healthwatch Staffordshire

Domiciliary, Residential and Nursing Care in Staffordshire

June 2016

Engaging Communities
Inspiring Change, Improving Outcomes

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Contents

1. Introduction

1.1 Healthwatch Staffordshire are an independent consumer champion in health and social care for residents of Staffordshire. We champion the consumer interests of those using health and social care services across the County and give local people an opportunity to speak out about their concerns and healthcare priorities. Our reports are designed to be transparent, clear, and easily accessible that create sustainable improvements in the delivery of services.

1.2 Healthwatch Staffordshire have undertaken this research into domiciliary and care home services in Staffordshire to understand the experiences of service users and providers of the current system and the needs of potential future users. The findings of this research will help Staffordshire County Council with decisions about the future commissioning of care services.

1.3 Participants in the research discussed the support that they received in choosing their care. Many of them had received support from social workers but the level of support and choice varied. For others families were the primary support in choosing their care provision. There was less support available for those people who funded their care themselves and for some being funded by continuing healthcare there was little or no choice in provision. Choice was lacking for some participants and it appeared that a move into care homes was often precipitated by an incident involving a hospital stay rather than an active choice.

1.4 Participants spoke about cost in relation to being able to afford additional care. Having to use savings to pay for care was also raised by service users. This was seen as a source of anxiety for service users. Providers raised issues around gaps between funding levels and the actual cost of care and consideration should be given to ways of closing that gap.

1.5 Participants spoke about staff attitudes and how a friendly approach was important to them. Dignity and respect were a recurring theme and staff attitudes can impact in this with the way that they approach service users.

1.6 Quality of care was important and the stories in the press of bad experiences in care homes and the poor care they had witnessed had an influence in the preference of future users for domiciliary care. However, current service users raised no particular issues with the quality of care. Some service providers seek feedback from service users and their families and wider use of this could help to improve care quality.

1.7 Service users of domiciliary care in particular raised the importance of continuity of carers as it helped build relationships between the carer and the service users. This was also echoed by a service provider who saw it as helping understanding of care plans. However, continuity was not always there partly due to issues around staff recruitment and retention. One provider had successfully taken the approach of paying higher hourly rates and providing high quality training in order to foster staff retention.

1.8 The time and length of calls were issues raised by both users and potential future users of domiciliary care. There was a perceived lack of flexibility over times and that they were set by the needs of the service provider rather than the service user. The lack of a night time service was also raised by some service users. The length of calls was seen to be too short by some to properly deliver care. A provider told how their minimum call was 30 minutes even if it was unfunded.

1.9 Loneliness was a factor for domiciliary care and care home service users, it was more marked for those in older person's care homes. Some of this was because of the conditions of other residents and some because of the loss of outside friendships.

1.10 Service users were asked about whether they were able to meet their aspirations. Many of them failed to answer the question and actual responses were mixed. Being able to take part in activities inside and outside the home were important to meeting the aspirations of people with learning disabilities and for those in a residential care setting these were largely supported. However, support for those using domiciliary care and for older people both in care homes and using domiciliary care was limited.

1.11 Families had a large amount of influence over the choice of care providers and they were also pinpointed as an important support in managing budgets. Although care providers said that they involved families this was not always the perception of families themselves. However, domiciliary care services were pinpointed as a valuable support for family carers that meant that they were able to continue in their caring role.

1.12 The findings of this research has resulted in a number of recommendations for both service providers and the local authority.

2. Background

2.1 The provision of domiciliary care in Staffordshire has been a Healthwatch Staffordshire priority during the past two years. In order to facilitate contact with service users accessing Domiciliary Care Healthwatch Staffordshire have worked with Staffordshire County Council (the Council) and expanded the scope of the project to include people receiving care home services too.

2.2 The Council currently supports 5,500 older people to live independently at home in the community and 3,000 people within care homes. This is currently delivered through approximately 90 domiciliary care providers and over 500 care homes.

2.3 The Council is commencing a programme of work to re-commission domiciliary care and care home provision. Healthwatch Staffordshire have undertaken engagement with individuals who use services, families, carers and service providers to seek their views and ideas on future development of domiciliary and care home services. The intention of the engagement is to help to inform the Council's commissioning of services.

Plan & Methodology

3. Objectives

3.1 The overall objective of this research was to seek individual's views and ideas regarding the future development of domiciliary care and care home services which will be used as evidence to inform new service specifications.

4. Methodology

4.1 The research aimed to engage with 200 recipients of services, split between domiciliary care and care home services. 1156 paper surveys were sent out to providers who indicated that they were willing to circulate surveys to their service users. Each was accompanied by a business reply envelope to aid the return of the completed surveys. 115 replies were received and the split between care home services and domiciliary care were 32 and 77 respectively with a small number identifying themselves as having other care but comments suggested that they were receiving domiciliary care. Figure 1 below shows the type of care that respondents to the survey were receiving.

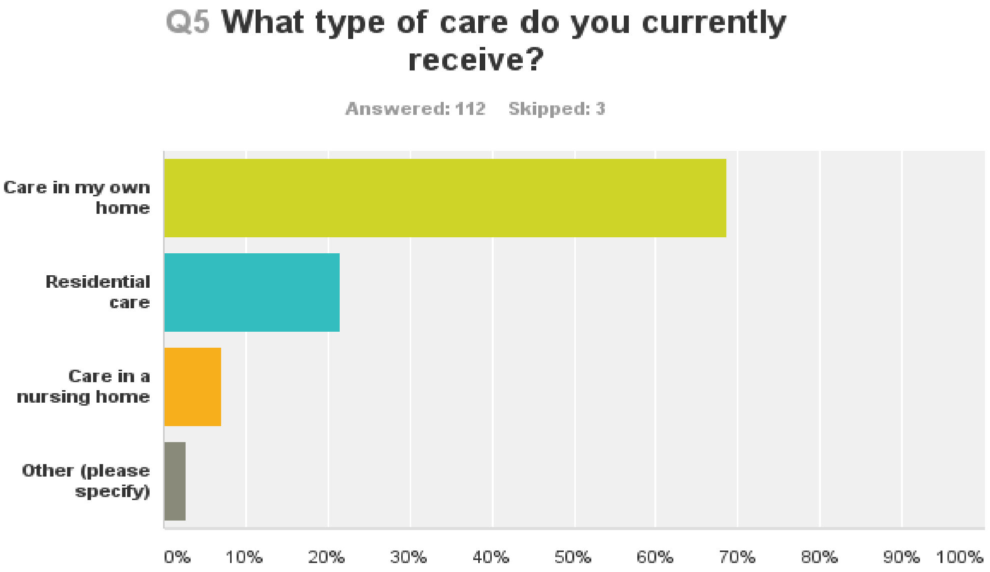

Figure 1

4.2 Surveys were not all completed by the service users themselves due to carrying degrees of ability to complete them. There was scope built into the surveys for people to complete them on behalf of the service user. However, the largest single group completing the survey were the service users themselves. Figure 2 below shows the breakdown of people completing the survey.

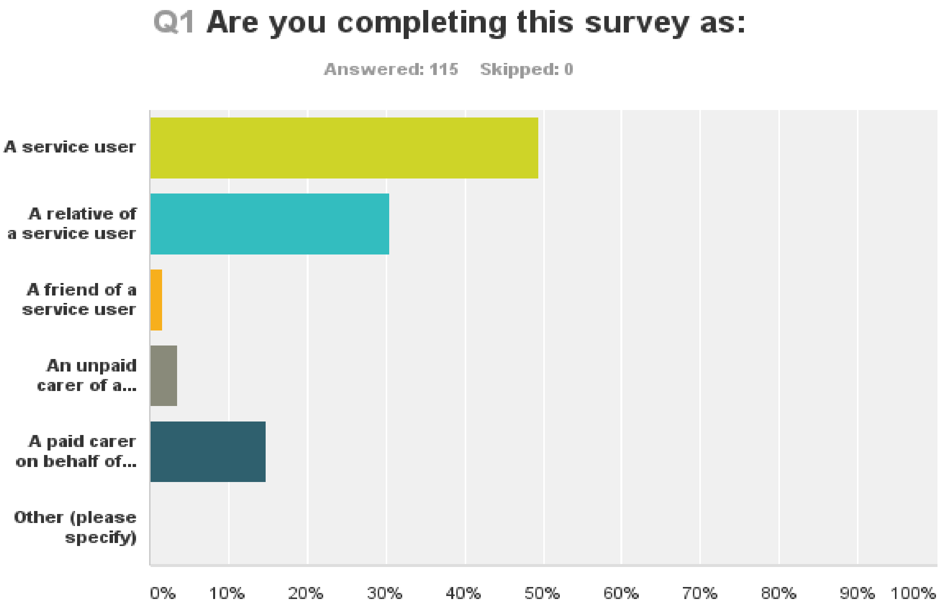

Figure 2

4.3 Survey respondents came from across Staffordshire although none identified themselves as being from Stafford Borough, despite service providers in the Stafford area having been contacted to take part. Figure 3 below shows the geographic breakdown of respondents to the survey.

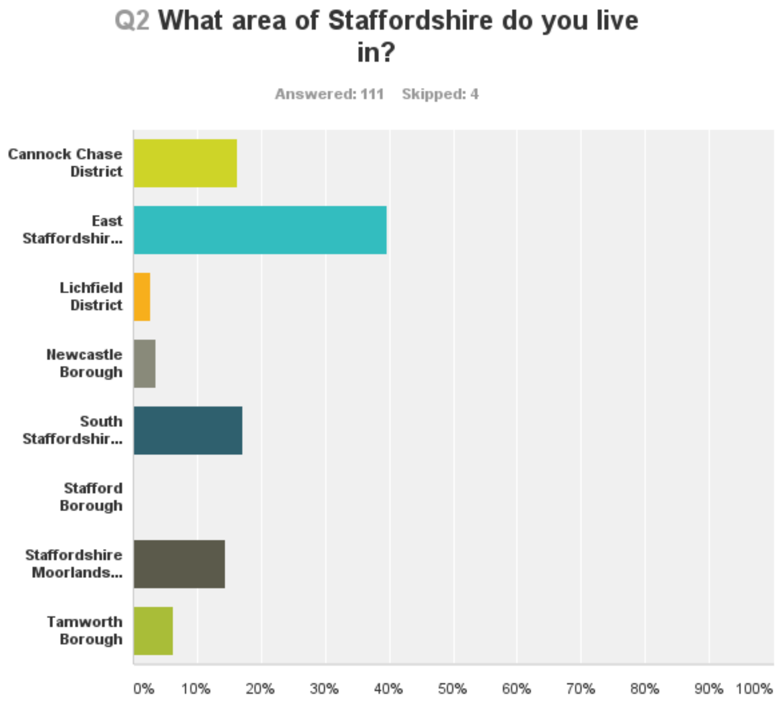

Figure 3

4.4 People who receive learning disability services were a much smaller cohort than those accessing older person's services however, this may be expected as there are higher numbers of older service users generally. The chart below labelled figure 4, shows the percentage breakdown of responses from older people or people with learning disability.

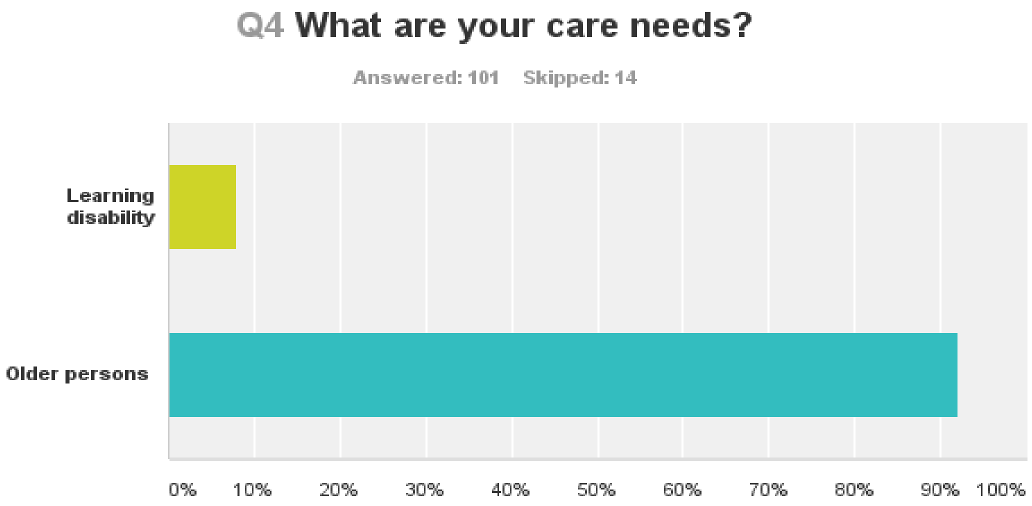

Figure 4

4.5 There were no specific requirements for respondents to have their care funded by the local authority and so there were a range of funding types amongst the respondents, although people who funded their own care were the biggest group. Figure 5 shows the percentage breakdown of how care was funded for participants.

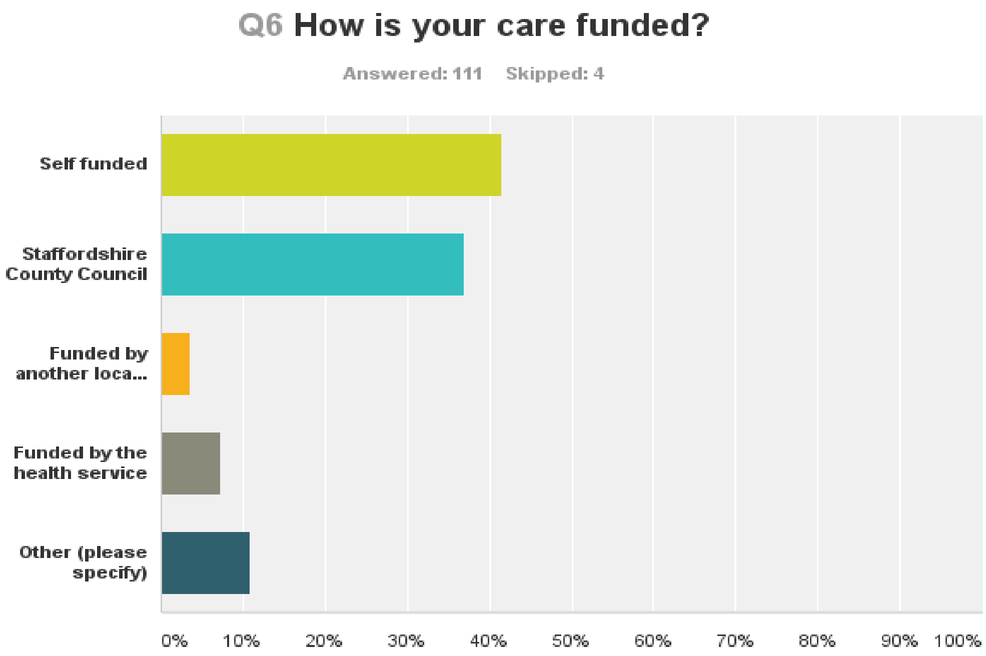

Figure 5

4.6 There were also 15 semi-structured interviews undertaken with service users of residential care services including 6 with people with learning disabilities and 6 with people with dementia related conditions the remaining 3 participants were older people. The interviews followed the same basic questions as the survey questions but allowed scope to explore answers more thoroughly.

4.7 Eight semi-structured interviews were undertaken with service providers. These included providers of residential, nursing and domiciliary care. One was a provider of both residential care and domiciliary care and the other providers provided domiciliary care services.

4.8 Potential future users were targeted through the use of focus groups and three groups were undertaken through existing support group meetings. A total of 26 people took part in focus groups for potential future users.

4.9 A further focus group was undertaken by Asist with people who have learning disabilities. There were 15 people who took part in the focus group and nine of them were current users of domiciliary care services.

4.10 At the request of the Council a further focus group was undertaken with service users of residential care who had physical disabilities. This group consisted of seven participants.

4.11 There was also a request that physically disabled people using domiciliary care services and people with mental health needs using domiciliary care and residential or nursing care were interviewed for the project. Despite contacting a number of providers only two agreed to send out requests to their service users and there was no response from those requests. Contact was also made with a mental health support organisation in order to see if they could identify potential participants but they were unable to do so.

5. Quality plan

5.1 ECS and Healthwatch Staffordshire have a responsibility to ensure that the evidence and insight it created is of high quality and aligned to best practice across the industry. Research ultimately provides the evidence on which sound decisions should be made, which is why it is important to state up front how quality has been ensured throughout this project as shown below.

5.2 ECS and Healthwatch Staffordshire underpin our research activities by applying the Market Research Society (MRS) Codes of Conduct, which allows us to demonstrate that we are credible, fair and transparent. ECS is an MRS accredited Company Partner.

5.3 ECS and Healthwatch Staffordshire also adhere to a strict data protection policy which ensures that:

- Everyone handling and managing personal information internally understands that they are responsible for good data protection practices.
- There is someone with specific responsibility for data protection in the organisation
- Staff who handle personal information are appropriately supervised and trained
- Queries about handling personal information are promptly and courteously dealt with
- The methods of handling personal information are regularly assessed and evaluated
- Necessary steps are taken to ensure personal data is kept secure at all times against unlawful loss or disclosure.
- ECs have firm guidelines for data storage, data retrieval, data security and data destruction. There is also a strict process in place should a data breach occur (which includes containment and recovery, assessment of ongoing risk, notification of breach, evaluation and response).
- To further ensure the quality of the final report, an internal peer review process was initiated to ensure that the report is fit for purpose before submission. Where data was not robust it would have been statistically suppressed to prevent disclosure. This was not needed for this piece of work.

Findings

Themes

6. Choice

6.1 Service users were asked about the support that they had received in choosing which care service to use whether they were self-funded or by their local authority or continuing healthcare. It is clear that for many they had support from social workers in making their choice. See appendix for the surveys that were used.

6.2 Figure 6 below shows the words that people used in their responses about the support that they received in making choices about their care. It is drawn from the survey responses and the larger the words the more frequent the usage of the word.

Figure 6

6.3 However, the involvement of social workers was variable with some saying that their social workers had 'supported me to choose where to live' but for others the social worker made the choice for them. One commented that 'my social worker chose here for me. There were no other options discussed.' Whilst there are sometimes issues around capacity in being able to make choices of where to live there appeared to be less choice afforded to people who were being funded by the local authority. The comment about being supported to make a choice came from an interviewee who had learning disabilities whereas, the comment about not having a choice was made by an older person.

6.4 One participant expressed a view that where people were not funded by the local authority there was less support available with one family carer saying that she had visited a number of nursing homes for her husband and that nobody from social services would make a recommendation. However, another service user said that a social worker had made a recommendation. The difference between these two participants was that one was self- funded and one was funded by the local authority.

6.5 One service provider commented that they did not receive referrals from social services because ‘the cost of care can come into decisions made by social workers as they will have preferred homes that they use as they are constrained by budgets.’ This particular care provider had the view that they were more expensive than some others due their higher wage costs and enhanced service.

6.6 With this in mind it appears that there is variable support in choosing a service provider from social services based on who is paying. For some that are self-funding they felt that they receive little support in making decisions despite the importance of that decision and those that are being funded by the local authority are denied a wider choice due to budget constraints. For both groups there is the potential that they are missing out on the best care for their circumstances.

6.7 For other service users support was provided by their family members and indeed the choice of provider was made by their family. On occasion the decisions made by families were not welcomed. One resident of a care home told us ‘It was a big shock. My daughter put me in here. I had no choice in coming here. She brought me here one Sunday afternoon. I asked “what is this place?” and she said “this is where you live.” It didn’t go down well.’

6.8 Experiences like this calls into question how much assessment is carried out prior to people moving to the home and whilst there are considerations like capacity to make decisions for some people the lack of choice made by the resident is a cause for concern. Allowing the resident to at least have had visits and an assessment of suitability prior to moving in would be preferable. One provider did speak about how they carried out assessments. 'We don't just take anyone. We go out to assess all potential residents to ensure that the setting is appropriate.' But for others the assessments are made during the initial period of the resident living there as one provider explained. 'Within the first six weeks the client assesses whether they like it here and staff are able to assess whether they can meet the client's needs.' Whilst the six week assessment period does enable both sides to make an assessment of the reality of the care setting there is also an impact of uncertainty when a placement breaks down and the need to then find another care home.

6.9 For a number of residents of care homes there were comments about the lack of choice in going into a care home although they did recognise on the whole that it was the best option for them. One resident commented that 'I didn't really make a choice. I fell at home and went into hospital. I ended up in here. It is a lot to cope with and my family aren't nearby.' She went on to say 'I wouldn't want to go back to my own home. I am happy here, honestly. My own home would be a worry.' Another service user commented that they were resigned to being there stating that 'I've got in it in my head that I am going nowhere else. '

6.10 For participants in focus groups for future service users there was a preference for domiciliary care rather than going into a care home with one of then commenting that 'it is a preference to stay at home.' For some who were carers of a family member there was a belief that the person that they care for would be resistant to entering a care home. 'I'd rather have carer's in because he certainly won't want to go into a home.' However, for the family carers any type of care was seen as a last resort. 'I think we all agree that whilst we have the health and strength to look after' we wouldn't have any outside care provision. This preference appears to support the notion that few people actively choose to enter a care home and that their moving to one is often the result of an incident or crisis and are a consequence of a hospital admission.

6.11 Respondents to the survey also said that they had received no support from anywhere in making decisions about what service provider to use. For one survey respondent they said that they had received 'not a great deal. And the first care provider was appalling.'

6.12 For some respondents there has been help in choosing a service from healthcare providers, either through a discharge care package or via their GP, although the latter was less common. However, there were sometimes issues between the NHS and social care and one respondent commented that they would have had no support 'without pressure from the local hospital.' However, others gave examples of where there had been good support with one saying that they had had 'support of social worker and the team at Samuel Johnson and Queens Hospital to arrange care package.'

6.13 However, one provider raised concerns with the way in which care is procured for those that are being financed through continuing healthcare. She explained that the home that she manages does not take people who are funded in that way because they have fundamental issues with the lack of choice for service users under the system as she described it as a system by which providers 'bid for the contract.' She went on to describe it as the 'most horrific way of providing care.' She said that she had to explain to families who approached them 'they don't get a choice about where their relative goes and we didn't take continuing healthcare for that reason.' However, this was a view expressed only by one provider and another provider said that they did take people through continuing healthcare. This provider is a specialist service and this may have a positive influence on how much choice there is for service users with a smaller number of providers nationally.

6.14 The information that is available to people in order to make a decision about the care services that they use is variable. This in some ways may be influenced by the nature of the service and the capacity that service users have to make an active choice. Survey respondents spoke about having someone explain to them about 'the alternative services' and another said that they had 'visited my residential home.' Although service providers spoke about their websites and service brochures these were not mentioned by service users, suggesting that they have limited impact.

6.15 Although survey respondents gave variable answers on the support that they had received in making decisions on what care service to use when asked to rate the support that they received the majority rated it favourably. Figure 7 shows the breakdown of how people rated the support and information that they received in choosing their care service.

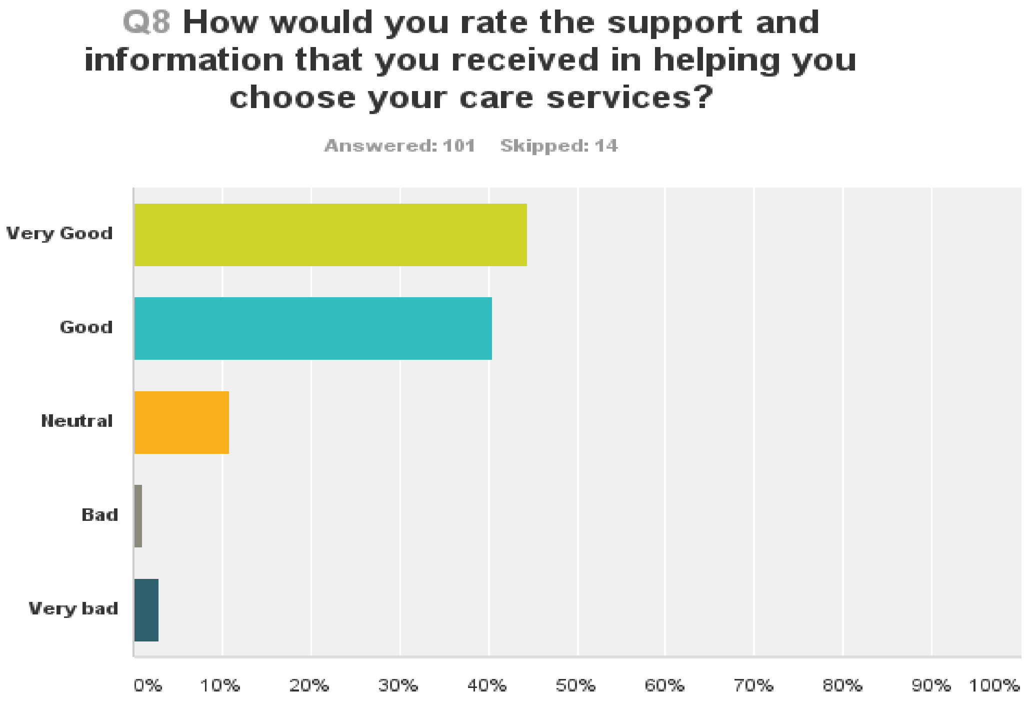

Figure 7

7. Cost

7.1 For survey respondents who fund their own care cost was raised as an issue with suggestions about it being made cheaper so that carers can be here for longer.' Alternatively, it was suggested that there should be more help available to pay for care with one respondent talking about how their relative had to pay for care. 'Dad has some savings, not a great deal, just above the threshold. It seems most unfair that he has to use that to fund his care. It worries him a lot.' Our conclusion from this is that reducing the cost of care whilst attractive would have wider implications for service delivery and for some providers would be impossible to accommodate.

7.2 Providers spoke about costs and how for those service users that were being funded by the local authority there was often a gap between what was paid and the actual cost of providing the service. This was raised by both a domiciliary care provider and a care home provider. A care home manager spoke of different levels of funding depending on the local authority. She commented that 'funding rates are quite low and they are lower with Staffordshire than with East Cheshire.'

7.3 A domiciliary care provider there was a belief that they did not receive referrals from social services because they cost more than other providers. Their costs were in part due to their paying care staff above the usual rates. The provider said 'we pay £9 an hour whereas most providers pay the minimum wage.'

7.4 Wage costs were also discussed by the care home provider in relation to the introduction of the national living wage and the failure of the local authority to adjust their rates to take account of the additional costs. They commented that 'when the living wage came in the cost for owners in terms of wage bills went up 8%, whereas Staffordshire increased their rates by 1%'.

7.5 Whilst a reduction in costs would be attractive to self-funders and local authorities facing funding cuts the reality could be that there would be a reduction in services as providers were unable to keep providing care such as a situation spoken about by one respondent where they had to find a new provider ‘as our old carers went out of business.’

8. Staff attitudes

8.1 Participants in the research whether completing a survey, taking part in an interview or a focus group felt that the attitudes of staff were important in the care that they received or may receive in the future.

Figure 8 below shows the words that people used in survey responses about the attitudes of staff involved in their care.

Figure 8

8.2 The attitudes of staff can have a particular influence on how someone views their care overall. One resident of a care home pinpointed her emerging dissatisfaction with her care provision as relating to the staff at the home saying ‘I just don’t like some of the people.’

8.3 She also said that she had liked the home when she first moved there but that there had been changes there in relation to the staff and she no longer liked it so much.

8.4 Service users across the research methods commented that being treated with dignity and respect were important to them. Staff attitudes towards the people they are caring for place a large part in whether service users felt that they were treated with respect. One focus group participant spoke about an incident when they were looking for a home for a relative.

‘We went to look round one and the person showing us around, I don’t know if she was the manageress. She didn’t knock before she went in the room but the person was on the toilet. But she apologised to us… not to the person on the toilet. I though how terrible.’

8.5 Another service user with learning disabilities who used domiciliary care also commented on how the carers ‘give me no privacy, they just walk in.’ This lack of privacy for service users indicates a lack of respect for the service user by the carers. Training needs to be in place to ensure that staff consider the impact that their actions have on the dignity of service users.

9. Quality of care

9.1 For future users of care services the quality of care was a primary consideration. At the focus groups there was a preference expressed for domiciliary care rather than being in a care home. This was in part due to poor perceptions of the quality of care in care home settings with some equating care homes with one commenting we’ve heard bad reports in the press, about what happens, I don’t particularly want him knocked about.’ Others based their views on what they had witnessed in care homes when their friends or families were residents. One said how she had witnessed ‘there was often a bell ringing down the corridor, somebody ringing a bell and ringing a bell, and calling out and they weren’t going to their rooms.’ Another spoke about a family member who had become resident in a home and ‘they’d get her sitting in a chair. Tea break would come and they’d give her a mug of tea. Then they’d come round half an hour later and she hadn’t touched it because it meant nothing to her. And they’d say “oh aren’t you thirsty?” and take it away again.’ This lack of awareness and care can have a detrimental impact and there is evidence to suggest that there are issues with dehydration in care homes leading to hospital admissions. [1]

9.2 Training for staff providing care is important in ensuring that there is quality care and one provider explained how ‘we spend a lot on training. A lot of our service users have high level needs. We train people over and above what they need to make sure they are competent.’ Other providers did not specifically mention training other than one provider who said that they have their own training company that works with the job centre to train long term unemployed people to provide care and then guarantees them an interview.

9.3 From the feedback from providers regarding the need to provide training it can be inferred that ensuring that staff have quality and ongoing training is key to ensuring that the quality of care is maintained and that resident and their families are reassured about their care.

9.4 Whilst for those who were not using services currently there were some poor views of care homes there was little feedback from actual service users suggesting that there was poor care in their care home.

9.5 In the same way people who completed the surveys and who were receiving domiciliary care were on the whole happy with the care that they were receiving and had no suggestions to make to improve the care. However, there were some comments from domiciliary care users about small improvements that could be made such as one who said that she wanted her carers to ensure that they ‘wrapped up food’. Whilst suggestions like this may seem to be relatively insignificant they do show that there is a need for service user’s preferences to be listened to. A number of

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[1] Steve Ford, 16 January 2016; Nursing Times; www.nursingtimes.net/roles/older-people-nruses/dehydration-common-in-patients-admitted-from-care-homes/5078175.fullarticle

survey respondents said that being listened to was important to them in their receipt of care with comments like ‘making sure that I am heard.’

9.6 Being able to maintain their personal hygiene was a persistent theme with service respondents and there were comments about being able to wash and get dressed. One survey respondent said that it was important to them ‘that I am washed and clean.’ And this was echoed by other respondents. However, it was not always the case that people were kept clean and one focus group participant spoke about a relative in residential care being dressed in ‘stained clothes, when they have a wardrobe of clean ones’. They also cited examples of when a home smelled bad and how this made them reluctant to use that particular home. One participant said when she had been visiting homes ‘you go into these homes and the impression that they give even when you go in, the smell, err, you wouldn’t want to put anyone in there.’

9.7 To ensure that quality is maintained one service provider told us how they collected feedback from service users, their families and social workers. He said that ‘we share feedback with the staff’ and this meant that they were able to ‘act on concerns very quickly.’ None of the other service users said that they did anything like this although we are aware of some domiciliary care providers sending out surveys to their service users at the same time we were undertaking our research. For those that were not carrying out such exercises it may be something that they may like to consider. A family carer whose relative had received domiciliary care for a short time told us that she had written to the care provider with some suggestions but had not received any acknowledgement from them. This lack of responsiveness suggests a reluctance to listen to service users concerns.

10. Continuity of care

10.1 For users of care home and domiciliary care services, continuity of care was seen as being important in care services. It was also the case that for future users continuity was also pinpointed as being of importance.

People spoke about the importance of knowing who was coming to their home with one saying that they had a ‘rota [that] helps me know who is coming.’

10.2 They also spoke of the need to develop a relationship between the service user and the carer. One family carer of a person with Alzheimer’s commented that having that relationship may mean the carer would be more tolerant. For another service user that relationship was important because ‘you need to be able to trust the people who come into your home’. One service provider spoke about how building relationships with service users can help put information in the care plan into context and improve the care that is provided.

10.3 The need for continuity of care is impacted by the turnover of staff that some providers experience. One provider commented that ‘staff turnover is a massive issue.’ She went on to explain the difficulty in recruiting new staff saying that ‘the quality of applicants isn’t brilliant and there aren’t that many of them. We get very limited numbers of CVs and the market is very competitive.’

10.4 However, another provider who pays an above average wage said that they did not have any issues with recruiting or retaining staff. He said that ‘we pay above and beyond the going rates. I thought that if we create a nice place to work it would help staff retention. We have been operating a care home for a couple of years now and only had one member of staff leave.’ The same provider said that in exchange for the high rate of pay they expected the best and where that wasn’t forthcoming they had processes for dealing with it. They also provided a high level of training which is also shown to have a positive impact on staff satisfaction.

10.5 This suggests that there are good reasons for providers to invest in staff wages and training but this is made difficult when there is a squeeze on costs in order to continue to be viable. Whilst this may be assumed to be an issue just for local authority funded places there is also consideration of how shortfalls in funding can impact on self-funders in terms of providers needing to make back the losses from local authority funding.

11. Time of calls

11.1 For people using domiciliary care there were comments about the times of calls and the need for flexibility to make changes to suit the service user. There were also comments from future users of their perceptions of people being put to bed very early in order to suit the care provider. One future user spoke about when her husband had had care following discharge from hospital ‘they were putting him to bed at 7.30pm and not getting him until 11 the following morning.’

11.2 Others commented about the need for domiciliary care being available during the night as well, but that it wasn’t available other than at very high cost she commented that ‘domiciliary care offers no facility at night unless you are able to pay vast amounts for it.’ In these situations there are no options other than care homes which for one participant meant putting her husband into a home against their wishes. ‘I had to put my husband into a home. I was devastated. It upset me more than when he died.’ This lack of flexibility coupled with a lack of affordability meant that for this couple they were separated against their wished and it meant that they spent the last few months of her husband’s life apart. This demonstrates again how the system means that there is a lack of positive choice when there was a preference for domiciliary care albeit at an intensive level. This particular participant commented that had her husband had cancer rather than dementia there would have been more help to keep him at home and it would have been provided at no cost to them.

11.3 There was a sense that participants felt that the time of calls was dictated by the needs of the service provider rather than the needs of the service users. One participant said that ‘the office decides on the time that they come, not me.’ There were also comments made about the lack of flexibility in being able to change the times of calls in order to allow service users to participate in activities. One learning disabled participant said that ‘I can’t change the carer’s time, so that I can do the things that I want to do.’

11.4 In addition to the planned time of calls participants in focus groups and respondents to the survey raised the need for reliability on the times of calls. One participant told of how the lack of reliability on times of calls had caused her more stress than simply caring for her husband herself, despite her undergoing treatment for cancer at the time. When she was having radiotherapy she said that she 'had to go to Wolverhampton Hospital every day for 8am.' The carer was supposed to come at 6am as she and her husband needed to leave at 7am. They turned up at 7am. 'This went on for two or three days' before she cancelled the carers and managed on her own. Although for some family carers the provision of domiciliary care means that they continue to care for their relative at home for some carers the experience of domiciliary care is negative and prevents them from considering using it in the future.

12. Length of calls

12.1 As well as the timing of calls respondents to the survey suggested that the length of calls should be increased because they weren't long enough to do everything that was needed. This was echoed by a service provider who said that 'there isn't much you can do in 15 minutes. If they need changing, etc. and then a meal making.'

12.2 Although social services assessment may be that a 15 minute call was all that was needed this particular provider had a minimum call length of 30 minutes and meets the additional cost themselves. He said 'I tell the carers to stay for 30 minutes even if we are only being paid for 15 minutes. We don't do 15 minute calls.'

12.3 Participants in focus groups also commented that they would want longer calls believing that short calls were inadequate to meet all care needs. One participant said 'how can you get someone out of bed, washed and showered and dressed and breakfasted in 20 minutes?'

12.4 Some existing service users said that they would like some calls to be longer with one commenting that 'the 15-minute evening call is not really sufficient.'

12.5 Consideration needs to be given to the funding of longer calls as there appears to be agreement that the existing length of calls is too short, particularly for those with more complex needs and who require more care such as bathing and meals making.

13. Companionship

13.1 For people considering what they want from care services in the future, moving to a care home setting, there was a view that it could provide companionship. One focus group participant said ‘if you’re on your own and you go into a home, you’ve got companionship and so and so forth.’ For one resident of a care home also said that she felt that ‘we are better here than being in our own little house with nobody. We don’t feel lonely.’ However, having to make new friends wasn’t necessarily seen as a positive with another participant saying ‘that’s another thing having to meet new people going to live in a residential and you’re 70 or 80 something and who would you be able to strike up new friendships with? It’s difficult isn’t it?’

13.2 This was echoed by some care home residents saying that they still felt lonely even in the home because of difficulties forming new friendships. One resident commented that she had not made friends because the other residents had varying degrees of dementia. She said ‘the other residents don’t talk much because of their conditions’ As a result she was quite dependent on the staff of the home for company. Another commented that ‘I like conversation but you can’t have a conversation with the other residents.’ As a result ‘sometimes I feel very lonely.’

13.3 A focus group participant spoke about how her mother had kept to her room and not mixed with other residents. This had been the norm for residents in that particular care home and it was reflected in comments from some of the interview participants in older people’s residential care with one participant saying that ‘I only bother with [name], keep myself to myself.’ In this case she was only friendly with the person in the room across the corridor and tended to keep to her own room.

13.4 For people in residential care the feeling of loneliness can be exacerbated by their lack of visitors and the loss of friendships from when they were living independently.

Whilst it wasn't the case for everyone there were a number of residential care users who said that they no longer had contact with old friends. One resident said 'I don't see my friends now I am in here' and another said that 'my other friends are too far away.' A lack of visitors meant that feelings of loneliness could be exacerbated and one care home resident commented that she was 'envious of people who get more visitors.'

13.5 For some the only relationships that they had were with the staff member of the care home. It was suggested by some future users that there should be arrangements in place to have visitors to come to homes to ensure a change of company. It was suggested that inter-generational contact with young people coming into the home would be beneficial. One focus group participant said 'one of our friends used to keep a retirement home, but she believed in having young people going into the home and having contact with old people. The residents used to really look forward to them going in and just having someone different.'

13.6 One relative of a domiciliary care service user commented that 'Mum gets anxious alone for times in between carers and family and this needs addressing.' It was suggested that there should be an additional befriending service for people using domiciliary care who live alone to help combat anxiety about being alone and also to provide companionship. However, it is apparent that feelings of isolation are not confined to those who are living alone in their homes with carers coming in and is a wider issue.

13.7 It was notable that residential care homes that catered for younger people with physical and learning disabilities do make provision for supporting visits to friends and family which maintains links and helps to combat feelings of isolation. One provider commented that contact with family and friends will be included in care plans and one service users told how family, friends and football are important to me. I have regular contact with family and friends.' This however, did not necessarily translate across to domiciliary care for people with learning disabilities with one service users saying that they *'feel isolated. I can't see my friends.'*

14. Activities

14.1 Service users were asked if they were able to achieve their aspirations. The percentages that responded are shown in figure 9.

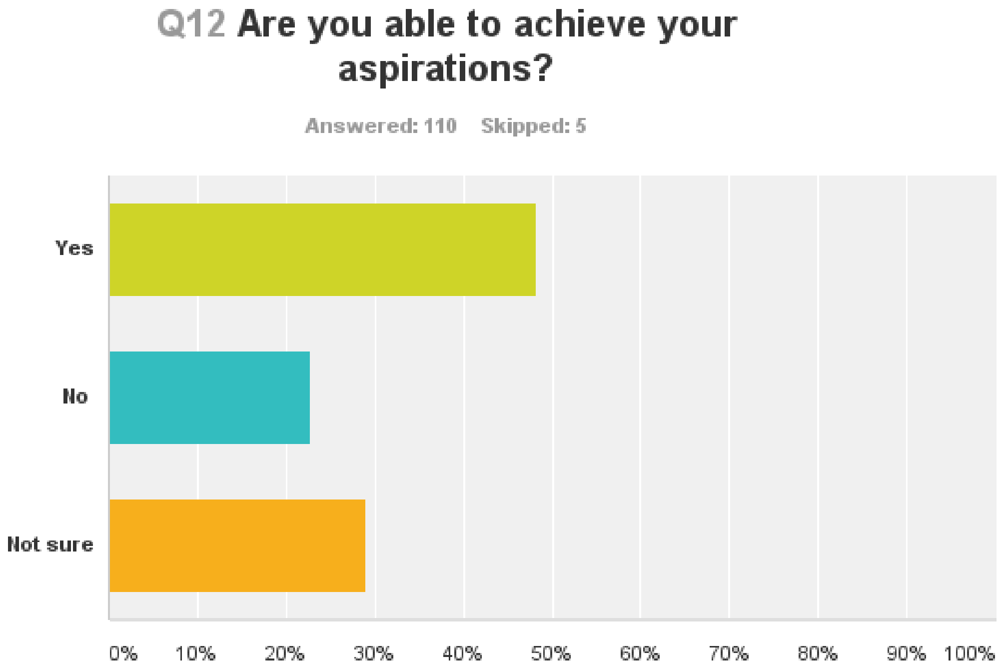

Figure 9

14.2 Many declined to answer the question and may be considered to be unsure about whether they are able to meet their aspirations, but for some being supported to take part in activities either in their care home or outside played a part in whether they felt they could achieve their aspirations. Once again it was notable that based on the comments by providers and participants in the interviews those with learning disabilities were more likely to be taking part in activities than those in older person's care home settings or those receiving domiciliary care.

14.3 Those in a learning disability residential setting were being supported in a variety of ways including going to college. One service user commented that 'with the support of staff I go out and have been to college and am getting a tattoo!'

14.4 Providers also spoke about how they had supported residents to attend college, although for some of their residents their aspirations were lower, being described as simply wanting to be happy. Where those with learning disabilities were supported to take part in external activities the staffing levels were described as being 'two to one'. Whilst the levels of supervision needed for older people may not at as high as two to one it may be expected that there needed to be a higher ratio of staff support out in the community and this clearly has a cost implication and may explain why there was less of an emphasis in activity outside the home for older persons' provision. One provider of care for older people did also comment about the difficulties of being able to access services saying 'access to community services closes once they are in a home and it can be difficult to overcome that.'

14.5 Some of those that were in older persons care homes did have access to activities within the homes with singing being observed in one setting and cake decorating in another. A focus group participant told how she had gone to a home as part of a group to teach the residents how to knit. 'Once a month we'd go to a nursing home, teaching the residents how to knit because a lot had forgotten. You'd be surprised at the glow on their faces when they saw us walk through the door.'

14.6 One home had taken residents on a trip to Wales but one resident felt that 'they could do with taking us out more often' and said that 'sometimes we don't get to go out at all.'

14.7 Being able to go out, even just into the garden, was a recurrent theme for care home residents and potential future users. A focus group participant said that 'I visit someone in a nursing home and no-one seems to go into the garden, even on a sunny day. I'm surprised on a sunny day that one of the carers doesn't persuade a little group to go and sit on a garden bench or something.' One resident commented that

'I have an electric wheelchair that I have never been able to use because I can't go out on my own.' Being a resident in a home and not being able to go out impacts on the independence of the resident and consideration needs to be given to how residents can be supported to maintain their independence of free movement. The Joseph Rowntree Foundation found that it was important for older people to be supported to engage in external community activities. [2]

14.8 However, when some were asked if they had been able to continue with hobbies and interests they said that they had not. 'What could I do here? I used to do a lot of baking. I am not able to have hobbies in here.' This differed to the experiences of people using learning disability care where they were supported to take part in hobbies and activities. 'I like to go out and about and enjoy the good weather. I go to the 80's disco and go on holidays.'

14.9 Providers spoke of trying to meet their service users' aspirations but also spoke of the additional costs that they entailed. 'We recently enabled a resident to go to Euro Disney. It wasn't cheap but it was the right thing to do.' For other providers there was sometimes a need to increase their staffing in order to support service users to access activities 'extra staff are employed to enable this to happen on a 1-2-1 basis.' Taking on additional staff obviously has an implication on costs for the care provider. However, those that had done additional activities spoke of it being worthwhile. 'It takes a lot of planning but it is worth it.'

14.10 There were also issues raised about ensuring that the aspirations of service users were appropriate to their situations and being sensitive to their capacity to achieve them. One provider spoke about how one of their service users 'wants to live on his own but due to his condition this isn't possible.' This was also a similar issue as for another provider of services for people with learning disabilities. She explained that there was a need for a sensitive approach 'we do have conversations with them about working towards supported housing but at the moment there is only one here where I

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[2] Joseph Rowntree Foundation, My home life: Promoting quality of life in care homes; October 2012

think that would ever be a possibility…I wouldn't want to put a time limit on her time here or on any resident.'

14.11 For those who received domiciliary care services there was not support to take part in activities and many respondents spoke of their age or poor health as being barriers to achieving their aspirations. One respondent who cares for their relative explained that they were 'very limited in what Dad can do now. Very dependent on carers and family.' But that the care provision had enabled him to 'achieve his goal of getting home after five months in hospital.'

15. Family Involvement

15.1 Care providers spoke of involving families in the care of their relatives and this is particularly pertinent considering that large numbers of respondents said that their families had either chosen or helped to choose their care provider. The development of care plans was particularly mentioned in relation to involving families saying 'we meet with families so that their views can be taken on board as well.' The providers that particularly spoke about involving families with care plans and decision making were those that provided services for people with learning disabilities or younger people with a range of disabilities.

15.2 However, one relative whose family member used domiciliary care commented that they had not been kept informed when their son had become ill and told of the impact that it had.

'[Name's] care is generally good on the whole but there are occasions when I could be better informed. If on occasions he is not well…it would be nice to know so if necessary a doctor or advice could be given. A few weeks ago he was in severe pain but it was only when he was crying down the phone that I could do anything. The carers had not told me.'

15.3 Domiciliary care has a role to play in supporting family carers with one commenting that they 'couldn't cope without the professional team coming in.' However, for some they would only consider using a care service in an emergency or if something had happened to the main family carer. One family carer told how 'my wife won't let anyone else look after her. Therefore, I can't see a need for this type of care unless there was an emergency need.' For some there needed to be the flexibility in the system for them to be able to call upon a care provider when they were needed at short notice. This included for those where there could be changing needs during the day

15.4 Survey respondents were asked how they would prefer their budgets to be managed and for a large number they chose to have their family member managing their budgets rather than having responsibility for their own budget or having an agency manage it for them.

16. Conclusions

16.1 Participants across the research discussed choice in finding a care provider and the differences in support that are there depending on how the service is funded. Support from social workers was variable and the involvement of service users in making an active choice was limited as social workers and/or families appear to be the key decision makers.

16.2 Cost had an impact on choice for those who were both funded by local authorities or self-funded and there was concern for self-funders about being able to afford adequate care. Providers raised issues about the level of funding available and the actual cost of providing care and how this impacted ion quality of care.

16.3 Staff attitudes were a dominant theme in the quality of care and it was important to people that their carers should be friendly in particular. The attitudes of staff had an impact on perceptions of dignity and respect and again examples were given where it was felt that carers and therefore, service providers lacked respect for their service users.

16.4 The quality of care was a concern particularly for future service users and they were influenced by what they had heard in the media and the contact that they had with care homes in the past into having a preference for domiciliary care services. Whilst there is little that can be done to influence the media there is a need to reassure the public that care is of good quality and therefore, service providers and the local authority should seek feedback from service users and act upon it.

16.5 There was a requirement for continuity of care, particularly in relation to domiciliary care. This was in relation to the development of relationships and having trust in the person caring. Recruitment and retention issues impact on the continuity of staff and this needs to be addressed by providers in order to minimise its impact.

16.6 The time and length of calls were an issue for the users of domiciliary care users with a perceived lack of flexibility in the time of calls that are set according to the needs of the service provider rather than the service user. There was also an identified need for domiciliary care to be available 'out of hours' and at an affordable cost. The length of calls was an issue with many seeing the shorter calls as being inadequate to meet the care needs of service users and also impacting on the reliability of carers in terms of timeliness for their next calls.

16.7 Loneliness was a factor for a number of participants in the research. It was not confined to one type of service user, although those using residential care services for people with learning disabilities were less likely to say that they lacked companionship. It was particularly marked for people who are living alone with domiciliary care or those in residential care for older people.

16.8 When asked if they could meet their aspirations many respondents failed to answer the question however, those that said they were able to were more likely to be living in residential care for people with learning disabilities as there appears to be a more specific effort to support service users to take part in activities and develop life skills.

16.9 Families has a large amount of influence over the choice of care providers and providers said that they made sure to involve the families of service users in care plans and activity. However, this was not always the case. Domiciliary care services were seen by some family carers as being a source of support that allows them to continue caring for their relatives at home.

17. Recommendations

17.1 Activities

Consideration should be given to developing wider activities for older people in care home settings. This should include enabling people to continue with hobbies and interests that they had prior to going into a home. Activities that include being able to go out of the home and socialise with the wider community should also take place on a regular basis.

Additionally, consideration should be given to including in specifications for home care that providers are invited to consider radical solutions to tackle to problems of loneliness, isolation and the consequential demotivating and debilitating impact that this has on residents. Solutions could include working with community groups and their service users to make use of the homes communal facilities and undertake activities such as baking, sewing, gardening, etc.

There should be provision for those receiving domiciliary care to be supported to take part in activities both inside and outside their home.

17.2 Choice

Given the concerns raised around choice and the implications around Deprivation of Liberty safeguards a further piece of work should be considered around the issues of capacity and choice in care provision.

17.3 Length of calls

Users of domiciliary care services wanted some calls to be longer. Consideration needs to be given to providers the responsibility to assess the needs of potential clients, along with input from service users and their families to reach a realistic assessment on the time needed to provide for care requirements.

17.4 Assessments by providers

Assessments should be undertaken by service providers before they enter an agreement with service users. This is particularly pertinent for those who are going into a care home setting. Assessments should include home/hospital visits but the provider and where practicable a visit to the care home by the potential service users.

Where possible six week assessment periods should be avoided as the only assessment mechanism as they can cause uncertainty and anxiety for the service user.

17.5 Information for families

As families were widely involved in the decision making about what service to use there needs to be wider information available to them about the types of care available and how the care system works. This should include information from the local authority as a trusted source, on the standards of providers, types of care available and how funding systems operate. Information and support should be available whether service users are self-funding, local authority funded or funded by continuing healthcare. It is notable that participants in the survey and interviewees did not reference Staffordshire Marketplace as a means to address that need.

17.6 Reliability

Domiciliary care providers should ensure that their scheduling of visits is realistic on order to increase reliability. Whilst there will be unavoidable delays in occasion there should not be regular disruptions to expected times of arrival. Care plans should be reviewed to ensure that the correct amount of time is allowed to meet client needs and reasonable travelling time is built in.

Service providers should ensure that service users know when their carer's are expected and who to expect in advance. Where changes have to be made they should be communicated to service users in an appropriate and timely manner.

17.7 Continuity of care

Providers of domiciliary care in particular should ensure that where reasonably practicable they should use the same carers for the same service user. This is in order to build up a relationship and better understand the service user's care needs.

17.8 Staff retention

Providers should give due consideration to how they can increase staff retention on order to give service users reassurance about the care that they receive. Examples of how staff can be retained include reviewing pay and conditions and providing regular, paid, training to enhance skills and improve job satisfaction.

17.9 Companionship

Providers should review ways in which they can support service users to maintain relationships with friends and family, including enabling visits of out to other locations. For providers of domiciliary care there should be consideration of how service users can be assisted to develop and maintain relationships outside their home.

Consideration should be given to commissioning voluntary sector organisations alongside care providers to provide support for good neighbour schemes and befriending services in order to reduce loneliness and social isolation.

17.10 Access to community services

Care service providers and the local authority should look at ways that access to community services can be maintained for people entering care home settings. This would ensure that they would be able to remain participants in wider society.

17.11 Review payment levels for care

The local authority should review its allowances for care to ensure that they are in line with neighbouring authorities and care reflective of the costs of delivering quality care. This should be done in conjunction with service providers in order to ensure that account is taken of the different types and levels of care and isn't a 'one size fits all' approach.

17.12 Support for self-funders

The local authority should ensure that there is parity of support given to choosing care providers given to self-funders and local authority funded individuals. The care market can be complex to navigate and having additional support would help to alleviate anxiety for service users and their families.

17.13 Quality of care

Whilst it recognised that care quality is regulated by the Care Quality Commission in order to ensure that service users voices are heard it is recommended that providers provide regular feedback mechanisms for service providers and are able to demonstrate learning and service improvement from feedback. This should include a robust complaints system and learning from complaints.

17.14 Staffing levels

Providers should ensure that they staffing levels are sufficient to deliver care services that meet the needs of service users. This should include staffing to ensure that there is time to carry out tasks both for domiciliary care and care home settings. There should be sufficient staffing to support service users to pursue activities.

17.15 Flexibility

There should be investigation into the provision of ‘out of hours’ care where required and this should be funded where possible to ensure that there is availability. Domiciliary care providers should also make provision for service users to be able to access assistance at short notice where there is a recognised need.

17.16 Training

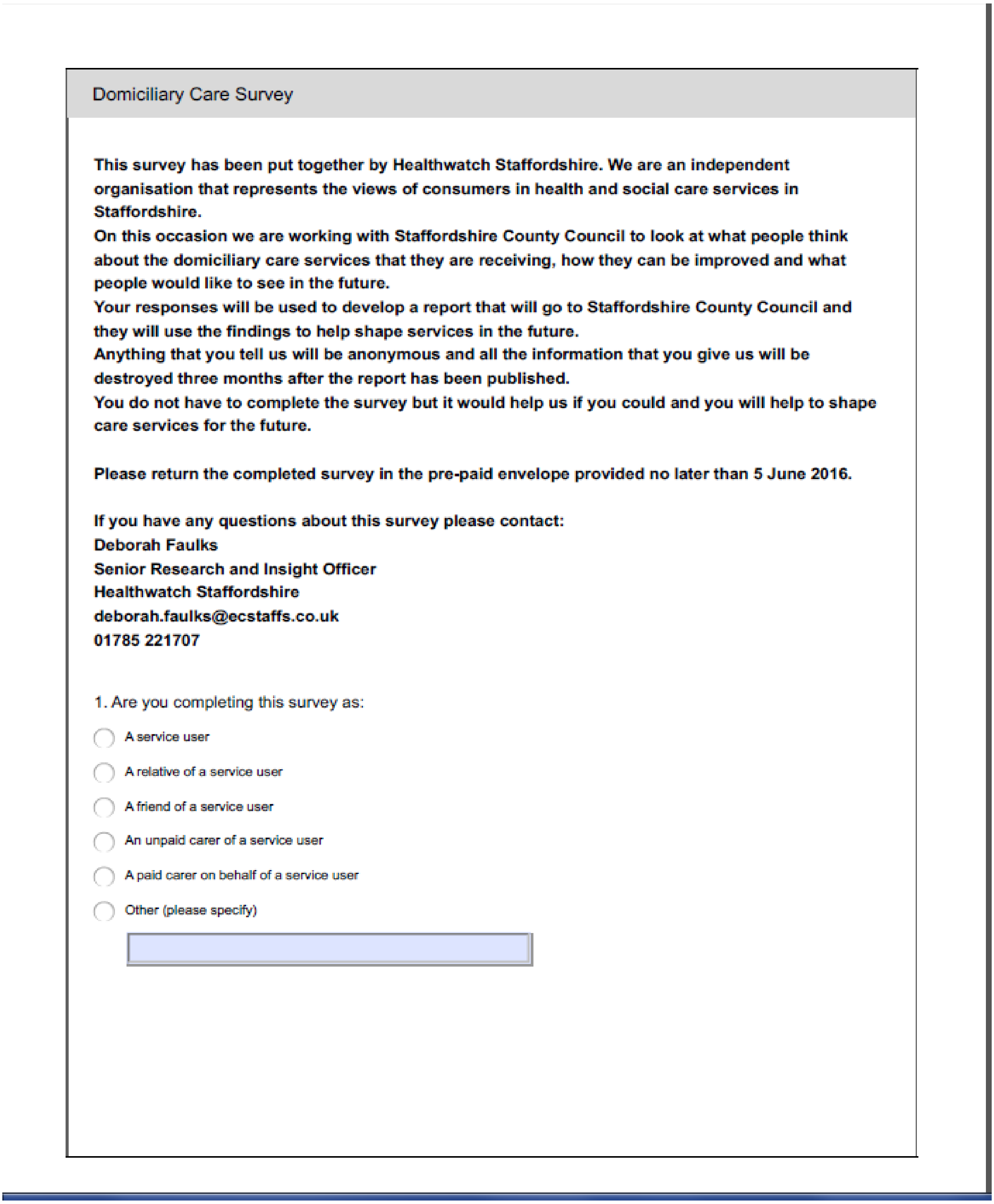
Providers should ensure that there is regular paid training for their staff. This should include ‘technical’ training in relation to practical care needs but also training designed to foster ‘dignity and respect’ for service users.

References

Ford, S; 16 January 2016; Dehydration common in patients admitted from care homes; Nursing Times.

Appendix

Survey for service users



Domiciliary Care Survey

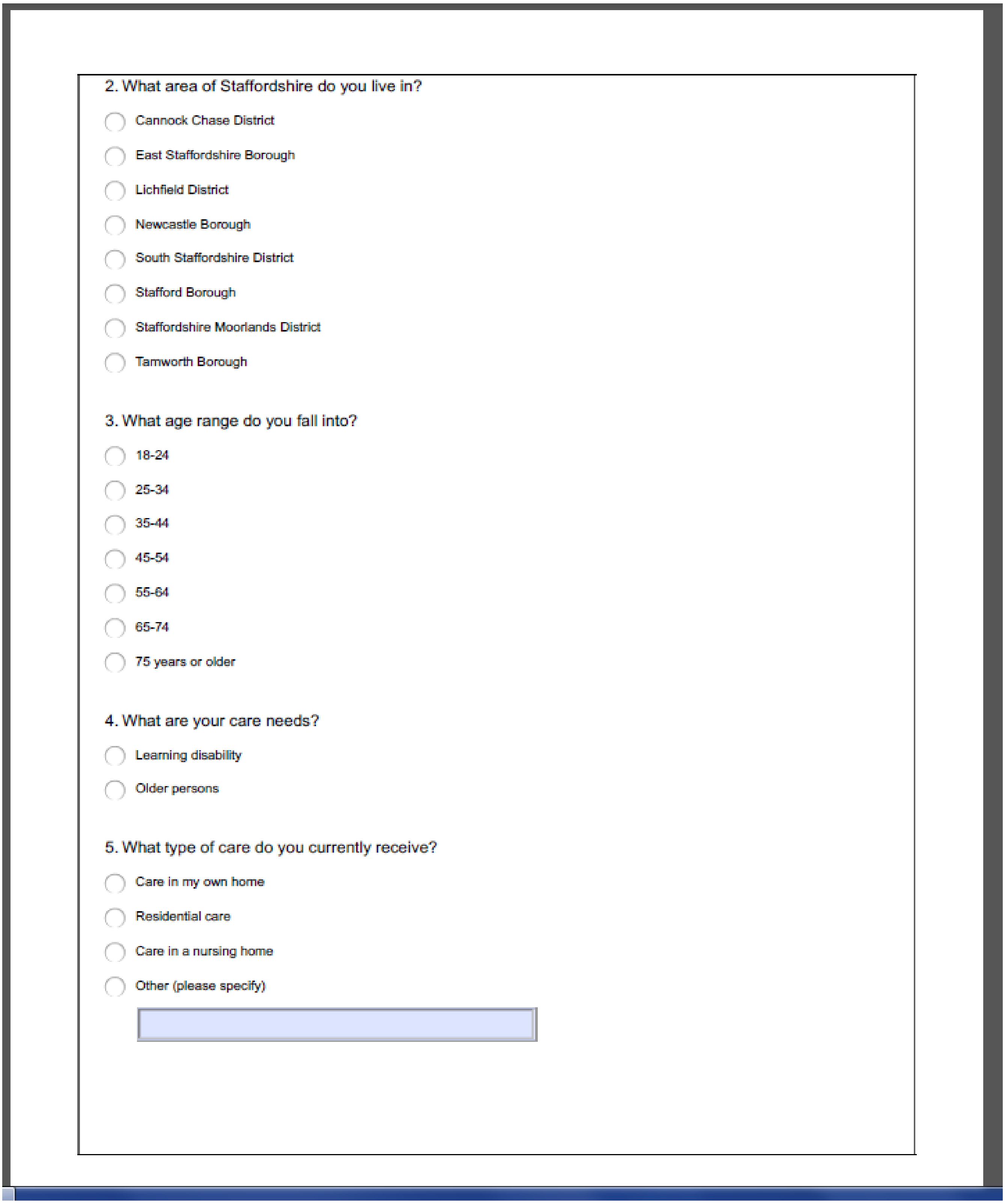
This survey has been put together by Healthwatch Staffordshire. We are an independent organisation that represents the views of consumers in health and social care services in Staffordshire.
On this occasion we are working with Staffordshire County Council to look at what people think about the domiciliary care services that they are receiving, how they can be improved and what people would like to see in the future.
Your responses will be used to develop a report that will go to Staffordshire County Council and they will use the findings to help shape services in the future.
Anything that you tell us will be anonymous and all the information that you give us will be destroyed three months after the report has been published.
You do not have to complete the survey but it would help us if you could and you will help to shape care services for the future.

Please return the completed survey in the pre-paid envelope provided no later than 5 June 2016.

If you have any questions about this survey please contact:
Deborah Faulks
Senior Research and Insight Officer
Healthwatch Staffordshire
deborah.faulks@ecstaffs.co.uk
01785 221707

1. Are you completing this survey as:

○ A service user
○ A relative of a service user
○ A friend of a service user
○ An unpaid carer of a service user
○ A paid carer on behalf of a service user
○ Other (please specify)



2. What area of Staffordshire do you live in?

○ Cannock Chase District
○ East Staffordshire Borough
○ Lichfield District
○ Newcastle Borough
○ South Staffordshire District
○ Stafford Borough
○ Staffordshire Moorlands District
○ Tamworth Borough

3. What age range do you fall into?

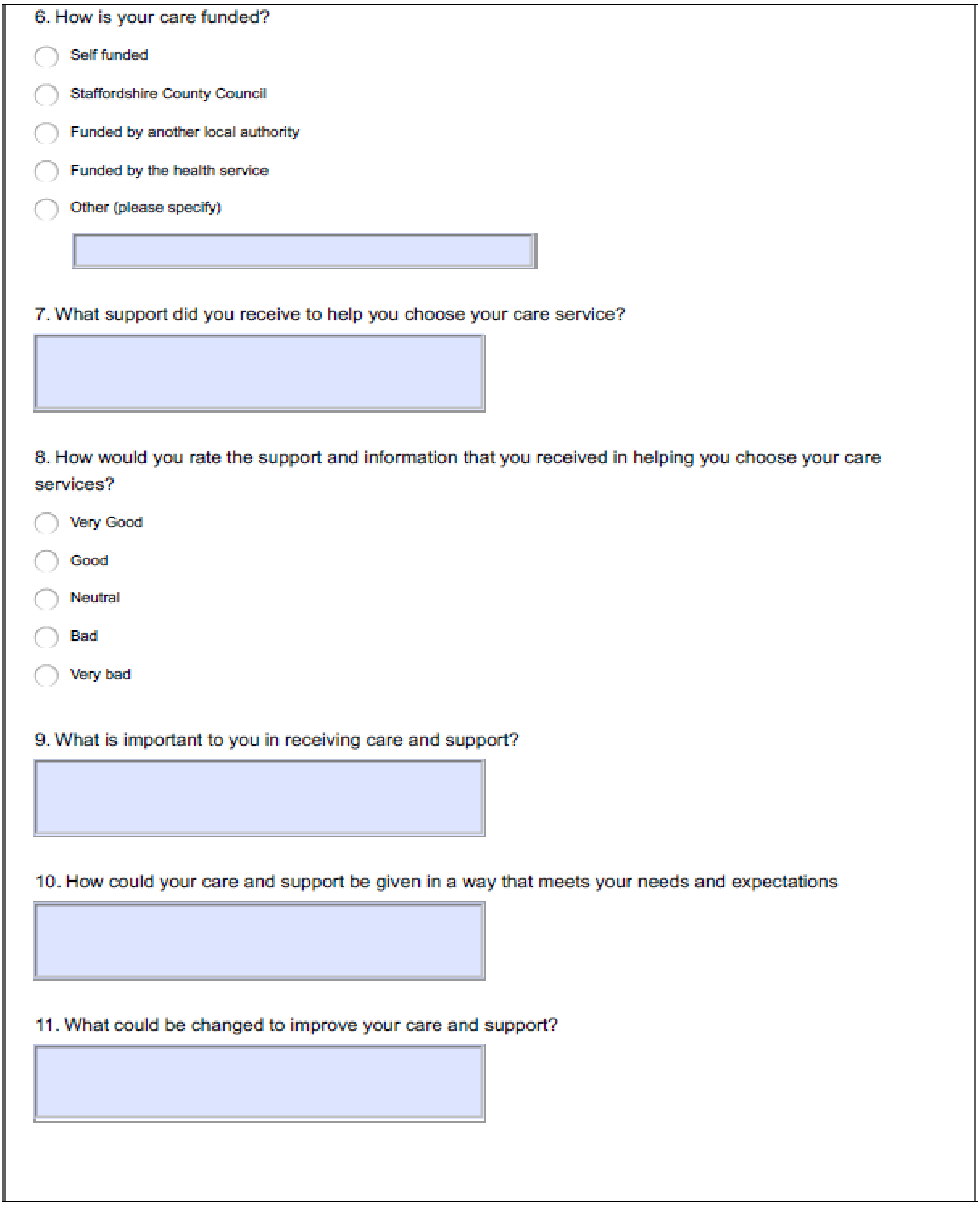
○ 18-24
○ 25-34
○ 35-44
○ 45-54
○ 55-64
○ 65-74
○ 75 years or older

4. What are your care needs?

○ Learning disability
○ Older persons

5. What type of care do you currently receive?

○ Care in my own home
○ Residential care
○ Care in a nursing home
○ Other (please specify)



6. How is your care funded?

○ Self funded

○ Staffordshire County Council

○ Funded by another local authority

○ Funded by the health service

○ Other (please specify)

7. What support did you receive to help you choose your care service?

8. How would you rate the support and information that you received in helping you choose your care services?

○ Very Good

○ Good

○ Neutral

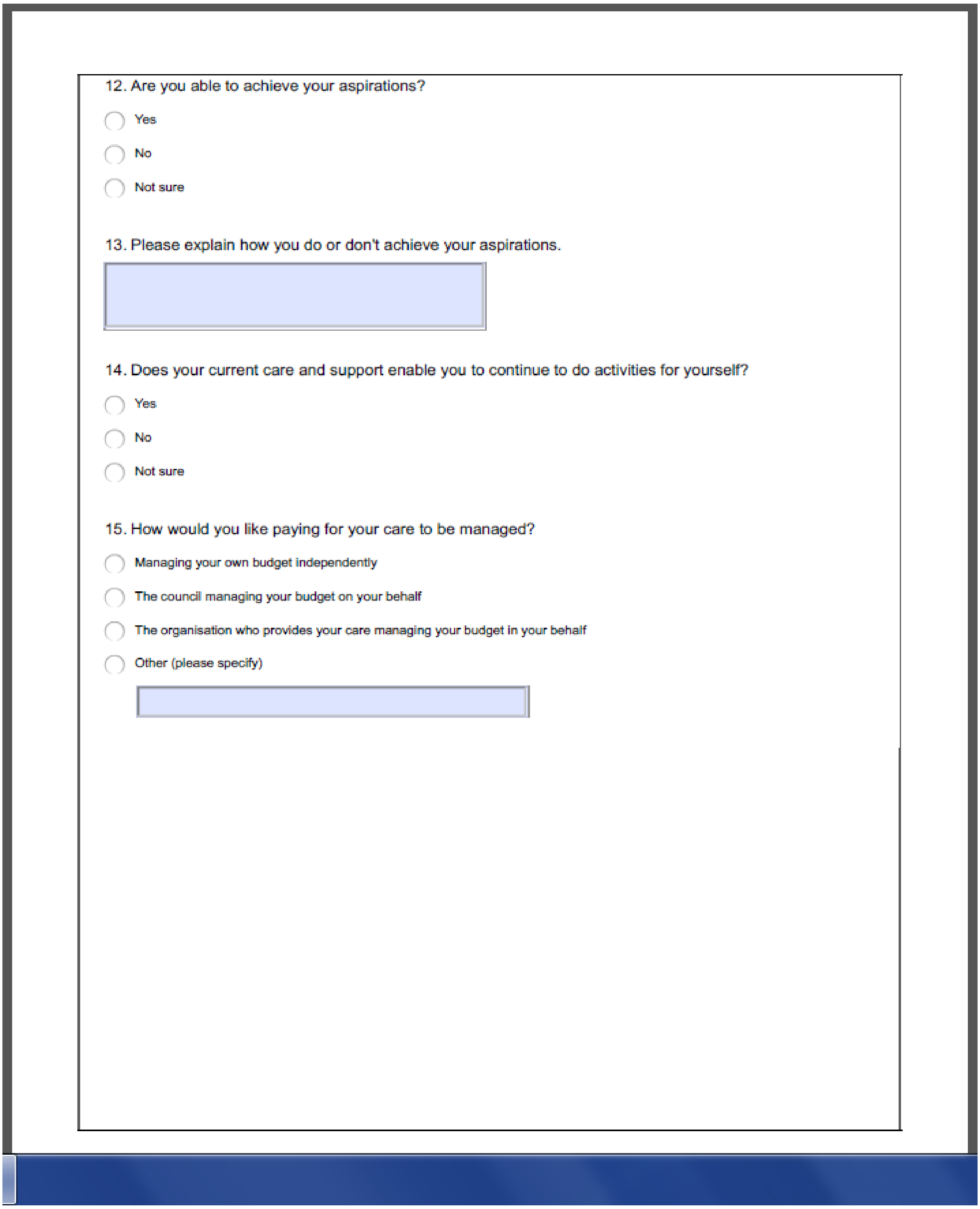
○ Bad

○ Very bad

9. What is important to you in receiving care and support?

10. How could your care and support be given in a way that meets your needs and expectations

11. What could be changed to improve your care and support?



12. Are you able to achieve your aspirations?

○ Yes

○ No

○ Not sure

13. Please explain how you do or don't achieve your aspirations.

14. Does your current care and support enable you to continue to do activities for yourself?

○ Yes

○ No

○ Not sure

15. How would you like paying for your care to be managed?

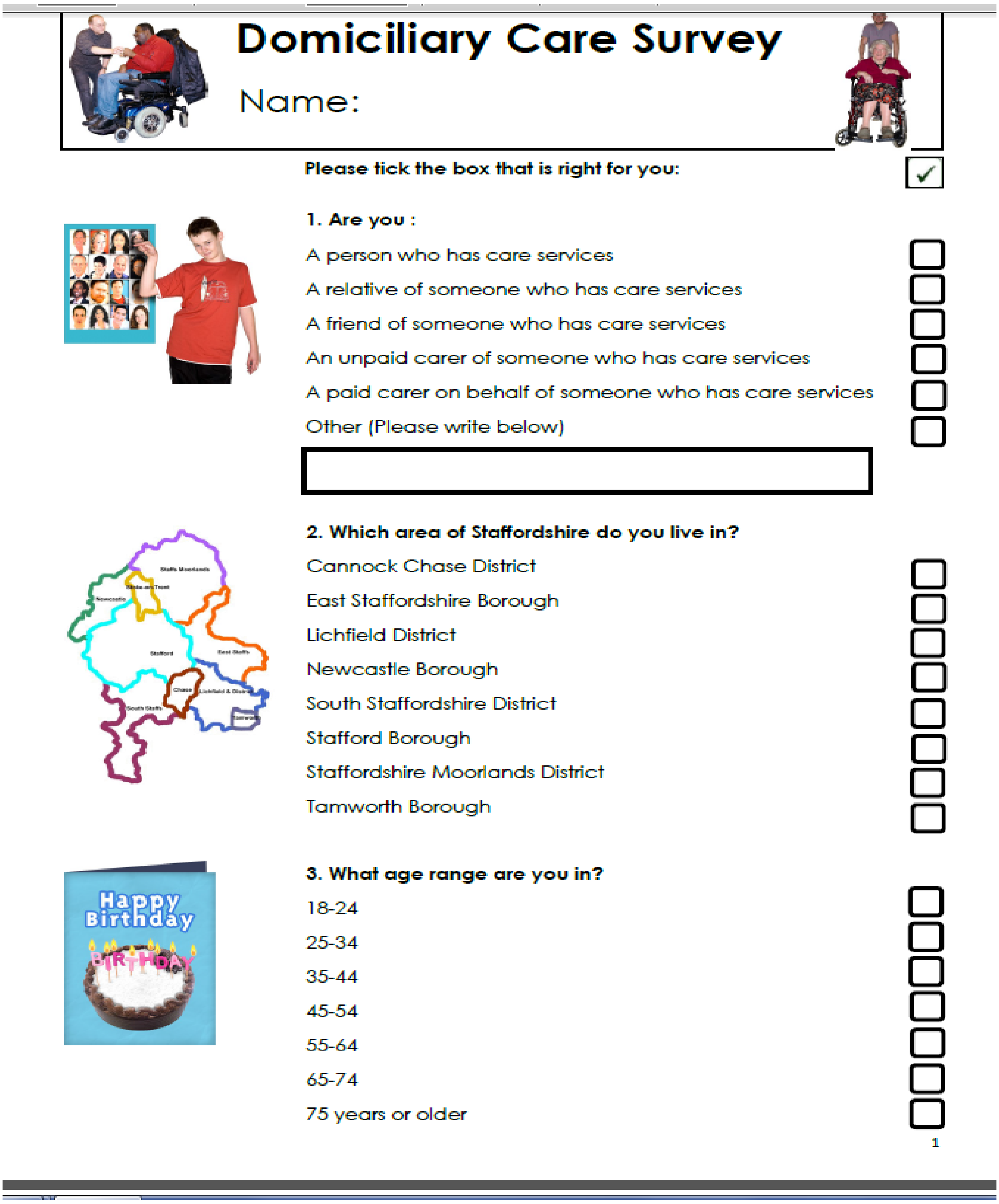
○ Managing your own budget independently

○ The council managing your budget on your behalf

○ The organisation who provides your care managing your budget in your behalf

○ Other (please specify)

Accessible survey developed by Asist



Domiciliary Care Survey

Name:

Please tick the box that is right for you: ☑

1. Are you :

- A person who has care services ☐
- A relative of someone who has care services ☐
- A friend of someone who has care services ☐
- An unpaid carer of someone who has care services ☐
- A paid carer on behalf of someone who has care services ☐
- Other (Please write below) ☐

2. Which area of Staffordshire do you live in?

- Cannock Chase District ☐
- East Staffordshire Borough ☐
- Lichfield District ☐
- Newcastle Borough ☐
- South Staffordshire District ☐
- Stafford Borough ☐
- Staffordshire Moorlands District ☐
- Tamworth Borough ☐

3. What age range are you in?

- 18-24 ☐
- 25-34 ☐
- 35-44 ☐
- 45-54 ☐
- 55-64 ☐
- 65-74 ☐
- 75 years or older ☐

1

4. I need care and support because I am:

A person with a learning disability or, ☐

An older person ☐

5. What type of care do you receive now?

Care in my own home ☐

Residential care ☐

Care in a nursing home ☐

Other (Please write below) ☐

6. How is your care paid for?

Self funded (You pay) ☐

Staffordshire County Council ☐

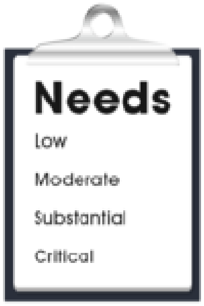
Funded by another local authority ☐

Funded by the health service ☐

Other (Please write below) ☐

7. What support did you have to help you choose your care service?

Group Discussion.



8. Was the support and information you received when choosing a care service:

Very Good ☐

Good ☐

Neutral ☐

Bad ☐

Very bad ☐

9. What is important to you when receiving care and support?

Group Discussion.

10. How could your care and support be given in a way that meets your needs/dreams?

Group Discussion.

11. What could be changed to improve your care and support?

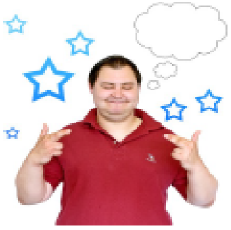
Group Discussion.

12. Are you able to do the things that you want?

Yes ☐

No ☐

Not sure ☐



13 a) What helps you to do the things that you want?

Group Discussion.

13 b) What stops you doing the things that you want?

Group Discussion.

14. Does your current care and support help you to continue to do the things that you enjoy doing?

Yes ☐

No ☐

Not sure ☐

15. How would you like to pay for your care and support?

Managing **your** own budget independently ☐

The council managing your budget on your behalf ☐

The organisation who provides your care managing your budget on your behalf ☐

Other (Please write below) ☐

☐

4

Service provider interview template

Domiciliary care project- Provider interview

This template is designed to:

- *Examine the experience of providing care services in Staffordshire.*
- *The understand the perspectives of care providers in Staffordshire*
- *The understand what could be improved from the perspective of care providers*

Suggested Steps

1. Identify providers who are willing to take part in the interview
2. Use prompts
3. Analyse the information and produce as a story
4. Look at themes, main issues and measure improvements

Participant Information Sheet

You are invited to take part in a short interview to help us understand your experience of providing care services in Staffordshire. We are interested in hearing about your views and experiences in providing care. This information will help to inform the research that is being carried out throughout Staffordshire and to help inform future procurement of services.

Your insights about your experience will be shared with representatives from Staffordshire County Council. Ultimately the report will also be published by Healthwatch Staffordshire. While we may talk about aspects of your experience, you will not be identified in any reports, presentation or papers arising from the project.

In sharing your insights about delivering care in Staffordshire, any information that we collect about you in connection with this interview will remain confidential, and will be disclosed only with your permission.

If you have any questions about the interview, you can contact the following Healthwatch Staffordshire representative: deborah.faulks@ecstaffs.co.uk or on 01785 221707

Participant Consent Form

I agree to participate in an interview regarding my experiences delivering care services.

I consent to taking part in the discussion and have understood the information contained within the Participant Information Sheet, a copy of which I have been given to keep.

I understand I can withdraw my comments at any time and do not have to give any reason for withdrawing. I also understand that I may be contacted in the future as part of an evaluation of this Interview method and my telephone number or email has been requested for this purpose.

I understand that my personal information will remain confidential as outlined in the Participant Information Sheet.

Participant

Print Name: ______________________________ Date: ________________________

Signature: ______________________________ Telephone: __________________

Interview Template

The following questions provide the framework for the types of questions you may ask the staff member when collecting their story. This is flexible and should not form a list of questions for the respondent to answer but to broadly frame the story within the realms of the delivering care services in Staffordshire.

Type of care delivered

a. What type of care do you deliver?
b. What type of care needs do your service users have?

Funding

c. How are your service users funded?
d. What is the approximate split between self-funders and local authority funded service users?

Choice

e. In terms of choosing what care service to use, how would you rate the amount of information that your service users had before they came to you?

Providing care

f. What is the most important thing to you in providing care?
g. How could care and support be better delivered from your point of view to meet the needs and expectations of service users?
h. What barriers are there to being able to meet the needs and expectations of service users better?

i. Are you able to support your service users to achieve their aspirations?
j. Please explain how you are able to support service users to achieve their aspirations?

k. Are you able to support your service users to continue to do activities for themselves?
l. How do you achieve this or what barriers are there to doing this?

PLEASE USE BOXES PROVIDED FOR COLLECTING RESPONSES

Type of care delivered
Residential, nursing, dom care Care needs of service users- such as learning disability, older persons, dementia

Funding
Types of funding for residents Approximate split of funding.

Choice
Information that service users have before using the service Liaison with family and social services?

Providing care
Most important things; better delivery to meet needs and expectations; barriers to meeting needs and expectations.

Aspirations
How able to meet service users aspirations

Independence
Support to do things for themselves, barriers

Future user focus group template

Domiciliary Care Focus Group Template –

1. *Before Starting*

- *Ensure the room is conducive to promoting discussions.*
- *Make sure you (the facilitator) set the tone for discussions and put the group at ease*
- *Ensure that every participant is given a chance to air their opinions (including the quiet ones)*
- *Make sure you monitor time closely and allocate enough time to each question.*
- *Inform people that they have a right to leave the group at any time session will last approximately 30 minutes*
- *Set ground rules: switch mobile phones off, everything will remain confidential, only one person to speak at a time, there is no right or wrong answers etc.*
- *Ask if the group are happy to have the group recorded audibly for the purposes of the write up only*
- *Capture all observations including non-verbal body language and morale*
- *As this is a focus group aimed at young people and children make use of post it notes and pens to facilitate discussion. Use them as an aid to introduce a subject.*

2. Introduction

Activity	*INTRODUCTION*
Guidance	• **Spend no more than 5 minutes on this activity** • Welcome the Group o Thank them for attending & Invite them to sit wherever they wish o Remember the points listed in 1. • Introduce the purpose and context of the focus group o Explain how the project came about o Explain the format and duration of the focus group session o Explain how the information will be fed back • Explain how the information will be recorded o Inform them that a note tacker will be recording the information o Inform them that no names will be recorded or comments attributed to any individuals o Assure them that there any audio recording will be used for transcription only and destroyed thereafter o Explain how information will be analysed and used • Make introductions o Introduce yourself and co-facilitator & Ask group to introduce themselves • Ask if anyone has any questions before you start
Script	*Introduce self.* *Healthwatch Staffordshire are an independent voice for consumers of health and social care services in Staffordshire. On this occasion we are working with Staffordshire County Council to look at domiciliary care services. This includes paid care in your own home, or care received in a residential or nursing home.* *For this focus group we would like to know what people who are not currently receiving care would like to see if they began to need care and what they would prefer.* *All the feedback will be collated into a report for Staffordshire County Council and Healthwatch Staffordshire. The findings will help to shape the way that the Council buy services in the future and what they will include.*

3. Focus group questions

Question	*What is your understanding of domiciliary care?*
Guidance	• Spend no more than 15 minutes on this question • Ensure everyone contributes • Prompts: o Who provides it? o How do you access it? o Where is it delivered? o What services does it include?
Feedback	

Question	*What are your thoughts about receiving care in the future?*
Guidance	• Spend no more than 10 minutes on this section o Staying at home o Family carers o Going into residential/nursing care o What are your preferences?
Feedback	

Question	*What would be important to you in relation to care that you received that enabled you to stay in your own home?*
Guidance	• Spend no more than 10 minutes on this question ○ Consistency and continuity ○ Dignity and Respect ○ Knowing when to expect them ○ Maintaining independence ○ Involvement in decision making ○ Cost
Feedback	

Question	*What would be important to you in relation to care that you received in a residential care/nursing home?*
Guidance	• Spend no more than 10 minutes on this question ○ Consistency and continuity ○ Dignity and respect ○ Maintaining some independence ○ Freedom of movement ○ Involvement in decision making ○ Cost
Feedback	

Question	*Can you foresee or anticipate any specific needs that you might need providers of care to meet in the future?*
Guidance	• Spend no more than 10 minutes on this question ○ Health ○ Mental well-being
Feedback	

Activity	*FOCUS GROUP CLOSE*
Guidance	• Spend no more than 10 minutes on this question ○ Summarise key findings for each question ○ Seek clarification on any ambiguous areas ○ Offer a last opportunity to provide any additional comments ○ Thank them for their support and input ○ Reassure them that we will keep all info confidential and non-attributable ○ Inform them of next steps ○ Leave email / phone number in case they think of anything else of use ○ Close meeting
Feedback	