vulnerability", ill-health and increasing dependency - together with the anticipated growth in the numbers of people who need support and the complexity of that need. Yet it is the very success of health policy that gives cause for celebration with the rise in life expectancy and the improvements in health care. Thus, the focal purpose of social care policy must change accordingly – it is individuals' strengths which are important, support should be aimed at well-being and self-care, families and communities are assets within which people can live interdependently.
24. The agencies which provide social care services, including care homes and the system of care management, must adapt to evolving policy. Assessment and care management is pivotal to realising the evolving policy objectives around personalisation, self-direction, shared and collaborative models of care and living. It is this policy context which has sown the intentions to introduce an adaptive, holistic, person-centred assessment and to support people to live as normal a life as possible in their own home wherever it is in the community.

[7] For example, there is a Community Hub within BHSCT.

25. This Evidence Paper considers older people and their families' experiences of the assessment and care management systems. It asks if they are providing appropriate support to older people and their families within the values and principles set out in the policies. The overview concludes that there is "drift" between how the system works and the good policy intent. It is by listening to people's experiences and choices – older people, families and professionals – that the Review draws on to identify learning and propose change and improvements.

Community Care

26. Sir Roy Griffiths' *Community Care - Agenda for Action*[8] highlighted the "perverse financial incentives" which encouraged local authorities to place older people into residential care unnecessarily. It provided the backdrop to DHSS' (1991) paper, *People First: Community Care in Northern Ireland for the 1990s* which emphasised the requirement, "within available resources, to identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible." [9]
27. The document set out the need:
    i. *to help people to lead, as far as possible full and independent lives*
    ii. *to respond flexibly and sensitively to the needs and wishes of individual people and the relatives and friends who care for them*
    iii. *to concentrate professional skills and public resources on those who need them the most.*
28. It acknowledged the increasing demands on services and rising public expectations. It was envisaged that full use would be made of the independent sector, that there would be new funding structures for residential and nursing homes, and that registration and inspection units would be established to monitor standards.
29. The section, *Meeting Individuals' Needs*, confirmed the tendency to fit clients to services, rather than adapting services to client's needs. The *comprehensive assessment process should always be activated when the decision to be taken is whether the client should move on a permanent basis into a residential or nursing home as this is a critical one in the life of any person. Once he or she has moved out of his or her own home into any form of institutional care, it may become difficult to go back to independent living. The purpose of requiring a full assessment at this important juncture is to establish whether a coordinated package of domiciliary care – perhaps including personal care, emotional support and help with mobility, domestic tasks and financial affairs, accommodation, leisure and employment – would enable the person to go on living at home. Equally no vulnerable person should be discharged from hospital without a complete assessment involving all appropriate disciplines* (para 4.6, p26).
30. The document states that assessments should take account of the wishes of the individual and their carers if the best means of assisting a person are to be determined. They should focus on what people can do and cannot do, what is expected to be achieved and should be

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[8] Griffiths R. (1988) *Community care: agenda for action* London: HMSO.

[9] People First documents may be accessed at https://www.health-ni.gov.uk/publications/people-first-literature (accessed 21 February 2020)

attentive to people's "personal and social relationships." Regular reviews would ensure that an individual's needs were being met and that resources were being effectively managed. Case management was described as an *effective method of targeting resources and planning services*.

31. The Circular HSC (ECCU) 3/ 2006 reinforced the *People First* commitment to enabling people to live in their own home, practical support for carers and the importance of *proper assessments of need and good care management being the cornerstones of high-quality care,* [plus] *the development of a flourishing independent sector alongside good quality services.* The report set out standards for effective assessment and care management from the point of receiving the referral to reviewing and filing records.

Review of Community Care policy

32. The introduction of the Human Rights Act (1998), into domestic Northern Ireland law in October 2000, was significant insofar as social work intervention into people's lives had to be moderated by human rights considerations such as privacy in family life, non-interference and rights to participation - to be 'heard.'
33. The *Review of Community Care - First Report* (DHSS 2002)[10] confirmed the need to "make proper assessment of need and good case management the cornerstone of high-quality care." The Department of Health, Social Services and Public Safety's Circular HSC (ECCU) 1/2010), *Care Management, provision of services and charging guidance*[11] stated that *the central objectives of community care services remain:*
    - *helping people to remain in their own homes, or in as near a domestic environment as possible, for as long as they wish and it is safe and appropriate to do so;*
    - *providing practical support to carers to support them in their caring role; and*
    - *ensuring that residential care, nursing home and hospital care is reserved for those whose needs cannot be met in any other way.*

    Services must be delivered in ways that appropriately manage risk for service users, carers, staff and the public. It is acknowledged, however, that in some situations, living with an identified risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking (when it is appropriately managed) can be considered to be a positive action. Health and Social Care (HSC) staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, carers, families and communities.
34. The Circular states that the term Care Management *is used to describe the whole concept which embraces the key functions of:*
    - *case finding, i.e. making information available to the public and service users and carers about the range of services available and potential sources of help;*

[10] http://www.dhsspsni.gov.uk/review_of_community_care.pdf (accessed on 2 February 2020)
[11] The Circular replaced Circular: ECCU 3/2006, *Care Assessment and Placement Guidance*

- *screening and determining the level of assessment to be undertaken when a person is referred;*
- *undertaking a proportionate, person-centred assessment of the individual's needs, having due regard to the needs of carers;*
- *developing and implementing a care plan and a care package (which may comprise a range of services) to meet identified needs; and*
- *monitoring, reviewing and adjusting the care plan and care package as required.*

35. The Circular set out the Northern Ireland Single Assessment Tool ("NISAT") as the assessment vehicle and promoted it as being validated and comprehensive. NISAT runs to almost thirty pages and has 11 associated forms to cover the assessment and support process.
36. During 2008, the Department commissioned the Northern Ireland Social Service Council ("NISSC") to carry out a review of the roles and tasks of social work in Northern Ireland in the 21st Century. The outcome of the review concluded: *a statement must be produced not only to the profession but to the wider audience of Northern Ireland who need to understand what social work does, what it contributes and how it will respond to the societal challenges ahead.*
37. The Health and Social Care (Reform) Act (Northern Ireland) 2009,[12] heralded the restructuring of administration of health and social care. Crucially, it gave Personal and Public Involvement a legislative basis. It stipulated that people affected by health and social care intervention should have their views sought in regard to the planning and delivery of services.
38. During 2010, consultation began on, *A 10-year strategy for social work in Northern Ireland 2010-2020.*[13] In 2012, the Department published *Improving and Safeguarding Social Wellbeing - A Strategy for Social Work in Northern Ireland 2012-2022.*[14] The Ministerial foreword noted: *It provides a framework for social work practice that reflects the role of social work in early intervention and prevention as well as in more targeted and specialist services for those in need of care and protection.*
39. The strategy confirms the international definition of social work: *The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (International Association of Social Workers).*[15]
40. Social worker is a protected job title and can only be claimed by qualified and registered practitioners. Most social workers practice their profession in the assessment and care management part of the system. One of the tasks of social workers is to assist older people and their families cope with the emotional upheavals and distress of moving into a care home. As social workers they practice casework. The job role is called care manager, however the

[12] http://www.legislation.gov.uk/nia/2009/1/contents (accessed 2 June 2020)
[13] https://www.basw.co.uk/system/files/resources/basw_124017-2_0.pdf (accessed 2 June 2020)
[14] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/swstrategy.pdf (accessed 21 February 2020)
[15] https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/ (accessed 21 February 2020)

activities around care home admission require more than form filling and 'managerialist' oversight. The knowledge and theoretical base of social work has evolved since the advent of "community care" to underpin and inform the skills of supporting older people and their families. It is not always appreciated how much social workers support older people to cope with loss, transitions, onset of multiple illnesses and disability and the approach of end-of-life. Moreover, they support health therapists with embedding rehabilitation and creating opportunities for people to remain connected with friends and family and to do the things they enjoy.

41. Social care is commonly used to describe the overarching social service/welfare system of which social workers are one feature along with, among others, care homes and the associated workforce. The care home workforce includes registered nurses – a protected title and statutory regulated role – and Registered Managers – a position regulated as part of the service that can be performed by variously qualified people and most commonly held by the home manager. In Northern Ireland the Registered Manager of a nursing home must be a registered nurse. Care staff make up the bulk of homes' workforces and they, like social workers, must be registered with the Northern Ireland Social Care Council ("NISCC").
42. A report of December 2018 set out the progress against the 2012 strategy (*Improving and Safeguarding Social Wellbeing: Stage 2 Progress Report*). It stated that *Social workers play an important role in assessing need, acting as gate keepers to finite resources, providing targeted social work services or signposting people to services that can help them. As gatekeepers, social workers need to maintain professional integrity in their assessments and decision-making; ensure transparency and fairness in decisions about access to services; and work within the relevant legal framework and organisational procedures* (p7).
43. With reference to health funding in Northern Ireland and specifically social care, it was noted that "while there was great intent…and a lot of effort, unfortunately, there has been a minimal impact, in terms of how much bureaucracy has been taken out of the system."[16]
44. *Transforming Your Care* (DHSSPS, 2011) endorsed the principles which shaped *People First*[17] – making visible person-centred care throughout health and social care practice.
45. In June 2015, a *Review of Legislation and Policy Guidance Relating to Adult Social Care in Northern Ireland*[18] was published. Commissioned by the COPNI, it aimed to present possible options for legal reform to adult social care provision for older people. The study compared adult social care in Northern Ireland with other jurisdictions and sought to identify "best practice." It concluded that, *legislative reform to adult social care in Northern Ireland is necessary. This is based on the findings that the current legislation and accompanying policy guidance is both confusing and fragmented. Our findings have also indicated that the*

[16] https://publications.parliament.uk/pa/cm201919/cmselect/cmniaf/300/30007.htm (accessed 21 February 2020)

[17] To help people lead as full and independent lives as possible; to respond flexibly and sensitively to the needs and wishes of service users and carers; and to concentrate resources on those who need them most

[18] Duffy, J., Basu, S., Davidson, G. and Pearson, K. C. (2015) *Review of legislation and policy guidance relating to adult social care in Northern Ireland.* https://www.copni.org/media/1138/review-of-legislation-and-policy-guidance-relating-to-adult-social-care-in-ni.pdf (accessed 2 June 2020)

legislation overlaps in key areas of social care provision and is both highly complex and inconsistent across Northern Ireland. "Harmonising legislation" would, *enable older people to have their citizenship rights and entitlements more meaningfully protected* (p9).

46. The study's recommendations remain pertinent:
    - *There should be a single legislative framework underpinning adult social care in Northern Ireland with accompanying guidance for implementation. This could either be new or consolidated legislation, based on human rights principles, bringing existing social care law together into one coherent framework providing clarity on: Eligibility; Entitlement, Rights to Services, Personal and Public Involvement (PPI); Assessment of Need and Unmet Need; Health and Social Care Trust Duties; Existing frameworks for mental incapacity and adult protection;* [and] *other support services including housing and benefits entitlements.*
    - *All older people in Northern Ireland, once they reach the age of 75 years, should be offered a Support Visit by an appropriately trained HSC staff member. This will be based on principles of choice and self-determination and is aimed at helping older people to be aware of the support and preventative services that are available to them.*
    - *Increasing demands for health and social care reinforce the importance of considering how these services should be funded. All future funding arrangements must be equitable and must not discriminate against any group, including older people, who may have higher levels of need.*
47. The study concluded that enacted legislation should demonstrate *allegiance to explicit human rights principles to secure a social care framework that permits individual decision making, based on need and preferences, with early opportunities for assessment and intervention to reduce the possibility of crisis and otherwise preventable institutionalisation…we recognize that the recommended consolidated piece of legislation will need to include not just adult social care, but also mental capacity, developmental disabilities and adult protection concerns* (p97).
48. During 2016, the then Minister for Health announced the creation of an Expert Advisory Panel on Adult Care and Support and appointed John Kennedy and Des Kelly as independent experts.[19] It was tasked with producing evidence-based proposals for change. The actions arising from this work – reported in December 2017 as *Power to People* - are currently being managed by the Deputy Chief Social Worker through the Reform of Adult Care and Support in Northern Ireland Board. This is a representative group of people with a clear focus on older people and care homes.
49. During 2017, the NISCC completed a workforce review entitled *Social Care Matters.* The stimulus for the report was recognition that there were serious difficulties in recruiting and retaining social care workers and there were concerns about the limitations on career options in the sector. The report noted that there was a major challenge in responding to workforce instability due to the lack of comprehensive data on social care which impeded workforce planning at a system-wide level. It recommended continued development of a competent

[19] https://www.health-ni.gov.uk/articles/reform-adult-care-and-support (accessed 2 June 2020)

social care workforce through core training, continuous professional development and opportunities for training and qualification which would open up career pathways to higher level roles within social care (p21).

50. Questions must be asked about why these long-standing policies and associated guidance are not working as intended. Information from families, together with the views and opinions of professionals, point to failings in the systems created to implement the polices. The IRT concluded there was inconsistency across HSCTs, a dominance by the health/hospital part of the system and social work with older people being afforded low status.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ The contribution of social work (casework) with older people and their families should be highlighted and the value of the role be drawn to public attention.
- ✓ The process of assessment and care management needs to be refocused on the Human Rights in Practice approach
- ✓ A consistent, regional approach needs to be implemented across Northern Ireland - people are entitled to the same standards of social work wherever they live.
- ✓ Social workers need to be more actively involved in the development of systems and processes.

Reform of Adult Social Care

51. Discussions and feedback sessions on emergent findings with senior social worker managers and staff at DH acknowledged that the processes of assessment and care management were not working effectively. The IRT gathered from families that care management staff did not always operate in the best interests of older people. The Deputy Chief Social Worker is responsible for leading the Reform of Adult Social Care programme. A working group has wide representation from the care sector and a helpful addition would be to include families of older people. What better way than for practitioners and families to co-produce the necessary changes? When embarking on such reform it is vital that the whole (registered and ancillary) social care workforce really understand the implications in the impact of their practice. The IRT participated in sessions of the group and consider the programme's priorities to be consistent with the findings of the Review.

52. The reform work's strategic priorities have secured engagement from across the social care sector:
    1. Individual Choice and Control
    2. Prevention and Early Intervention
    3. Supporting Carers
    4. Valued Workforce
    5. Primacy of Home
    6. Sustainable System Building

Each of these priorities relates to elements of care management.

53. In parallel, the *Strategic Framework for Social Work*[20] identifies three high level outcomes which relate to the workforce, the services and the profession. This states that the ultimate measure *is the difference social workers make to people's lives*.

OUR VISION:	Every person engaged with the social work services will live safely and well within supportive communities
OUR MISSION:	Social workers will support communities, families and individuals to enhance their quality of life and social wellbeing.
OUR GOAL:	Put improvement at the heart of social work.
Improvement	Strengthen the effectiveness of social work in improving people's social wellbeing.
Leadership	Develop social workers at all levels as leaders and ambassadors for the profession, modelling high professional standards and contributing to the development of social work.
Outcomes	Measure, evidence and communicate the difference social work makes in people's lives.
Co-production	Plan and deliver social work, including improvements in practice and services, in partnership with those who use our services.
Human Rights	We will uphold and promote individuals' dignity and wellbeing and respect and support their rights where this does not threaten the rights, safety or legitimate interests of others.
Social Justice	We will challenge discrimination, respect diversity, promote social inclusion and support fair and just policies, practice and decisions.
Professional Integrity	We will act in a reliable, honest and trustworthy manner and uphold the values and reputation of the profession
Ethical Practice	We will act with integrity and treat people with respect, compassion and empathy and comply with regulatory, employer and professional requirements where these are consistent with professional values

54. The Health and Social Care Workforce Strategy, *Delivering for our People* (2018) confirmed the reliance of social care services on the independent sector for the delivery of efficient and effective social care. It stated, "Lower pay, less favourable conditions, temporary or zero hours contracts and a perceived lack of recognition of their value to society, have all contributed to low morale and a high turnover of the workforce."
55. It is with the issues of workforce that the Reform Group is highlighting concern about the best way for DH to support care home providers and develop capacity. The initial plan was to develop a prescriptive model of 'who does what in a care home'. This is about the delegation of tasks undertaken in a care home by nurses and care staff. Care home providers and managers foresee problems with capacity and therefore cost. Most care tasks can be

[20] https://www.scie.org.uk/files/northern-ireland/hscb-a-strategic-framework-for-social-work-2017-2022.pdf (accessed 2 June 2020)

undertaken by capable and competent social care workers who are professionally trained and registered. There are clinical tasks in a care home that can only be done by a registered nurse, and these should be identified in resident's care plans. A prescriptive model is not personalised, takes responsibility from the provider and registered manager and does not make the best use of the knowledge, skills and abilities of either nurses or social care workers.

56. Provision of training for the workforce in care homes has always been the responsibility of the employer with their employees. In the same way the responsibility for training of care managers, undertaking assessment and planning, rests with HSCTs. It is the opinion of the IRT that prescriptive policy related to the roles and tasks of the workforce leads to bureaucratic procedures and narrow practice. The aspiration of DH social care workforce policy ought to be to enable imaginative and innovative practice with older people and their families. To that end it is pleasing to hear that the wider opportunities afforded by the involvement of the *My Home Life* Programme are being encouraged by DH. Many social care workers the IRT met were satisfied with this model of training and feel it really focuses on the individual.

Carers

57. Department for Communities' data reveals that over 200,000 people in NI have some form of caring role. *At February 2018:*
    - *The number of Carer's Allowance* claimants *was 73,350, a rise of 3,090 since February 2016;*
    - *The number of actual Carer's Allowance* recipients *was 46,820, a rise of 2,610 since February 2016. Of these, 32% were male and 68% female at February 2018…NI is lagging behind the rest of the UK in addressing carers' issues, in terms of both strategy and legislative development…The ongoing NI Reform of Adult Care and Support is the vehicle by which change should be forthcoming for carers in NI, from legislative, policy and service provision perspectives.* [21]

58. Spouses, relatives and others are the foundation of older people's care and support. The HSC Circular (ECCU) 2010, identifies underpinning principles concerning carers which include: *Ensure the provision of practical support to carers is a high priority;* [and] *integrate and co-ordinate the service user's journey through all parts of the health and social care system.* The Circular states that the Northern Ireland Single Assessment Tool (NISAT) was developed "primarily in relation to assessing the needs of older people." A Carer's Support and Needs Assessment is one of the seven components of NISAT.[22] It noted that the carer's assessment *should also be used as the "stand alone" carers assessment tool…The Carers and Direct Payments Act (Northern Ireland) 2002, places a statutory duty on HSC trusts to:*
    a) make information generally available in the areas about a carer's right to an assessment and in such a manner that carers in the HSC Trust's area have access to that information; and

[21] https://www.assemblyresearchmatters.org/2018/07/24/supporting-carers-in-northern-ireland/ (accessed 2 February 2020)

[22] Other components are: contact screening; core assessment; complex assessment; specialist referral; specialist summary and recommendations; and GP and medical practitioner report

b) *to inform individual carers, where the HSC Trust is aware that they are providing care, of their right to an assessment.*

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Effective service interventions require a close understanding of older people's individual needs and views and those of their relatives.
- ✓ Professionals questioned whether they were working in an effective and compassionate system given older people's experience of its processes and checks.
- ✓ Being "person-centred" and attentive to Human Rights are enduring themes in attempts to reform adult social care. However, in the context of transition to residential care, they remain to be realised.
- ✓ NISAT should be replaced with an assessment process which focuses on what a person can do as well as the areas they need help with. It should be devised in consultation with families, carers, care providers and care managers and other professionals.
- ✓ Families, carers and people who may be considering residential and nursing care should have access to independent advocacy and information to inform their decision making.
- ✓ There should be financial transparency about fees, the 'top-ups' payable and the contractual arrangements underpinning admission to a care home.[23]

Structure and systems

> *Millions of people worldwide have complex care needs resulting from multiple concurrent chronic conditions, functional and cognitive impairments, mental health challenges and social vulnerability. Illness has a significant impact on the lives of individuals, over and above managing treatments and medicines including social participation, relationships and societal contributions. Despite the growing numbers of people who present with complex health and social care needs, health systems continue to deliver care that predominantly focuses on one illness at a time or prioritises medically oriented care (management of disease and symptoms) over socially oriented care (attention to quality of life and social support).*[24]

59. Northern Ireland has had an integrated structure for health and social care services since 1973. The Northern Ireland Executive's *Programme for Government* (2000), called for "a public health strategy which maximises, across all sectors, our efforts to improve health and wellbeing and reduce health inequalities." The resulting strategy, *Investing for Health* was launched in 2002, and adopted a cross-disciplinary and multi-sectoral approach. A review of public administration followed that and resulted in a decision that the four Health and Social Services Boards would be dissolved and replaced by regional organisations to facilitate the

[23] See paragraphs 141 to 149 on the Charging for Residential Accommodation Guide (CRAG) and Financial Assessment

[24] Kuluski, K., Ho, J.W., Hans, P.K. and Nelson M.L.A. Community Care for People with Complex Care Needs: Bridging the Gap between Health and Social Care. *International Journal of Integrated Care*. 2017;17(4):2. DOI: http://doi.org/10.5334/ijic.2944 (accessed 2 June 2020)

strategy's aims. These decisions were given practical effect through *The Health and Social Care (Reform) Act (Northern Ireland) 2009*. This was introduced to reduce the number of organisations involved in the commissioning and delivery of health and social services, to maximise economies of scale and to improve outcomes for people. The legislation created the Health and Social Care Board, the Public Health Agency, Regional Business Services Organisation and the Patient and Client Council. Northern Ireland's public health system under the direction of the Department of Health is currently structured around:

- Five regional Health and Social Care Trusts with responsibility for the management and administration of regional health and social care facilities and services (the Belfast, Northern, Southern, South-Eastern and Western HSC Trusts) together with the Northern Ireland Ambulance Trust;
- the Health and Social Care Board, which commissions services, performance manages the HSC Trusts and deploys funding from the Northern Ireland Executive;
- the Public Health Agency, a multi-professional body which aims at improving and protecting public health and social well-being, reducing health inequalities and professionally assists in the commissioning process;
- and a number of other bodies including the Patient and Client Council, the Business Services Organisation, Regulation and Quality Improvement Authority and the Northern Ireland Social Care Council.

60. On 24 March 2016, the Health Minister announced that the Health and Social Care Board would be abolished with all commissioning powers transferred to the Department of Health and a new group established to hold the five HSCTs to account. Plans to implement the transition were underway but incomplete at the time the IRT met with those charged with leading on the changes. Work was advancing but was yet to be consulted on publicly or formulated into a legislative programme.[25]

61. Examining structures and systems in more detail sets the scene for the analysis of Assessment and Care Management. The current accountability framework of the Department of Health has five HSCTs[26] - providing health and social services on a geographical basis - via the HSCB. Among other bodies it has arms-length responsibility for RQIA (see Evidence Paper 3 on Regulation and Inspection), PCC and NISCC. The HSCB resides between the Department and the Trusts and (i) is responsible for governance and accountability of the HSCTs – including assessment and care management; (ii) has overall responsibility for commissioning services (see Evidence Paper 6 on the Care Home Market and Commissioning) through local HSCT commissioning groups; and (iii) it funds GP practices according to the numbers and types of patients registered. The practices are monitored through the Quality and Outcomes Framework. The HSCB works in partnership with the Public Health Agency, Integrated Care

[25] The drafting and checking of this Paper took place during the pandemic which itself will have caused delays to planned reforms. Consultation on the Reform of Adult Social Care opened on 26 January 2022 with a closing date of 1 June 2022. There are proposed actions in respect of care management.

[26] The sixth - the Northern Ireland Ambulance Service Trust operates on a regional basis and has a relationship with the HSCB as well as with the PSNI and the NI Fire and Rescue Service. It also has a Hazardous Incident Response Team.

Partnerships, GP Federations and those who represent doctors in practice. The HSCB promotes safety and quality in General Practice and assesses clinical outcomes through evidence gathering. The HSCB does not employ GPs as they are independent providers of services and are not partners or agents of the HSCB. GPs play an integral part in the care of an ageing population since the pressures on other parts of the health and social care system are resulting in a greater need for multidisciplinary working and innovation.

62. The five HSCTs have the status of Arm's Length Bodies ("ALBs") with their own Chief Executives and Boards. Assessment and care management are the remit of care managers (who are largely social workers, nurses and allied health professionals) employed by the HSCTs in community and hospital settings. There are differences between the HSCTs in the way the roles of a care manager (or keyworker) are carried out. Hospital social workers primarily support the discharge process and handover the role to community-based colleagues for longer term care management.
63. There have been a series of strategic frameworks - *Caring for People Beyond Tomorrow* (2005), examining the future of primary care, *Transforming Your Care* (2011), reviewing the future of health and social care and *The Right Time, The Right Place* (2014), by Sir Liam Donaldson, which focussed on health and social care governance arrangements. The Bengoa Report, *Systems not Structures: Changing Health and Social Care* (2016) found "an unassailable case for change." *Health and Wellbeing 2026: Delivering Together* was published in 2016, which closely followed the Bengoa report and translated those recommendations into a ten-year plan. This included investment in workforce, prevention strategies and tackling health inequalities and advocated co-design and co-production.
64. The *Transforming Your Care Review* proposed a new model of care with twelve major principles for change:
    - placing the individual at the centre of the model by promoting a better outcome for the service user, carer, and their family
    - using outcomes and quality evidence to shape services
    - providing the right care in the right place at the right time
    - population-based planning of services
    - a focus on prevention and tackling inequalities
    - integrated care – working together
    - promoting independence and personalisation of care
    - safeguarding the most vulnerable
    - ensuring sustainability of service provision
    - realising value for money
    - maximising the use of technology
    - incentivising innovation at a local level.
65. The HSCB works in partnership with Northern Ireland's Public Health Agency ("PHA") to commission services, allocate resources and improve services for all people of Northern Ireland. It has three functions:

- Arranging or 'commissioning' a full range of health and social services for the 1.8 million people who live in Northern Ireland.
- Performance managing HSCTs that provide services to the population and supporting service improvements to ensure optimal quality and value for money, in line with relevant government targets.
- Deploying and managing annual funding from the Northern Ireland Executive – currently around £4.5 billion – to ensure this is targeted according to need and reflects the aspirations of local communities and their representatives.

66. The Department of Health is responsible for the development of policies and standards. It ensures that there is professional advice and input across all branches of DH and related areas of government activity. Within the DH senior management there is a Chief Social Work Officer, a Chief Medical Officer and a Chief Nursing Officer who has responsibility for Allied Health Professions, of which there are 12. All three report to the Permanent Secretary who leads the DH and the Minister of Health has overall responsibility for the Department. The accountability for the care of older people spans several parts of the DH and is structured across the professional disciplines of medicine, nursing and social work. There is a policy branch called the Elderly and Community Care Unit[27] that deals with day-to-day enquiries and policy issues and a Professional Officer for Older People and Community Lead who works to the Deputy Chief Social Work Officer.[28]

Perceptions concerning services

67. Information, views and perceptions concerning services for older people were gathered. Although families did not specifically refer to structurally integrated provision in NI, people did reflect on the ways in which the five HSCTs work; their experience of accessing health care; and the promise of *Transforming your Care* and *Power to People.*
68. The *New Decade, New Approach* ("NDNA") is the 9 January 2020 agreement which sets out the priorities for the restored Executive and describes commitments to the people of Northern Ireland. Within the documents is the statement: *deliver reforms on health and social care as set out in the Bengoa, Delivering Together and Power to People reports.*
69. This is underpinned by pledges to reform public services and the civil service itself. A review of Arm's Length Bodies with a view to rationalisation and delivering a fair and compassionate society is promised. There is an emphasis on co-design and public engagement. The rebuilding of trust and making clear the accountability of ministers paves the way for a different and revitalised programme for Government.
70. On 31 March 2020, "Pivotal," a new public policy think tank, followed its reports, *Moving Forward - Putting Northern Ireland on Track for the Future* (2019) and *Good Government in*

[27] Structure changes during drafting have created a Care Homes Unit.

[28] In seeking to be pragmatic about nursing homes being able to supply an enhanced model of health care the IRT suggests that the care home system should retain its "primacy of home" foundation and seek personalised ways to meet people's differing social care and health support and treatment needs as they change. Care homes should not be allowed to become adjuncts of hospitals. The assessment system is at the heart of a holistic multi-disciplinary appraisal of need and consideration of how and where it can be met.

Northern Ireland (2020), by giving evidence to the Northern Ireland Affairs Committee. Pivotal's representatives expressed concern about the scale of the task and the need for prioritisation and capacity building. They observed: *several independent reports have set the need for radical reform. Little has happened in practice, although there were some signs under the previous Executive of an appreciation of the magnitude of change necessary*.

71. Although public services (health and social care) through integration have a long history in Northern Ireland, its benefits were not readily obvious to older people and their relatives:
    - *It was as if he didn't matter.*
    - *The information they shared about his health was entirely wrong!*
    - *I was not listened to about my Mum's likes and dislikes and I know her more than the professionals who think they know best and they do not.*
    - *Your Mummy cannot go home [from hospital]. She will be at risk and needs a care home.*
72. At the most basic level, the meaning of "the comforts of home" is determined by personal choice, income, memories and the variety of uses of our households. The different arrangements speak of the changing structure of families and of necessity. Few families described the readiness of Trusts to provide help to return older people to their homes at times when their comforts[29] were most needed. It is against this backdrop that the experience of older people being assessed and discharged from acute hospital care directly into care homes, without reference to what 'home' means to them, is pertinent:
    - *Someone has been to see me* [in hospital] *and asked me a lot of questions and I don't know why.*
    - *How can they say that he won't manage at home without even visiting his home?*
    - *It was terrible to see her distress. She was desperate to return home to her husband who needed her help. It was traumatic and sad for both of them. I still get upset just thinking about it.*
    - [A relative stated] *you cannot easily challenge the professionals. We have to do what we are told.*
73. These examples are remote from: a "whole system" approach; "patient-centeredness;" regarding older people and their relatives as equal partners; or even enabling older people to resume living at home. They did not result from comprehensive assessments and are not suggestive of multi-disciplinary working. However, the examples resonate with recent research[30] concerning the pre- and post-placement experience of older people moving into care homes. That is, older people are at the mercy of professionals. When 'step down' or intermediate care was raised, it was termed "a postcode lottery" by one family. Their relative had moved to her son's house to get better care. It is striking that families who had experience of intermediate care services[31] said that the focus of care was to get people out of hospital.

[29] https://www.ndti.org.uk/blog/the-last-homely-house (accessed 2 June 2020)

[30] O'Neill, M., Ryan, A., Tracey, A. and Laird, E.A. (2020) "You're at their mercy": older people's experiences of moving from home to a care home: a grounded theory study *International Journal of Older People Nursing* 15 (2) e12305

[31] Time limited services to promote recovery from illness, prevent unnecessary acute hospital admission, prevent premature admission to long term residential care, and to support timely discharge from hospital

One family said, "it was like a holding bay for the care home." It is noteworthy that admissions for 'step down' or intermediate care were perceived as a pathway to care home admission rather than a route leading back to the older person's home. Professionals considered 'step-up' or 'step-down', intermediate care or forms of rehabilitation as both ways of preventing hospital or care home admission as well as facilitating safe discharge back to a person's home property or to a care home.

74. The Kings Fund (2020),[32] outlined the pre-pandemic situation in England and reports the trends of increasing delays in transfers of care from acute hospitals and fewer older people receiving re-ablement services, for example.
75. A range of initiatives to enhance the health and wellbeing of older people at home have been developed across the UK. In Northern Ireland this has been typified by each of the five HSCTs adopting individual approaches as opposed to a collective one. The Institute of Public Policy Research (2010)[33] identified three drivers of quality in social care: a long-term funding settlement for social care; a "new deal" for the social care workforce to ensure social care staff are well trained, well paid and well respected; and an ethical commissioning charter to drive low quality and unethical providers out of the market. This could be applied to Northern Ireland.
76. More fundamental failings were revealed when the perspectives of hospital social workers, nurses and care home managers were considered:
    - *This is about quick discharges and not always about their medical condition. We would not see this happening like this in other age groups. Older people are being penalised and seen as a problem with blocking beds. We know that quick discharges lead to people being readmitted very quickly.*
    - *"Medically fit for discharge" means "free up a bed." It's difficult to challenge.*
    - *It's about numbers and not patients.*
    - *We can receive several calls asking us urgently to go to the hospital to carry out a pre-admission assessment. Staff from the ward will regularly ring and say, "it is urgent you attend."*
    - *We assessed this lady and the nurse described how she was: mobile with support, no particular health issues, responded to treatment for a chest infection. The person arrives at the home and she is not mobile* [and has] *several health issues so we were told information that was not correct.*
77. The Royal College of Nursing, NISCC and Unison confirmed that these comments reflected the views of their members working in the sector. These issues also permeated all their reports, surveys, research findings and submissions to consultations.
78. Six years after RQIA's[34] review of hospital discharge, its listing of "*the factors that contribute to poor quality discharges*" remains relevant:

[32] https://www.kingsfund.org.uk/publications/social-care-360 (accessed 2 June 2020)
[33] https://www.ippr.org/research/publications/ethical-care (accessed 2 June 2020)
[34] RQIA (2014) *Review of discharge arrangements from acute hospitals* Belfast: RQIA https://rqia.org.uk/RQIA/files/f6/f62f6f24-2b4c-4608-ade5-9747c5d48d3e.pdf (accessed 2 February 2020)

- *the timing of ward rounds*
- *the wait for diagnostic test results*
- *delay in referring for social services support*
- *organisation and management of medication*
- *availability of transport*
- *coordination of hospital and community-based services*
- *capacity and resource issues*
- *limited availability of transitional and rehabilitation places*
- *placement difficulties associated with care homes*
- *availability of a home care provider*
- *patient /carer/involvement/choice*
- *lack of engagement with patients/carers in decisions about their care*
- *limited availability and choice of care options*
- *ordering or availability of community equipment*
- *ability of community staff to respond to rehabilitation needs, including timeliness of response or level of input available* (p6).

79. It is disappointing that care homes have a low profile in the continuum of organisational and professional relationships – rarely featuring in strategic forums for example. The Independent Health Care Providers ("IHCP")[35] and other care providers, which were not members of the organisation, reported a lack of engagement on key initiatives; limited or no consultation on issues affecting the sector; and no established communication routes to report trends, concerns or to share innovation. Families highlighted the fragility or absence of care management and the challenges of working with homes' staff.
    - [Care home] *brochures did not tell us what we needed to know, such as how often can we visit? Can we be involved in the care?*
    - *When I walked into the care home there was a group of older people being entertained by a singer. I asked if my Dad could join them, he was on the nursing unit, and the nurse said, "No. He is nursing and does not need that." I was shocked as weeks earlier, when he was at home, he listened to music and enjoyed a sing song.*
    - *I always showered my Mummy on a Saturday but was told we could not do that due to health and safety.*
    - *I did not know from one day to the next who was caring for my Mummy. Because she was a quiet lady it seemed she was often left until last to go in for meals or to just engage with. Saying "We are so busy" is not good enough. She deserves more than this.*
    - *My* [relative] *was struggling at home and her needs were increasing. As a family we were struggling to manage the care and support. We rang the Trust late afternoon and no one called us back. We rang an out-of-hours number and were told it was not a situation they could deal with. We were directed to the out of hours GP. We rang them*

[35] A non-profit making organisation representing private, voluntary, charitable and church-affiliated providers of health and social care.

and were told they did not have the capacity so we just had to cope… what are we as families supposed to do?

80. The structural integration of services in Northern Ireland was not the result of an evidence-based evaluation of how best to meet the population's needs.[36] Forty years after the structure's introduction, it was noted that, "*Community care has been neglected, under-developed and under-funded…(p6) [and that] there is broad agreement among health and social care professions that integration has not been a marriage of equal partners*" (p16, Ham *et al*).
81. Health priorities have eclipsed those of social work and social care for adults and older people most particularly in terms of resources. In 2009, Heenan and Birrell[37] identified the requirements of full structural integration:
    - a higher profile for social care in the modernisation initiative
    - a joint initial training session for health and social care professionals to reinforce a culture of integration
    - a focus on outcomes for service users
    - a renewed debate on social models of care
    - the composition of the new bodies to reflect a more equal status between health and social care
    - a systematic programme of research and evaluation in integrated working to provide a robust evidence base.
82. The case for change was at the centre of the *Transforming Your Care*[38] and three factors underpinning this were the growing and ageing population, the increased prevalence of long term conditions and an overreliance[39] on hospital beds.[40] It confirmed that *there are many benefits associated with delivering care within people's homes and in their local communities*… (p21) [and that] *Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements... The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process* (p40). The review reported the findings of a Patient and Client Council's engagement concerning future priorities: *Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process* (p63). In addition, it was noted that *The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and*

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[36] Heenan, D. (2013) Northern Ireland. In C. Ham, D. Hennan, M. Longley and D.R. Steel, *Integrated Care in Northern Ireland, Scotland and Wales: Lessons for England* London: The King's Fund

[37] Hennan, D and Birrell (2009) Organisational integration in health and social care: some reflection on the Northern Ireland experience. *Journal of Integrated Care* 17 (5) 3-12

[38] Compton, J., Ham, C., Heenan, M., Rutter, I., Simpson, P. and Ennis, M. (2011) *Transforming Your Care: A review of Health and Social Care in Northern Ireland*

[39] It is understood that there is now funding for home-based intermediate care to reduce the reliance on hospital beds.

[40] Additional factors were clinical workforce supply difficulties and the need for greater productivity and value for money

carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas (p65)…*Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects* (p66).

83. Care Home providers and managers reflected on the increasing practice of 'monitoring' or 'inspection' visits from HSCTs. They found the reasons for the visits to be unclear with no reports provided. The approach from the HSCTs was to review the whole service which managers considered to duplicate the work of the RQIA. On occasions there were differing outcomes to that of RQIA leading to confusion in responses and hindering any conspicuous improvements. With reference to assessment and care management, the approaches of the HSCTs were variable. As a care home manager noted: *Everyone from the Trusts and RQIA think they know about how a care home works. The bureaucratic demands they place on us with no added value for residents or staff have taken time away from the real job of caring. It is demoralising and does not help with staff recruitment and retention.*
84. Care homes described a disjointed approach in accessing health services which led to difficulties in accessing specialist help and services such as Speech and Language Therapy ("SALT"), Occupational Therapy ("OT") and dietetic advice. In addition, accessing primary health care for care home residents exercised care home owners and managers. It was reported that contact with a resident's GP may result in the advice to take them to hospital,[41] even if there was no escort available from the home. As a home manager observed: *The resident is then in the care of paramedics and hospital staff. This means that older people who are unwell have no familiar faces who can support and reassure them and share information about their condition.* Care home staff say they contact the family who is expected to meet their relative at the hospital. Many care staff expressed their concern about the lack of escorts saying; *if RQIA or the Trust arrive at the home we would be criticised for not having enough staff on duty – there is no flexibility or understanding about the staffing levels and skill mix.*
85. The Northern Ireland Ambulance Service ("NIAS") confirmed the high number of avoidable attendances to hospital from care homes. It was reported by home managers: even if they assessed people as not requiring hospital admission, they had to do what was expected by HSCTs and RQIA and that is to report to the GP who frequently says to send the person to the hospital. Experienced nurses and care staff, sometime trained by HSCTs to support people in the home, say there are times when people do not need to go and could be observed in the home, but they are not trusted to make these decisions, even when it is in the best interests of the older person.
86. A care home manager stated: *this is a good example of how me as a care home manager is not trusted to make a decision about a person I know very well, we know we should arrange an escort as it must be frightening for an older person to go to hospital on their own but we dare not as we would be in trouble, some homes charge for an escort but I think this is also*

[41] Typically, during surgery hours

wrong it should be an integral part of care and we should be trusted – this shows the risk averseness being promoted by all Trusts and RQIA.

87. Care home staff acknowledged that there is nothing person-centred about such practice. The RQIA and NIAS engaged in a joint initiative to reduce hospital admissions from care homes and at the time of writing this report, the results have not yet reached the public domain.
88. The IRT confirm that the local GP role is important to a care home and the residents. They have a right to choose a GP or retain their GP if they will travel to the home. What can work[42] well is when GPs are paid extra to carry out weekly or fortnightly visits to the home and provide advice to the staff. Such an approach is likely to reduce unplanned GP callouts, A&E referrals and hospital admissions. Most GP practices have community nurses and they can take a lead role for a home with the GP responsible for requesting specialist services such as SALT, OT, and Physiotherapist. The care home manager can organise optician, dentist, chiropody and local pharmacy. Frequently people will have long-term community relationships with these specialists that they wish to continue.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ When families and older people contact the HSCTs for help and support the processes should be clear, timely and supportive. Understanding people's needs and preferences essentially involves understanding their home – the people, the relationships and the place – as the primary starting point.
- ✓ Structural integration of health and social care has not realised the benefits of holistic needs assessment, timely interventions, rapid responses to crises and investment in understanding people's needs and preferences.
- ✓ Funding should follow residents and contract oversight should be undertaken on a local basis by the host HSCT.
- ✓ The experience of older people, their relatives and professionals is suggestive of subservience of social care to health care.
- ✓ The availability of primary health care to care home residents requires attention.
- ✓ There is merit in a consistent yet local approach to GP support, in-reach nursing and specialist services to care homes. Each resident has a right to a local GP service.
- ✓ There needs to be more consultation on matters affecting the sector and methods of identifying trends and concerns so that knowledge and innovation can be shared across HSCTs, and with the IHCP and care providers.
- ✓ The HSCT escalation mechanisms to ensure more senior managers and the CEO are informed of identified problems should invoke methods of intervention that lead to solutions.

[42] Briggs, D. and Bright, L. (2011) 'Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs', Working with Older People, vol 15, no 1, pp 4-12.
At the time the IRT undertook its field work there were pilots underway for an enhanced GP service. Now there is a Northern Ireland Local Enhanced Service offering a 'proactive' approach to health care support. See https://hscbusiness.hscni.net/pdf/poldocmt.pdf (accessed 5 December 2021).

Section C: The processes of care management and assessment

Preamble

89. The next two sections consider firstly the processes of assessment and care management followed secondly by the roles and responsibilities of care managers. Both the processes and the professionals – social workers, nurses and allied health professionals - who carry them out are within the duties and responsibility of the HSCTs. For social work this is distinct from broader social care.
90. The Department of Health Circular (HSC ECCU) 1/2010, CARE MANAGEMENT, PROVISION OF SERVICES AND CHARGING GUIDANCE distinguished care management and case management. The distinction was referenced in discussions at working sessions and meetings attended.
91. **Case** management as set out in *People First* describes the activity included in the concept of advocating and co-ordinating services for individuals who have complex and/or frequently changing needs. It is the DH view that both definitions are captured within the whole concept of *People First*. Where a person has significant health or clinical care needs then the case manager is likely to be a nurse or allied health professional. Where social care needs are predominant then a social worker is likely to be the care manager. In practice the criteria for allocation may not be so clear cut with people both accessing social work, nursing and/or therapy support as well as care management. The HSCTs reported the care management teams comprise of social workers, nurses and allied health professionals. The term **care** management was the familiar term used by organisations and professionals during the meetings held by the IRT.[43]
92. A linear approach is taken here to describing the processes involved:
    - Information, advice and guidance
    - Advocacy
    - Assessments
    - Care planning
    - Care reviews

    The experience for older people and their families may not be so staged.
93. Assessment and care management arrangements are a cornerstone in implementing social care policy. The outcomes are about the quality of life of individuals, families and about the resilience and capacity of communities to support people with care needs to have meaningful lives at home and close to those who care for them. There should be a clear and unambiguous line of accountability between government policy and the deployment of public resources through to the actions of professionals fulfilling care management functions on behalf of the HSCT. The link of accountability between government, commissioners, managers and professionals should be plain for all to see.

[43] Such parlance was not readily used by families. One HSCT has reverted to calling "care managers" social workers or nurses. The term "keyworker" is being used to identify lead and coordinating roles.

Information, advice and guidance

94. An integrated health and social care service ought to decrease the likelihood of admissions to care homes being the result of assessing people's support needs at the time, pace and place most suited to them. Families described their contacts with HSCTs as typically involving protracted delays when promises to return calls were broken. Websites were not the "first port of call" for families because the information across the HSCT's websites is poor, difficult to navigate and largely health focussed. Some people rang Age NI and other charitable organisations, many just wanted to speak to a professional who could offer advice and help. At the IRT's first meeting with DMCH families, it was explained that not having information about how to choose a care home, the assessment process, funding arrangements and what potential residents may be entitled to, meant that they had to navigate "the system" unaided.[44] Although Age NI provides information and advice about care homes and community assessments, few families were aware of it.
95. *Power to People* proposes a social worker-led community navigator role. That is, if individuals are to have their own purchasing power then with the support of a navigator there would be an impetus for radical change. The reality is that the power of finance and information currently resides with the HSCTs
96. Information via the internet has improved during the time of the Review. NIDirect[45] provides comprehensive and clear public information. There are plenty of other examples in the region and UKwide such as *Which.*[46] What they all depend on is access to the internet, knowing how to use it and being able to do so at a time of crisis. Securing a place in a care home is sometimes known as a "distress purchase" with people feeling "at the mercy" of organisations and professionals.
97. Since family members may be senior citizens themselves, not all are familiar with or have access to the internet. Several families explained that if their relative was moving into a care home directly from the hospital, at least then they knew which was the funding HSCT. Families confirmed that the abrupt changes of HSCT employees without being informed about their replacements caused needless difficulties.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Where are older people and their families expected to find information about residential and nursing care?
- ✓ HSCT websites should include information specifically for older people about assessment, the work of care managers and care homes in their localities.

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[44] As highlighted by Competition and Markets Authority (2017) https://assets.publishing.service.gov.uk/media/5a1fdf67e5274a75088c4287/northern-ireland-short-summary-care-homes-market-study.pdf (accessed 2 June 2020)

[45] See https://www.nidirect.gov.uk/articles/care-homes-and-hospital (accessed 9 December 2020)

[46] See https://www.which.co.uk/later-life-care/care-services-directory?gclid=CjwKCAiAiML-BRAAEiwAuWVggl4Y1VCmUihpQEuIL6fjnSeUSG273WtlCxFs6dldGehp-HNxah0YtBoC_OwQAvD_BwE (accessed 9 December 2020)

- ✓ The language used, including job titles, must be understandable to older people and their families.
- ✓ HSCTs add to people's distress if they are unresponsive to requests for help and do not communicate changes in personnel to older people and their relatives.
- ✓ Families want to understand the financial implications of care home placements and to know which organisations may be of help.
- ✓ Evidence of good HSCT partnership working with residential and nursing homes was not forthcoming from most providers? Joint training and the creation of relevant community networks and forums offer a way forward.
- ✓ A strategic programme of engagement and "connectedness" with older people, families, communities and care providers must inform the change process.

Advocacy

98. The Social Care Institute for Excellence identifies four approaches to "non-instructed advocacy" which are relevant to care management:
    - *a rights-based approach - we all have certain fundamental human rights that can be defined and measured*
    - *person centred approach - based on the development of long term, trusting and mutually respectful relationships*
    - *watching brief approach - placing the person at the centre of thinking about the best way to support them*
    - *witness/observer approach: in which the advocate observes or witnesses the way in which a person leads his or her life.*[47]

99. The purpose of RQIA's (2016) review of advocacy services for children and adults in Northern Ireland[48] was to consider whether the principles and standards were being met as set out in the Policy Guide of 2012. It confirmed that *Independent advocacy plays a crucial role for service users and carers. It can support people who use HSC services to: articulate their views and wishes; secure their rights; have their interests represented; and influence the services they receive to reflect their own interests and preferences. Independent advocacy can mean different things to different people in different contexts. However, the following descriptions reflect the role of advocacy in a HSC context: "Advocacy seeks to support individuals to express and have their views heard. It aims to redress any imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised people" (*Bamford Review Report on Human Rights and Equality of Opportunity*).*[49]

100. With reference to commissioning advocacy services, the HSCB has responsibility for identifying the need for advocacy services and commissions some services through the regional contract. RQIA's review describes a regional social care procurement group ("SCPG")

[47] https://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/inclusion-empowerment-human-rights/types.asp (accessed 2 June 2020)
[48] https://rqia.org.uk/RQIA/files/d7/d79ff542-b906-4118-b56d-ac405f10d9f2.pdf (accessed 2 June 2020)
[49] https://www.health-ni.gov.uk/publications/bamford-published-reports (accessed 2 June 2020)

that provides advice to the HSCB about social care procurement. It also describes the selection procedure for commissioning services.

101. In 2016, there were two agencies providing advocacy services for older people and their carers, both in the Southern HSCT; and two for older people in the South Eastern HSCT. The majority were for people with learning disabilities and for people with mental health problems. BHSCT advised that they have a long-standing contract for advocacy with the Alzheimer's Society and that they commission advocacy from other groups specific to individual need. As far as the IRT could determine, the remaining HSCTs had no advocacy provision for older people.

102. RQIA found that the contracts for commissioning advocacy services were focused on outputs rather than outcomes and recommended outcome-based advocacy provision. It concluded that the range of advocacy services had not substantially changed since 2012, noting *a lack of regional information available to inform current practice and future requirements*.

103. There was no evidence of any advocates being used to support residents and families at DMCH. Some residents had neither relatives nor friends to act on their behalf.

104. The Patient and Client Council states that its advocacy service will:
   - *Give you information on how to complain and who to complain to*
   - *Help you write letters of concern*
   - *Make telephone calls for you about your concern*
   - *Go with you to meetings about your concern and make sure you are responded to*
   - *Work with health and social care organisations to improve services as a result of your concern.*[50]

105. Many families were unaware of the full role of the PCC with social care and believed it to be a signposting service because it did not resolve their concerns and directed them elsewhere. There is scope for the PCC to explore with older people and their relatives how independent advocacy should be given expression in a refreshed complaints system.

106. Age NI is the leading charity for older people in Northern Ireland. Its Advice and Advocacy Service has a freephone; it produces fact sheets about Care Needs Assessment[51] and Adaptations and equipment to make home tasks easier,[52] for example; it has identified over £1m in unclaimed benefits for older people; its Policy and Engagement team listens to and represents thousands of older people; and many of its volunteers are older people.

107. COPNI provides assistance to individual older people who need advocacy or legal support so long as it does not duplicate the work of another public authority. However, where an older person is having problems dealing with a public authority the Commissioner can advocate on their behalf.

108. During the Review, the work of several other organisations was shared, for example, the Association for Real Change NI (ARC), the Alzheimer's Society, Action on Elder Abuse NI and

[50] https://patientclientcouncil.hscni.net/advocacy/ (accessed 2 June 2020)

[51] https://www.ageuk.org.uk/northern-ireland/information-advice/care/social-care-and-support-where-to-start/care-needs-assessment/ (accessed 2 June 2020)

[52] https://www.ageni.org/pages/category/bathroom2020)ireland/search/?q=Adaptations+and+equipment+to+make+home+tasks+easier (accessed 2 June 2020)

Marie Curie in Northern Ireland are all active in public education, advice, policy making and training and have resources to assist. Families reported positive experiences and appreciation for their work, even though they are constrained by resources and meeting needs that exceed their capacity. In implementing the outcomes of this Review, the role of the charitable and voluntary sector must be factored in and consideration given to funding projects and schemes that support the required outcomes.

109. For example, it is understood that several of the families of older people living at DMCH[53] are developing a voluntary organisation to support families when their relatives move into a care home. They are using their experiences to support people with issues and concerns with the HSCTs, RQIA and care homes. The number of contacts received by the organisation appears to be growing quickly which suggests demand for the type of support offered by people who have had personal experience of the system.

110. In the light of *the shortcomings in the current complaints and redress systems*, the Competition and Markets Authority's short summary report[54] recommended that *the Northern Ireland Executive…review the coverage of advocacy services for care home residents.*

111. Care home managers accept that there is insufficient advocacy provision for older people, most particularly when needs assessments are undertaken by care managers and care home managers.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Advocacy intervention should be considered at every stage of the care management and assessment process, particularly where older people have few relatives or friends.
- ✓ Family relationships are a high priority for most older people. They would expect the knowledge and experience of family and friends to be reflected in their needs assessment.
- ✓ Supported decision-making may be facilitated by advocacy, most particularly when older people are referred to care management.
- ✓ The PCC is well placed to provide a professional independent advocacy service for older people.
- ✓ Care home managers should be able to access direct advocacy for residents.
- ✓ RQIA inspection reports of care homes should provide commentary on residents' support by advocacy services. This could be reflected in annual reports in terms of general effectiveness and impact.
- ✓ Greater engagement with the charitable and voluntary should be developed and their contribution to the care of older people recognised.

[53] DMCH families' group, which was active before and during the Review fieldwork, has now changed to CHASNI (Care Home Advice, Support NI)

[54] https://assets.publishing.service.gov.uk/media/5a1fdf67e5274a75088c4287/northern-ireland-short-summary-care-homes-market-study.pdf (accessed 2 June 2020)

Assessments

People First

112. Assessment is a purposeful activity. *People First*[55] remains the Northern Ireland government policy in place for adult social care and clearly sets out the policy expectations and objectives as to the purpose of assessment for community care services. Emphasis is placed on individualised approaches to the provision of community care which is responsive to individual wishes and needs in the context of their personal, family, social and community lives. Thereby equipping people to live "full and independent" lives supported by well-coordinated responsive services tailored to their needs and arranged by professionals responsible for assessing, planning and putting in place care services.
113. The purpose of comprehensive assessment set out in *People First* is to "decide on the best means available to help individuals and their carer. It should focus positively on what people can and cannot do and can be expected to achieve taking account of their personal and social relationships. It should not focus only on the person suitability for particular services." [para 4.8]
114. *People First* placed central importance on responsive, flexible and enabling individualised care planning. The decision to move into a residential or nursing care home is described in policy as an important and significant transition necessitating comprehensive assessment and case management. Critical to this is an obligation to carry out a positive enquiry appraisal of the individual and their families wishes and choices, and an evaluation of how they can be supported to remain living in their own home or to return home.
115. "The procedure for comprehensive assessment should always be activated when the decision to be taken is whether the client should move on a permanent basis from his or her home into some form of continuing care or back from such care to an independent lifestyle. One purpose of comprehensive assessment in these circumstances is to establish whether a co-ordinated package of care would enable the person to go on, or revert to, living at home. Such a package may include health and personal care, emotional support and help with mobility. Domestic task, financial affairs, accommodation, leisure, education, training and employment." [People First Care Management: Guidance on Assessment and the Provision Community Care, Para 7.46.6]
116. "The principle of ensuring that service provision should as far as possible preserve or restore independent living must always be paramount. This implies an order with which the suitability of care packages should be considered: A package to support the person at home, living aids and adaptations as necessary: A package including move to sheltered or other forms of special needs housing: Residential care: Nursing home care: Continuing care in hospital." [People First Care Management: Guidance on Assessment and the Provision Community Care, Para 8.5]
117. "For many people entering a residential care or nursing home will mean moving permanently from their own home and neighbourhood where they may have lived for a long time. This can

[55] See https://www.health-ni.gov.uk/publications/people-first-literature (accessed 11 June 2021)

be a difficult step. Subject to the availability of resources people should be able to exercise the maximum choice about the home they enter and its location which need not be in the area of the Board making the arrangements. The preferences of relatives and carers should also be taken into account."[para 6.19]

118. In contrast the IRT heard that when families contacted the HSCT for support with their older relative they sometimes did not get a response or there were long delays and then rushed decisions made by professional staff. There was a general concern from many families about the referral system, ascertaining how it works and who takes the initial calls and how are these triaged. Many families said: *we did not know how it worked… we felt not listened to… it seemed to take ages.* Rather than prevention and early support some families were left with difficult situations becoming critical before any initial assessments were started.

119. Clarity is needed for the public on how they make contacts with the HSCTs. The first responses to people requesting support sets out the basis for future working relationships. Getting this right is critical to the best use of time, expertise and money of everyone involved.

The approach to assessment - needs or services

120. A strength-based approach will always prioritise what matters to the older person and their family. It hinges on supportive senior managers and professional leaders and their readiness to engage with older people and their families. In contrast, a deficiency-based approach hinges on health diagnoses and custom and practice, for example, *dementia,* or the use of descriptors as *fully dependent.* Older people's relatives understand that treatment based on such incomplete descriptions is ineffective.

121. *The Senses Framework: Improving Care for Older People through a Relationship-Centred Approach* [56] identifies six senses which are fundamental to wellbeing: security, belonging, continuity, purpose, achievement and significance. Similarly, *My Home Life*[57] underlines the rights of older people to retain their personal agency, dignity and control regardless of age and health status. Although many social care staff were familiar with these approaches, achieving change must break with custom and practice and incorporate engagement, mediation and negotiation.

122. Families and professionals advised that assessments are mostly very brief and generally about people's physical health needs and activities of daily living. Some required tick-box information. Rarely did they feature information from older people and their families. Although self-assessment has promise in enabling older people to manage and identify their

[56] *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice* (GRiP) Report No 2. Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/280/; (accessed 4th September 2019)
Nolan, M. Lundh, U., Grant, G. and Keady, J. (Eds.) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press McGraw-Hill Education, 2003

[57] See https://www.myhomelifeni.co.uk/ (accessed 16th July 2019). My Home Life is an initiative to promote quality of life for those living, dying, visiting and working in care homes. In Northern Ireland the programme is led by the team at Ulster University in partnership with Age NI and Independent Health Care Providers ("IHCP"). The programme reinforces community and transition as well as improving healthcare and promoting a positive culture. It undertakes research, practice development and supports shared decision making

own health and social care needs,[58] it has not gained a foothold in Northern Ireland. Whilst discussing assessments with families many concurred with an expressed view that: *we need to be involved and write the personal information about our loved ones.*

123. Arguably discussion about risks has supplanted considered and inclusive assessments. Families reported that the claim, *Will be at risk at home,* was used to justify a care home placement. However, with no evidence that people's own homes had been risk assessed by professionals, the claim is without foundation. A patient in her 90s wrote on a hospital form '*I want to go home.'* It was not acted on.

124. Care home managers have a clear legal responsibility as stated in both The Residential and Nursing Care Home Regulations (Part 111 Conduct of the Care Home Regulation 12 and Regulation 15 Assessment of Residents). 15 –

(1) The registered person shall not provide accommodation to a patient at the nursing home unless:

a) the needs of the resident have been assessed by a suitably qualified or suitably trained person.
b) the registered person has obtained a copy of the assessment
c) there has been appropriate consultation regarding the assessment with the patient or representative of the patient as appropriate
d) the registered person has confirmed in writing to the patient that having regard to the assessment the nursing home is suitable for the purpose of meeting the patients' needs in respect of his health and welfare
e) the nursing home has been registered for the category of nursing appropriate to the patients' needs

(2) the registered person shall ensure that the assessment of the patients' needs is

a) kept under review and
b) revised at any time when it is necessary to do so having regard to any change in circumstances and in any case not less than annually.

125. It is the care manager who coordinates the multi-disciplinary assessment of needs and the care home manager who assesses whether the need can be met at the service.

126. Having some health care needs does not signal the necessity of nursing care either for residential home residents or for older people living in their own homes. Older people living at home can be and are supported by domiciliary care and community health support workers. During the Review it became apparent that older people living in care homes do not always have access to the full range of community services. "Primacy of home" is a principle which means that people living in a care home should receive health services based on need and not on setting. Many professionals feel that a recovery model for older people living in care homes involves people taking positive risks whereas the health support systems rarely consider such possibilities. The approach created is risk averse. Care plans are based on

[58] Griffiths, P.D. and Harris, R. (2005) *Self-assessment of health and social care needs by older people: a multi-method systematic review of practices, accuracy, effectiveness and experience*. Report for the National Coordinating Centre for NHS Delivery and Organisation R&D (NCCSDO)

maintenance rather than rehabilitation of skills. Adopting the principle of "primacy of home" in practice will lead to extra care housing or housing with support being the preferred model of provision (See Evidence Paper 6). A policy development step along the way is to reshape care homes as accommodation with support and care or assisted living.

127. How is the need for nursing or residential care determined? The IRT was told of criteria such as: *needs two people to lift the person; needs to two people to bathe; needs help with eating; needs to be looked after in bed.* In contrast, *if a person is continent and mobile then they are residential.* These are not credible eligibility criteria. Many people with complex health conditions and disabilities receive support and care without the need to move home. Physical relocation, whatever the purpose, threatens people's health and well-being.[59]

128. The criteria for residential and nursing care home hospital discharges were described as similarly problematic: *It is a lottery. There is no consistency across Trusts. When you hit November and winter crisis, all policies and procedures go out of the window.* The assessment tools used to assess people's daily living activities differ across homes and are associated with establishing a home's staffing levels. DMCH used the Rhys Hearn Dependency Tool, for example.[60] Since such tools are limited to identifying physical care needs and specialised nursing needs, they omit the likelihood of recovery or the support required to enable recovery. The Northern HSCT uses a Community Nursing Assessment which addresses the management of mental dysfunction; management associated with medical condition and wound care; moving and manual handling; and mobility. The scoring reflects a person's independence and whether assistance is required in certain areas. Social workers reported that on the basis of such assessments, they are expected to find alternative places for people who are settled in residential homes but became unwell and were deemed as "needing nursing." As one person noted, *It is so wrong*. W*hy would anyone want to move from their home and then be made to move again?*

Case and/or care management

129. The *People First* guidance supports the role of the case manager, over time this has become synonymous with the job title and job role of the care manager. It describes a relationship-based role setting out the paramount importance of case managers establishing a "caring and supportive relationship" with the service user. The expectation is the case manager will support the individual to have their personal needs met through coordinating and leading assessment processes, by identifying options for care and though effective multi-professional and multi-agency working.

130. The approach is a systems theory informed one that seeks to understand the individual within a system of formal and informal community resources. Individual choice and understanding of personal capabilities are promoted. What care and support can enable individuals to achieve, to strengthen and to build on, is reiterated throughout the guidance document.

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[59] See for example, Jolley, D., Jefferys, P., Katona, C. & Lennon, S., (2011) Enforced relocation of older people when care homes close: A question of life and death? *Age and Ageing* 40, (5), 534-537

[60] https://pureadmin.qub.ac.uk/ws/portalfiles/portal/141349141/Safe_Staffing_Review_Manuscript_Accepted_Version_2_.pdf (accessed 2 June 2020)

131. Case management is intended to be to be an individualised, attuned, responsive, supportive relationship between the case manager and the individual service user and their family and carers. It is important that attention is paid to the quality of this relationship as well as to role functions of the case manager as the relationship supports the effective delivery of the key role functions:
   - Exploring and understanding personal circumstance, choices and coordinating the holistic assessment of needs.
   - Evaluating the outcome of the care plan, including the provision of social and occupational activities, evaluating how needs are being met, responding to changing and emerging needs over time.
   - Coordinating and brokering the relationship between the individual and the care and support systems including providers, professional, multi-agencies, formal and informal resources
132. This will mean forming and sustaining enabling relationship with individual residents living in care homes and with their families. It will involve observation, exploration and enquires with individuals as to their experience of care, as well as about the quality of their life and wellbeing. It will involve case managers being sufficiently knowledgeable, experienced and skilled to identify and evaluate what is working well in respect of the delivery of the care plan to each individual as well as what may need to change or be adjusted. It will involve being able to respond effectively and make a professional determination about a range of presenting issues which may include issues of risk or the quality of care. An imperative of this is case managers having a clear understanding of their role and accountability including limitations of this in relation to raising issues of quality on behalf of individuals, in supporting people to make complaints, or in identifying, assessing and - where necessary - escalating risk.
133. The role might reasonably be expected to include:
   - Demonstrating attention to the individual, actively taking account and seeking their views about the delivery of the care plan. Openness/ Enquiring? How is the care here for you?
   - Alerting Raising /bringing issues, enquiries to attention of care providers.
   - Advocating on behalf of individuals for improvement in quality or experience of care.
   - Supporting/ empowering individual / families to make complaints or raise a concern.
   - Establishing and maintaining effective working relationships with care providers.
   - Working collaboratively and collectively with individual service users, families, care providers, other HSC professionals and agencies to agree and improve the outcomes of the delivery of the agreed care plan for individual.
   - Reviewing outcome of care plan and evaluating impact of care including impact of poor or substandard care on individual
   - Appropriately escalating issues within their own line operational and professional lines of accountability

- Raising issues of risk or harm or poor or substandard care with a range of agencies and professionals who are responsible and accountable for the delivery of the agreed objectives of care plans to individual service users.
- Exercising professional judgment in identifying and managing risk in line with agency and HSC policy, procedures including Adult Safeguarding policy.

134. The role of the case manager is about supporting and caring for the individual, actively promoting the individual and their family in assessment, in care planning and in developing enabling options for care which supports their choices, wishes and individual needs. It is not clear in policy that there is any role for those carrying out care management and case management in monitoring the operational delivery of care by agencies.
135. Case managers, who are well informed about the personal needs, choices, wishes and circumstances of individuals who may be at risk of harm, are able to evaluate issues of adult protection. They do so in a context of identifying, assessing and managing risk and balancing rights-based decision making.

Northern Ireland Single Assessment Tool

136. During 2009, the Health and Social Care Board (HSCB) accepted responsibility from the DHSSPS for the ongoing implementation of the Northern Ireland Single Assessment Tool (NISAT). In 2016 and 2017, it produced Procedural Guidance (NISAT version 4). The document's preface stated, *The HSCB is fully committed to the concept of a tool which optimises inter-disciplinary cooperation and improves the experiences for patients and clients by minimising replication of assessment and promoting more consistent practice.*
137. The most recent, fourth version of the guidance document[61] is 83 pages. The IRT was told that the purpose of the NISAT is not being realised; and that the risk anxiety concerning people remaining in their own homes accounts, in part, for care homes being the default service. Hospital social workers described the NISAT process as:
    - *Conveyor belt of decision-making based on medical assessments alone*
    - *Almost always lead to decisions about a person, not with them*
    - *Decisions are more about the needs of staff and organisations than those of the patient*
    - *Families are often not involved in the initial admission assessments with social workers and care home staff – it's due to time. There is no time.*
138. Care home managers described urgent requests from hospitals to undertake pre-admission assessments. Assessment is jeopardised by withholding critical information concerning a patient's support needs citing "data protection." *We were told information that was not correct.* Incomplete and reactive assessments omitting personal information, including family involvement, undermines the process. Rarely did harm/benefit analyses feature in assessments. The care home managers were unaware of arrangements for checking and finalising assessments. This is remote from the HSC Circular's (1/2010) caution that, *All HSC staff should be aware that assessments carried out before individuals have had time to*

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[61] https://www.health-ni.gov.uk/publications/northern-ireland-single-assessment-tool-and-guidance (accessed 2 June 2020)

recuperate or rehabilitate from illness or a stay in hospital will not always be able to accurately determine their potential to improve or their capacity to cope at home. Some families reported that their relatives' temporary delirium resulting in diagnoses of "probable dementia" led to nursing home placements. This echoed the experience of some DMCH residents diagnosed as having cognitive challenges. They were not believed when they reported harms.

139. The care home manager or senior person is required to carry out a pre-admission assessment of a prospective resident to ensure that the home can meet the persons care and support needs. It was gathered that pre-admission assessments are not always carried out. Gathering verifiable information when assessing an older person in a hospital ward is rarely feasible. Hospital social workers confirmed that this was because they do not always have the time to meet with care home staff. Other blind spots concern the failure to involve the older person and families. Care home staff agree that ideally, they should undertake pre-admission assessments in hospitals when families can be present and older people must be involved. This would require prioritising and timetabling. As home managers noted,
    - *We spoke to the ward staff and visited the older person. What are we to do? We always have to rush this work because the hospital wants the person out quickly.*
    - *We have to do these quickly as the hospital demands it, at times they want us to go the same or next day.*

140. Comments were received from families, care home staff and hospital social workers questioning the terminology 'medically fit for discharge'. They suggested that this was not always the case and older people were being discharged early to clear the beds. Care home staff stated that when some older people arrive at a care home their physical and overall conditions were not always as described. Sometimes they were still very poorly. When this is the practice, it can undermine multi-disciplinary teamwork. At worst it reduces the care management task to that of placing people directly into homes.

Charging for Residential Accommodation Guide (CRAG) and Financial Assessment

141. The HSCT must carry out a financial assessment to work out how much someone should pay for care home fees. They must follow regulations that are explained in the guide.[62] There is usually an upper limit on how much the HSCT will spend on a person's care home fees. This is referred to as the 'standard rate.' Often, families were provided with a list of care homes in the area that they would fund and advised people to ring up the homes. The HSCT has a duty to meet a person's assessed care needs. Therefore, if those needs could only be met in a more expensive care home than the HSCT would normally pay for, it is obliged to fund the person in that home. This was rarely explained to families and only after challenging the HSCTs did families receive answers to questions about funding people with more complex support

[62] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/charging-for-residential-accommodation-guide-crag-2015.pdf (accessed 2 June 2020)

needs. Many families reported problems. One family said they were tired of "being shunted around the system and feeling as if we were all drowning."

142. 'Top-up' fees set by care home providers are controversial. Families objected to the term 'top-up' and in many cases believed that they were in a position where they were funding care that should have been available within the standard rate. When the HSCT agrees to fund a place in a care home and the provider requires a "top up", there is a requirement for a third party – such as a relative or a friend – to pay the addition. This is referred to as a 'top-up' fee. The CRAG states that the older person cannot pay the 'top-up' fee themselves. The HSCTs may ask the third party to pay the 'top-up' fee to them, or directly to the care home. This causes problems for families who want their relative to be cared for in a specific home. It is difficult to understand why older people may not make these payments themselves.

143. Many third sector, charitable and voluntary agencies expressed concern about the resulting injustice. During workshop sessions it was opined that the rules were there "to make sure too many people didn't end up in the position where they were eligible for fully funded care by reducing their own savings." An alternative view is that rule was put in place to protect people from spending their money unwisely. A rule that needs changing for people with capacity to choose how they spend their money.

144. The HSCT has a contract with the home which, in turn, is expected to have an agreement with the resident. The IRT was unable to view any of the agreements between DMCH and individuals. A format of "tripartite agreement" where the Regional Contract has a personalised section appended based on the individual's assessment and care plan do not exist. People have a right to know what service to expect both generally and personally to them.

145. Many families are unaware of the Regional Contract between the HSCT and care home providers. Often residents and families did not see or sign any of the agreements with the financial arrangements not being apparent. The only document families signed were the 'top-up' agreements – an approach that requires attention as there is the potential to withdraw security of residency. It is the case that when older people move to a care home, they and their families expect this to be a home for life. Agreements, contracts and care plans should reflect this.

146. Inconsistency and variability in contracting arrangements was uncovered. Information was received about people having to move homes. These were mainly around the registration category issues and what were described as evictions. These seem to be where families complain, where a service cannot meet a person's needs and a few cases related to behaviours.

147. No cases were brought to the attention of the IRT where a person was required to move for financial reasons – although the potential exists if a 'top-up' agreement is breached. 'Top-ups' are optional – if a care home that can meet assessed need at the regional tariff is available - but at times families believed they had to pay them – particularly if they wanted the home of their choice. There are few homes without a 'top-up' system. One that is not perceived to be

working well by families, care home providers or HSCT staff. As it can be difficult to assess the time that will be spent in a care home, some families felt this to be unfair.[63]

148. Families with experience of their relative having to move home were upset and distressed, most commonly, by the lack of consultation. All care homes must be able to meet a person's assessed needs at the point of admission. If there is a necessity to move homes – for whatever reason - it is likely to involve a reassessment of need.

149. Families were often unaware of the financial implications of their older relative moving to a care home. Typically, financial assessments are completed after the admission. Several families recalled that the only form they signed was the 'top-up' agreement form. HSCT staff expressed concern about restrictions placed on the individual and their family in the use of personal money and specifically the arrangements which do not allow residents themselves to contribute to 'top-up' fees.

Care home categories

150. Families described how lack of information about care homes has led to discharges from care homes for their older relative when they thought it would be a 'home for life'. Care Home providers challenged the changes in how registration categories are applied as being harmful for older people.

151. Professionals and families confirmed that a care home's registration categories can mean that if an older person develops a health condition, then they must physically move from a residential to a nursing home or from a 'residential bed' to a 'nursing bed'. This move is integrally linked with the issue of registration categories and the changes that have been made in how they are applied.[64]

152. Evidence Paper 3, Regulation and Inspection, extensively covers the issue. In brief, prior to the Review, RQIA had changed how it applied the registration categories of Nursing and Residential Homes. Families and care home managers described the detrimental effect of these changes. They led to older people being moved out of residential care homes that they had lived in for many years to nursing homes or from 'residential beds' to 'nursing beds' in a different part of the home. One manager recalled the implications for a woman resident. She was in her *late eighties* [and had] *lived with us for eleven years in the same room. She was very settled and it truly was her home. She had no close relatives but was comfortable with her friendships with the staff. She developed an acute condition and we were alarmed when we were told she had to move to a nursing bed. We argued on her behalf that she had chosen the room and it was her home. We were then told by RQIA she had to be moved. She did not want to move to a room on the nursing unit. We were then told legal action would be taken against the home and that* [it would] *become public. We moved her to a room that was very different. She became withdrawn and very low. She died very quickly after that move. This is*

[63] Sufficient anecdotes were heard about 'top-ups' to raise concerns about checks, balances, accuracy and irregularity in the charging/fee arrangements of both some care homes and HSCTs. These are considered more fully in Evidence Paper 6.

[64] It is noteworthy that the position in Northern Ireland differs from that applicable in England, Scotland and Wales.

about a system and process and not about people. It was okay for RQIA to get registration categories wrong for many years, but why penalise older people? No one from the Trust stood up for [her]*. We were the only people who stood up for her rights. It was not enough. We all failed* [her]*. How can this be right?*

153. These changes to policy implementation result in confusion of assessment of need with assessment for a service. It is not acceptable that a resident's stay in a care home can be terminated because of changes in how a policy is applied. The Evidence Papers include proposals for 'tenure agreements' that provide rights and control for the individual person for good reasons, this being just one of several. People should not be made to fit into a service that is available, nor should their life be dictated by a registration category. A principle of 'primacy of home' demands that services go to people where they live and implies an end to the current model of registration categories.

Summary

154. Assessments should involve getting to know a person and understanding how they and their family see their support needs. These must provide the pivotal basis for the care manager's engagement with health and social care providers, including domiciliary care, and housing providers, for example.
155. There is more to assessment than identifying physical and clinical needs. Wherever assessment takes place, it is important that it is linked to negotiated interventions. For people moving from hospital, this should be a discharge pathway designed to meet the needs of the older person.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Intervention in the lives of older people and their families during times of illness and life change must be led by initial and ongoing assessments.
- ✓ Assessment seeks to understand a person's health and cognitive status, their environment, relationships and the choices, decisions and actions they would like to happen. On this basis a negotiated outline care plan is developed.
- ✓ There should be consistent assessment practice across the HSCTs. DH should adopt an inclusive, personalised and strength-based assessment model, where older people and their families actively contribute. The model should permit people and their families to write aspects of the assessment themselves and facilitate self-assessment.
- ✓ Hospital social workers, nurses and care home managers should be supported to resist the pressure from hospitals to undertake quick assessments, most particularly since these are instrumental in determining placement in either a residential or nursing home. They are under a positive professional duty to advocate for older people and act in their best interests.
- ✓ Assisting older people and their families to better understand financial arrangements – to know what they are paying for requires improving as an important part of assessment. There should be a duty to check families' understanding of financial

arrangements prior to discharge and subsequent checks to ensure that a sustainable financial model has been devised.

- ✓ Assessment records are not consistently reliable information sources. This must be remedied through multi-disciplinary cooperation, agreed regional and professional standards and with the resident, family and care home staff and provider involvement.
- ✓ Community needs planning would be enhanced by valid information from assessments and the outcomes of these.
- ✓ The need for data to support this process and to identify trends has been emphasised by the HSC and independent provider sectors.

Admissions

156. Information about people relocating into care homes from acute hospitals and from their own homes is not readily available. Care home managers stated that the most typical referrals for care home placements are from hospitals. The responsibility for identifying a home was delegated to families who described the experience as distressing, rushed and made even worse because of inadequate information. Although some families were able to visit a couple of homes, there was no opportunity to make considered decisions.

157. Many families recalled that they did not meet the DMCH manager(s) or that introductions took place several weeks after admission. One family described their experience of arriving at the home, finding that they were not expected and that the room was not ready. "This was so upsetting and just meant we had a terrible start." It was rare for discussion to be invited. Thus, the opportunity to establish and build relationships with families was delayed or overlooked altogether. This was at a time when families themselves were helping their relatives adjust to relocations about which some had had no choice. Families were unaware of what life in the home would be like or how the staff teams worked, for example.

158. Moving into a care home is a profound transition in people's lives. Although older people appeared mostly passive in the process, for some it appeared to represent a relief from uncertainty about being able to manage in their own homes or from considering themselves a burden on family carers. There appeared to be reluctance to initiate discussions about the move with older people themselves. The absence of a standard professional approach is stark:
    - *We are working to a care management circular from the 1990s which has not been systematically reviewed or audited and requires fundamental updating.*
    - *We are under pressure to undertake pre-admission assessments very quickly.*
    - *There's no basic information for residents or families*
    - *Full assessments are rarely completed*
    - *Are 'top-up' fees being used by some providers to make up for the insufficient levels of fee payment from HSCTs? Families feel that they have no choice but to make the 'top-up'?*

159. Even in retrospect, some families questioned the fact that non-specific risks may determine a care home placement without any discussion. There appeared to be confusion between hazards and risks – a hazard can cause harm and a risk deals with the likelihood of harm *or*

benefit. Some hospital workers felt it was important in some situations to attend the first care review so they could actively share their information with the care home:

- *Professional responsibilities need clarification - why do we need to attend bed state meetings?* [65]
- *The handover of individual cases from hospital social work to the HSCT care management teams needs to be strengthened. Hospital social workers should receive feedback about the outcomes of patients' discharges from hospitals.*
- Some hospital social workers believed *It is important in some situations to attend the first care review so we can share their information with the care home. It is a very rare occurrence.*

160. The following *practice implications* from the aptly named study, *You're at their mercy*[66] underline the importance of ensuring that assessment and care management are coordinated and consistent across Northern Ireland.
    - *There is a need to standardise approaches and develop person centred interventions to support older people considering a relocation to a care home and all professional staff have a key role in making this happen*
    - *If an older person has no family to support them then an independent advocate is appointed to support them*
    - *There must be opportunities for older people to be supported in the relocation and closing their own home and choosing what they want to take with them to the care home*
    - *There must be a change in how older people are moved to care homes and reduce the rushed nature of these activities to avoid the long-term emotional distress for the individual*
    - *Best Practice policy directives on moving to a care home should include the development of auditable guidelines to include equal access to health and social care services post transition*
    - *The Human Rights Commissioner and the Commissioner for Older People need to be involved in how older people are moved to care homes to be satisfied that all their rights are being upheld*
    - *The My Home Life work is essential in supporting overall improvements and future studies. This could include supporting and empowering care home managers and care managers, social workers and nurses of their role in admissions to care homes and their role in helping older people to close one part of their life in the right way that helps them to adjust to living in a care home.*
    - *The study could then be repeated in the future to check out improvements.*

[65] These meetings evaluate bed capacity and availability and identify the patients who are ready for discharge

[66] O'Neill, M., Ryan, A., Tracey, A. and Laird, E.A. (2020) "You're at their mercy": older people's experiences of moving from home to a care home: a grounded theory study *International Journal of Older People Nursing* 15 (2) e12305

- *Changes are needed to ensure that once a person has moved into their care home there is security of tenure*
- *Carrying out assessments is also reviewing the difficult areas that may involve risks and both assessments and care planning should not see these as barriers to choices but try to understand them and mitigate against them. It is also imperative to recognise that the 'blame approach' of individuals who are trying to do the right thing is causing staff to leave working in the care home sector.*

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ The objectives of the NISAT are not being realised and should be consulted on.
- ✓ It is important that people in hospital who may need care and support have an assessment with the decisions being made by the individual/family and the aim should always be to help people to return to their own home.
- ✓ A number of people living at DMCH were moved into Intermediate Care and then moved to the care home. The outcome of these interim stays to free up hospital beds were not always in the person's best interests.
- ✓ It is not clear how are the conflicting elements of a deficit-focussed assessment ("unable to achieve") are balanced with one that is assets/strengths based (prioritising what matters to an individual). When assessing 'risk' the test should be whether an action or inaction improves the older persons quality of life.
- ✓ Older people and their families did not recognise the remit and tasks associated with care management because it was invisible and its impact unknown.
- ✓ It was not clear to families that older people's care was being managed or that their own contributions to care-giving merited a carer's assessment.
- ✓ Inter-professional collaboration in assessment and care management is notable for its absence prior to older people moving into care homes.
- ✓ A radical reappraisal of admission to care homes is an important inter-professional task. An important aspect being discussion and understanding of expectations.
- ✓ Older people should be encouraged and supported to return to their homes after an acute hospital episode with re-ablement, "step down" and rehabilitation services always being considered as part of expediting appropriate hospital discharge.
- ✓ Care home residents are disadvantaged by not having security of tenure. As part of admission to a care home there should be tenure agreements that are consistent with the human rights framework.

Care Planning

161. Care plans should result from the decision-making phase of assessments. No older person would wish to be defined by a health condition or a collection of morbidities. However, there is a risk of assessment and care planning sacrificing people's identities to ill health and preoccupations with safety. They should be about helping people to recover skills and interests through rehabilitation – a process aimed at helping people to regain, attain, keep or

improve skills and functioning for daily living which can be achieved with support from physiotherapy, speech and language and occupational therapy.

162. Age should not be a barrier to rehabilitative approaches. These help a person cope more effectively. A person's wellbeing, quality of life and self-control over their lives can be enhanced, preventing further loss of functioning and deterioration. Rehabilitation support ought to be considered a human right.

163. Entry into re-ablement and rehabilitation services for older people requires ongoing assessment because long term medical conditions may render them vulnerable to relapse. One family member noted: *My mummy went into one of these units. She was still in a wheelchair, still had an incontinence pad on and* [there was] *no attempt to aid and encourage some* [rehabilitation] *of the skills that she had whilst at home* [just] *six weeks earlier. Before she went to hospital, she was able to go to the toilet herself. Why didn't anyone help her get back to that?* Care planning should have been integral to planning this woman's discharge from hospital. Although she was over the health crisis and physically recovering, intermediate care was not geared to enabling her to return home. Her experience reveals an unfair and conspicuous shortcoming. People with dementia may require extended periods of intermediate care while their physical conditions stabilise.

164. In addition to establishing the 'fit' of a person's support needs with services, the latter should be attentive to people's self-identity because the ways in which older people are addressed in hospitals and care homes can be infantilising. Terms of endearment and the use of first names are commonplace. A relative recalled: *My Daddy was Patrick but was called Paddy. As a family we did not like this but felt we could not raise it. All the staff had to do was to ask him.*

165. The Care Plan records what should be done and how. They require reviewing and updating to reflect people's support needs as they change. Some confusion regarding who does what in care planning and review was found. The initial care plan should be developed by the care manager following an assessment and clearly set out a person's needs. If and when the person is considering admission to a care home, then the staff get to know them and their family so that they can together develop a care plan and record 'how' the care and support will meet the identified needs. The care home manager and staff have clear responsibilities set out in the Nursing and Residential Care Home Regulations. The care home must take full responsibility for how needs are to be met within the home.

166. The Health and Personal Social Services Nursing Care Homes Regulations (Northern Ireland) 2005 and the Health and Personal Social Services Residential Care Homes Regulations (Northern Ireland) 2005 state:

Nursing Homes Regulation 16 - the Patient's Plan.

(1) The registered person shall ensure that a written nursing plan is prepared by a nurse in consultation with the patient or patient's representative as to how the patients' needs in respect of his health and welfare are to be met.

(2) The registered person shall ensure that-

(a) The patient's plan is available to the patient

(b) The patient plan is kept under review

(c) Where appropriate and, unless it is impracticable to carry out such consultation, after consultation with the patient or a representative of his, revise the patients plan; and

(d) Notify the patient of any such revision

Within the Residential Homes, Regulation 16 - Residents Care Plan

(1) The registered person shall ensure that a written care plan is prepared in consultation with the resident or resident's representative as to how the residents needs in respect of his care, health and welfare are to be met

(2) The registered person shall ensure that

(a) The resident plan is available to the resident

(b) The resident plan is kept under review

(c) Where appropriate and, unless it is impracticable to carry out such consultation, after consultation with the resident or a representative of his, revise the residents care plan: and

(d) Notify the resident of any such revision

167. Care home managers confirmed that care plans are reviewed internally each month and within nursing homes' the care plans are reviewed by nurses. These are not mandatory requirements but represent good practice[67]. Typically, the task does not involve the older person or/and the family and although described as 'time-consuming' it may be minimalist, for example, 'no change'. Care home staff noted

- [care plans] *have grown out of all proportion*
- *It is not about the older person but is a record to prove that we have provided the care or not.*
- *They are mainly a record of how we manage and provide care for people's physical and health care needs.*

168. Families visiting their relatives at DMCH recalled seeing the nurses and senior staff spending many hours in the office writing reports and records. Care home staff are accustomed to completing records concerning toileting, fluid intake, turning people in bed and 'daily records'. The primary purpose of care plans appears to be providing inspectors and visiting professionals with evidence that residents' needs are being met.

169. Reports about poor and variable record keeping across health and social care are not new. They are generally accompanied by recommendations that their standard and detail require improvement.[68] It is curious that in some care home settings, social care staff are not generally permitted to write the daily records or contribute to residents' care plans – even though they are working closely with the residents.

170. Significant work has been undertaken by organisations such as the Public Health Agency ("PHA"), Northern Ireland Practice & Education Council ("NIPEC"), NISCC and the Royal

[67] The Code of Professional standards of practice and behaviour for nurses, midwives and nursing associates creates a requirement and accountability process associated with assessment, care planning and evaluation to enable safe and effective person-centred care. Clearly it should not be minimalistic, should involve the older person and family and is part of the overall process of recording.

[68] See for example: *Recording and reporting in social care: practice guide,* Social Care Association 2002

College of Nursing in undertaking improvement projects on recording care, improving record keeping practice in Northern Ireland and co-ordinating regionally agreed care planning practice standards. It remains work in progress. The RCN has been proactive in this area and helps to promote best practice through its Care Home Nurses Managers network and extensive education programmes. Some of the Transformation funding which has underpinned the work of the PHA has been directed at supporting these initiatives. NISCC has been doing similar work but more collaborative effort is needed to form a consolidated position on issues such as delegation, record keeping standards and care planning. This cross-professional work should embrace the Allied Health Professions ("AHP"). The AHPs have a lead officer at DH which falls into the portfolio of work led by the Chief Nursing Officer. The roles of AHPs in the care of older people is recognised in the UK Allied Health Professions Public Health Strategic Framework 2019-2024 (2019) and builds on the DHSSPS: Northern Ireland Making Life Better. A Whole System Strategic Framework for Public Health 2013-2023, 2014: Ten Year Public Health Strategic Framework.

171. At a workshop held by the RCN a Coroner described his concern at the standards of recording both in hospitals and care homes and he urged the audience to review the standards and accuracy as implications of getting this wrong were serious. He observed that there had to be some priorities on what always needed to be recorded. It is not uncommon in nursing homes for recording to be a nurse's task. Whereas the Coroner expressed concerns that records should be contemporaneous notes made at the time or shortly after an event occurs by the staff member involved. He said that if homes did not want to move to care staff making record entries, then the nurse making the recording should state - *I was told by ....* before the information.

172. However, what is absent for care home managers and staff, is consistency in the application of standards on records and notifications. Whilst the regulations are clear the requirements of each HSCT are additional and varied. The IRT heard from care home managers that they spend about 72% of their time record keeping and checking those records. They feel this takes them away from working with staff and residents. This echoes the remarks of several families that staff are often seen spending time writing in records.[69]

173. Families expressed frustration that familiar routines were neither encouraged nor allowed:
    - *I always washed my Mum's hair, did her nails and had a beauty session every week, usually on a Friday or Saturday. We both enjoyed it. When my Mum went into a care home I was not allowed to do this and no-one else did it. My Mummy always took pride in her appearance*
    - *I always took my Daddy a fish supper on a Friday evening when he was at home and occasionally took him out for a drink. I was not allowed to bring food into the home. The*

[69] Responses to concerns about recording are not just about the rollout of a single approach to electronic recording keeping – something that does need to extend to care homes – or about compliance with regulation rather it is fundamental to day-to-day practice which promotes the right care and support: good communication; individual's rights and choice; anti discriminatory practice; acknowledgement of resident's preferences.

manager told me RQIA said we would have to have a policy as we don't know where the food was from.

- *My husband had dementia and I showered with him in my swimsuit. It did not take long and it reassured him. On the first morning at the care home, I arrived early and…the senior staff… told me I could not do this as it was about health and safety and they would be in trouble with RQIA. I said it will distress him but they said "No." I went home and visited later. I was told he was very distressed; he panicked and was upset for many hours and would not settle. I told them that it could have been avoided but they still said "No."*

Such experiences suggest that systems' rules trump people's relationships. Although HSCTs and care homes' approaches to care planning vary, the outcome is constant: older people and their families are marginalised.

174. The behaviours of some older people are, unsurprisingly, suggestive of them not settling into a new environment. It is important that people's emotions are considered during any assessment, admission and subsequent care planning. Many older people move into care homes following significant losses in their lives. Losses may include - a partner, an ability, memory, possessions, familiar surroundings, place or abode. No evidence was found to show that the impact of loss was ever considered during an assessment and this is unacceptable. Establishing with people's families the most effective ways of providing reassurance and support are the legitimate content of care plans.

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Assessment should be guided by personalisation and attend to current and future needs where these may be reasonably foreseen.
- ✓ There is scope for creativity in care planning that builds on people's biographies, personal strengths and the trajectory of their lives.
- ✓ The Health and Personal Social Services Nursing Care Homes Regulations (Northern Ireland) 2005, and the Health and Personal Social Services Residential Care Homes Regulations (Northern Ireland) 2005 provide valuable frameworks for care planning practice. There is space for the active participation of older people and families and the professional judgement of care home staff and providers.
- ✓ Care planning should always involve older people and their families.
- ✓ Rehabilitation support is an essential ingredient of care plans for most older people recovering from ill-health, traumatic incidents or living with long term conditions.
- ✓ Care managers and care home managers should ensure that Allied Health Professionals' input into the care of older people is recognised and responsive to variable health and social care needs
- ✓ There is scope for a collaborative initiative between care managers[70] and care home managers to improve the standard of record keeping.

[70] The Safeguarding Audit (See Evidence Paper 1) showed the standard of recording of care managers to be poor.

Care Reviews

175. The Health and Personal Social Services Nursing Care Homes Regulations (Northern Ireland) 2005 and the Health and Personal Social Services Residential Care Homes Regulations (Northern Ireland) 2005, state:
    1. *The registered person shall introduce and ensure systems are maintained for reviewing at appropriate intervals the quality of nursing and other service provision in or for the purposes of the nursing home and that such a review is undertaken not less than annually*
    2. *The registered person shall supply to the Regulation and Improvement Authority a report in respect of any review conducted by him for the purpose of paragraph (1) and make a copy of the report available to patients*
    3. *The system referred to in paragraph (1) shall provide for consultation with patients and their representatives*
176. The purpose and frequency of care plan reviews is vital for the older person, family and care manager. It is an opportunity to discuss the standards of care and support being provided, to ask if a person is happy and settled at the home or not and to identify actions needed for the future. The older person and family can say if the decision to move to the care home was correct or if they wish for an alternative. *Home Truths* and feedback in interviews and working sessions provide evidence that reviews are not seen as a priority by the HSCTs. There was a continuing failure to carry out formal reviews at DMCH and other homes visited. If these were completed, then the views of residents and families about the standard of care would have been highlighted.
177. Professionals were attuned to the distinction between ambition and delivery and acknowledged that reviews should:
    - demonstrate how the care and support are meeting needs and achieving the outcomes identified in care plans
    - reassess people's care and support needs
    - gather the perspectives of the older person, the family and advocates
    - check that the financial arrangements are clearly understood and are working for the older person, family and service
    - identify areas of the service that are failing and discussing how these can be resolved
    - agree the date of the next review and understand the circumstances that might indicate the need for an earlier review
    - allow families to request earlier reviews if they have questions concerning how their relatives' support needs are being met.
    - complete a report that is shared with the care home, older person and family
178. The IRT was advised that a care review starts with the care home manager completing the relevant HSCT form which is forwarded to the care manager and a review date is identified. Although the care manager may not know the person whose care is being reviewed, visits and contact with relatives do not routinely occur in advance. Some care managers favour reviews

by telephone. No care homes could recall care managers enquiring about the convenience of the timetabled reviews for the older person, the family or home.

179. A first review is generally held six weeks after admission to a care home. It is essential in confirming the placement or otherwise. Since so few families participated in this, or subsequent reviews, there was no discussion about how the service provided achieved the outcomes of the care plan. Professionals reported that:
    - residents may reside for many months in a home before reviews are undertaken.
    - caseloads were too high to complete all reviews and/or to undertake anything other than a telephone check
    - care homes are expected to provide information to care managers
    - care managers may change and care homes may not be informed of the changes
    - sometimes, care managers have not met the person whose care is being reviewed or their relatives
    - the variability of HSCTs' forms is challenging for providers with homes across the region and for homes with residents from several HSCTs.

180. Families recalled:
    - [the review] *did not last long. It was going through a form and* [my relative was] *not invited to attend. It was about care tasks and not about my relative.*
    - *We felt we did not have a voice.*
    - *As I was listening, I thought they don't know my Mummy at all, so what was the point of it?*

181. If senior care home managers were not able to attend, families were critical of the practice of care staff attending who knew nothing about their relative. *She had not worked there very long and said almost nothing.* Families described constant staff-turnover, discontinuity and the failure to prioritise care reviews at the home. The reviews rarely involve the perspectives of other professionals or included advocates.

182. One family said, *We had met the OT several times and she had spent some time with Dad talking to him and helping him. We thought he needed more time with her. He wanted to get up and walk more after he saw her. She made him feel happier. He was so much brighter when she came, we wanted her to be part of his care but no one listened or did anything about that. When we were told a review was going to happen, we asked if we could be there and whether she could come too. When I asked again, I was told it had already happened. No one had told us and when I spoke to Dad, he didn't know anything about it.*

183. The IRT heard about the roles that independent advocates could have played with older people whose families were not close by or unable to visit frequently. One family explained*, My husband had cancer, my daughter has special needs, which worsened, she then started to have fits during the day and my Dad was still at home with me and needed me to help him. Mum was in a home about eight miles away and I feel so bad as she was just there and I couldn't visit much. When I did go, I brought food which she always enjoyed. She needed more company and someone to talk to and I needed someone to let me know she was alright. She needed more from me, but I couldn't give it. They were getting her up too early in the morning*

and she tried to tell them about it. I tried too but it didn't work out. Now she has passed and so has my husband. My daughter is better and I have more time now. I think about it a lot. I can't do anything about it now.

184. Necessarily the perspective of the care home must form part of reviews and the importance of the home's manager or senior staff preparing a report about the older person's life at the home should not be underestimated. Families need assurance that practitioners at the home are fully engaged in the process. The report should describe how the person spends their days as well as how activities reflect their choices, skills and interests. It should give the person's and their family's perspectives, not just that of the staff. However, practice remains constrained because:
    - *Trust staff will do countless monitoring visits or safeguarding visits but do not do the reviews as they should.*
    - *We have care managers calling us to hold telephone reviews and we say "No."*
    - *Reviews are planned to suit them* [even] *when the nurse or senior staff are not freely available. Often families are not invited, given a time too late or appointments are cancelled at the last minute.*
    - [Care homes] *do not get written feedback from care reviews.*
    - *Care managers - they are more interested in the monitoring visits.*
    - [A care manager said we] *can have high caseloads between 80-100 and this leaves no time for in depth discussions and/or working with older people.*
    - *It is not uncommon on a Thursday or Friday for RQIA to contact us and identify concerns about a care home or they have issued a failure to comply notice. They expect us to follow that up. Many of us feel that if they issue the notices it is their responsibility to follow this up at a service level and, if needed, we go in to check on individuals.*

POINTS TO CONSIDER - LEARNING AND CHANGE

- ✓ Undertaking care reviews in children's services is a performance indicator and failure is likely to be a matter of management supervision and may be deemed professional misconduct.[71] For older people, it has taken a report by COPNI to highlight the fact that their reviews were not taking place.
- ✓ A care review provides a formal, open and transparent meeting to establish if the older person and their families are satisfied with the care and support being provided.
- ✓ The role that social work, nursing and other professionals such as OTs can play in the care of older people should be promoted and developed. This could be achieved if consistent and high-quality social work was a central part of the system.
- ✓ At best, care reviews are a positive means of building relationships with older people and their families. They are the milestones of care management.

[71] Hayes D, *Relationships Matter*, Queens University, Belfast, December 2018. This analysis of complaints about social workers to the Northern Ireland Social Care Council and Patient and Client Council is based on the 49.5% of social workers employed in children's services being responsible for 91% of complaints.

- ✓ The first care review after admission to a care home should confirm the acceptability and adequacy of the placement. An onward plan should be formulated for future reviews including identification of what might be an indicator for an earlier review taking place.
- ✓ Training for effective assessments, care planning, reviews and record keeping requires attention across health and social care.

Section D: The care managers – their roles and responsibilities

Preamble

185. The professionals – social workers, nurses and allied health professionals - who carry out the remit and role of assessment and care management undertake their work within the duties and responsibility of the HSCTs. Despite repeatedly asking it was not established how a person is appointed to be a care manager for an older person, how work is allocated within a multi-disciplinary team or how initial screening/assessment is carried out.
186. It appeared that there was a focus on health condition of the person and the necessity of hospital discharge. The role was described as being more about monitoring care homes standards than casework with individuals and their families.
187. At DMCH from October 2014 – August 2017, there were over 40 visits to the home from HSCTs. These included a HSCT nurse arriving unannounced on a Saturday evening, to witness the night shift.
188. The picture was suggestive of a situation where the HSCTs were deploying their care managers to fulfil a duty of quality by checking (care home) services rather than the primary obligation to make sure an individual's assessed needs are met. It is in that context findings on care managers' roles and responsibilities in respect of casework and monitoring are reported.[72]

Casework

189. In 2019, there were 6,169 social workers registered with the Northern Ireland Social Care Council ("NISCC"), 700 Social Work Students and 35,599 social care staff. 'Social worker' is a protected job title.[73] The use of professionals' titles matters to families since several wanted to know who were operating as care managers and whether they were qualified to do so. When advised that most care managers are either social workers, nurses or allied health professionals, families asked *why not call them nurses, social workers? Just tell us who they are and how they're trained to help.*
190. Neither safeguarding concerns, reports and complaints from families nor the monitoring and raising of issues at DMCH by HSCTs' resulted in risks being identified that triggered social work intervention – casework - with older people or families. In fact, families reported being excluded from relevant meetings and discussions to which older people appeared peripheral.
191. 'Casework' describes a direct way of working with individuals, families, groups and communities. With reference to older people and their families, there is "case-specific" knowledge concerning the life course, frailty, future-proofed housing and cognitive decline, for example. "Biographical knowledge" is as important, most particularly at a time when an

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[72] The contextual position was arrived after several discussions with HSCT and care home managers. It was evident from the care home managers that the HSCT primary focus was on the monitoring visits of care homes. In one HSCT the team had been expanded. The IRT received information on the lack of care reviews from care home managers and a spreadsheet was viewed at DMCH that was used to 'chase up' reviews. Questions were asked on all visits and the response followed a common theme. The IRT even attended meetings on how HSCT approached the monitoring work.

[73] See paragraph 40

older person is weak and powerless. Casework results from assessments that include hoped-for outcomes and involve older people and their families as informed participants. It involves high quality care reviews and "intervention knowledge" such as using technology, providing financial and welfare benefits advice.

192. Social workers stated that they have a lower profile than health professionals in the HSCTs. They reported that their caseloads were too high and that there are frequent changes in staff:
   - *Social work is lost in Trusts. We need to go back to our business, assessment, reviews, casework. Caseloads between 80 and 120* [means that we are] *rushing at all times*
   - *Financial eligibility criteria are critical and appear to be the only part of the assessment that is followed through in detail.*
   - *Financial assessments are not completed before a person moves into residential care. People don't know what they* will *have to pay as contributions.*
   - *The use of* [residents'] *personal money is too restricted.*
   - [With reference to Care Reviews] *We don't always have time to do them…six-week review not always done.*
   - *It is assumed* [that] *when a person moves into a care home, they are likely to remain there.*
   - *There is a difference between self-funders…and* [those] *whose care is then managed through a Trust…may not know about* [the self-funders].
   - *It's a paperwork driven system* [in which] *health dominates.*

193. One working session confirmed that:
   - People's job titles should be used such as social worker, nurse, OT. Although some HSCTs have reverted to this, there is no consistency.
   - The difference between social care and social work is not widely acknowledged, clear distinctions would enhance the professionalism of social work and ensure that social care was properly recognised.
   - The discharge of older people from acute hospitals should be given higher priority. The shared accountability of nurses, social workers and social care staff should be better defined and understood.
   - *There seems to be no clarity about how data is managed or then used to help and inform us, improve practice or respond to trends*
   - More time is needed for casework with older people and families
   - Monitoring older people in care homes has eclipsed assessments and reviews.

194. The Review found little evidence of casework, robust assessments or care reviews that offered a timely response to the changing needs of older people in care homes. In an integrated service the role and numbers of social workers employed for older people should be at a level that respects all aspects of a social workers responsibilities.

Monitoring

195. RQIA is the statutory body for the registration, inspection, improvement and enforcement of the regulations related to care home establishments. That said across the HSCTs, social

workers, nurses and allied health professionals identified a major part of their work as the *monitoring of care homes* to ensure people's health, safety and wellbeing. The HSCTs had different arrangements but overall staff reported this work to be time consuming. It was evident that many people in HSCTs felt the monitoring work was duplicating work that RQIA should be doing. A major difficulty with this focus was that essential social work – casework - as described in the policies was not being fully carried out.

196. The HSCT in which a care home is located is the 'host trust.' This may or may not be the funding HSCT. It was found that a single HSCT placed more residents into homes in other HSCTs but only performed annual contract monitoring on homes in its own Trust area. The 'host trust' alerts the funding Trust if there is a problem reported to them which can lead to concerns as some of the labelling of the issues, for example as safeguarding, were not always agreed between Trusts. Where the primacy of decision-making rests is unclear in the system. Carrying out reviews in a timely and regular way would enhance the contract monitoring system. No checking of those contract monitoring processes was being undertaken.

197. This is an example of the mixed accountability that exists between host and funding Trusts. From the perspective of the care home, the current arrangements are less than ideal. Typically, the host HSCT attends to safeguarding matters, for example, and the funding HSCT is responsible for undertaking care reviews, but even that is not consistent across all HSCTs. The IRT was advised of the confusion for homes when the host HSCT and funding HSCT challenge safeguarding referrals and responses and/or the outcome of care reviews and results of monitoring activities. Needless duplication arises when 'monitoring' visits to care homes are carried out by the host and funding HSCTs. Some monitoring is reactive to incidents and notifications although Trusts vary in the responses.

198. Four HSCTs placed people at DMCH. This meant that each Trust had to 'put and keep in place arrangements for the purpose of monitoring and improving the quality' of the service provided,[74] and responsibility for monitoring individual residents was distributed across the Trusts. In reality, meetings, led by South East HSCT, were held between the four HSCTs when questions about the practice at DMCH were raised. The meetings' minutes reveal misgivings about all aspects of the care; the remit of RQIA; and divergent views about the urgency of problems and their associated risks. The Trusts attempted to resolve issues, there was escalation to Director level and Head of Contracts who made the decision on suspension of placements through contracts and this may have been unknown to RQIA.

199. Belfast HSCT has a Care, Review and Support Team of social workers and nurses that monitor care homes. This resulted from the Trust's three-year change programme which included a workforce review of social work with systems of individual reviews and support to clarify the distinction between the remit of the regulator and that of the Trust. This resulted in phasing out care management and replacing it with social work. A multi-disciplinary team focused on the provision of individual reviews for the 2,500 care home residents within the Trust; revamped the documentation; and engaged the care homes and RQIA. The multi-disciplinary

[74] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

team identifies care homes in difficulties so that management of the associated risks may be shared with other HSCTs and RQIA. Care home providers and managers were not involved with setting up these arrangements.

200. Similarly, the Southern and Northern HSCTs have dedicated care home teams. South Eastern HSCT's improvement initiatives under the Quality Improvement in Social Work 2018,[75] stated, *The lack of direction and cohesion within the monitoring process in nursing homes has led to confidence issues amongst social workers within Primary Care and Older People's Services, who are tasked with monitoring the health and social care needs of service users.* The outcomes among other things, include a Permanent Placement Team[76] led by a senior nurse and a Regional Quality Network for Social Workers trained in quality improvement and a person-centred approach to monitoring visits. In addition, the Trust has sought to "maximise the benefits" for people using a community based inpatient rehabilitation unit.

201. Care home managers perceive monitoring visits as additional inspections and recalled some stark descriptions of monitoring:

   - [HSCT staff said] *We are here to inspect the home and we will be worse than RQIA.*
   - [HSCT staff said] *We have a right to look at everything, including staff records*
   - *The HSCTs put the monitoring work before good assessments, before holding reviews or responding to managers* [requesting] *additional support for a* [resident].
   - *They monitor us but many have never worked in a care home. That is insulting to us…it sends messages that we are not trusted or valued.*
   - *They never leave reports of the visits*

202. Some HSCTs' employees believe that they have the power to enter and walk around care homes: *They never make appointments* [it is as though] *they want to catch us out. It is people's home. They would not do that if someone lived in their own home.* During IRT visits to care homes, HSCT staff arrived unannounced and expected the person in charge to be available. On one occasion, two OTs arrived and asked to see a resident. The manager explained that he had gone for his lunch. They asked the manager to collect him from the dining room and take him to his bedroom immediately because they had *others to see and a busy day.* The manager did so and explained that refusing to cooperate would get them *into trouble*. On another occasion, the manager was called to the reception because two HSCT staff wanted to see a resident with a pressure ulcer which had triggered a notification. The manager – a nurse - subsequently advised that this was unnecessary because the doctor was satisfied the ulcer was healing. The resident was undressed so that his ulcer could be checked by two HSCT staff he had never met - because of their insistence. The manager said *I am so fed up with this lack of trust and the way they behave. They never asked the person for consent*

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[75] https://www.scie.org.uk/files/northern-ireland/quality-sw-summary-of-improvement-initiavities-booklet-2018.pdf (accessed 2 June 2020)

[76] See https://setrust.hscni.net/service/permanent-placement-team/ (accessed after the drafting of the Paper and added by way of illustration of how HSCT support to care homes is developing. Up to date information should be available on each HSCT website)

to see his body. I could leave my keys on the desk and walk away from this but I won't because I care for my residents.

POINTS TO CONSIDER – LEARNING AND CHANGE

- ✓ The profile and role of social workers working with older people needs to be elevated and consistent across all HSCTs
- ✓ There is work to be done to reinforce personal professional accountability – acting on behalf of the older person rather than the system - which operates despite employment settings or individual allegiances.
- ✓ Regional work is required on caseload/workload management and allocation.
- ✓ Multi-disciplinary teams undertaking assessment and care management should deploy social workers, nurses and OTs in way that has the greatest benefit to older people and their families.
- ✓ *Monitoring*, whilst it may be necessary on occasion for identified and practical safety reasons, rarely provides extensive improvement to either the wellbeing and health of individuals nor the functioning of a care home in meeting regulations and standards. There was no evidence that the extensive monitoring of DMCH led to sustainable improvements.[77]
- ✓ Eradicating duplication of roles and responsibilities between RQIA and HSCTs around performing and *monitoring* the duty of quality is an opportunity to free-up resources to improve both how care home establishments function and the support offered to individuals and their families.
- ✓ *It is the interplay between commissioning and provision that is likely to be most helpful to the users of services. There is an enormous advantage to existing and potential users of services in having the opportunity to discuss and reflect on their circumstances within a case work relationship secure in the knowledge this process can achieve the optimum outcome.*[78]

Professional practice

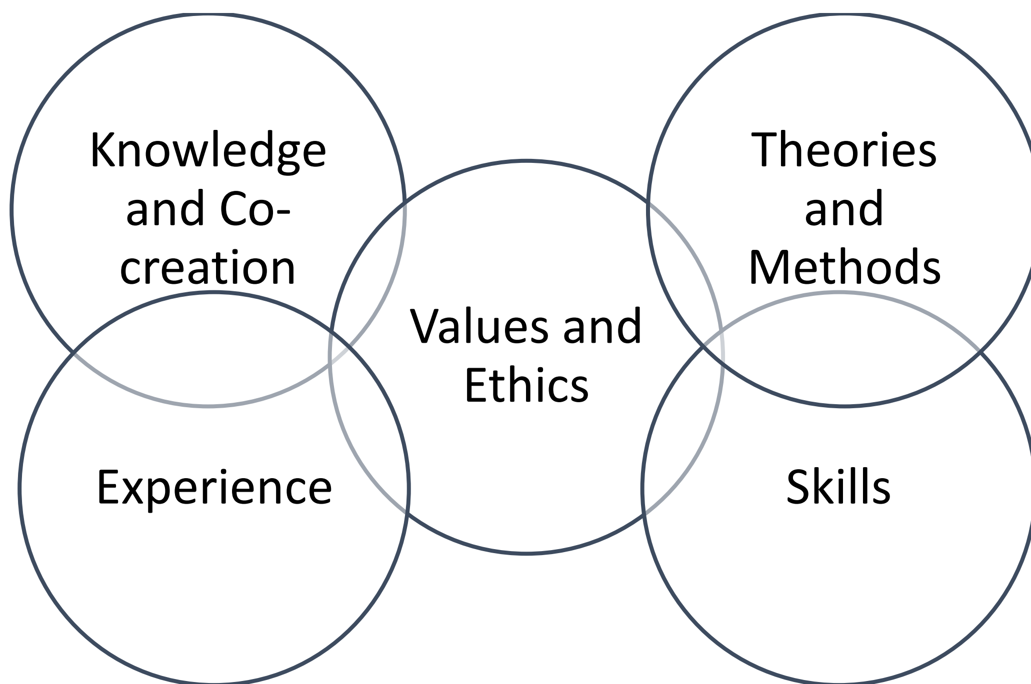
203. Making ethical and justifiable decisions is at the heart of professional practice.[79] In social work, *Any agreed practice framework needs to reinforce the use of up to date practice knowledge (K) and research, promote core social work values (V) and ethics, render visible social work theories (T) and methods, and promote a range of practice skills (S). The practitioner's experiential learning is also recognised (E) and promoted – important if we are to drive decisions based on our professional standards.*

[77] Evidence Paper 6 on the Care Home Market and Commissioning considers the Regional Contract and the way this may be developed to improve the quality of life for people who live in care homes.

[78] Blewett, J., Lewis, J. and Tunstill, J. (2007) *The changing roles and tasks of social work: A literature informed discussion paper* https://www.researchgate.net/publication/237834709_The_Changing_Roles_and_Tasks_of_Social_Work_A_Literature_Informed_Discussion_Paper (accessed 2 June 2020)

[79] Stanley, T., Baron, S. and Romeo, L. (2018) How social workers could make more ethical and justifiable decisions for service users. *Community Care* 21 December

204. The acronyms "KVETS" (and KcVETS[80]) are responses to calls for greater accountability for professional decisions. How social workers make decisions and how well they are made is a matter of interest to older people and their families – not least because they bear the personal and financial costs of inferior decision-making. If the organisational context of acute hospitals means that certain groups of patients are perceived as candidates for care homes, regardless of their hospital discharge policies, then "strengths-based" approaches to decision-making have little impact.



205. The NISCC Standards of Conduct and Practice for Social Workers (August 2019) specifies that as a social worker you must:

   i) protect the rights and promote the interests and wellbeing of service users and carers.
   ii) strive to establish and maintain the trust and confidence of service users and carers.
   iii) promote the autonomy of service users while safeguarding them as far as possible from danger or harm.
   iv) respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.
   v) uphold public trust and confidence in social care services.
   vi) be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

206. The Code (updated October 2018) for Nurses published by the Nursing and Midwifery Council compels nurses to prioritise people, practice effectively, preserve safety and promote trust. This means:

[80] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778134/stengths-based-approach-practice-framework-and-handbook.pdf (accessed 2 June 2020)

"2.1 you must work in partnership with people to make sure you deliver care effectively.
2.2 recognise and respect the contribution that people can make to their own health and wellbeing.
2.3 encourage and empower people to share in decisions about their treatment and care.
2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care.
2.5 respect, support and document a person's right to accept or refuse care and treatment.
2.6 recognise when people are anxious or in distress and respond compassionately and politely.
3 Make sure that people's physical, social and psychological needs are assessed and responded to.
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages.
3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life.
3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it.
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.
4 Act in the best interests of people at all times.
To achieve this, you must:
4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment."

Developing the roles and responsibilities

207. Social workers and nurses have a clearly defined and mandatory code of professional practice, requirements to be advocates and to act in patients and residents' best interests. So why is the system failing? *Power to People* offers some insight into this question suggesting that the knowledge, skills and expertise of professionals are being deployed on the wrong tasks. The system's purpose is not person-centred but designed to minimise risks of harm in the community, ration scarce specialist resources and facilitate rapid hospital discharge. To focus professionals on the tasks associated with this agenda means at best they are doing the wrong thing the right way and at worst they become conflicted and alienated. The loss to the system is in the application of their expertise on the tasks of assessment and care management. This is at the root of an oft-heard criticism that professionals have become 'managerialist'.
208. The Expert Advisory Panel proposed *that neighbourhood based, preventative and citizen-focused community support models are encouraged and enabled. This should include the concept of a social worker-led Community Navigator role with such models available to every locality in Northern Ireland.*

209. The implication is a shift towards a strengths-based and self-determined approach to assessment and care management. The multi-disciplinary care management team becomes a community resource offering, among other things:
    - Information about self-care, carers support and community skills and supports.
    - Access to advice and advocacy options
    - Supported self-assessment of needs.
    - A community resource centre approach to care homes and development of a 'housing with support' community network
    - Continuity and connection when people need to move accommodation or into long term care settings.
    - Facilitated care planning and review involving older people, their families and relevant care providers.
    - Professional leadership and self-management of multi-disciplinary teams of generic and specialist workers whose job roles are understood by the community and its citizens.

210. One of the common barriers to implementing the types of change and improvement advocated by *Power to People* and endorsed by the IRT, in respect of the care home and its workforce, is professional protectionism and embedded learning emanating from higher education bodies. It is suggested that there is an appetite, based on common values, to draw up a practice framework for a new model of assessment and care management which capitalises on the best traditions of community social work, nursing and specialist rehabilitation therapies.

211. The DH will need to find ways to support multi-disciplinary learning at qualification and post-qualification levels that support professionals such as social workers, nurses, allied health professionals, registered social care managers and inspectors to:
    i. Understand each other's roles and responsibilities.
    ii. Know when generic skills and when specialist skills are required
    iii. Explore together the possibilities of self-management and team leadership
    iv. Collaborate with community leaders, families and older people in a system based on shared purpose, self-determination and citizens' definition of the 'duty of quality'.
    v. Promote services, including care homes, which are founded on human rights and wellbeing
    vi. Relinquish control – this is what *Power to People* means

POINTS TO CONSIDER – LEARNING AND CHANGE

- ✓ Work is needed to adapt and update the learning and improvement strategy to reflect the strategic priorities of the adult social care reform group
- ✓ One of the methods of learning should include gaining basic knowledge, understanding and experience of the fundamental roles and responsibilities in work with older people.
- ✓ Care managers, care home managers and inspectors should be able to "walk in each other's shoes" through work shadowing, job swaps and placements.
- ✓ Older people and their families are a resource that can be engaged in the design, delivery and evaluation of training.
- ✓ The relevant academic, professional and employment interest bodies should have a forum where they can coordinate how their common values are translated into multi-disciplinary self-managed locality teams that make a reality of *Power to People*.

Section E: Learning and Change – proposals for action

Strategic priorities

212. The Chief Social Work Officer has established a working group on Adult Social Care Reform that is led by the Deputy Chief Social Worker, with the lead officer for older people, to implement *Power to People* and reform (or "reboot") adult social care. It has five strategic priorities which are:
   - Valued workforce
   - Individual choice and control
   - Prevention and early intervention
   - Supporting carers
   - Primacy of home

213. Insofar as assessment and care management is concerned there are plethora of strategic actions that are necessary *to ensure the individual has control over the decisions affecting their social wellbeing and their care and support needs.* Writ large amongst them is growing the valued workforce envisaged to support and care for older people wherever they live. This Paper offers a series of POINTS to CONSIDER in learning and changing adult social care. Proposed actions follow an analysis of findings in respect of assessment and care management. They are derived from the experiences of residents and families at Dunmurry Manor. They have been tested and challenged more widely in the field.

Analysis

208. The older people and families who sought to share their experiences as part of the Review were not advantaged by the inter-professional corroboration expected of integrated HSCTs. Integrated services should improve a person's experience of services and yet families highlighted insensitivity, harm and neglect as impacts of their relatives not receiving adequate, timely and compassionate care. Families' experiential knowledge appeared to be set aside in favour of custom and practice.

209. There is a strong sense that integration is underdeveloped at many levels, particularly in terms of: ensuring access to advice and help; individual assessment; delivering the help required; limiting unnecessary bureaucracy; and providing opportunities for individuals and their families to control what happens.

210. Families who are anxious about the health crises of older relatives are not sophisticated users of health and social care services. They want (i) a single gateway to information, advice and possibly advocacy to understand their relatives' conditions, expected treatment and implications for returning home, for example; (ii) knowledgeable and responsive professionals who do not expect them to solo 'navigate' the service system; (iii) evidence that they, and their relatives, are expected to be involved in decision-making;[81] and (iv) familiarity with care and support options - and optimism about these.

[81] Although it might be expected, it should not be assumed that all families would wish to be involved. Nor should it be assumed that all relatives have equal standing and hold a shared view about the older person's support needs

211. Effective long-term conditions' management is underpinned by a holistic assessment of needs. In crisis, older people are susceptible to falls and confusion. Viable and valued ways of supporting older people result from assessments of needs, strengths and presenting conditions. Such detailed understanding of a person's circumstances is required if effective interventions and outcomes are to result.

212. Although families described the undue haste with which they were expected to make decisions about identifying a care home in readiness for hospital discharge, they did not describe the efforts of HSCTs to avoid or reduce hospital admission. Yet once admitted to hospital, families described how their relatives' independence diminished. This resulted in inaccurate assessments which did not reflect their relatives' biographies or strengths.

213. Respondents to the Review were confused about the powers and the responsibilities of HSCTs and RQIA. Social work staff, nurses and managers within the HSCTS commented that they are left to pick up the work of RQIA, without having the powers to do so. An example of this is when RQIA issue a Failure to Comply Notice it is the HSCT who are asked to make the visits to carry out checks which may be at the weekends. The general view was RQIA should make the checks on notices and assess compliance.

214. Not all families were familiar with RQIA's inspections of care homes. They did not recall being encouraged to visit homes prior to their relatives being placed and were mostly unaware that (i) the homes' responsibility for producing a personal/care plan is mandated by the nursing/residential home regulations[82] to ensure that the home can meet a person's needs; (ii) financial assessments were required and that contributions from the family may be required; (iii) information for the initial care plan should be derived from the combination of the care manager's and the home's pre-admission assessments; (iv) care reviews occurred.

215. An initial review at six weeks is considered best practice. Although there are circumstances where flexibility is required, it does not appear that care reviews are being undertaken with the frequency and rigour required. HSCTs need to support the person in a care home placement by a first review that confirms the placement. Thereafter, the care manager should ensure that the person's needs continue to be met.

216. There are opportunities for care homes to be inclusive of people with a range of care and support needs - with access to nursing and allied healthcare as required. Nurses play a crucial role in ensuring older people have fulfilling lives and their health care and nursing needs are met. The input of nurse specialists in diabetic care, tissue viability, and continence care, for example, can make a real difference to the quality of life and health status of an older person. The input of nurses is likely to acquire a higher profile in the sector, in the post-pandemic era, given their investment in teamwork to address infection control and prevention and support for homes.[83] There is considerable variation across HSCTs concerning nursing in-reach to

[82] Even when an older person pays for their own care and chooses not to access care management, the care home provider/manager must carry out a pre-admission assessment.

[83] The IRT is aware of work underway to enhance clinical care for residents in care homes and to review intermediate care including standardising nursing in reach. However, the IRT completed its fieldwork in March 2020 and the Paper was drafted in December 2020.

homes. Neither nursing strategy documents[84] nor more general workforce strategies have resulted in a consistent approach.

Proposed Actions

a) Build on improvements in intermediate care services by making an explicit investment

Two questions merit consideration: (i) What services do you need to have in place so that no older person admitted to hospital from their own home is discharged directly to long term care?[85] (ii) What intermediate care services do you need to have in place so that older people may be assessed in a setting other than hospital? There is a strong sense that integration is not working well at many levels, particularly in terms of: ensuring access to advice and help during crises; individual assessment; delivering the help required; limiting unnecessary bureaucracy; and providing opportunities for individuals and their families to control what happens. It was not clear to families that older people's care was being managed or that their own contributions to caregiving merited a carer's assessment.

b) Provide a single gateway to information, advice and guidance

The experience of older people defines the effectiveness of service responses. Families who are anxious about the health crises of older relatives are not sophisticated users of health and social care services. They want (i) a single gateway to information, advice and possibly advocacy to understand their relatives' conditions, expected treatment and implications for returning home, for example; (ii) knowledgeable and responsive professionals who do not expect them to solo 'navigate' the service system; (iii) evidence that they, and their relatives, are expected to be involved in decision-making;[86] and (iv) familiarity with care and support options - and optimism about these.

One way to do this is to prepare anonymised case studies to provide families with real examples of the range of people's pathways from acute care.

c) Reformulate the remit and functions of the Patient and Client Council (PCC)

In Evidence Paper 2 on Complaints, it was proposed that the PCC should reassert the primacy of advocacy for complainants.

There is scope for the PCC to explore with older people and their relatives how independent advocacy should be given expression in a refreshed complaints system, and to assist with collective and individual grievances. Advocacy has a place in supporting older people and families when needs are being assessed and reviews undertaken to advance people's best interests and ensure human rights. Attending to the voice of older people

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[84] Evolving and Transforming to Deliver Excellence in Care: A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025); A District Nursing Framework 2018-2026: 24 Hour District Nursing Care No Matter Where You Live; Nursing Now NI Campaign Jan 2019

[85] A question asked by the Health and Social Care Change Agent Team. Department of Health (2003) *Changing Places: report on the work of the Health and Social Care Change Agent Team 2002-03* London: DH

[86] Although it might be expected, it should not be assumed that all families would wish to be involved. Nor should it be assumed that all relatives have equal standing and hold a shared view about the older person's support needs

has democratic validity because it reveals how services are provided and how they are used.

d) **Ensure a consistent approach to assessment and care management and set standards**
Negotiations should commence to bring working practices together and curtail variation across the HSCTs.

Effective long-term conditions' management is underpinned by a holistic assessment of needs. In crisis, older people are susceptible to falls and confusion. Viable and valued ways of supporting older people result from assessments of needs, strengths and presenting conditions. Such detailed understanding of a person's circumstances is required if effective interventions and outcomes are to result.

Home Truths referred particularly to care reviews, their timing after admission to a care home and their subsequent frequency. Standards or good practice guidance should be enshrined in the admission care plan,[87] built into an individual's contract, checked as good practice and sampled at inspection. There is an argument for inspecting the assessment and care management practice of HSCTs. The first care review after admission to a care home should confirm the acceptability and adequacy of the placement. An onward care plan should be formulated for future reviews including identification of what might be an indicator for an earlier review taking place.

e) **Introduce a 'tenure agreement'**
This could be achieved through an addendum to the Regional Contract - personal to each resident - which recognises their care plan within a 'tenure agreement.'

Care home managers stated that the most typical referrals for care home placements are from hospitals. The responsibility for identifying a home was delegated to families who described the experience as distressing, rushed and made even worse because of inadequate information. Although some families were able to visit a couple of homes, there was no opportunity to make considered decisions.

f) **Practice collective and pragmatic leadership**
There is considerable variation across HSCTs concerning training and workforce issues. A good example is the differences in approach to nursing in-reach to homes.[88] The input of nurse specialists in diabetic care, tissue viability, and continence care, for example, can make a positive difference to the health status and quality of life of an older person.

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[87] Decisions about the arrangements for sharing care plans – which are personal to each resident - should be part of the admission and care planning processes

[88] The IRT is aware of work underway to enhance clinical care for residents in care homes and to review intermediate care including standardising nursing in-reach. However, the IRT completed its fieldwork in March 2020 and the Paper was drafted in December 2020.

Neither nursing strategy documents[89] nor more general workforce strategies have resulted in a consistent approach across the HSC Trusts.

The enhanced health care approach led by nurses and clinical staff can lead to people being 'labelled' by their health condition such as the 'person with dementia' and not viewed as a whole person with families and interests. Whilst people living in care home are entitled to the best of health care in a timely way, care homes are not clinical settings and nor should they be. The IRT endorse leadership which stresses the 'Primacy of Home' and what that means to people living and working in such settings. Care and support must take into account people's interests, relationships and dreams and this will not be achieved by just focusing wholly on health.

There are common training needs for care managers, registered managers and inspectors. This requirement transcends individual professional categories and instead, focuses on the essential training and leadership needed to ensure effective care for older people. The requirements to work in a multi-disciplinary team would be more easily delivered if interagency, multi-professional training were embedded in a system designed to take account of the scale of demand. Such a system would require consideration of career structures with the introduction of seniority as a legitimate objective. The work of Allied Health Professionals would gain greater recognition if this were adopted. In strategic planning terms, the care of older people is likely to become an even larger part of the work of the DH. The growth in care homes with dementia registered places demonstrates the rising need for such provision.

The NISCC, NIPEC as well as the RCN and other Trades Unions should be centrally involved in workforce planning and training and should build on the *Rapid Learning Initiative*[90] with families, care home providers, IHCP and managers. There are opportunities for care homes to be inclusive of people with a range of care and support needs - with access to nursing and allied healthcare professionals, as required. The input of nurses is likely to acquire a higher profile in the sector, in the post-pandemic era, given their investment in teamwork to address infection control and prevention and support for homes.

Workforce leadership and management in care homes is an employer and registered provider's responsibility. Professional regulators could have a more significant role if registration was based on qualifications according to a job role. It is a concern that some of the named organisations set down 'rules' that may be difficult for providers to meet. Codes of conduct, standards and guidance are helpful, but they need to be enshrined in regulation and funded to be enforceable.

[89] Evolving and Transforming to Deliver Excellence in Care: A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025); A District Nursing Framework 2018-2026: 24 Hour District Nursing Care No Matter Where You Live; Nursing Now NI Campaign, Jan 2019

[90] The 17 June 2020, *New Framework Planned for Nursing and Medical Input into Care Homes* and 24 June 2020, *Work underway to learn from care home Covid-19 experiences*

For example, the IRT considered drafts of delegation of duties which were restrictive of employer's duties and likely to cause staffing issues. The enabling role of DH using the RQIA should be seen as a supportive aid to improvement. It is important that DH has an overall view of the workforce in NI across health and social care sectors. Data is the foundation of workforce leadership and management – for planners, commissioners and employers. It was disappointing that during the Review there was no meaningful workforce data available.

g) Learn, change and improve through data and information

Since too much information gathering is duplicated and unevenly and inconsistently collected it makes sense to identify 'signals' of how well commissioning, assessment and care management are functioning. This is a model which is replicated in Evidence Paper 1 on Adult Safeguarding. The task is one that should be undertaken with residents, families and practitioners. The importance of building commissioning models based on neighbourhood /local/community planning, cannot be over-emphasised. Individual data can be aggregated to plan for supply to meet demand rather than demand to fit supply. Outcomes-based assessment and care planning are essential to effective commissioning. Questions such as; did people get what they wanted /needed? And, were they satisfied? are fundamental. The information gathered may be used to identify signs of success - the 'signals'.

The task is not to generate hundreds of 'signals', but rather ones that highlight residents' and families' experiences. This is not to reinforce or duplicate performance management data and information but rather to sharpen the focus on what matters to care home residents and their families in assessment and care management. For example, it matters to people that they and their families are involved in assessment, that an admission to a care home considers the loss and change entailed, that family members contribute to care plans and reviews and their individuality and strengths – what they can contribute – are recognised.

The question is: how data and information might be useful to commissioning, assessment and care management in terms of (i) relevance, (ii) accuracy and reliability (iii) timeliness (iv) accessibility and clarity and (v) coherence and comparability.

h) Set out the remits for monitoring quality in care home services

Care home providers are responsible for the quality of the whole service and of residents' care plans. The regulator is the primary monitor of care home providers and the HSCTs care managers monitor the care plans of individual residents. The regulator, registered managers and care managers must work together to avoid duplication and omission.

However, across the HSCTs, social workers, nurses and allied health professionals identified a major part of their work as *monitoring care homes.* This has eclipsed assessments and care reviews to the detriment of residents and strays into inspection's

territory. The capacity of professionals to impact on outcomes appears to be greater in local, closely specified collaborations.

Conclusions

217. Information and advocacy are the foundation stones of social and health care assessment and care management. It is where relationship building with individuals, their families and communities begins. It is where the structural underpinnings of staying in-control, self-determination, involvement and participation are assembled.
218. This Evidence Paper draws a different picture of care management, not as the coordination of multi-professional activities, but as an administrative process from which older people and their families are excluded. Hospital Social Work could be seen as a secretarial process due to the pressures of early discharge. There is no doubt that feedback from social workers shows the systems limit their ability to carry out both the social work and the care management functions. Continuing relationship-based casework support to older people and their families is not common or prioritised.
219. The Adult Social Care Reform strategic priorities provide meaningful opportunities to reinforce a primary role for social workers in raising the profile and setting out what social workers can provide to support older people to live their lives with control, choice and a strong sense of wellbeing.
220. A detailed assessment of presenting problems – and strengths – and the contexts which may exacerbate or mitigate these should be central to discussions with older people and their families. They want (i) effective 'history-taking' which encourages practitioners to use reflection and to respond with empathy (ii) account taken of other relevant assessments, and (iii) an expectation of their willingness, and that of their relatives, to participate fully including writing their own assessments.
221. Deficit-focused processes which attend to only risk and limitations are both counterintuitive to the values of the professionals who lead and participate in care management and clearly contradict the statutory duties and responsibilities of HSCTs in delivering care management arrangements. The principle of ensuring service provision should, as far as possible, preserve or restore independent living must always be paramount. This is the context in which the suitability of care packages should be considered. The provision of choice and information should be firmly anchored as key imperatives of assessing individual needs and tailoring a suitable and enabling package of support.
222. As a minimum, HSCTs are required to offer the individual choice of a care home which can meet the individual's unique needs at a regional contracted rate. HSCTs need to demonstrate not only that the care home support being offered meets assessed needs but that it is fair and equitable in terms of cost. To do so requires an assessment process/system that empowers professionals to engage and involve older people and their families as equal partners.
223. The proposal in *Power to People* for a social worker-led community navigator role, when put alongside the notion of self-managed multi-disciplinary teams of community health care professionals, plays to the strengths of the social work profession. Assessment and care management is about supporting people to improve their lives.

224. The importance of clarifying the remit and legal powers of the RQIA and the HSCTs was identified in the Adult Safeguarding and Regulation and Inspection Evidence Papers. Since care homes' staff question the monitoring activities of HSCT personnel, clarification requires attention since it has become an enduring challenge. It is the role of care managers to undertake assessment and care management with individuals and their families. They should not be diverted into a role about checking care home compliance with standards. The interface between HSCTs' professionals assessing and reviewing older people's care and support and RQIA inspectors issuing failure to comply notices concerning breaches of care standards should not weaken the capacity of both to serve older people.

225. The increasing number of older people living in Northern Ireland indicates more people will need support. A system of assessment and care management can be co-designed by professionals and families that is adaptable to individual circumstances and flexible to changing needs. Such an approach will be central to improved responses and the right support arrangements. The weaknesses in the current system actually create demand whereas a move away from control holds out the win-win of getting people what they need and with time and cost savings.

Appendix A: Sources of data and information

a) Meetings[91] where assessment and care management were discussed along with other topics:

- 103 family members of residents in care homes. 86 of whom were DMCH resident's relatives including two who wished to remain anonymous. There were 17 family members related to residents in other care homes including one from another Runwood home and four who wished to remain anonymous. In all but two cases they told of elderly relatives being harmed and/or neglected. Six of the DMCH families loaned documents, including video recordings, photographs and contemporaneous records of failings in care. Some meetings took the form of semi-structured interviews, in groups and with individuals. Meetings with families spanned the period from 26 September 2018 and continued throughout the Review.
- Over 400 contacts with managers and providers of care homes; (including 189 at face-to-face meetings and the others at conferences, sessions and forums attended by the IRT);
- Four voluntary sector agencies and charities; Age NI, Alzheimer's Society, Association for Real Change, Action on Elder Abuse;
- Age Sector Platform;
- Federation of Small Businesses (FSB);
- Northern Ireland Ambulance Service (NIAS);
- Northern Ireland Health and Safety Executive (NIHSE);
- Eight PSNI personnel;
- Policy advisors, MLAs and local councillors;
- 176 individuals with responsibility across the five HSCTs for operationalising the policies and procedures;
- Managers networks' meetings convened by the RCN, ARC, NISCC and the My Home Life Team, University of Ulster;
- Two working sessions were held about complaints on 15 and 20 May 2019, attended by 78 people, care homeowners, providers and care home staff,
- Nursing and Midwifery Council (NMC);
- Northern Ireland Social Care Council (NISCC).
- Unison
- Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC)

b) **RQIA**

- 11 December 2018: Jennifer Lamont, Head of Business Support Unit, RQIA and Olive Macleod, CEO, RQIA.

[91] In respect of family members this includes face to face individual and group formal meetings, informal meetings at DMCH, the families' meeting called by DH, as well as telephone and email contacts. Contact ranged from multiple with some family members to single instances with others

- 19 December 2018: Full team meeting at RQIA.
- 15 January 2019: Meeting with Professor Mary McColgan Chair of RQIA, and later joined by Olive Macleod, CEO, RQIA.
- 18 April 2019: Meeting regarding the working session at RQIA.
- 12 June 2019: CPEA Working Session with the RQIA.
- 21 October 2019: RADaR session with the RQIA.
- 10 January 2020: Conference call with CEO.
- 16 January 2020: CPEA meeting with RQIA Board Members and senior members of the RQIA Executive Team.
- 10 March 2020: meeting cancelled by RQIA Board Chair.

c) **COPNI**

29 November 2018 (Conference call)
4 December 2018
6 February 2019
26 February 2019
4 July 2019
7 August 2019
9 August 2019
20 August 2019
29 August 2019
3 September 2019
19 October 2019 (Conference call)
23 October 2019
25 October 2019
17 December 2019
17 February 2020

d) **PCC**

11 December 2018
21 February 2019
10 April 2019
2 May 2019
6 June 2019
20 September 2019 (Conference call)
10 March 2020 (Conference call)
11 March 2020 (meeting with Independent Consultant)
12 March 2020

e) **NIPSO**

13 March 2019
4 April 2019

17 September 2019
24 September 2019 (Research Event)
13 November 2019
18 December 2019
15 January 2020 (Reference Group Meeting)
19 February 2020
12 March 2020
11 May 2020 (Conference call)

f) **NIHRC**
29 August 2019

g) **DH**
Reference Group
Meetings were held with DH officials throughout the Independent Review and four meetings of a DH convened Reference Group took place on 11 Feb 2019, 9 April 2019, 1 October 2019, 15 January 2020 and a meeting date was set for 31 March 2020, which was cancelled due to the Coronavirus, COVID-19.

Other DH Meetings
22 January 2019. Meeting with Permanent Secretary and Senior Team.
25 June 2019. Meeting with Permanent Secretary and Senior Team.

A DH convened meeting with 69 attendees of Dunmurry Manor Families took place on 11 April 2019 attended by the Permanent Secretary, Richard Pengelly and the Senior Team.

Chief Nursing Officer and Sponsorship Team for the Patient and Client Council (PCC)
7 November 2018, 13 December 2018, 7 August 2019, 17 December 2019. Meetings with Professor Charlotte McArdle, Chief Nursing Officer and on 7 November 2018 and 7 August 2019, Rodney Morton, Deputy Chief Nursing Officer was in attendance. On 17 December 2019, the team met with Heather Finlay, CNO Office, Professional Lead.

Chief Medical Officer and Sponsorship Team for the Regulation and Quality Improvement Authority (RQIA)
26 November 2018, 13 December 2018. Meetings with Dr Paddy Woods, Deputy Chief Medical Officer and on 26 November 2018, Fergal Bradley, Head of Quality, Regulation, Policy and Improvement Unit, was in attendance.

21 February 2019 and 7 June 2019. Meetings with Dr Michael McBride, Chief Medical Officer and Linda Greenlees, Acting Head of Quality, Regulation, Policy and Legislation Branch in attendance on 21 February 2019.

16 April 2019. Meeting with Donna Ruddy, Head of Quality, Regulation, Policy and Legislation Branch and Linda Greenlees, Acting Head of Quality, Regulation, Policy and Legislation Branch.

4 October 2019 Conference call with Donna Ruddy, Head of Quality, Regulation, Policy and Legislation Branch, Linda Greenlees, Acting Head of Quality, Regulation, Policy and Legislation Branch.

10 October 2019. Meeting with Dr Michael McBride, Chief Medical Officer, Donna Ruddy, Head of Quality, Regulation, Policy and Legislation Branch, Linda Greenlees, Acting Head of Quality, Regulation, Policy and Legislation Branch, Brian Godfrey, Principal of the Safety Strategy Unit (Complaints Policy Lead).

15 October 2019 Conference call with Donna Ruddy, Head of Quality, Regulation, Policy and Legislation Branch, Linda Greenlees, Acting Head of Quality, Regulation, Policy and Legislation Branch.

14 January 2020 Conference call with Donna Ruddy, Head of Quality, Regulation, Policy and Legislation Branch.

Complaints Policy Team
25 September 2019, 19 November 2019, 19 February 2020, 12 March 2020. Meetings with Brian Godfrey, Principal of the Safety Strategy Unit and Karen Jeffery, Deputy Principal of the Safety Strategy Unit was in attendance on 25 September 2019.

Social Work
28 August 2018, 21 November 2018, 22 May 2019, 11 June 2019, 5 July 2019, 29 October 2019, 18 November 2019, 19 December 2019, 10 January 2020 (Conference call). Meetings with Sean Holland, Chief Social Worker and Senior Team.

9 November 2018, 22 February 2019, 4 July 2019, 6 August 2019, 29 October 2019, 3 December 2019. Meetings with Jackie McIlroy, Deputy Chief Social Worker.

Workforce
15 January 2019, Meeting with Andrew Dawson, Director of Workforce Policy, Paula McGeown, Pay and Conditions Lead, Peter Barbour, Workforce Directorate Policy Adviser.

h) **HSCB**
15 November 2018
4 February 2019
26 February 2019
26 June 2019
8 August 2019
19 August 2019
3 December 2019

17 February 2020
20 February 2020
10 March 2020

i) **Health and Social Care Trusts**

Meetings took place with all the Health and Social Care Trusts throughout the Review.
15 November 2018, SEHSCT;
29 November 2018, 17 January 2019, NHSCT;
5 December 2018, 8 April 2019, 20 February 2020, BHSCT;
6 December 2018, 10 May 2019, 19 December 2019, SHSCT;
18 December 2018, 19 June 2019, WHSCT;
14 May 2019, 19 September 2019 (hospital social workers), 13 January 2020, all Trusts attended except WHSCT.
11 July 2019 meet of HSCT Directors
Trust representatives attended the meetings of the Reference Group and meetings regarding Safeguarding.

j) **Runwood Homes and Runwood Homes visits**

3 October 2018
8 November 2018
13 November 2018
22 November 2018
3 July 2019
10 October 2019
22 October 2019
31 January 2020
13 February 2020
26 February 2020
27 February 2020
Meetings scheduled for March 2020 cancelled due to Covid-19, Coronavirus.
All Runwood Homes in Northern Ireland were visited as part of the Review.

k) **Other home visits**

Visits were made to the other providers homes where the regulation and inspection process was discussed among other things.

25 September 2018 (Nazareth House Care Village, Camphill Community, Glencraig)
12 December 2018 (Nazareth House Care Village)
5 February 2019 (Park Manor Care Home)
18 February 2019 (Daisyhill Private Nursing Home)
6 June 2019 (Muckamore Abbey Hospital)
11 November 2019 (Nazareth House Care Village)
14 February 2020 (Ratheane Nursing Home)