N A O
National Audit Office
MALTA

Performance Audit:
Community Care for Older Persons

January 2020

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Performance Audit

Community Care for Older Persons

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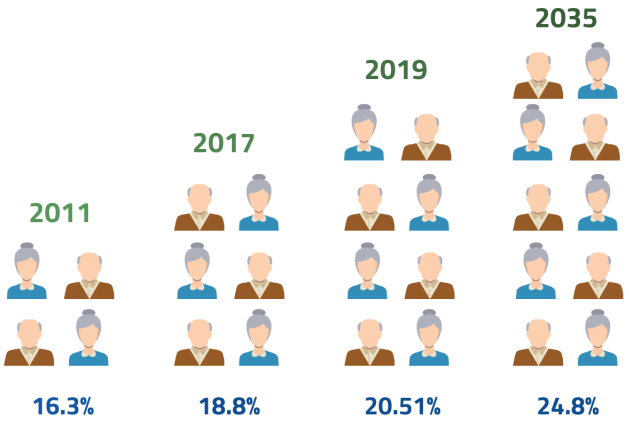
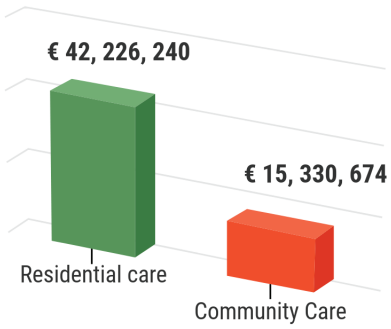
Key Facts

Ageing population statistics



Costs (2018)

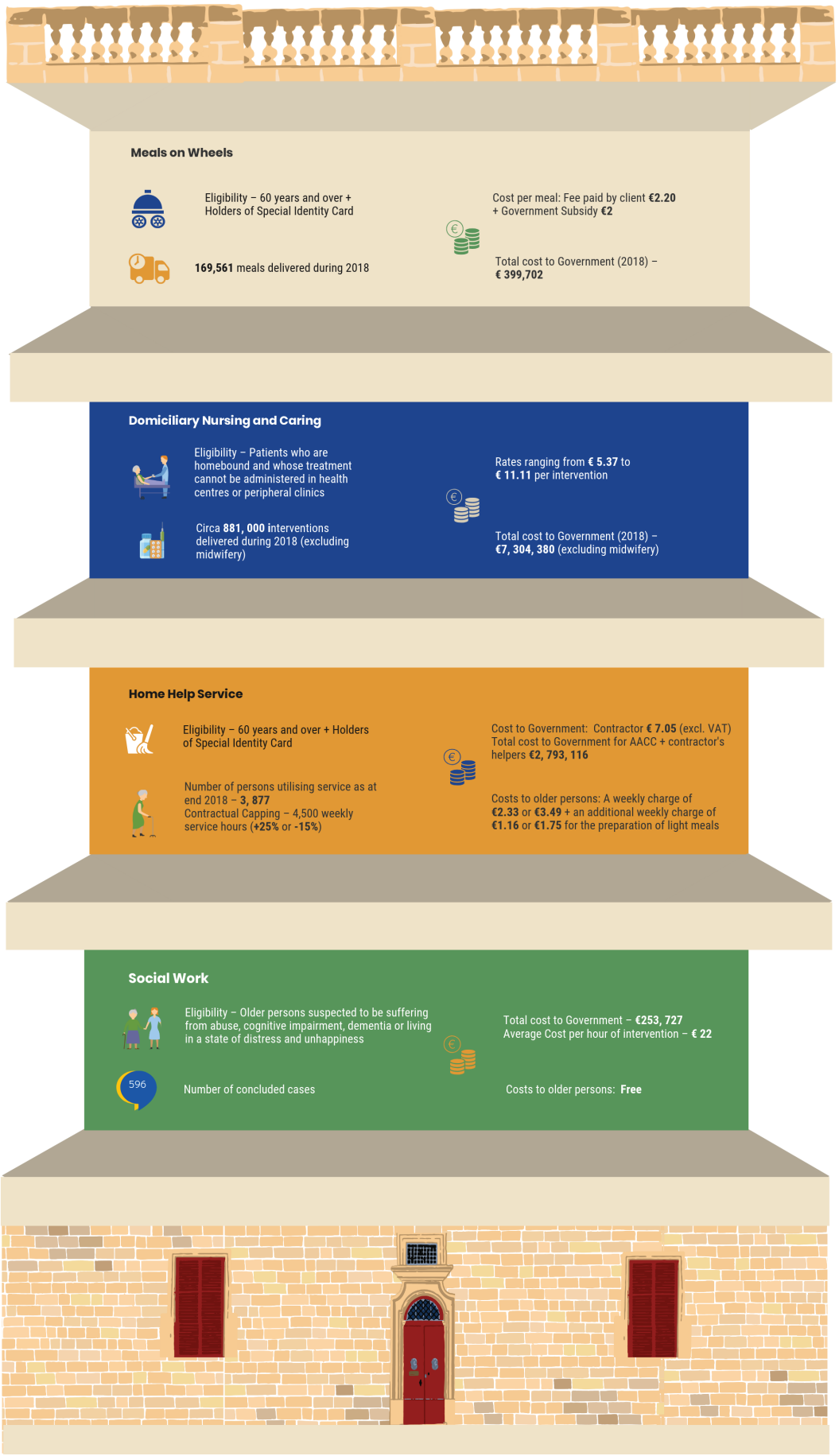


Total Expenditure - € 57, 556, 914

Community Services (2018)

- Community Geriatrician Services
- Dementia Activity Centre
- Dementia Intervention Team
- Domiciliary Caring
- Domiciliary Nursing
- Allied Health
- Respite
- Respite at Home
- Social Work
- Day Centres & Active Ageing Centers
- Carer at Home Scheme
- Continence Service
- Home Help Service
- Handyman Service
- Meals on Wheels
- Night Shelter
- Telecare+
- Telephone Rent Rebate

Community Care enables older persons to remain active and reside longer within the community


Meals on Wheels
Eligibility – 60 years and over + Holders of Special Identity Card
169,561 meals delivered during 2018
Cost per meal: Fee paid by client €2.20 + Government Subsidy €2
Total cost to Government (2018) – € 399,702
Domiciliary Nursing and Caring
Eligibility – Patients who are homebound and whose treatment cannot be administered in health centres or peripheral clinics
Circa 881, 000 interventions delivered during 2018 (excluding midwifery)
Rates ranging from € 5.37 to € 11.11 per intervention
Total cost to Government (2018) – €7, 304, 380 (excluding midwifery)
Home Help Service
Eligibility – 60 years and over + Holders of Special Identity Card
Number of persons utilising service as at end 2018 – 3, 877
Contractual Capping – 4,500 weekly service hours (+25% or -15%)
Cost to Government: Contractor € 7.05 (excl. VAT)
Total cost to Government for AACC + contractor's helpers €2, 793, 116
Costs to older persons: A weekly charge of €2.33 or €3.49 + an additional weekly charge of €1.16 or €1.75 for the preparation of light meals
Social Work
Eligibility – Older persons suspected to be suffering from abuse, cognitive impairment, dementia or living in a state of distress and unhappiness
596
Number of concluded cases
Total cost to Government – €253, 727
Average Cost per hour of intervention – € 22
Costs to older persons: Free

List of Abbreviations

AACC	Active Ageing and Community Care
CPD	Continuous Professional Development
HACCP	Hazard Analysis Critical Control Point
IT	Information Technology
KPI	Key Performance Indicator
MFIN	Ministry for Finance
MMDNA	The Malta Memorial District Nursing Association
NAO	National Audit Office
NSPAA	National Strategic Policy for Active Ageing
SOP	Standard Operating Procedure
SVPR	St Vincent de Paule Residence
VAT	Value Added Tax

Executive Summary

Executive Summary

1. Ensuring that older persons maintain their independence, mobility and health and have access to the required health and social services is key to achieving the quality of life that older people yearn for. The Active Ageing and Community Care (AACC) offers an array of community services catering for older persons of different dependency levels. The social benefits of community care are well-documented in research, as is the assertion that inappropriate or inadequate home care may lead to higher and more costly institutionalisation in the future. In total, during 2018, the provision of these services incurred an expenditure of €15,330,674[1].

2. For the purpose of this performance audit, the National Audit Office (NAO) review focused on the Social Work, Domiciliary Nursing and Caring, Meals on Wheels and Home Help Services. These integral services help older persons to maintain, as far as possible, an independent life within a community environment. During 2018, these four services entailed an expenditure of €10,560,414. Consequently, the audit objectives aimed to establish the degree to which:

    a. the strategies and policies in place were comprehensive in relation to all aspects of community care for the older person;
    b. the supply of services was in equilibrium with demand;
    c. services reviewed were being delivered in an efficient and effective manner;
    d. mechanisms were in place to enable effective monitoring of the services available to the community and their respective outcomes; and
    e. the provision of community care services was cost-effective from a services users' and government's point of view.

3. The cut-off date for this performance audit was end 2018. During this review in 2019, AACC sought to address service delivery and administrative shortcomings. Consequently, wherever possible, the Report provides an outline of AACC's latter initiatives. It is pertinent to point out that these initiatives did not fall within the scope of this audit but the NAO will refer to these developments and assess them through a follow-up audit in due course.

[1] The amount of €15,330,674 excludes the Domiciliary Midwives service provided through the AACC.

The National Strategic Framework

4. The National Strategic Policy (2014 to 2020) on Active Ageing highlights in broad terms how older persons can be empowered and supported to live independently within the community for as long as possible. To this end, the national strategic framework elicits expert opinions on the anticipated way forward.

5. Nonetheless, references therein related to elderly community care are not comprehensive. Statements and policy recommendations included within the strategic framework do not provide in-depth information about the approach to be adopted as well as detailed presentations of the measures to be implemented. These circumstances limit long-term business planning. Moreover, until recently, the national strategy was not supported by an action plan which outlines implementation schedules as well as ownership of the respective policy recommendations. To date, implementation progress is mainly being registered on measures elicited in the electoral manifesto.

6. To this effect, AACC compiled action plans whereby anticipated measures were listed against time schedules as well as envisaged outputs and outcomes. Although not formally adopted, AACC is already implementing strategic measures in accordance with the provisions stipulated in the respective action plans.

7. During 2019, AACC complemented the action plan initiative with the compilation of Standard Operating Procedures (SOPs). The merits of such an initiative mainly relate to streamlining of procedures, business continuity and critically, the consistent treatment of clients.

Social Work Services

8. Gerontological social work is concerned with maintaining and enhancing the quality of life and well-being of older people. During 2018, AACC had a major problem to address the demand and supply issues since the number of social workers declined by around 50 per cent. During this performance audit, AACC has substantially increased its capacity through the recruitment of social workers and social welfare professionals. The engagement of more professionals implies that the Unit is now in a much stronger position to improve its reach, coverage and work processes, which in the period under review were conditioned by capacity issues.

9. Through process and Unit re-engineering, AACC sought to address issues relating to the Unit's efficiency issues prevailing in 2018. At the time, social workers spent significantly more time performing case-related administration rather than being directly involved with clients.

10. Up to this audit's cut-off date, the extent of monitoring of social work was limited. Recently, AACC has sought to strengthen the social work monitoring function where data related to logistics and case management are now centrally maintained. At a macro-level, AACC is still in the process of developing and installing an integrated Information Technology (IT) system, which is seen as key to facilitate coordination and further promotes the principle whereby AACC operations become increasingly client centric.

Domiciliary Nursing and Caring

11. The CommCare Unit within AACC, as at end 2018 was responsible for authorising requests for domiciliary care provided by nursing professionals and carers to "*elderly, disabled, terminally-ill as well as those who are temporarily home-bound due to an acute illness, or for those requiring specific preparations and/or treatments*''. This Unit is also responsible for monitoring and ensuring that the service provider delivers nursing and caring services in accordance with contractual provisions. During 2018, AACC expenditure in relation to this contract amounted to over €6 million. This review raised the following issues:

a. The contractual rates of the Domiciliary Care Services increased substantially following the change in service providers in 2015, where the previous operator, among others, cited financial viability as one of the reasons for terminating the service provision.

b. The Department of Contracts authorised AACC to enter in a negotiated procedure with the current service provider and award a contract for Domiciliary Nursing and Caring for 12 months, which was to be followed up by an open call for tenders. Despite the terms of this approval, this Contract is still effective to date. The subsequent four contract renewals through direct orders are seen as stifling the competitive element in the award process and encroaches on the principle of transparency.

c. Despite the overwhelming sense of satisfaction and appreciation for the service there is still room for improvement. The main points of contention revolved around the timeliness of the service, the time available for patients, language barriers in cases where services were delivered by non-nationals, deviation from continuity of care principles and the interpersonal skills of a few members of staff delivering these services. These issues are caused by a combination of operational and logistical factors,which fall within the Contractor's responsibility, as well as shortcomings relating to the contracting authority's monitoring and enforcement function.

Meals on Wheels Service

12. AACC outsourced the Meals on Wheels Service through a competitive call for tenders. The Agreement between AACC and the Contractor, signed in September 2016, stipulates that clients will be charged €2.20 while Government will incur a further expenditure of €2.00 per meal. During 2018, the Contractor invoiced AACC for 169,561 meals for a cost of €339,062.

13. This performance audit established that while the price of a meal is reasonable for all stakeholders, a number of issues diminish the effectiveness of this service. The following refers:

a. The ambiguity of contractual clauses and monitoring weaknesses diminished management's control over this service.

b. As implied by customer surveys, contractual non-compliance translates itself into client frustration as older persons are never sure of delivery times. In other instances, the delivery was different to their meal selection.

c. Delivering meals in an environment of congested roads and parking problems contribute to the decline in service quality. Matters become further complicated through the shortfall in the Contractor's staff and vehicles deployed for the delivery of the Meals on Wheels Service. This is a situation which breaches contractual provisions.

d. As an interim measure, in November 2019, AACC agreed an addendum to the contract with the service provider whereby another person will accompany the driver when delivering meals. This initiative is estimated to cost around €95,000 annually. In the medium term, AACC are drafting new tender specifications which aim to address more comprehensively the prevailing service delivery issues.

Home Help Services

14. The Home Help Service offers assistance to older people and persons with special needs in performing light domestic chores, shopping and preparation of light meals and is intended to complement family support. The service is granted on the basis of social needs and/or medical problems and limitations. The service is provided against a weekly contribution of €2.33 or €3.49, depending on whether the beneficiary is a one-person household. The provision of this service through the Contractor or directly through AACC pool of helpers amounts to less than €8 per hour. During 2018, expenditure on this service amounted to €3,002,297. During the period under review, AACC encountered various difficulties in its contract enforcement function.

15. The main point of contention revolved around the Contractor's inability to engage more helpers in line with contractual obligations. In turn, this resulted in over 5,684 hours of undelivered service as well as a ripple effect on the efficiency and overall quality of service delivery. AACC were also aware that clients had issues with timeliness, short visits, the unwarranted behavior of some helpers and unhygienic practices.

16. AACC acknowledges these service shortcomings. Within this context, AACC has recently implemented an important initiative whereby applications pertaining to persons over 80 years do not need to be approved by the Home Help Board as eligibility is automatic. Other recently introduced initiatives include the provision of immediate temporary Home Help Service to older persons in emergency cases for two hours per week and an increase in the pool of assessors to improve the efficiency of the Home Help assessment process.

17. Moreover, AACC recently launched a new scheme, effective during the first months of 2020, whereby older persons would be able to choose their own helpers and get refunded by Government. AACC envisages that the introduction of this scheme would go a long way towards addressing the efficiency and service quality shortcomings that prevailed during 2018.

Overall Conclusions

18. NAO focused on services provided in 2018. It reviewed the Social Work, Meals on Wheels, Domiciliary Nursing and Caring as well as Home Help services. This performance audit elicited concerns regarding contract awards, service delivery, customer satisfaction as well as administrative efficiency. To varying degrees, these circumstances materialised through an array of common causes.

19. Increasing demand and customer expectations were not always balanced with the appropriate level of resources at both AACC and at the Contractors delivering this service. Contract implementation, on occasion, deviated from the relative provisions. Furthermore, AACC's monitoring and enforcement were not allocated their deserved priority.

20. This performance audit notes AACC's initiatives to improve its coverage and monitoring of the services provided, specifically through the planned setting up of its Quality Unit. To this end, this Report outlined these measures which ranged from re-engineering of services, changes to administrative processes and procedures, and changes in contractual provisions through the signing of addenda to existing Agreements. Work is also in hand on the drafting of new specifications, which pave the way for calls for tenders for the supply of existing and new services in the near future.

21. These initiatives do not automatically imply that all issues raised with respect to the period under review are now resolved. While some measures will have an immediate impact, others will bear fruit in the medium to long-term. Consequently, it remains imperative that AACC maintains effective mechanisms in place to ensure that care services adhere to good governance principles for the benefit of older persons living within the community.

Recommendations

22. In view of the findings and conclusions emanating from this performance audit, the National Audit Office is proposing the following recommendations:

23. **Strategy** - The AACC is to finalise and adopt the community care strategic document for the period 2019 – 2022. This strategic document is to include concrete measures based on the National Strategic Policy for Active Ageing. These initiatives should aim to alleviate or address social phenomena such as poverty, homelessness, loneliness, dwindling numbers of informal carers and transport issues. Dealing with these issues may entail that AACC cooperates with other governmental entities.

24. Measures included in the new strategic document are to be backed by studies which include timelines, costings, Key Performance Indicators (KPIs) and resources required for each service. The measures are to be discussed with stakeholders, including entities representing the interests of older persons. Such an approach would provide the platform for older persons to directly influence the future strategies or policy documents.

25. **General Processes** - The AACC is to continue initiatives whereby community services processes are reengineered to address issues related to prolonged procedures and inefficiencies. These initiatives should encompass all phases related to a service, namely from application to the timely evaluation of service.

26. The opportunity exists for AACC to exploit the benefits of competition through competitive calls for tenders for all contracted services. This would entail that AACC's Procurement Unit is strengthened and mechanisms are introduced to ensure that services are procured in a timely manner to avoid negotiated procedures and direct orders.

27. AACC is to further facilitate case conferencing, which entails the mapping of patients health and social needs amongst different professionals. This approach ensures that, as far as possible, clients receive targeted care. In part, the introduction of an integrated Information Technology (IT) system would facilitate case conferencing as AACC's professionals would have access to client information. Moreover, case conferencing would not only benefit the client but would avoid procedural and administrative overlap.

28. Application forms for services provided by AACC should be more widely available. There is scope to make these forms also available from social services district offices, health centres and local councils. While acknowledging that these forms can be downloaded from AACC's portal and are available at the One Stop Shop in Valletta, increased availability would be beneficial to older persons.

29. **Information Technology (IT)** - AACC are encouraged to finalise the introduction of electronic systems through the CONVERGE EU funded project to facilitate the generation of reports illustrating the number of services provided to the same individuals. The availability of such information would enrich the quality of management information available for decision making purposes.

30. **Monitoring** - The AACC is to embark on a robust monitoring set-up for all community services. Monitoring is to consider full traceability of interventions / services, compliance to internal protocols and Standard Operating Procedures (SOPs), and clients' satisfaction levels. Moreover, mechanisms should be in place to ensure that issues of concern are expediently dealt with or, where necessary, action to reengineer services is resorted to.

31. AACC is to establish an independent multi-disciplinary internal audit team to evaluate various aspects of service delivery, namely in terms of its effectiveness and compliance to internal protocols and, where applicable, to contractual provisions. This audit unit should also be entrusted to assess operations' costs and procedural efficiency.

32. **Social Work** - The AACC is to reintroduce customer satisfaction surveys as outlined in the Social Work Unit's Manual of Policies and Procedures.

33. The Social Work Unit is to ensure that thorough needs assessments are always carried out and that these translate into individual social work plans.

34. AACC should address the lack of holistic social work intervention especially in circumstances leading to and following admission to a residential care home for older persons.

35. **Meals on Wheels** - The AACC is to ensure the finalisation of a revamped new contract for the Meals on Wheels Service that safeguards government's interests and ensures a higher quality service. To this end, a new contract is to cater for increased AACC accessibility to Contractor's records and systems relating to operations. Moreover, new specifications within a new contract are to address service concerns, such as a more reasonable time window to affect meal deliveries.

36. AACC is to ascertain that the service provider utilises all the resources necessary to ensure that service delivery complies with contractual obligations. The deployment of the required resources becomes essential in a labour-intensive activity.

37. **Domiciliary Nursing and Caring** - Although there is a high level of satisfaction with this service, AACC is to ensure that the service provider addresses issues raised by some clients. Despite the low level of complaints received, concerns related to timeliness, the length of visit, courtesy and language barriers are critical aspects of this important service.

38. AACC is to raise clients' awareness on the cost of futile visits, which are wasteful and capricious. To this end, AACC is to explore ways to mitigate the unnecessary expense arising through futile visits.

39. AACC and other health services providers, such as hospitals and health centres, are to increase their level of communication on clients' treatment. Such communication could take the form of AACC's accessibility to certain documentation from medical files and IT systems maintained by these entities.

40. AACC is to actively consider whether the current diabetes protocols are the most time- and resources-efficient. Education campaigns aimed at encouraging older persons to, as far as possible, be less dependent on AACC visits for the administration of diabetes care would reduce the cost on government and make the overall nursing service more efficient. This would entail collaboration with the Ministry for Health, more outreach and communication with family doctors and geriatricians.

41. **Home Help** - AACC is to monitor regularly the implementation of the recently-introduced initiative involving the re-engineering of the service. AACC is to ascertain that such a service is sustainable and is delivering the intended benefits to older persons.

Chapter 1

Community care for older persons

1.1 Introduction

1.1.1 The phenomenon of an ageing community like Malta's brings with it many challenges that cannot be overlooked or not dealt with sustainably due to the increasing numbers of older persons. Ensuring that older persons maintain their independence, mobility and health and have access to the required health and social services is key to achieving the quality of life that older people yearn for. As the national average age increases, older persons continue to play a key role in society well beyond their retirement age. If one takes into account the volunteering efforts and caring responsibilities older persons carry out, as well as their spending potential and tax contributions if they continue to be active within the labour market, older persons contribute much more than they receive in pensions and social and healthcare services. Such benefits also translate into more opportunities to remain active in family and community life, thus leading to a reduced call on health and care services.

1.1.2 This introductory Chapter outlines the:

a. community services available to older persons,
b. audit focus and methodology, and
c. report structure.

1.2 During 2018, AACC provided several services to older persons within the community

1.2.1 Community services provided by the Active Ageing and Community Care (AACC) aim to enrich the well-being of older persons in various ways. To this end, AACC offers an array of community services catering for older persons such as the Continence or Domiciliary Nursing and Caring Services. For more independent persons, AACC provides services such as Active Ageing Centres as referred to Table 1. Some services such as the Dementia Intervention Team and Allied Health Services have been introduced in 2018 while others including the Domiciliary Nursing and Caring, Home Help and Meals on Wheels have been available for several years. In total, during 2018, the provision of these services incurred an expenditure of €15,330,674[2].

[2] The amount of €15,330,674 excludes the Domiciliary Midwives service provided through the AACC.

Table 1 - AACC services for older persons within the community

Community care and other services offered by AACC	Number of persons making use of the service during 2018[3]	Cost to Government for service provision (€)	Average cost to Government for each older person receiving the service provision during 2018	Cost to older persons receiving services
Community Geriatrician Services	23	17,737	771	Free
Dementia Activity Centre	31	17,737	572	Free
Dementia Intervention Team	542	69,980	129	Free
Domiciliary Caring	2,461	600,386	244	Free
Domiciliary Nursing	5,537	6,703,994[4]	1,211	Free
Allied Health[5]	4,571	1,130,499	247	Free
Respite	463[6]	33,063	71	Free
Respite at Home	224	42,256	189	Free
Social Work	1,661[7]	253,727	153	Free
Day Centres & Active Ageing Centres	1,855[8]	1,241,694	669	Between €2.33 to €10.48 depending if per person or for a couple and as per frequency per week.
Carer at Home Scheme	276	47,878	173	The beneficiary receives up to a maximum of €5,200 per year.
Continence Service	6,727[9]	985,351	146	Older persons falling under the 'Scheme A' are entitled for a supply of fully subsidised nappies, while older persons under the 'Scheme B' receive a partial subsidy of between €0.07 to €0.34 per nappy.
Home Help Service	3,877	3,002,297	774	A weekly contribution of €2.33 for a household with one beneficiary or €3.49 if more than one beneficiary. An extra weekly charge of €1.16 or €1.75 respectively if light meal is prepared.

Community care and other services offered by AACC	Number of persons making use of the service during 2018[3]	Cost to Government for service provision (€)	Average cost to Government for each older person receiving the service provision during 2018	Cost to older persons receiving services
Handyman Service	997	347,104	348	Service is free of charge to persons entitled to Free Medical Aid (Pink Form) or Special Identity Card. Other persons receive this service at a nominal fee between €0.58 to €11.65.
Meals on Wheels	1,281	399,702	312	€2.20 per meal.
Night Shelter	26	17,737	682	€2.00 per night.
Telecare+	8,061	401,796	50	€25 deposit is paid upon installation, and €4 rent every month for the service.
Telephone Rent Rebate	2,322	17,737	8	€11.50 for rental charges.

[3] The figures may not include all persons who have utilised the services during 2018 if these persons were not availing themselves of the services until the end of 2018.
[4] For the purpose of Table 1, the Domiciliary Midwives service provided through the AACC has been excluded.
[5] The Allied Health Service includes the Occupational Therapy Service, Physiotherapy Service, Podiatry Service and Speech Services.
[6] The amount of 463 refers to the total applications for the year 2018.
[7] The amount of 1,661 includes 1,065 as Home Help and 596 as Social Work.
[8] The amount of 1,855 includes 1,281 as Day Centres and 574 as Active Ageing Centres.
[9] The amount of 6,727 includes 3,459 as 'Scheme A' and 3,268 as 'Scheme B'.

1.2.2 Securing the coordination of a wide range of health and social services within AACC and with external entities is a complex endeavour, especially when the aim is to provide a personalised service and when resources are lacking. However, without such services, residential care is the only available course of action. The Domiciliary Nursing and Caring, Social Work, Home Help and the Meals on Wheels are four important services, which help older persons who are at their most vulnerable and in most cases without adequate familial support. These four services were audited in terms of their performance in 2018 by this Office. The scope of this audit did not extend to the provision of these services in Gozo.

1.2.3 During 2019, AACC expanded the Silver-T service, which was previously provided in three localities. As at the time of drafting this report, AACC was operating this service in 10 localities. This service enables older persons to have access to personalised transport services within their community. During this year, AACC also launched a pilot project providing mobility scooters for older persons to commute within Valletta. AACC recently also introduced a Phlebotomy Service to housebound older persons. These services are provided free of charge. In addition, the AACC also continued to upgrade existing services. This report will discuss these upgrades with respect to the four services under review.

1.3 The provision of care services for older persons living within the community is generally less financially onerous than those within a residential care setting

1.3.1 It is unclear to what extent and under what conditions home care is less expensive than institutional care. Expansion of home and community-based services entails a short-term rise in spending, followed by a decline in institutional spending and long-term cost savings.[10] Some evidence, such as the Canadian National Evaluation of the Cost-effectiveness of Home Care, has shown that home care is less costly than institutional care.[11] However, home care consumes an increasing share of long-term care expenditures.[12]

1.3.2 Nonetheless, the social benefits of older persons remaining active and independent within their own residences in a familiar community setting is well-documented. Moreover, research and academic literature show that costs tend to be lower for community services than for residential clients, regardless of whether costs only to the government were taken into account or whether both formal and informal costs were taken into account. Within this context, informal costs relate to care provided by family members or voluntary groups. However, international research shows that should the informal caregivers' time be valued at either minimum wage or replacement wage, there would be a substantial increase in the average annual costs for Government.

[10] Kaye et al., 2009.
[11] Hollander and Chappell, 2002.
[12] Byrne et al., 2008.

1.3.3 Within the local context, a similar scenario prevails. This takes into consideration that the actual direct and indirect costs of providing care services provision for older persons living within the community are lower than for those within a residential care facility. This assertion considers that Government recoups a set percentage of costs related to residential care through older persons' pensions and also in part recoups various other costs provided in the community, such as Home Help Service and Meals on Wheels. Similarly, Government's annual expenditure on community care and residential care also illustrates the financial advantages of the former.

1.3.4 The cost of residential care incorporates a higher element of fixed costs and cost components, such as maintenance and depreciation of assets, the procurement of new equipment and other overheads, which are drastically less within a community care context. The foregoing implies that it is financially more advantageous to, wherever possible, provide community-based care rather than institutionalised residential long-term care. To this effect, during 2018, AACC expenditure for community and residential long-term care homes amounted to €15,330,674[13] and €42,226,240 respectively, where the latter implies an average of €47.71 per person per night.

1.4 Ten case studies indicate that AACC community care services are less financially onerous than residential care homes

1.4.1 A case-study review, based on 10 randomly selected persons receiving AACC community services during 2018, further highlighted the financial advantages of providing care for older persons within the community. The Government costs highlighted in Table 2 assumes that the services were provided throughout 2018.

Table 2 - Overall costs of the 10 case studies[14]

Case	Total costs for 2018 (€)								Average daily cost for 2018 (€)
	Allied Health	Home Help	Incontinence	Nursing and Caring	Respite	Social Work	Telecare	Total Cost for 2018 (€)	
1		774.39	146.48	3,738.73				4,659.60	12.77
2				157.96			49.84	207.80	0.57
3	247.32		146.48	2,125.31			49.84	2,568.95	7.04
4				213.33				213.33	0.58
5		774.39		111.79	71.41		49.84	1,007.43	2.76
6		774.39		1,405.83	71.41			2,251.63	6.17
7				395.30				395.30	1.08
8			146.48	2,246.05		152.76		2,545.29	6.97
9				1,778.48				1,778.48	4.87
10				349.93		152.76		502.69	1.38

[13] The amount of €15,330,674 excludes the Domiciliary Midwives service provided through the AACC.

[14] These costs relate to expenditure incurred by AACC prior to any recoupment of fees from clients.

1.4.2 Table 2 shows that there is a significant disparity between the costs within residential care at an average of €47.71 per night as opposed to the costs related to community care. While acknowledging the limitations in the compilation of Table 2, which mainly relate to representativeness, when one takes into account the unit cost of community services portrayed in Table 1, the financial benefits of providing community-based services remain advantageous.

1.4.3 Methodological limitations also arise as AACC do not have comprehensive and integrated electronic systems in place to generate reports relating to the community services received by an individual. The National Audit Office (NAO) are informed that currently AACC is actively pursuing the introduction of electronic systems through the Converge EU funded project to facilitate the generation of reports illustrating the number of services provided to the same individuals. The availability of such information would enrich the quality of management information available for decision-making purposes.

1.4.4 In Table 2, there are also limitations about the appropriateness or cost-effectiveness of community care for high-need users requiring round the clock care and supervision, which differ from the cases outlined in Table 1. Despite the will of older persons to live independently in their own homes and communities, users with significant impairments may still need continuous care in a residential home environment[15] or in adapted-living, service-housing arrangements with 24 hour care.

1.4.5 Nonetheless, coupled with the social benefits of having older persons remaining within their community, the financial ramifications of providing such care services present the opportunity for policy considerations that would broaden the range of services and make more accessible such services at a more expedient rate. This assertion stems from research which concludes that, in some cases, inappropriate or inadequate home care may lead to higher and more costly institutionalisation in the future.[16]

1.5 Audit Focus and Methodology

1.5.1 Thus far, this introductory Chapter discussed the need and the cost-effectiveness of community care services for the older persons. For the purpose of this audit, the NAO reviewed in greater depth the Social Work, Nursing and Caring, Meals on Wheels and Home Help Services. The review of these services enabled the evaluation of services provided by either the AACC, or the contracted service provider or a combination of both. The four services reviewed are financially material as, in 2018, the annual expenditure related to their provision ranged from €253,727 to €6,703,994. The NAO also considered the number of persons receiving these services. To this effect, during 2018, service recipients for these four services ranged from 1,281 to 5,537. Another criterion influencing the choice of these four services was their contribution in enabling older persons to continue to pursue, as

[15] Miller and Weissert, 2010.

[16] Long-term Care Reform Leadership Project, 2009.

far as possible, an independent way of life within the community. Within this context, this audit sought to determine the extent to which community care services provided by AACC are conducive to enabling the older person to continue living indecently within the community. Consequently, the audit objectives aimed to establish the degree to which:

a. the strategies and policies in place were comprehensive in relation to all aspects of community care for the older person;
b. the supply of services was in equilibrium with demand;
c. services reviewed were being delivered in an efficient and effective manner;
d. mechanisms were in place to enable effective monitoring of the services available to the community and their respective outcomes; and
e. the provision of community care services was cost-effective from service users' and Government's point of view.

1.5.2 The cut-off date for this performance audit was end 2018. However, during the course of this review in 2019, AACC embarked on various initiatives to address service delivery and administrative shortcomings. Wherever possible, this Report will provide an outline of AACC's latter initiatives.

1.6 Methodology

1.6.1 The attainment of the above objectives entailed a number of methodological approaches. These included the following:

a. **Documentation review**: This performance audit entailed reviewing contracts relating to the Home Help, Meals on Wheels, and Domiciliary Nursing and Caring Services to ascertain that provisos therein safeguarded Government's and clients' interests appropriately. The documentation review also included AACC administrative and financial records as well as statistics maintained by the AACC.

b. **Semi-structured interviews**: Interviews enabled the collation of qualitative data to substantiate audit evidence gathered through other sources. NAO interviewed AACC's senior management as well as key officials in charge of specific services.

c. **Data analysis**: The data analysis exercises undertaken mainly related to the operations involved in the provision of the services under review. This included data regarding clients' application processing times, surveys, customer care data and service delivery statistics.

d. **Financial analysis**: These evaluations enabled the determination of unit costs of the various services provided by AACC. In turn, these costs contributed to cost effectiveness analysis as well as comparative analyses between services for the older persons provided in a community or residential setting.

1.7 Report Structure

1.7.1 Following this introductory Chapter, the Report proceeds to discuss the services under review. The following refers:

a. **Chapter 2** - This Chapter discusses the extent to which the national strategic framework comprises initiatives aimed at promoting community care for the older persons to encourage further independent living.

b. **Chapter 3** - This Chapter on Social Work seeks to determine the extent to which the Social Work Service provided by AACC within the community is conducive to older persons living better within the community and whether this service is reaching those who require it in an effective manner.

c. **Chapter 4** - This Chapter discusses the Domiciliary Nursing and Caring Services for home-bound patients suffering from terminal and acute illnesses, requiring specific preparations and/or treatments, discharged from acute-care hospitalisation, requiring short-or long-term care. The Chapter looks into the contract between AACC and the service provider, aspects of service delivery and monitoring.

d. **Chapter 5 –** This Chapter discusses the Meals on Wheels Service. This service aims to support senior citizens aged 60 years and over as well as eligible disabled persons living within the community who are unable to prepare a meal. The discussion herein mainly focuses on service delivery issues.

e. **Chapter 6** - This Chapter discusses the extent to which the Home Help Service encourage further independent living for older persons living in the community. This service offers assistance to older people and persons with special needs in performing light domestic chores, shopping and preparation of light meals.

1.7.2 The conclusions and recommendations emanating from this performance audit are included in this Report's Executive Summary on pages 13 to 16.

Chapter 2

The National Strategic Framework

2.1 Introduction

2.1.1 Malta faces a considerable challenge posed by demographic changes due to a high proportion of older people in society. Population projections indicate a continuously ageing population and, as time goes by, an increasing proportion of the population will be of pensionable age. Birth rates are falling while increases in life expectancy have risen from 79.9 years in 2007 to 82.6 years in 2016. Within this context the National Strategic Policy for Active Ageing Malta 2014 – 2020 (NSPAA) provides the national framework within which national entities are to focus their work to promote the well-being of older persons.

2.1.2 This strategy encourages longer working lives whilst maintaining work ability, promoting social inclusion and non-discrimination of older persons, safeguarding health and independence in later life, maintaining and enhancing inter-generational solidarity. To this effect, Malta's strategic framework focuses on three key aspects: active participation in the labour market, participation in society as well as independent living.

2.1.3 In line with the objectives and scope of this performance audit, this Chapter discusses the extent to which the national strategic framework comprises initiatives aimed at promoting community care for older persons to encourage further independent living.

2.2 The National Strategic Framework does not deal comprehensively with community care for older persons

2.2.1 This performance audit adopted a number of criteria to assess how deeply the national strategic framework covers community care. The relevance of this assessment is that a strategy is key to marshalling resources in the most efficient and effective manner to attain policy objectives. The discussion within this Section does not focus in any way on the technical content of the national strategic framework but seeks to determine the extent to which the compilation of the strategy adheres to generally accepted practices.

2.2.2 The National Audit Office (NAO) elicited these criteria from strategic plans dealing with similar topics pertaining to other countries within the European Union (EU), as well as academic literature. Table 3 illustrates the extent to which the national strategic framework concerning community care for older persons fulfils the criteria adopted for this review.

Table 3 - Elements which should feature within the national strategic framework

Criteria	Yes	No
Strategy compiled by experts and specialists	Yes	
Outlines vision, mission and relative objectives	Yes	
Development of a supporting business plan	Yes	
Assigns responsibilities		No
Includes milestones and timeframes		No
Refers to outcomes and measurable outputs		No
Relates impact to Key Performance Indicators		No
Determines the demand and supply for services over time		No
Economic feasibility of specific initiatives		No
Incorporates side strategies relating to the implementation of specific measures		No

2.3 The National Strategy had the appropriate technical input and clearly outlines its objectives

2.3.1 Table 3 shows that among the critical criteria fulfilled was that Government engaged experts and specialists in the field to compile the strategy. In addition, the national framework sought to integrate community care – the subject of this audit – with other key areas of active ageing. Moreover, the Active Ageing and Community Care (AACC) mission and vision statements are in synchronization with the national strategy's objectives.

2.3.2 Another fulfilled criterion related to the competent authority, in this case AACC, developing a business plan, which identified the human resources required to enable the implementation of strategic initiatives.[17]

2.3.3 On the other hand, among others, the NSPAA does not comprehensively refer to aspects relating to implementation responsibility, demand and supply for services as well as outcomes and impacts of strategic initiatives. Moreover, apart from dementia, this document does not make policy recommendations for the adoption or development of strategies relating to specific conditions.

2.4 The National Strategic Policy for Active Ageing was not supported by implementation responsibilities

2.4.1 A key aspect of a strategy is that it clearly assigns implementation responsibility. This ascertains transparency, accountability and ensures that the entity concerned is in a position to acquire and mobilise resources to enable task implementation. The national strategic policy, however, does not make such references.

[17] This business plan highlights a severe administrative deficit in monitoring the implementation of the plan.

2.4.2 The AACC, in part, mitigated this concern by designating responsibilities in its work plan. The problem remains when the implementation of a specific measure requires inputs from sources outside the AACC. As the NSPAA does not formally designate roles, these entities would encounter difficulties to secure resources and to deploy them towards the implementation of measures listed in the strategy.

2.5 The strategic plan does not delve in detail into the supply and demand for the services under review

2.5.1 The NSPAA does not discuss comprehensively and conclusively the anticipated demand for elderly community care services falling within the scope of this audit. While ageing statistical projections are available, the strategy does not include extrapolation exercises to estimate the demand for various services over time.

2.5.2 In turn, such an information gap within the strategic framework prohibits the national competent authorities from estimating the resources required to provide the required level of supply. In practice, this is leading to disequilibrium between demand and supply in a number of community care services for the older persons offered by AACC. Examples in this regard relate to Home Help and Social Work Services provided to the older persons within the community.

2.6 The implementation of the National Strategy is not based on concrete timeframes and milestones

2.6.1 Schedules through timeframes and milestones are a key feature in a strategy since they provide implementation guidelines. The NSPAA implies that the implementation of measures is to take place between 2014 and 2020. This constitutes a broad implementation timeline which does not appropriately guide national authorities to plan effectively to address policy recommendations indicated therein.

2.7 The National Strategy does not base its initiatives on projected outputs and outcomes

2.7.1 The NSPAA does not link the policy recommendations outlined therein to outputs and outcomes. In the absence of timelines and supply estimates, the national plan would consequently be unable to phase outputs over predetermined periods.

2.7.2 Similarly, the NSPAA omits references to quantifiable outcomes. While the plan's main objective is active ageing, which implies that it seeks to encourage and influence older persons to remain living within the community for as long as possible, such outcomes are not supported by key performance indicators.

2.8 The National Strategy does not justify measures with economic feasibility studies

2.8.1 The social benefits emanating through increasing the scope and frequency of services for the older persons within the community are evident. The NSPAA, however, does not complement the envisaged social benefits with economic feasibility studies. The absence of such reviews does not guide national authorities on aspects relating to the sustainability of provision of such services.

2.9 The Strategic Framework does not incorporate side strategies to various aspects of community care

2.9.1 A positive development which strengthens the strategic framework relates to Government's dementia policy. However, this positive development is yet to extend to other aspects of older persons care within the community such as loneliness and homelessness which need to be monitored better in order to be addressed through actionable policy measures.

2.10 AACC's implementation plans also consider the measures identified in the electoral manifesto

2.10.1 The implementation of measures which falls squarely within the remit of AACC outlined in the NSPAA is, to varying degrees, dependent on policy direction by the Ministry for Family, Children's' Rights and Social Solidarity. In these circumstances, this Ministry directs the AACC to concentrate its efforts on specific themes featured in the electoral manifesto.

2.10.2 To this end, AACC has developed a working document with respect to the measures identified in the electoral manifesto, and which are being implemented. AACC has established implementation timelines and keeps regular track of progress achieved. However, documentation maintained in this regard does not relate to future resource requirements or the extent to which services will be broadened. While these electoral manifesto themes contribute to the attaining of the national strategy's overall objectives, there is no direct relationship between the two documents. AACC contends that these issues are being addressed in the strategy document which at present is being drafted.

2.11 AACC has recently drawn up action plans to support strategic measures

2.11.1 During the course of this audit in 2019, AACC compiled various action plans dealing with four strategic pillars, namely: modernizing infrastructure, reengineering of current services, introduction of new services in the community and increasing resources and training. This initiative greatly mitigates the shortcomings noted in the preceding Section concerning the national strategic framework and aims to further rationalize the implementation of measures outlined in the national strategy and the electoral manifesto.

2.11.2 To this effect, these action plans linked with anticipated measures against time schedules as well as envisaged outputs and outcomes. Although not formally adopted, AACC is already implementing strategic measures in accordance with the provisions stipulated in the respective action plans.

2.11.3 During 2019, AACC complemented the action plan initiative with the compilation of Standard Operating Procedures (SOPs). The merits of such an initiative mainly relate to streamlining of procedures, business continuity and critically, the consistent treatment of clients.

2.12 Conclusions

2.12.1 The NSPAA highlights in broad terms how older persons can be empowered and supported to live independently within the community for as long as possible. To this end, the national strategic framework elicits expert opinions on the anticipated way forward. Nonetheless, this Chapter identified two major issues, which to varying degrees influence the attainment of objectives therein relating to the delivery of community care and services.

2.12.2 Firstly, the strategic framework in relation to the area of community care for older persons falling within the scope of this audit is not comprehensive. Statements and policy recommendations therein do not provide in depth details about the approach to be adopted as well as detailed presentations of the measures to be implemented. This state of affairs prohibits the determination of resources required. Secondly, the implementation of elderly community care aspects within the national strategic framework have only recently been supported by action plans which stipulate schedules as well as ownership of the respective policy recommendations. The foregoing raises the risks that in some cases policy recommendations will remain outstanding beyond the validity period of the national strategic policy.

2.12.3 The main objective of the national strategy is to support independent living within the community. Nonetheless, the opportunity exists for a future expanded national strategy that delves into issues affecting older persons which so far have not been discussed thoroughly within the strategy. Moreover, it is critical that the national strategy is supported by a comprehensive roadmap which will enable it to attain its objective.

Chapter 3

Social Work

3.1 Introduction

3.1.1 By end 2017, 18.8 per cent of the total population in Malta was aged 65 years and over and 26.4 per cent of this cohort were at-risk-of poverty or social exclusion. The increase in an ageing population pose challenges to the social security system both in terms of pension reform and in the area of care. Such an increase also calls into question the adequacy of social work intervention in this area. Similarly to the European situation, in Malta, social work is now facing a rise in requests for access to services and resources commensurate with an expanding number of older people, who also have increased levels of need.

3.1.2 Social work with older persons is no less multi-faceted than social work intervention with other cohorts and age groups. Specifically, gerontological social work is concerned with maintaining and enhancing the quality of life and well-being of older people and their families through independence, autonomy, and dignity. The main focus of gerontological social workers is on understanding the physical and mental health problems that older people may experience within the context of economic, social and environmental influences. Social workers interact with the individual older person, families and community resources and often facilitate difficult decisions, for example a move to a care home.[18]

3.1.3 This Chapter sought to determine the extent to which the Social Work Service provided by the Active Ageing and Community Care (AACC) is conducive to older persons living better within the community and whether this service is reaching those who require it in an effective manner. Against this backdrop, this Chapter covers the following aspects:

a. the resources available to deliver the service;
b. the demand for social work;
c. whether the service is being delivered in an efficient and effective manner;
d. the monitoring of the service provided by the competent authority; and
e. whether the Social Work Services provided within the community constitute value-for-money.

[18] http://www.cpa.org.uk/cpa-lga-evidence/College_of_Social_Work/Milneetal(2014)-Socialworkwitholderpeople-avisionforthefuture.pdf, accessed 1 November 2019.

3.1.4 This Office carried out several semi-structured interviews with the Acting Head of Unit and social workers as well as AACC management. Since at the time of the audit the Social Work Unit was also responsible for carrying out Home Help eligibility assessments, the National Audit Office (NAO) reviewed a sample of 30 files relating to this service as well as another 30 files pertaining to social cases. The data gathered through this review enabled an evaluation of Social Work Unit's working methods and procedures. Further documentation such as Annual Reports, the Departmental Manual of Policies and Procedures, minutes of internal meetings and statistics drawn by the Social Work Unit were resorted towards better understanding of the Social Work Unit within AACC.

3.2 AACC social workers would benefit from specialist gerontological training

3.2.1 The Social Work Unit is responsible for providing its services to the older persons living within the community, that is, within their own residences, and to older persons living within government-run homes. In 2018, the Unit included social workers who had the appropriate qualifications, namely a diploma or an undergraduate degree in social work.

3.2.2 These social workers had years of experience working with vulnerable groups, with over half of the social workers having spent years working directly with older persons within AACC or elsewhere. However, the Units' social workers have not been formally exposed to specialist knowledge and training related to the ageing process and models of ageing, the impact of age-related health issues, losses and transitions, communication with people with dementia or other age-related conditions[19], social work in different settings such as within care homes or end-of-life care. Despite their years of experience, the lack of continued professional development in gerontology represents a loss of opportunity for this Unit to deal with cases more effectively and efficiently. To date, AACC has not invested in a structured programme relating to the continued professional development of the Social Work Unit.

3.2.3 **Recent Developments** - AACC is ring-fencing a budget for training and also sponsors interested employees for the Masters in Gerontology programme. In 2019, AACC requested its Social Work Unit to propose relevant training programmes.

[19] Ray, M., Milne, A., Beech, C., Phillips, J.E., Richards, S., Sullivan, M.P., Tanner, D. and Lloyd, L., 2014. Gerontological social work: Reflections on its role, purpose and value. British Journal of Social Work, 45(4), pages 1296-1312.

3.3 AACC's social work manual does not include comprehensive objectives

3.3.1 The role that social workers within AACC are expected to carry out as specified in the Departmental Manual, and in the Unit's 2017 and 2018 Annual Reports, is outlined in the fifth column of Table 4. For comparative purposes, the Table depicts other examples from literature outlining the role and common objectives of a social worker working in a community setting with older persons. It is clear that, whilst there are similarities between all examples, the terms of reference of the social workers within AACC should aim to be more comparable to the other examples as highlighted in Table 4.

Table 4 - Comparison of gerontological social work objectives within the community

Objectives of a social worker's role	British Journal of Social Work[20]	The Irish Association of Social Workers': Special Interest Group on Ageing[21]	A paper prepared for the Scottish Executive by the Social Work Research Centre, University of Stirling[22]	Manual of Policies and Procedures, AACC, Malta[23]
Social work assessment/interventions		✔		✔
Needs assessment		✔	✔	
Communication and empowerment	✔		✔	✔
Counselling/ Practical guidance and assistance to elderly and family members due to crisis/loss or change of environment	✔	✔	✔	✔
Advocacy for older people	✔	✔		✔
Assessment of elder abuse (physical and emotional) and neglect, (including self-neglect)		✔		✔
Working with other professionals and other stakeholders			✔	✔
Helping the carers	✔		✔	
Developing and case managing a care plan	✔	✔		
Monitoring quality of care	✔	✔		
Supporting people whose lives are constrained by illness and disability			✔	✔

[20] Ray, M., Milne, A., Beech, C., Phillips, J.E., Richards, S., Sullivan, M.P., Tanner, D. and Lloyd, L., 2014. Gerontological social work: Reflections on its role, purpose and value. British Journal of Social Work, 45(4), pages 1296-1312.

[21] The Role of the Social Worker with Older Persons; Prepared by: The Irish Association of Social Workers' (IASW) Special Interest Group on Ageing (SIGA) Introduction Revision: August 2011.

[22] Marshall, M (1990) Social Work with Older People, Second Edition, Basingstoke: Macmillan; Quoted in Effective Social Work with Older People Brian Kerr, Jean Gordon, Charlotte MacDonald and Kirsten Stalker, a paper prepared for the Scottish executive by the social work research centre, University of Stirling as part of the 21 century social work review, Scottish Executive Social Research (2005).

[23] Manual of Policies and Procedures, Social Work Unit within the Active Ageing and Community Care Department.

3.3.2 Table 4 illustrates that, to varying degrees, there are similarities between the AACC social workers' remit and social workers within other countries. However, at the time of the audit, the needs assessment was not fully documented while this assessment was not translating into individual social care plans by AACC. Despite the liaison between the Social Work Unit and the Residential Care Unit within AACC, lack of staff issues prohibit a more comprehensive social work intervention involving family members and informal carers especially in circumstances leading to and following admission of older persons to a residential care home.

3.4 Capacity and planning shortcomings prohibit the Social Work Unit from providing a more holistic service

3.4.1 The previous Section provided an introduction into what social work for older persons entails and what is expected of social workers. This Section discusses how capacity issues, the determination of current and future demand for social work among older persons as well as the processes adopted, to varying degrees, impede the provision of a more holistic service. At the time of the audit, such circumstances are exemplified by the absence of care plans, as well as limited counselling and regular assistance in anticipated life-changing situations, such as the demise of a partner. This state of affairs was generally confirmed through one-on-one interviews with five of the six incumbent social workers at the time. AACC contends that at the time of the audit, the Social Work Unit was not supported by a psychotherapist and a psychogeriatrician who would have contributed to a more complete service.

3.4.2 **Recent Developments** - AACC contends that in the latter part of 2019, a psychotherapist was detailed to provide assistance to the AACC. Moreover a psychogeriatrician has also been contracted to cater for older persons within the community.

3.5 During 2018, the Social Work Unit's capacity declined by around 50 per cent

3.5.1 Research highlights the value older people place on social workers' knowledge about specialist services, their commitment, reliability, and support.[24] Yet, the staff shortages in this critical area have not only affected the Unit's service delivery, reach and its efficacy but are potentially also impeding older persons from continuing to live independently within the community. Moreover, as quoted in the Social Work Unit's Annual Report (2018), the outcome of such a state of affairs impedes proper functioning of the Social Work Unit.

3.5.2 Milne et al. (2013), Ray et al. (2015) and Rizzo and Rowe (2006, 2014)[25] have considered the efficacy and cost- effectiveness of social work with older people. They concluded there was good evidence for the cost-effectiveness of social work with adults and for positive impacts on older people themselves in terms of their quality of life.

[24] Manthorpe, J., Moriarty, J., Rapaport, J., Clough, R., Cornes, M., Bright, L. and Iliffe, S., 2007. 'There are wonderful social workers but it's a lottery': Older people's views about social workers. British Journal of Social Work, 38(6), pages1132-1150, page 1142.

[25] Milne et al. (2013), Ray et al. (2015) and Rizzo and Rowe (2006, 2014).

3.5.3 The main frustrations noted by Cutajar, 2009[26] that are expressed by social workers working with older persons, were evidently still on-going within the Social Work Unit at AACC in 2018. These were the lack of importance attached to and the lack of appreciation of social work in general within and outside the Department; lack of support and respect for social workers; the lack of visibility of social workers within the community; the limited number of social workers compared to the caseload and lack of resources.

3.5.4 Despite the Unit's limited resources, in 2018, the Unit concluded 596 social cases and carried out 1,065 Home Help assessments. During the first quarter of 2018, the Social Work Unit pertaining to AACC comprised of 11 social workers. By end 2018, there were only four full-time and one part-time social workers and a clerical member of staff since several members of staff retired or moved on to other roles within and outside the public sector.

3.5.5 The shortage of social workers and the practice of assigning caseloads according to districts resulted in caseload disparity within the Unit. A contributory factor to the different caseload allocation emanates from different catchment areas as well as some areas presenting bigger challenges and a larger number of clients than others. During March to December 2018, the caseload of social cases and Home Help assessments among the six social workers[27] ranged from 381 to 115 cases each.

3.5.6 To facilitate the Unit and caseload management, AACC appointed a social worker in the role of Acting Head of Unit in August 2018. The Acting Head of Unit was also responsible for own caseload, which was previously covered by hours of service provided by social workers from St Vincent de Paule Residence (SVPR).

3.5.7 Furthermore, efficiency within the Social Work Unit is negatively impacted since this Unit was not appropriately supported operationally. A case in point relates to the Unit's direct access to legal advice. While AACC has the facility to engage legal consultants, on enquiry, social workers contended that such services were not readily available to the Unit.

3.5.8 **Recent Developments** - During the third quarter 2019, the Acting Head of Unit was officially appointed as Service Area Leader to fully focus on the management of the Unit rather than the actual day-to-day duties relating to a large caseload. A senior social worker, two social workers and a social welfare professional were recruited. Social welfare professionals, whose role has been described as similar to social work assistants, were recruited as an interim measure to assist the social workers until the staff complement of social workers are recruited. These changes helped AACC address the frustration of the Social Care Unit as per paragraph 3.5.3

[26] Cutajar, M. D. (2009). Community-based services for older persons (Bachelor's thesis, University of Malta), page 60.

[27] The Acting Head of Unit is included amongst the six social workers as at end December 2018.

3.6 Comprehensive studies on current and future demand trends for social work are not available

3.6.1 More than one Unit within AACC, especially the Social Work Unit, contended that social issues, such as unaffordable rental prices and homelessness, enhanced awareness of mental health disorders, loneliness, and an insufficient number of informal carers, were on the rise. Despite the availability of ad hoc studies, AACC does not have the appropriate administrative capacity to analyse the ramifications that such social phenomena may bring about. Consequently, the Department will not be in a position to update its strategic approach and to concretely plan supply-related initiatives concerning to social work within the community.

3.6.2 The situation depicted in the preceding paragraph becomes more apparent since the only statistics available at AACC relate to the number of social case referrals. Referrals generally emanate from family doctors, family members, other services such as the Nursing and Caring unit (CommCare) within AACC, helplines, upon discharge from Mater Dei Hospital or Karin Grech Rehabilitation Hospital, or through call-ins by concerned family members or citizens. Nonetheless, AACC has not broken down these figures in accordance with case categories.

3.7 The Social Work Unit has only recently established mechanisms to manage and control its operations

3.7.1 As per Manual of Policies and Procedures, the Social Work Unit's mandate is to work on cases whereby older persons suffer or are involved in physical, emotional and sexual abuse; mobility problems; homelessness; problems of sanitation; harassment and domestic violence, and/or require support to continue living in the community.

3.7.2 Discussions with the Acting Head of Unit and social workers showed their concern at not being able to tackle effectively issues afflicting a bigger number of older persons including homelessness (listed in the Manual) and other prevailing social conditions, such as loneliness and the rise in mental health issues. This, notwithstanding that AACC provides over 20 community services and that other Government Departments provide complementary services. Social workers also pointed out the need to improve support for informal carers, respite services to satisfy demand, shelter provision for older victims of domestic abuse, and transport services to night shelters towards successful social work interventions. In the circumstances, the Social Work Unit is severely restricted in developing practical personalised solutions that cater to a broad spectrum of cases. Consequently, once the Social Work Unit recommends the intervention of other AACC or Governmental agencies, the case is considered closed.

3.7.3 Audit evidence showed that until July 2019, the Social Work Unit did not have the appropriate level of mechanisms in place to enable better implementation and control of its operations. In part, this state of affairs materialised as the Social Work Unit did not maintain and manage its case data centrally within the section. Matters were further complicated as there was no uniformity between social workers with respect to the data collated, pertaining to cases within their responsibility.

3.7.4 A review of 30 out of the 635 case files available revealed that AACC case files had scant information on how the social workers dealt with the social cases. These randomly-selected social work files focused on the physical and medical aspects rather than the individuals' psychological condition or social environment.

3.7.5 The files lacked forms as stipulated by the Manual of Policies and Procedures of the Social Work Unit. Furthermore, from the 30 case files reviewed, it clearly emerged that the Unit did not document a planned schedule of action for clients. Within this context, file cases reviewed did not sufficiently document the following:

a. the profile of the clients;
b. if there were pending visits or assessments by other professionals;
c. when the cases were up for review; or
d. any complaints which may have been received.

3.7.6 The sampled files indicated that, generally, cases were closed and put away after just one visit to the client or after the clients received another service provided by AACC. These files, however, lacked detailed documentation explaining or justifying the course of action adopted by the Unit. Consequently, this situation implies an absence of reliable audit trail, which ultimately influences management's direction, control and monitoring functions.

3.7.7 The AACC management elicited various reasons justifying the conclusion of cases after just one intervention. The following refers:

a. Cases related to the eligibility assessment for other services, such as Home Help and Night Shelter. Home Help assessments are subsequently passed on to the Board following assessment. As these are not social work cases, no follow-up is usually needed. Currently, such applications have now been diverted to a multi-disciplinary team.

b. Cases where clients are hospitalised – nonetheless the National Audit Office (NAO) queries cases closures in such instances since the probability exists that clients would need to be followed up following their discharge from hospital. This situation reflects the Foundation for Social Welfare Services protocol, whereby hospital social workers take over the case while a client is hospitalised. If the need arises, upon discharge, the client is followed up by AACC social workers. This practice, however, implies administrative inefficiencies as AACC's Social Work Unit would need to reopen the case.

c. Cases where other sections, such as the Dementia Unit, are detailed with follow-up interventions. Similarly to the preceding point, the NAO contends that the opportunity still remained available for the Social Work Unit to follow up the case jointly with the Dementia Unit. On the other hand, AACC management contends that following up with the Dementia Unit may result in duplication of work. If a client is being monitored and followed up by another unit, the Social Work Unit will then focus on more urgent and pertinent cases.

d. Staff shortages enhanced the risk of case closures.

e. The amount of time invested in Home Help assessments rather than actual social work with vulnerable older persons.

3.7.8 Information elicited from files and staff interviews related to the Social Work Unit indicated that, at the time, management had not found a solution to the prevailing human resources situation and pressing issues, such as the amount of time invested in Home Help assessments rather than actual social work with vulnerable older persons. Moreover, AACC was not filtering cases prior to assigning them to the Social Work Unit – as a consequence this Unit is burdened with cases which could easily be tackled by other service providers within it, such as the Customer Care Unit.

3.7.9 During the third quarter 2019, AACC management envisaged process revisions whereby the Unit will not retain responsibilities for Home Help eligibility assessments. In the meantime, the Unit will cease to classify and treat non-Home Help cases as de facto social cases, even when these would be cases of older persons applying for other community care services. This implies that the Unit will be solely responsible for actual social work. To this effect, the Service Area Leader will be classifying cases according to risk criteria to better address the needs of older persons.

3.7.10 Concerning file maintenance, AACC management acknowledged the need for the appropriate recording sheets to be included in the file to better record details of social work interventions and to document the relevant clinical details.

3.7.11 **Recent Developments** - AACC management contends that, since audit fieldwork was concluded, the processes related to case documentation have been strengthened. To this end, the Head of the Social Work Unit now has easier visibility of on-going cases. The roll-out of the new Information Technology (IT) System in August 2020 and the increase in staff within the Social Work Unit should also improve operations.

3.8 Records show that few hours are spent on each social case, especially contact hours

3.8.1 A criterion which provides an indication of the extent of efficiency and effectiveness of the Social Work Unit relates to the hours allocated to each case. This necessitated the determination of the total man hours availability to the Unit, and how these hours were actually utilised. Data in this regard also enable the determination of the ratio of contact hours to administrative and case related work. Time estimates of the hours spent on social cases and Home Help Service eligibility assessments were jointly devised by NAO and the Social Work Unit. This exercise focused on the Unit's activities in 2018. In the absence of a centralised daily list of interventions, this task was rendered more problematic. The findings elicited through this exercise were discussed with AACC social workers management.

3.8.2 Table 5 shows that the Unit consumed 9,817 manhours to deal with a workload of 596[28] concluded social cases in 2018. The hours presented in Table 5 are exclusive of man-hours pertaining to public holidays and the average vacation leave and sick leave of each social worker. On the basis of these figures, each case is estimated to have taken 16.5 hours with 9.9 of these hours spent on administrative and follow-up work (report writing, telephone calls, follow-up work). Client interface time was on average estimated at 5.5 hours, and the rest of 1.1 hours on travelling time.

Table 5 - Actual work carried out on social cases (2018)

Social Cases	Concluded cases	Average hours per case	Total hours
Telework (Office Work)	596	2.1	1,248
Office Work		7.8	4,631
Field Work		5.5	3,282
Travelling		1.1	656
Total		**16.5**	**9,817**

3.8.3 Table 5 raises the following issues:

a. Sixty per cent of the time spent on a case was taken up by case administration and follow-up (9.9 out of 16.5 hours). Additionally, social workers utilised 6.7 per cent of available man-hours travelling (1.1 out of 16.5 hours). This Office cannot comment on whether this proportion of administrative work is excessive or not since Social Work Unit protocols do not allocate or estimate the minimum recommended hours per social case. This is understandable in view of the specific circumstance of each case. Determining whether such a percentage of administrative work per case is reasonable becomes more elusive due to unrecorded administrative interventions, namely through telephone calls and emails.

[28] This figure is based on the social workers' individual statistics for closed cases for year 2018.

b. On the other hand, it is estimated that only 33.3 per cent of the time spent on a case is attributable to actual contact hours (5.5 out of 16.5 hours – usually lasting one visit). Furthermore, the Social Work Unit contended that there may be cases where social workers carry out visits to clients, which however go unrecorded in the case file. If this is the case, this Office is critical of practices where social work intervention remain unrecorded in case files. Such approaches prohibit case monitoring, planning and management control. As reported in Paragraphs 3.7.10 and 3.7.11, AACC management contends that circumstances relating to case documentation have been addressed.

c. Even when considering that each case, on average, comprises 5.5 hours of client interface, irrespective of the number of visits, the question remains whether such an allocation is sufficient. This observation also emanates from the absence of time allocation protocols within the Unit.

3.8.4 **Recent Developments** - AACCD management contends that the recently introduced practices concerning case documentation should alleviate concerns relating to continuation of care. Moreover, as pointed out earlier, the engagement of additional social workers and social welfare professionals implies that that social workers can now dedicate more time to each case. Nonetheless, AACC management reiterated that urgent cases were always allocated the full amount of time needed to resolve the presenting problem immediately.

3.9 Work processes in place did not ensure timely Social Work Unit interventions

3.9.1 NAO analysed 29[29] files relating to cases dealt with by the social workers within the Social Work Unit during 2018. The main aim of such an exercise was to determine whether older persons were provided with services in a timely manner. Table 6 refers.

Table 6 - Average processing time of Social Work cases

Process	Social Work	
	Number of cases	Average Days
A: From receipt of application at AACC until forwarded to Social Work Unit	29	4
B: Social Work Unit Assessment	22[30]	76

[29] One file was excluded from this analysis due that although departmental records showed that it was pertaining to a social case, it resulted to relate to a night shelter application.

[30] Seven Social cases were excluded as cases were either still open or needed to be reviewed.

3.9.2 Table 6 shows that based on the 29 cases reviewed, on average, the internal processes took around four days from when an application was received at AACC until it was forwarded and assigned to a social worker. This process refers to:

a. the opening of a new file as per the clients' application;
b. the registration of the file by the main registry;
c. the registration of the file by the administrator of the Social Work Unit; and
d. the allocation of the case by the Acting Head of Unit to a social worker through the administrator.

3.9.3 The process outlined above is similar to that adopted by most Government Departments. Nonetheless, the time taken to complete this process is unjustifiably lengthy; although urgent cases were always fast-tracked. The process is stalled when key persons are unavailable since shadowing of key officials was not in place.

3.9.4 Furthermore, with reference to the 22 sampled cases presented in Table 6, the Social Work Unit, on average, took 76 days to conclude a case. Since social work standards or benchmarks do not cater for case duration, this performance audit sought the advice of social workers on whether such a period is considered reasonable.

3.9.5 This Office acknowledges that cases are closed when older persons require other services that are unrelated to social work interventions or if an issue is solved upon the intervention of social workers. In the same vein, AACC noted that if the appropriate support or service required is provided e.g. admission to a home, community service support, or transfer to another Social Work Unit, then a period of 76 days would seem adequate. Nonetheless, discussions and case reviews with the Social Work Unit revealed that there may be cases where an average of 76 days to conclude a case would not be ideal. The Unit contended that such circumstances materialised due to the following:

a. the number of social workers available was not adequate to deal with the existing caseload; and
b. the Unit was not equipped to provide peripheral services as ancilliary staff were not available to support and alleviate some of the duties carried out by social workers.

3.9.6 **Recent Developments** - AACC management contended that recently the situation has been partly addressed through the engagement of other professionals. A Principal was also allocated to the Unit to help in the administrative work. Moreover, preparatory work is in hand to enable the roll out of an integrated IT system to facilitate case management. AACC envisages that such a system would be in place in August 2020.

3.10 AACC monitoring of Social Work and Home Help cases is minimal

3.10.1 Monitoring is a critical management function as it enables the identification of unproductive processes, which ultimately impact the delivery of Social Work Services to older persons. NAO's focus on the Social Work Unit's monitoring function mainly related to 2018.

3.10.2 This audit established that the monitoring function was weakened. Outstanding monitoring duties included case reviews, case / intervention scheduling, follow-up scheduling and case conferencing. This state of affairs mainly resulted since:

a. The Acting Head of Unit was not able to carry out fully the responsibilities outlined in the Unit's Manual of Policies and Procedures as most of the available time was dedicated to addressing caseload assigned.

b. AACC is still in the process of installing an integrated electronic system which would provide holistic information on all services and related assessments pertaining to individual clients.

c. The Unit did not maintain case data centrally, consistently updated or uniformly.

d. Social workers maintained logistical information in manual format and on individual basis.

e. Case files did not contain detailed information.

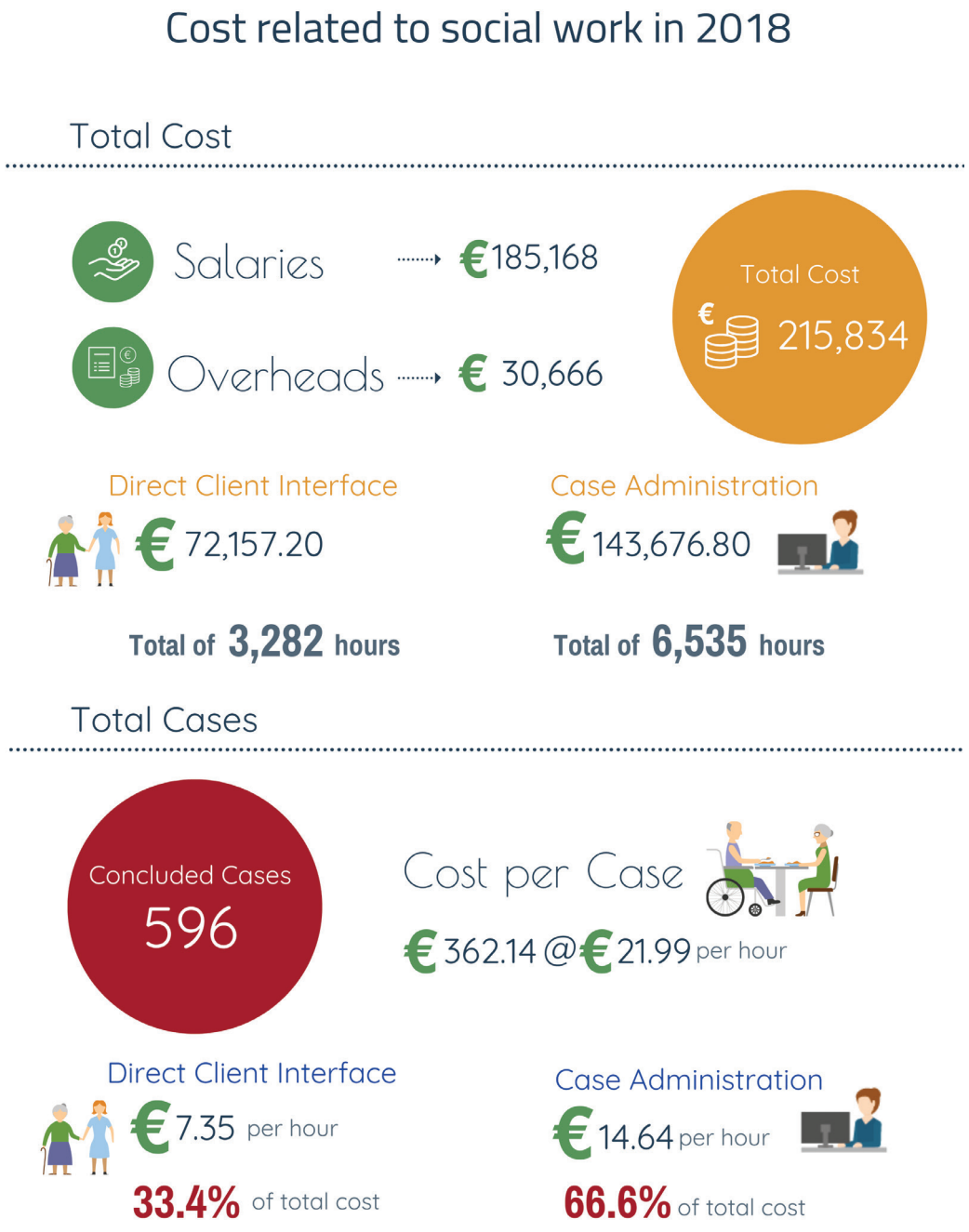
3.10.3 The foregoing prohibits the compilation of accurate monthly and yearly reports, which consequently impedes the evaluation of the Unit's performance in terms of output and quality of work. The Manual of Policies and Procedures for the Social Work Unit within the AACC highlights that every December, around 50 service users are to be randomly selected to answer a questionnaire regarding the service provided by this Unit. The aim of the short questionnaire is to provide feedback with regards to overall quality of service provided by the Social Work Unit. The feedback should be collected and the Head of Unit should prepare a report on the results of such exercise. This information was not collected for 2018 leaving the Unit in further need of feedback to address deficiencies.

3.10.4 **Recent Developments** - AACC contends that the monitoring concerns outlined within this section are now being addressed through the appointment of a Head of Unit. The monitoring function has also been strengthened through the increase in staffing capacity, which now enables the Social Work Unit to address the information gaps discussed within this section.

3.11 Administrative costs constitute the major component of community social work expenditure

3.11.1 This Section sought to establish whether the provision of Community Care Services is cost-effective from a services user and governments' point of view. This exercise excluded Home Help cases which the Social Work Unit spent time upon. Consequently, this review considered the average salaries paid within the Unit as well as the average total hours spent by the Social Work Unit to establish the costs borne by the Government in delivering this service. Figure 1 refers.

Figure 1 - Costs related to social work (2018)



3.11.2 The costs of delivering community social work amount to around €22 per hour. In the absence of national statistics related to costs of such services, the costs incurred by AACC to deliver this service cannot be benchmarked against similar services provided by other entities within the private or public sector. The major cost component within this hourly rate pertains to staff salaries, which comprises around 86 per cent of the costs. AACC is not in a position to influence these costs since these rates emanate from the Public Service Collective Agreement.

3.11.3 Nonetheless, further analysis of these costs raises similar issues to those presented in paragraph 3.8.3 where efficiency related questions arise since the ratio of man-hours allocated for direct client interface to case management amounts to around 1:2. These proportions are naturally reflected in these cost components depicted in Figure 1 since expenditure per hour amounts to €7.35 and €14.64 respectively. These circumstances are indicative that the potential for efficiency gains within the social work administrative process exists. In turn, such efficiency improvements would contribute towards inverting the ratios discussed within this paragraph in favour of direct client interface.

3.12 Conclusions

3.12.1 There can be no doubt that the provision of social work within a community setting to older persons is an indispensable service. This audit acknowledges the social benefits emanating from this service, and within this spirit established a range of management-related evaluation criteria for this performance review.

3.12.2 During the course of this performance audit, AACC has increased its capacity to address demand and supply issues. The engagement of more social workers and social welfare professionals implies that the Unit is now in a much stronger position to improve its reach, coverage and work processes, which were previously conditioned by capacity issues.

3.12.3 Through process reengineering, AACC sought to address issues relating the Unit's efficiency issues – particularly since at the time of audit fieldwork social workers spent significantly more time performing case related administration rather than being directly involved with clients. This included the strengthening of the Unit's management function and relieving the Social Work Unit of Home Help eligibility assessments, which during 2018 consumed around 25 per cent of the Unit's available time.

3.12.4 Up to this audit's cut-off date, the extent of monitoring undertaken with respect to social work was limited. At a Unit level, AACC has sought to strengthen the social work monitoring function where data related to logistics and case management are now centrally maintained. At a macro-level, AACC is still in the process of developing and installing an integrated system whereby all Social Work related activities are centrally available. The continued strengthening of the Social Work monitoring function is key since it facilitates management control and ensures timely corrective action is taken to help older persons retain their independence and dignity within the community.

Chapter 4

Domiciliary Nursing and Caring Services

4.1 Introduction

4.1.1 The CommCare Unit has a regulatory function within the Active Ageing and Community Care (AACC) and is responsible to monitor and audit the service provided by the Contractor, namely Healthmark Care Service Limited, through an Agreement valued at around €6 million annually. The CommCare Assessment Unit's role is to authorise requests for domiciliary care provided by nursing professionals, midwives and carers to "*elderly, disabled, terminally-ill as well as those who are temporarily home-bound due to an acute illness, or for those requiring specific preparations and/or treatments...to provide domiciliary post-natal care for the mother and child*"[31]. Domiciliary care clients may include any person discharged from acute-care hospitalisation, requiring short or long-term care and unable to attend health centres or peripheral clinics, pre-operative preparation, in need of treatment which cannot be appropriately administered at health centres or peripheral clinics.

4.1.2 As at end 2018, there were 21 nursing staff and five administrative or ancillary staff within the CommCare Unit responsible for:

a. assessments,
b. reviews relating to CommCare patients,
c. running the call centre,
d. liaison with the service provider, and
e. liaison with Mater Dei and Karin Grech Rehabilitation staff.

4.1.3 The CommCare Unit carries out assessments for nursing and caring services as well as other services offered by other Units responsible for community services such as the Meals on Wheels, Respite and Respite at Home, night shelters, Home Help and Carer at Home. Relevant patient data including patients' history, change in treatment and information related to reviews are easily accessible from the Information Technology (IT) systems used by CommCare. The system is accessible to the nursing and allied health professionals only and will eventually be integrated with the new IT system that AACC is setting up.

[31] The scope of this audit did not encompass post-natal care.

4.1.4 In 2018, according to estimates provided by AACC, the Contract cost the Government an average of €6,067,104 in nursing and caring costs within the community. This amount covered an annual average of 881,000 interventions. It enabled the provision of specialised services within private residences such as stoma care, wound dressing, continence and treatment management and other services which may not be specialised such as diabetes care and tablet preparation. Once doctors, private or hospital-based, request the Domiciliary Nursing and Caring services for their patients, services are provided immediately in view of urgency of need. Assessments to evaluate needs are carried out as soon as possible after the service starts.

4.1.5 The Chapter discusses the contract between AACC and the service provider, the responsibilities of both parties and aspects of service delivery and monitoring.

4.2 Non-agreement between Parties contributed to a change in service provider in October 2015 through a negotiated procedure

4.2.1 The National Audit Offices (NAO's) review of the Contract awarded to Support Services Ltd (later renamed Healthmark Care Service Limited) stems from the fact that this Agreement was still effective during the timeframe of this performance audit. Hereunder is an outline of the background and context leading to the award of the Agreement to Healthmark in October 2015.

4.2.2 An internal MHEC meeting held on 31 January 2013 noted that the standing Contract with the Malta Memorial District Nursing Association (MMDNA) was up for renewal and further discussed CommCare's unease on the quality of the service and administrative issues. Despite the issues raised in this meeting, the Parties reached an agreement which enabled MMDNA to continue to provide Domiciliary Nursing and Caring services.

4.2.3 An MMDNA internal memo claims that Government had, in January 2014, verbally confirmed to the Association that it intended to negotiate a direct order for the provision of services for a minimum of three years. Government also verbally committed itself to refund all expenditure that would be undertaken by MMDNA in the course of providing its services to the Department. Nonetheless, a chain of events led to MMDNA informing AACC in September 2015 that it was terminating the provision of domiciliary services as of 4 October 2015. AACC and Healthmark Ltd signed a contract for the provision of Domiciliary Care and Nursing services following a negotiated procedure which was approved by the Department of Contracts on 2 October 2015. Table 7 presents a chronology of these events.

Table 7 – Events leading to the awarding of Contract to a new service provider

26 April 2012	Government renewed Contract with MMDNA. • Contract extended on a yearly basis.
6 March 2013	MMDNA and Government renew Contract at same intervention rates based on costs prevalent in 2010.
8 April 2013	Department of Contracts gave approval, but Agreement remained unsigned.
January 2014	Government confirmed verbally its intention to retain the services of MMDNA for a minimum of three years.
16 June 2015	Parliamentary Secretary for Persons with Disability and Active Ageing (PSDAA) notified MMDNA she preferred to start afresh by taking a look at the Contract which expired December 2012 rather than issuing a direct order.
August 2015	• MMDNA requested that AACC settles €603,945 which remained outstanding under clawback arrangements pertaining to 2013 (€120,000), 2014 (€238,809) and 2015 (€245,136 as at end July). MMDNA contended that this affected its financial stability and future recruitment programme. • MMDNA asked AACC to rectify fees applicable from August 2015 onwards since the rates were based on costs prevalent in 2010. AACC refused on grounds of its strategic short-term plans. • MMDNA refused to take on new cases. • AACC initiated market research to seek a new service provider. • Consultations were held with Health Ministry in view of evolving situation. Alternative service providers to ensure continuation of service were sought as an alternative to discussions with MMDNA failing. Terms and quotations were sought from three community care operators.
September 2015	• MMDNA and two other further contractors submitted quotes. • MMDNA gave notice of termination of contract of service as of 4 October 2015 due to '*amongst other reasons, lack of complete funding from the Government as per agreement*'. • AACC invited MMDNA to reconsider its position and submit proposals for the continuation of service beyond 4 October 2015. • AACC responded that Government will consider MMDNA's claims for terminating its services and reserved the right to respond and take any necessary action. • Nonetheless, some days later MMDNA submitted a list of proposals to continue the service beyond the indicated date of contract termination. • Government proposed that MMDNA to be relieved of one third of the current operational workload. • MMDNA reiterated that such proposals were not conducive to enable the NGO to continue with the provision of services. • AACC intensified contacts with prospective operators to discuss terms and rates for provision of domiciliary nursing services in view of outcome of meeting between MMDNA and AACC held on 22 September 2015, and lack of concrete assurances by MMDNA that its services would continue. • MMDNA Council met to discuss outcome of meeting and reconfirmed its decision to go ahead with termination of services.

2 October 2015	Department for Contracts gives approval for AACC to enter negotiations with Support Services Limited for the procurement of domiciliary nursing and caring services in Malta and Gozo.
4 October 2015	New contract signed with Support Services Limited.
23 October 2015	Transition and Mutual Release Agreement signed between the Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing and MMDNA.
End of 2015	AACC paid MMDNA a net amount of €1.74 million for the period January to August 2015.
First quarter of 2016	A further payment of €607,790 was made by AACC to MMDNA.

4.2.4 Furthermore, as can be seen in Table 8, when one compares the fees proposed by MMDNA with the fees charged by Healthmark (the new service provider replacing MMDNA), it transpires that the fees charged by the new service provider were higher. It is pertinent to note that these fees were derived through three quotations that AACC had in hand. The Healthmark rates became the most advantageous following MMDNA's decision to wind down its operations.

4.2.5 AACC contended that it was in the process of seeking the obligatory Ministry for Finance approvals for the higher 2015 rates proposed by MMDNA. However, in the interim negotiations between the parties broke down and MMDNA gave termination notice. The Association, on the other hand, argued that together with higher costs and a need to reengineer services, its financial position made it untenable to continue to provide services. MMDNA raised its financial concerns on various occasions, including through an independent financial audit commissioned by the Association itself in September 2015. Although material payments from AACC were regularly paid, they were not timely. MMDNA maintained that its financial position remained precarious and insisted that it was not in a position to continue service delivery in accordance with the provisions of the existing terms and conditions.

Table 8 - Fees charged by MMDNA and Healthmark

	Fees charged by MMDNA (€)	Revision of fees by MMDNA (applicable August 2015) (€)	Fees charged by Healthmark (October 2015) (€)	Revision of fees charged by Healthmark (applicable for all of 2018 and to date) (€)
General Care Non-Nursing	4.30	5.00	7.25	7.47
General Care Nursing	6.00	8.00	10.75	11.11
Surgical / Medical	4.00	6.00	8.85	9.09
Post-Natal Care	6.50	9.50	10.75	11.11
Minor Routine Procedure	3.00	4.00	5.25	5.37
Diabetes	3.00	4.00	5.25	5.37
Injection	3.00	4.00	5.25	5.37
Treatment	3.00	4.00	5.25	5.37
Futile visits nursing	1.00	*to be paid in full*	3.20	3.36
Futile visits caring	1.00	*according to category*	1.70	1.92

4.2.6 AACC contends that the variance in the fees proposed by MMDNA and the higher rates agreed with the new service provider were intended to compensate the Contractor for maintaining a management structure for the smooth running of the domiciliary care service. This entailed inter alia that the Service Provider maintain a documentation system recording each visit provided by nurses, midwives and carers. To this end, AACC pointed out that the Contractor had to invest and maintain electronic systems. Nonetheless, the maintenance of documentation in electronic format, although amply desired, is not a contractual obligation.

4.3 The annual automatic renewal of the domiciliary care contract deviated from good governance and business practices

4.3.1 The Contract for nursing, caring and midwifery services was signed with Support Services Limited (later renamed to Healthmark Care Service Limited) with the commencement date of 4 October 2015 for the duration of 12 months. The Contract resulted out of a negotiated procedure following the termination of provision of services previously provided by MMDNA.

4.3.2 Table 9 below shows the timeline in relation to the contracts between the AACC and Healthmark. The first column lists the validity dates of the contracts while the second column shows the dates when the contracts were signed. The third column lists the changes to the contracts that were carried out.

4.3.3 As per Table 9, the main change in the most recent Contract, that is the April 2019 Agreement, is Clause 6 (as per Column 3). This provision assigned a total amount up to €5,810,881 for the delivery of the intervention packages, based on the 2018 intervention figures, for the period quoted by the Contract. However, expenditure in relation to this Contract amounted to €6,134,165 for 2018 intervention packages.

4.3.4 Furthermore, Table 9 raises concerns that the period October 2018 to April 2019 was not covered by a valid Contract. This situation resulted since:

a. AACC did not enter into a formal Contract with the operator for the period commencing October 2018. Instead email correspondence between AACC and the operator regarding the continuity of services for a further year ensued. According to the Agreement, the contracting Authority was to inform the service provider of it's intention to renew the Contract or otherwise, three months prior to the expiry of the Agreement.

b. There were no audits by AACC on service delivery and the cost-effectiveness of the service provided by Healthmark. The non-undertaking of these audits deviate from the terms of the Agreement and infer that AACC forfeited the opportunity to comprehensively assess this service.

c. The Parties signed a new Contract in April 2019. This was backdated to 22 January 2019, which implies that the period October 2018 to 21 January 2019 was not covered by a formal Contract. On the other hand, the period 22 January to April 2019 was covered by a formal Agreement retrospectively.

Table 9 – Timeline of Healthmark Contracts

Contract validity period	Dates when contracts were signed	Changes to Contract/Addenda
4 October 2015 – 3 October 2016	4 October 2015	None (as this was the first contract that was signed between AACC and Support Services Limited)
5 October 2016 – 4 October 2017	7 December 2016 / 17 November 2016	Clause 5 of B.1 Service: *Should Service Provider require additional vehicles to fulfil obligations assumed by virtue of the present agreement, such additional vehicles shall be leased by the service provider himself, at the charge of the Active Ageing and Community Care (AACC), after obtaining authorisation from Government within a week from notice of intention to lease the said vehicles.*
4 October 2017 – 3 October 2018	1 March 2018 / 19 February 2018	None
4 October 2018 – 3 October 2019	Email dated 26 September 2018 by Procurement Manager, AACC to General Manager, Healthmark enquiring whether Healthmark were interested in supplying the same services for another year at same terms and conditions. The General Manager, Healthmark agreed through a letter dated 1 October 2018. No contract dated October 2018 was made available during the audit visit.	None
21 Jan 2019 *(an email was sent by AACC to Contracts Department asking for Contract to be renewed whilst a new tender was being drafted)* A Negotiated Procedure (AACC CA13/2019) was signed on 8 April by Healthmark and 9 April by AACCD. Contract's validity was for 12 months.	9 April 2019	Pursuant to Clause 6: *"[T]he contracting Authority hereby agrees to pay the Contractor in consideration of the execution of the Contract and remedying of any defects therein the total amount of: €5,810,881 …including taxes, Other Duties and Discounts but excluding (Value Added Tax) VAT, or such sum as may become payable under the provisions of the Contract at the times and in the manner prescribed by the Contract…."*

4.3.5 The awarding of the Contract through a negotiated procedure in 2015 together with the timing and delays in its subsequent renewals have resulted in four cycles of the Contract being awarded through direct orders. Apart from hampering the competitive element in the award process, the absence of a tendering process also encroaches on the principle of transparency.

4.3.6 The renewal of the Contract awarded through a negotiated procedure has led to an extended Contract that could potentially have lasted only 12 months but by January 2020 would have been in place for more than 50 months. The continued extension of contracts deviates from the spirit of the public procurement regulations and hinders competition.

4.3.7 Moreover, the continued renewal of this Contract was not supported by feasibility studies or assessments to determine whether the competitive element associated with a call for tenders would result in more advantageous rates and a more qualitative service.

4.3.8 These circumstances deviate from the provisions of good governance practices as it exposes Government to avoidable litigation and possible legal repercussions. The seriousness of such a situation becomes more apparent in view of the materiality of this Contract, at an annual value of around €6 million.

4.3.9 Furthermore, the absence of a tendering process contributes towards establishing a dominant position within the industry. Within this context, such a position within the market may potentially develop in the light that the operator is already providing complementary services related to older persons through other Government contracts.

4.3.10 The situation relating to the award of the Domiciliary Nursing and Caring Contract through a negotiated procedure and the continued extensions of such Agreements is similar to the circumstances between 1990 and 2015 when the service provider was MMDNA. It is augured that AACC considers the award of such material contracts through a call for tenders.

4.4 Contractual provisions in the domiciliary care contract do not appropriately safeguard stakeholders' interests

4.4.1 Similarly, to the discussion in other Chapters of this Report, this Section sought to determine the extent to which contractual provisions appropriately safeguard stakeholders' interests, that is AACC as the contracting Authority, Healthmark as the operator and the clients. Table 10 explores further whether the Contract included best practice contractual clauses which could safeguard all parties.

Table 10 - Comparison of contractual provisions with best practice clauses

Best practice contractual clauses	Omitted	In Place	Does not appropriately safeguard Government's interest
Access and disclosure	X		
Assistance provided to the contractor		X	
Confidential information		X	
Conflict of interest	X		
Contract variations	X		
Disclosure of information (confidentiality)		X	
Dispute resolution		X	
Insurance		X	
Intellectual property rights	X		
Key personnel		X	
Liabilities and indemnities	X		
Payments		X	
Penalties			X (not comprehensive)
Incentives	X		
Sub-contracting	X		
Key Performance Indicators (KPIs)			X (not comprehensive)
Termination and contract end dates		X (but not observed)	
Transition arrangements	X		
Warranties and fitness for purpose		X	

4.4.2 With reference to Table 10, important clauses relating to access and disclosure, conflict of interest, contract variations, incentives, intellectual property rights, sub-contracting, and transition arrangements are totally absent from the contract. Other clauses are well-defined but are either:

a. limited in scope, as in the case of "*penalties and incentives*" which are only applicable to the three KPIs listed in the Contract;

b. too loosely defined as in "*warranties and fitness of purpose*" which the Department went beyond its remit in the help it provided e.g with complaints; or

c. not verified or adhered to by AACC as with "*termination and contract end dates*".

4.4.3 One of the more important issues highlighted in Table 10 relate to Key Performance Indicators (KPIs). The Contract specifies only three KPIs that relate to:

a. two customer satisfaction surveys to be carried out by an independent entity on behalf of the service provider,
b. the onus on the Contractor to reduce complaints by 10 per cent in the first six months and by 20 per cent by the end of the 12 months duration of the Contract, and
c. the insulin injections are to be given between 7.00am and 9.30am in the morning and 5.00pm and 7.00pm.

4.4.4 In view of the foregoing, the drafting of these Contracts leave room for interpretation and open to possible future disagreements between the two parties, namely the AACC and Healthmark. Considering the amount of money being spent annually by the Government, the significant number of clients receiving the service and the fact that the Contract specifies that CommCare can change the KPIs upon agreement with the Contractor, this Office deems that the KPIs within the Contract are not comprehensive or far-reaching enough to guarantee value-for-money and robust service monitoring. Furthermore, there are no liabilities and indemnities clauses that apply within the Contract.

4.5 Contractual provisions relating vehicles to be used in service delivery are biased towards the service provider

4.5.1. Contract provisions places the onus on Healthmark as the service provider for all provisions and arrangements required to provide the necessary infrastructure and operational management for all transport and travelling requirements. Nonetheless, the same Contract stipulates that Government was to provide the vehicles which were in use by the previous service provide, namely MMDNA. Moreover, should Healthmark as the current service provider require additional vehicles, Government would be obliged to reimburse the Contractor with the cost of these vehicles, inclusive of any hire purchase costs incurred after obtaining prior authorisation from Government. The sole Contractor's obligation regarding the fleet relates to running costs and insurances.

4.5.2. According to the Transitional and Mutual Release Agreement dated October 2015, AACC transferred 30 government-owned vehicles which were at MMDNA's disposition in accordance with contractual arrangements. AACC noted that most of these vehicles had problems and were without air conditioning while some others were not roadworthy. Additionally, AACC is currently being invoiced for the lease of a further 18 vehicles at an annual cost of around €46,000.[32] AACC granted its approval for the service provider's request for reimbursement for additional vehicles, solely on the basis that patient contacts rose from around 700,000 in 2015 to 824,850 in 2018. Within this context, the service provider's requests were not supported by any other documentation justifying the need for additional vehicles. Moreover, AACC is not fully cognisant as to how the service provider is utilising these vehicles since the Contractor is not submitting comprehensive logistical and operational data.

[32] The amount of €46,000 covers the nursing, caring and midwives services provided by the Contractor.

4.6 Timeliness, time available for patients and language barriers detracted from the quality of a generally satisfactory service

4.6.1. Apart from documentation relating to customer complaints, the CommCare Unit within AACC did not have customer satisfaction or quality of service-related information pertaining to 2018. This situation primarily resulted as the service provider did not fulfill contractual obligations regarding the commissioning of such surveys. Consequently, this performance audit was constrained to triangulate anecdotal information with a customer satisfaction survey pertaining to 2017, commissioned by the service provider and carried out by Grant Thornton.

4.6.2. The following main issues materialised:

a. over 90 per cent of clients ranked the overall performance of the nurses and carers as very positive;
b. nonetheless, the Grant Thornton Report noted that there was a slight decrease in overall client satisfaction;
c. issues raised related to timeliness - visits were to take place at mutually-agreed timeframes;
d. adequacy of length of visit – some carers/nurses tended to be in a rush;
e. language barriers involving foreign workers;
f. direction to clients through AACC and other professionals is to include clear guidance to facilitate the visit, such as preparation of items to be used during the visit / intervention;
g. customers expected more respect to be shown; and
h. retention of the same carer as much as possible.

4.6.3. This performance audit also reviewed the complaints received directly by AACC regarding the nursing and caring complaints received in 2017 and 2018. In accordance with the Contract, the service provider should have a complaints system and the Department should receive feedback on the complaints within three days of registration of complaints.

4.6.4. The audit indicated that complaints are still being received within AACC and that the Department are the main handlers of the complaints together with the service provider. Although during the audit no samples were taken to calculate the average time it takes to solve complaints, CommCare contended that the CommCare Unit and Healthmark were tackling issues without unnecessary delay. This was also verified against a sample of emails and complaints reports. It is worth noting that when compared to the other three services that were audited, CommCare fared much better with regards to record-keeping of complaints. The categorisation of these complaints bear similarities to the issues raised previously within this Section. Table 11 refers.

Table 11 - Complaints registered at AACC regarding domiciliary services (2017 and 2018)

Type of Complaint	2017			2018		
	Nursing	Caring	Total	Nursing	Caring	Total
Work not done properly	18	7	25	13	7	20
Unprofessional attitude or behaviour	4	6	10	5	12	17
Did not visit client	9	2	11	4	0	4
Healthmark staff are in a rush	2	4	6	1	3	4
Should visit earlier in the day	4	3	7	2	0	2
Language problems / barriers	1	2	3	2	3	5
Others	1	1	2	2	0	2
Totals	**39**	**25**	**64**	**29**	**25**	**54**

4.6.5. Although the number of complaints registered constitute a very small proportion of the circa 881,00 annual interventions (in 2018), the nature of these complaints are important elements of the service. As highlighted in Table 11, despite the limitation of various timelines, the sources evaluated indicated similar trends. Complaints ranged from those originating from market conditions – namely the difficulties encountered by the service provider to recruit suitable candidates. Other issues raised point towards deficiencies in the planning of logistics, continuity of care and communication skills. While the number of complaints is a very small proportion considering the amount of interventions, these customer concerns remain noteworthy since they relate to critical aspects of service delivery. It is also to be noted, that Table 11 does not include all complaints received at AACC since the CommCare Unit stated that when complaints were dealt with immediately they were not logged.

4.7 AACC was not in a position to accurately verify the level of service that the Contractor is providing

4.7.1 The CommCare Unit reported that, generally, there was an overall smooth relationship between the service provider and the Unit. The Contractor adhered to contractual obligations with respect to client information, Healthmark staff interventions and operational data related to the visits carried out as well as information regarding treatment. As contractually required, the Contractor forwarded such information to CommCare on a daily or monthly basis.

4.7.2 The service provider, however, did not comply with all obligatory reporting requirements including the annual user satisfaction survey to support the standard of care delivery – to this effect the last survey referred to the CommCare Unit pertained to 2017. This Report was also to include the results and action taken on internal clinical and care audits and performance.

4.7.3 The CommCare Unit stated that no formal or informal audits were carried out on the service provider. Furthermore, during the course of this review, CommCare was not in possession of the detailed operational policy manual including the main standard and specific operational procedures that, contractually, were the responsibility of the service provider in carrying out duties on behalf of the Government. Hence, whether this manual and the Standard Operating Procedures (SOPs) had been ever drafted by the Contractor could not be verified during the audit. This situation materialised since CommCare did not avail itself of the possibility to access this document since it contended that it utilised its own SOP manual. Nonetheless this Office maintains that the non-review of the Contractor's detailed operational manual weakened AACC monitoring capabilities.

4.7.4 **Recent Developments** - AACC contends that internal clinical and care audits will be carried out in 2020. The audits scheduled in the first quarter of 2020 are intended to analyse the previous year's performance.

4.8 There was minimal monitoring of essential contractual provisions related to operations

4.8.1 The Contract stipulates the Parties' responsibilities for the implementation of this service. In this respect, Table 12 provides details of the division of responsibilities between the CommCare Unit on behalf of AACC and the Contractor, Healthmark Care Services Limited. The respective responsibilities are crucial to the CommCare's monitoring function since they define tasks to be undertaken.

4.8.2 Table 12 illustrates that in a few cases the CommCare Unit is not always in a position to monitor the extent to which the service provider is fulfilling contractual responsibilities.

4.8.3 The foregoing significantly weakens the CommCare's Unit ability to monitor the extent to which the Contractor is executing contractually the obligations highlighted in Table 12. The monitoring function becomes impeded as the Unit is not privy to all operational and logistical information. Moreover, due to current volume of work and ensuing practices within AACC, the monitoring function of this Contract is not allocated a high priority.

4.8.4 **Recent Developments** - AACC claimed that it is seeking approval to establish a Quality Assurance Unit. This Unit included in a proposed organigram has been referred to the People and Standards Department within the Office of the Prime Minister.

Table 12 – Contractual obligations

Contractor's onus	Fulfilled	AACCD's responsibilities	Fulfilled
- Appropriate Staffing levels - Trained staff	No information available at CommCare Unit	Standard operating procedures	✔
Management and day-to-day operation	✔	Detailed operational policy including standards of practice	✔
A detailed documentation system recording each visit by nurses, midwives and carers	✔	Audits on the service provider for standards relating to planning, provision and review of delivery of care	x
Complaints system	The CommCare Unit assists with this task	Consumables for eligible persons	✔
Infrastructure and operational management for transport and travelling	✔	Cars previously used by MMDNA, and reimbursement of any new cars bought or leased	✔
To provide, maintain and repair equipment and pay for running costs	✔		
Professional risk assessment/health and safety obligations	✔		
Detailed operational policy manual	Could not be verified		
Daily reports: - detailing visits and treatment - handover of clients care if there are changes in care plan/ assessment is necessary/admission to hospital/refusal of treatment/ missed visits/passing away of client	✔		
Daily work list of the previous day as a result of intervention packages	✔		
Monthly report of visits carried out; complaints; Continuing Professional Development (CPD)	✔		
Annual satisfaction survey internal clinic and care audit	✔		
Monthly report of consumables supplied by the government and utilised by the service provider	✔		

4.9 The absence of a tendering process and the critical importance of not interrupting the domiciliary care services influenced the new contractual rates

4.9.1 Table 13 shows the total and different interventions for 2018 and the fees that the Department paid the Contractor for the services provided by its nurses and carers. The Table also features interventions which were cancelled or not carried out as the patients/ older persons were not at their premises at the time of the visit by the Healthmark staff.

4.9.2 This performance audit adopted two main criteria to evaluate the extent to which the rates and costs incurred by AACCD embrace the principles of economy. The first criterion revolves around the competition element derived through a tendering process. Secondly, this assessment compares the current fees with those payable to the previous service provider.

The fees charged for the various services were derived through a negotiated procedure

4.9.3 Paragraphs 4.2.3 has already discussed the circumstances which influenced this Contract to be awarded through a negotiated procedure. Consequently, the chargeable fees pertaining to this Contract were derived through negotiations between the Parties and not subjected to a competitive call for tenders. Although AACC sought quotations, the latter did not reap competitive advantages derived through an open call for tenders, which could have potentially led to more advantageous service fees.

There was a significant increase in domiciliary care fees between the MMDNA and Healthmark contracts

4.9.4 When MMDNA, the previous service provider, gave notice that it has no longer in a position to deliver the domiciliary care contract, AACC resorted to a negotiated procedure to ensure service continuity. The new rates agreed with Healthmark, the new service provider, were generally substantially higher. Table 14 refers.

Table 13 – Activities and Cost of Nursing and Caring services in 2018

Care type and costs (exclusive of AACCD overheads)	*Cost per intervention* (€)	Total interventions booked	Cancelled bookings	Futile (visits undertaken but client not found)	Resultant interventions carried out as per Invoice by Healthmark	Percentage of total interventions	Cost (€)
Diabetes Care	*5.37*	269,671	7,263	2,046	260,362	28.8	1,398,144
General Care Non-Nursing	*7.47*	355,742	8,132	3,592	344,018	38.1	2,569,814
General Care Nursing	*11.11*	11,282	663	168	10,451	1.2	116,111
Injections	*5.37*	35,154	1,527	661	32,966	3.6	177,027
Minor Routine Procedures	*5.37*	52,332	1,891	664	49,777	5.5	267,302
Post Natal Care	*11.11*	6,695	199	460	6,036	0.7	67,060
Surgical Medical Care	*9.09*	97,357	4,820	2,045	90,492	10.0	822,572
Treatment care	*5.37*	102,664	3,054	2,369	97,241	10.8	522,184
Futile Visits Non-Nursing	*1.92*	n/a	115	(3,592)	3,477	0.4	6,676
Futile Visits Nursing	*3.36*	n/a	333	(8,413)	8,080	0.9	27,149
Anti-Flu Vaccine (excludes the cost of the vaccine)	*5.37*	408	13	8	387	0.0	2,078
Total		**931,305**	**28,010**	**8**	**903,287**	**100.0**	**5,976,118**

Table 14 – Increase in domiciliary care fees between the MMDNA and first Healthmark Contract

Domiciliary Care	Revision of fees proposed by MMDNA (August 2015) (€)	Fees charged by Healthmark (October 2015) (€)	Percentage increase in fees
General Care Non-Nursing	5.00	7.25	45.00
General Care Nursing	8.00	10.75	34.40
Surgical / Medical	6.00	8.85	47.50
Post-Natal Care	9.50	10.75	13.16
Minor Routine Procedures	4.00	5.25	31.25
Diabetes	4.00	5.25	31.25
Injection	4.00	5.25	31.25
Treatment	4.00	5.25	31.25
Futile visits nursing	to be paid in full according to category	3.20	percentage increase differs according to category
Futile visits caring	to be paid in full according to category	1.70	percentage increase differs according to category

4.9.5 As noted in paragraph 4.2.4 AACC had three proposals concerning the delivery of caring and nursing services, which were received following a call for quotations. The MMDNA rates were the most advantageous, while Healthmark's rates ranked in second place. The MMDNA rates, however, could not be considered as the Association tendered its notices to terminate the provision of services.

4.9.6 Table 14 shows that the percentage increase in rates ranged from 13 to 47 per cent. The highest percentage increase, 47.5 per cent, related to Surgical / Medical interventions which, during 2018, attracted around 10 per cent (90,174) of all domiciliary care interventions (887,198). The increase in charges with respect to general care nursing, general care non-nursing, minor routine procedures, diabetes care, injections and treatments all exceeded 30 per cent.

4.9.7 As outlined in paragraph 4.2.6, AACC contends that the increase in rates is, inter alia, to enable the Service Provider to maintain a documentation system which records each visit provided by nurses, midwives and carers. To this end, AACC pointed out that the Contractor had to invest and maintain electronic systems. Moreover, AACC argued that services were now diversified and expanded. This notwithstanding, the current Contract does not provide details regarding new services which Healthmark might be or intends to carry out.

4.10 Cost savings opportunities regarding diabetes care and 'futile' visits exist

4.10.1 Almost 67 per cent of the Healthmark staff's activities are divided between diabetes care and general care non-nursing at €3,967,958 (67 per cent of total costs borne by AACC). The surgical medical care and the treatment care take up almost 23 per cent of the remaining activities at a cost of €1,344,756.

4.10.2 CommCare Unit staff pointed out that the time and money spent on diabetes care could be curtailed with better education as well as replacement of diabetes care tools with others which are easier to administer or use. Moreover, apart from the practicality and convenience to users, the self-administration of diabetes care, whenever this is a feasible option, would imply a potential saving to the public purse. Within this context, AACC would need to coordinate efforts with the Ministry for Health, the entity responsible for the Diabetes National Strategy.

4.10.3 Table 14 also indicates potential cost savings through the avoidance of 'futile visits'. These visits, understandably, also carry a charge. To this effect, whenever possible, clients have a responsibility to cancel the service if it is not to be utilised. In 2018, AACC incurred an expenditure of around €34,000 with respect to futile visits. While this cost constitutes a minimal percentage of the Contract value, it remains an avoidable cost and a misuse of the community care services.

4.11 The CommCare Unit identified various service delivery challenges

4.11.1 In its quest to provide a better service delivery which would benefit not only CommCare but ultimately the older and home-bound persons, CommCare Unit as the regulatory body for the awarding and monitoring of nursing and caring services drafted monthly reports highlighting operational shortcomings that needed to be rectified. These monthly reports were brought to the attention of senior management within AACC.

Figure 2 - Service delivery challenges

4.11.2 The challenges highlighted in Figure 2 have been repeatedly highlighted in the 2018 monthly reports. It is important to note that the actions associated with these challenges, ultimately all needed to be carried out directly by CommCare, and these actions do not relate to issues which the service provider could improve or deal with. Nonetheless, the challenges can be classified as those falling within the direct remit of AACC and those requiring a more coordinated intervention with the Ministry responsible for social policy or with other Ministries such as those responsible for health and finance.

4.11.3 Within this context, the challenges which require Ministries' interventions include the need for more community services and the need for staff recruitment to deal with the increase in demand for service. These include assessments for other community services pertaining to AACC, and audit teams to review the nursing and caring service provided by the Contractor. Challenges falling within the direct remit of CommCare include the lack of review visits, the lack of case conferencing and CommCare collecting consumables on behalf of the Contractor. It bears pointing out that for CommCare to deal with such challenges, it still relied on more staff to be recruited within AACC.

4.11.4 It is to be pointed out that the CommCare Unit had raised the issues outlined within this section of the Report in September 2015. While acknowledging the complexities surrounding these issues, the challenges raised by the CommCare Unit were already evident when the previous service provider, MMDNA, was delivering domiciliary services within the community.

4.11.5 **Recent Developments** - In 2019, AACC introduced the phlebotomy services, the revamped respite at home packages, community psychogeriatrician and specialised nursing services such as infection control and clinical nutrition. Moreover, within the last eight months, AACC engaged eight new nurses, a phlebotomist, three practice nurses and a clerk.

4.12 Conclusions

4.12.1 This performance audit's focus on the domiciliary care services stems from their importance within the range of community care services to older persons, the high number of users and the material financial Contract value, which amounted to over €6 million in 2018. The contractual rates of the domiciliary care services increased substantially in 2015.

4.12.2 Various aspects of the Contract are weighted in favour of the service provider as Government incurs additional costs, mainly relating to the leasing costs of vehicles utilised by the Contractor for the provision of domiciliary care services. This is an arrangement which was continued from the previous Contract. Moreover, the omission of or unclear provisions within the Contract detract from an optimal implementation of this Agreement.

4.12.3 Despite the overwhelming sense of satisfaction and appreciation for the service there is still room for improvement. The main points of contention revolved around the timeliness of the service, the time available for patients, language barriers in cases that services were delivered by non-nationals, deviation from continuity of care principles and the interpersonal skills of a few members of staff delivering these services. These issues are caused by a combination of operational and logistical factors, which fall within the Contractor's responsibility, as well as shortcomings relating to the contracting Authority's monitoring and enforcement function.

Chapter 5

Meals on Wheels

5.1 Introduction

5.1.1 To further support citizens aged 60 years and over as well as eligible disabled persons living within the community who are unable to prepare a meal, the Active Ageing and Community Care (AACC) provides the Meals on Wheels Service. Despite its critical contribution to a holistic approach to community services, a substantial number of elderly persons receiving this service raised complaints about various aspects of service delivery.

5.1.2 AACC farmed out this service through a competitive call for tenders. The Agreement between AACC and the Contractor, signed in September 2016, stipulates that clients are to be charged €2.20 while Government incurs a further expenditure of €2.00 per meal. As at end 2018, the Contractor invoiced AACC for 169,561 meals for a cost of €339,062.

5.1.3 AACC specifications stipulate that persons can receive one meal per day, which is delivered chilled so that the meal can be consumed at one's own convenience. This service also provides a menu with a choice of meals. The meals consist of a starter, main course and a dessert. Clients benefit from this service following an AACC assessment to ascertain their eligibility.

5.1.4 Against this backdrop, this Chapter discusses the extent to which:

a. supply and demand for this service is in equilibrium,
b. the Contract for the provision of this service safeguards signatories' and clients' interests,
c. service delivery complies to contractual provisions and is satisfactory to clients,
d. AACC monitoring contributes to a qualitative service, and
e. the Meals on Wheels Service constitutes value for money.

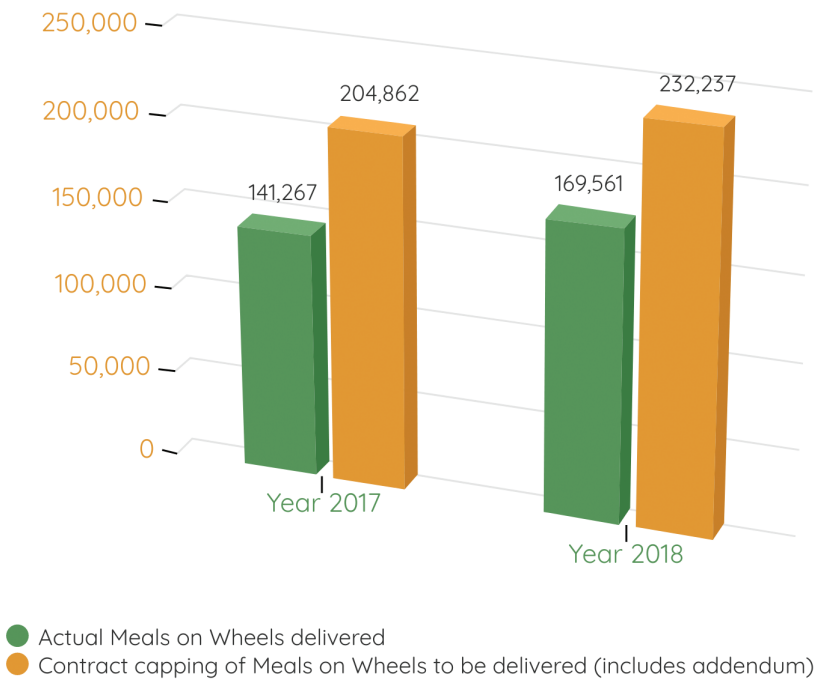
5.2 The Addendum to the Meals on Wheels Contract increased the potential supply of meals beyond current demand levels

5.2.1 During 2018, the Contractor delivered 169,561 meals at a total of €4.20 per meal to an average of 629 clients per month. Prior to the signing of the Addendum in 2017, the Contract signed on the 7 September 2016 capped the delivery of meals at 195,737 annually.

5.2.2 The Addendum signed on 25 September 2017, however, raised this capping by a further 36,500 meals at an estimated annual cost of €73,000. This cost was based on the price per meal, less the beneficiary contribution.

5.2.3 During 2018, the overall capping for the delivery of the meals was raised to 232,237. The 2018 capping translates into a contract value of €895,097 for the year. Chart 1 refers:

Chart 1 - Demand and Supply for the Meals on Wheels Service (2018)



5.2.4 The National Audit Office (NAO) were not presented with feasibility studies, which outline the reasons for increasing the Meals on Wheels Contract threshold and whether the new capping safeguarded Government's interests. It can be argued that the increased threshold brought about by the Addendum can be seen as a safety valve for the Government in the eventuality of a sudden expansion in demand within the validity period of the Contract. In such circumstances, Government's interests would be adequately safeguarded.

5.2.5 On the other hand, if the Contractor was to supply meals at the newly established threshold level, then the deal would be more favourable to the Contractor as better economies of scales related benefits could be accrued. In such a situation, the Contract would further favour the Contractor since fixed production costs would be distributed among more units, which decreasing the unit costs for the production of a meal.

5.2.6 The increased capping outlined in the Contract Addendum, signed around one year following the main Agreement, raises tendering related concerns. The newly established supply threshold could have attracted a larger pool of tenderers for the supply of the Meals on Wheels Service if this factor was specified within the tendering conditions at the outset. The Department of Contracts approved these contractual changes. AACC attributed these circumstances to this being the first Meals on Wheels Contract negotiated.

5.3 Certain provisions within the Meals on Wheels Agreement does not appropriately safeguard stakeholders' interests

5.3.1 The Agreement between AACC and James Caterers Limited signed in 2016 marked a rebranding of the Meals on Wheels Service. This Agreement sought to introduce a qualitative service through a number of features, mainly relating to the quality of food. Moreover, this Agreement was to contribute to the elimination of a waiting list of around 300 clients, which was prevailing at the time of signing this Agreement.

5.3.2 Over a four-year period, the Contract value signed in September 2016 was not to exceed €3,288,390. This figure comprised the Government subsidy of €2.00 per meal €391,475 annually and the €2.20 per meal payable by clients, totaling €430,622. An Addendum to the Contract signed by the Parties in September 2017 increased the value of the Contract through an additional 100 meals per day, that is, a further €153,300 annually at €4.20 per meal.

5.3.3 The NAO reviewed this Agreement through two simultaneous approaches. Firstly, we ascertained that the Contract included clauses which embrace generally accepted practices for this type of Agreement. Secondly, the review entailed determining the extent to which the Agreement safeguarded Government's and clients' interests.

5.4 The Contract omits provisions related to transition arrangements as well as warranties and fitness for purpose

5.4.1 Through various literature and guidelines, the NAO elicited elements which should feature in an Agreement of this type. With the exception of three factors, the Agreement generally makes appropriate references to elements outlined in good practice guides. Table 15 refers.

Table 15 – Best practice contractual clauses for the Meals on Wheels Service

Best practice contractual clauses	Omitted	In Place	Not Appropriately Defined
Access and disclosure		✔	
Assistance provided to the contractor		✔	
Confidential information		✔	
Conflict of interest		✔	
Contract variations		✔	
Disclosure of information (confidentiality)		✔	
Dispute resolution		✔	
Insurance		✔	
Intellectual property rights		✔	
Key personnel		✔	
Liabilities and indemnities		✔	
Payments		✔	
Penalties and incentives		✔	
Service delivery			✔
Sub-contracting		✔	
Termination and contract end dates		✔	
Transition arrangements	✔		
Warranties and fitness for purpose	✔		

5.4.2 Table 15 shows that the Agreement omits to refer to two best practice contractual clauses, namely '*Transition arrangements*' and the '*Warranties and fitness for purpose*' clauses. The following refers:

a. **Transition Arrangements** – The omission of clauses relating to transition arrangements implies that this Agreement does not refer to parties' responsibilities at the termination of the Agreement. This raises the risk of the service provider not preparing and furnishing the contracting Authority, AACC, with a transition-out strategy or plan by a specified time. Consequently, this might lead to a scenario where neither party will be in a position to ascertain that contract closure is smooth and does not disrupt the service in any way.

b. **Warranties and fitness for purpose** – The Agreement also omits references to the rights and obligations of the Contractor and the acquiring entity in relation to defective services. Consequently, the Agreement does not appropriately safeguard Government's interests. Furthermore, the absence of references to warranties does not guide AACC about its contractual rights to reject services and be paid compensation, or to have deficiencies rectified or whether the services are to be retained.

5.4.3 **Recent Developments** - In March 2019, AACD has set up a working group to draft a new tender whereby it was also tasked with addressing shortfalls in the current tender. It is envisaged that this draft will be referred to the Department of Contracts in the early part of 2020. The Current contract expires in September 2020.

5.5 Aspects of service delivery of Meals on Wheels Service deviate from contractual provisions to the detriment of clients' satisfaction

5.5.1 Contractual compliance is critical to ensure that clients are provided with an efficient service. Within this context, this audit established that a high percentage of randomly selected clients through AACC surveys revealed areas of dissatisfaction with the service. These mainly related to the timings of meal deliveries, the way with which meals are delivered, provision of unselected meals as well as administrative matters (including payments). The main contributary factor to this relates to the non-adherence of contractual provisions regarding service delivery.

5.5.2 **Recent Developments** - An Addendum signed in November 2019 between AACC and James Caterers Limited, in part, addresses the aforementioned shortcomings as the Contractor is now employing another person to assist the driver to enable clients' receipts to be collected, at an additional cost to AACC of around €95,000 (excluding VAT). The Department of Contracts approved this arrangement, which will be in place until a new contract is signed following the issue of a call for tenders. Through this measure AACC is now in a position to verify delivery details with invoice information.

5.6 The Agreement does not clearly define all aspects of delivering meals to clients' homes

5.6.1 The main deliverable emanating from this Contract refers to the delivery of a meal at a client's home. The Contract clearly defines what constitutes a meal. It specifies portion sizes, nutritional values and allergen information as well as user-friendly menu options, which include pictorial symbols of the food as well as dietary classifications.

5.6.2 Contractual clauses relating to the timing of deliveries of meals are, however, too broad since delivery can occur between 8.00am to 6.00pm. AACC officials contend that the contractor has sole discretion on delivery times. Nonetheless, based on complaints received, AACC contended that deliveries commence before 6.00am.

5.6.3 While these circumstances imply that the time window for the delivery of meals is too wide and can be inconvenient to clients, various other issues from the clients' point of view come into contention:

a. clients' routine and plans are disrupted as there are no fixed delivery time-windows, and

b. clients' meal times are not being respected, especially in circumstances where deliveries are significantly after '*traditional*' meal times. Such practices can cause undue hardship for elderly persons.

5.6.4 **Recent Developments** - AACC envisages that these issues will be addressed through the new tender specifications.

5.7 Delivery times are prolonged since the Contractor is using half the number of vehicles stipulated in the Contract

5.7.1 A contributory factor leading to prolonged delivery timings relate to deviations from contractual provisions concerning the number of cars which were to be utilised for the execution of this Agreement. The Contract stipulates that the operator was to utilise a minimum of 10 vehicles to expedite delivery. AACC contended that the operator was utilising five vehicles, or half the number stipulated in the Contract. AACC internal documentation shows that on enquiry, the Contractor lamented about problems relating to the recruitment of drivers.

5.7.2 Given that on average the Contractor delivers 464 meals on a daily basis and is supposed to utilise 10 vans within a 10-hour time window (8.00am to 6.00pm) as contractually stipulated, then the rate of meal deliveries would be 4.6 meals per hour per van. In practice, the Contractor is utilsing five vans to deliver 464 meals a day. This implies that the delivery rate is 9.2 meals an hour per van. At the outset this indicates that, at the time of preparing service specification, AACC could have anticipated delivery time-related problems due to the extensive delivery period. This delivery rate embraces the prudence principle as this calculation assumes that the contractor's fleet are being used solely for this service.

5.7.3 The estimates in the preceding paragraph raise the following issues:

a. If the operator utilised the minimum number of 10 vehicles as stipulated in the Contract and sustained delivery at 9.2 meals an hour per van, then a 5-hour time window would be required. This would contribute significantly towards service satisfaction since the time window would be halved and consequently it will be more convenient for clients.

b. Conversely, if the same amount of 464 meals were to be delivered daily at the rate noted of 9.2 meals an hour per van, but in approximately 3.5-hour time window, then the Contractor would need to utilse at least 15 vehicles. The foregoing implies that a lengthy delivery time window is a trade off against the quality of service and consequently its cost.

5.8 AACC documentation, including telephone surveys, reveal significant levels of client dissatisfaction

5.8.1 Article 24.1(ii), together with paragraph 1.96 of the Technical Offer forming part of the main Contract, stipulate that the Contractor is obliged to undertake annual client satisfaction surveys and to keep the AACC abreast of the issues arising through these exercises. However, up to July 2019, the Contractor did not update AACC with the results of satisfaction surveys undertaken. To this effect, the Department is not aware as to whether or not the Contractor has carried out these surveys in terms of the afore-mentioned contractual provisions.

Telephone Surveys

5.8.2 AACC is conducting monthly telephone surveys, each comprising of around 40 randomly selected clients. While this sample size is not statistically representative, the consistency of the results provides robust indication of the degree to which clients are satisfied with the Meals on Wheels Service, particularly when such information is triangulated with other sources, such as complaints received, interviews with AACC officials and AACC internal reports.

5.8.3 Table 16 shows the results of telephone surveys undertaken by AACC during 2018. For ease of reference and practicality, the results emanating from these surveys are being categorised in eight classifications.

Table 16 - Telephone surveys carried out by AACC (January - December 2018)[33]

Responses	January - December 2018	
	Quantity	Percentage
Client was satisfied with the service	106	23.2
Untimely delivery of meals (after 1.30pm)	74	16.2
Untimely delivery of meals (before 6.00am)	12	2.6
Meal remained undelivered	5	1.1
Client was dissatisfied with the contents of the meal (example: small portions, quality aspects)	30	6.6
Meal delivered was not in accordance with clients' selection from menu	163	35.8
Others (Example: Meal left outside clients' residence, clients were not given a menu, fees due not collected on a daily basis, general non-satisfaction)	27	5.9
No response - Clients opted not to comment	39	8.6
Total	**456**	**100.0**

5.8.4 Table 16 shows that over a span of 12 months, client satisfaction with the service was consistently low (68 per cent of clients surveyed). Dissatisfaction mostly related with different meals being delivered than those chosen by the clients (35.8 per cent). Clients also lamented about the timings of service delivery (18.8 per cent).

[33] Table 16 considers the first response in cases where clients provided multi-responses.

5.9 Internal AACC reports highlighted various service delivery concerns

5.9.1 The Meals on Wheels Unit within the AACC reports to the Department's senior management on a monthly basis. This internal report considers the various sources of client feedback on this service available to the Department. As noted earlier in this Chapter, these sources should also include feedback received by the Contractor. However, the latter has not adhered to contractual provisions by informing the AACC of clients' responses elicited through a satisfaction survey commissioned by the former. Consequently, the main sources of client feedback available to the Department remain the telephone survey (discussed in paragraph 5.8.3), complaints received by clients, spot checks undertaken by the Department, as well as other observations made by the Meals on Wheels Unit. The monthly reports consistently raise issues regarding the Meals on Wheels Service. However, the concerns raised therein are neither sourced nor quantified.

5.10 Clients lodged over two hundred direct complaints about the Meals on Wheels Service during 2018

5.10.1 During the period January – October 2018, AACC received service delivery related complaints from 206 clients, which the Department forwarded to the Contractor for rectification. These complaints revolved around the same issues as those portrayed in Table 16 as the main thrust of these complaints involved delivery timings, the delivery of erroneous menu choice and meals left outside their residence. The latter issue resulted as the delivery persons did not allow enough time for older persons to answer the door, or for a number of reasons such as parking issues and delivery persons not delivering meals in apartments above ground floor level.

5.10.2 Subsequent to October 2018, in accordance with contractual provisions, AACC transferred responsibilities related to the receipt of customer complaints to the Contractor. However, the latter breached provisions therein by not keeping the Department abreast about the volume and type of complaints received, even though AACC contractually has the right of access to such information. This breach hinders AACC's monitoring and enforcement of this Contract even though AACC is forwarding the complaints received to the Contractor and contends that it is following them up.

5.10.3 **Recent Developments** – AACC envisages that the Addendum signed in November 2019 will address the issues raised through customer complaints.

5.11 A case study comprising 30 randomly selected clients' Meals on Wheels files revealed process inefficiencies and further clients' dissatisfaction with the service

5.11.1 The absence of centrally maintained electronic records constrained the NAO to adopt a case study approach to elicit information about process efficiency and the extent to which the Meals on Wheels Service was being delivered in accordance to contractual provisions and clients' satisfaction. To this end, the issues discussed in this Section were elicited through a review of 30 randomly selected files. These cases were chosen from a batch of 637 files pertaining to service applications submitted during 2018. While the results emanating from this case study are not statistically representative of the population of clients' files, the consistency of findings lend strong credibility to the issues discussed hereunder.

An average of 16 days elapsed from the receipt of applications for the service to the delivery of meals

5.11.2 Up to June 2019, AACC did not have internal guidelines or customer charters outlining Meals on Wheels application processing times. The only criteria relating to processing times is included in the Agreement, whereby provisions therein stipulate that the Contractor is obliged to commence meals delivery within a day of being informed by AACC that the clients' application has been approved.

5.11.3 In the absence of other efficiency-related criteria, this review was constrained to evaluate the application processing time against reasonableness-based criteria. For various reasons, only 19 of the 30 randomly selected clients' files provided information related to application processing time and could thus be utilised for this exercise.

5.11.4 These files revealed that it took an average of 16 days from the submission of the application by the client until the meal delivery service commenced. The first seven days were utilised to enable approval of the clients' application. There is scant documentation available regarding the remaining days to enable any assessment. However, it necessitated a further nine days from approval to the commencement of the service. AACC contends that such a timeframe is utilised to enable a multi-disciplinary team to determine client eligibility for the service and to curb potential abuse.

It is a common occurrence for clients to terminate the Meals on Wheels Service

5.11.5 In the absence of documentation maintained by the Contractor and AACC, the NAO was constrained to adopt a case study approach to determine the rate at which clients terminated the service. Thirty randomly selected clients' files revealed that 10 service users terminated the service. Table 17 refers.

Table 17 - Termination of the Meals on Wheels Service

Days since start of service until terminated	Number
Up to 30 days	4
31 to 60 days	3
Over 200 days	3

5.11.6 Table 17 shows that in seven out of the 10 cases, clients opted to terminate the service within the first two months of commencement of service of which four clients opted to terminate the service within 30 days. AACC did not document the reasons for termination in all of the cases. Such circumstances impedes AACC from establishing the reasons as to why service termination occurred. AACC noted that in certain instances, clients book meals for a definite period and termination does not necessarily imply dissatisfaction with the service.

5.12 The monitoring function of the Meals on Wheels Service is subject to various limitations

5.12.1 The importance of the monitoring function of this service arises from the financial materiality of this contract and the monthly average of 629 older persons who benefit from the 169,561 meals delivered during 2018. AACC's monitoring of this Contract mainly comprises the monthly telephone survey. Nonetheless, as indicated in various sections of this Chapter, AACC does not have the mechanisms in place to ensure effective monitoring of this service.

5.13 The Contractor does not furnish AACC with documentation as contractually obliged

5.13.1 The monitoring function is severely impaired due to the Contractor's reluctance to furnish AACC with operational information as provided for in the Contract. Table 18 refers:

Table 18 - List of documentations as per Contract, not in possession by the department

Operational information	Contract reference
Official confirmation from the Environmental Health Directorate, Public Health Regulation Division that the Contractor's CPU premises, stores, vehicles and catering practices conform to the Food Safety Act 2002, the national food nutrition policy and any other applicable legislation.	Specific conditions 4.2, paragraph 10, page 20.
Monthly complaints reports.	Specific conditions 4.2, paragraph 11, page 20.
Documentation of supervision/investigation of complains and Client Satisfaction Surveys. This is also mentioned as an annual Client Satisfactory Survey.	Specific activities 4.2, paragraph 12, page 18.
Reports/notices/undertakings/orders by the Environmental Health Directorate.	Specific activities 4.2, paragraph 13, page 20.
Inspections leading to the improvement or replacement of any services provided by the Contractor.	Specific activities 4.2, paragraph 15, page 20.
Hazard Analysis Critical Control Point (HACCP).	Specific activities 4.2, paragraph 16, page 20.
Monthly bacteriological analysis results in connection with each of the constituents of a full meal.	Specific activities 4.2, paragraph 18, pages 20 to 21.
Delivery notes duly signed by the service user/representative as proof of delivery of the meal. Operations reports based on KPIs at the end of June and December of each calendar year.	Reporting Requirements 7.1, and Definition of Indicators 8.1, page 26.

5.13.2 Apart from constituting a contractual breach by the operator, the absence of the documentation listed in Table 18 translates into a situation where AACC's monitoring function is rendered ineffective. This statement considers that AACC is not cognizant of, customers' complaints received directly by the Contractor and other operational documentation logistics. Moreover, financial risks arose since at the time of the audit AACC could not perform reconciliations between invoicing details and clients' delivery notes.

5.13.3 **Recent Developments**: Since audit closure, AACC sought to obtain food quality and safety certificates relating to meal as specified within the Contract. Moreover, AACC contends that it is now receiving meal delivery notes.

5.14 AACC do not maintain key operational and logistical information to ensure Contract compliance

5.14.1 The monitoring function is further impeded since AACC did not maintain critical information to ascertain Contract compliance. The following refers:

a. AACC did not log the date when it informed the Contractor of its approval for a new client's application for the commencement of service. In such circumstances, AACC could not ascertain whether contractual clauses obliging the operator to deliver meals to a new client within a day of AACC's notice was being adhered to.

b. Staffing limitations prohibit AACC from broadening its monitoring function to perform spot checks relating to service delivery. Given that currently only two officials are dealing with all aspects of this service, it is unlikely that AACC can perform more regular checks to determine amongst other things the number of vehicles in use by the Contractor for the delivery of meals.

c. While acknowledging the benefits of AACC's telephone survey, this exercise captures information on service delivery at irregular intervals. Consequently, AACC does not have robust information to ascertain contractual compliance on a daily basis.

5.14.2 **Recent Developments** - AACC contends that the Meals on Wheels Section is now logging the dates when it informed the Contractor to commence the service. Currently such information is being maintained on a spreadsheet but it is envisaged that such information will in the future be maintained through a new Information Technology (IT) systems.

5.15 AACC did not invoke penalty clauses in cases of contractual breaches

5.15.1 Thus far, this Chapter has identified a number of issues where the operator did not comply with contractual provisions. Examples in this regard relate to the shortfall in the number of vehicles being used by the Contractor in the execution of this Contract and the non-adherence to clauses relating to furnishing AACC with operational and logistical information.

5.15.2 In addition, as noted in paragraphs 5.4.1, contractual ambiguities, namely related to service delivery, prohibits AACC from invoking penalty clauses. A case in point relates to how meals are to be handed over to clients, particularly when these reside in apartments above ground-floor level.

5.16 The cost of a meal is reasonable but service delivery issues diminish its value for money

5.16.1 In 2018, delivered 169,561 meals. Government forked out €339,062, which translates to a subsidy of €2 per meal. The Contractor received a further €2.20 per meal from the clients themselves. These costings imply that overall each meal had a cost of €4.20.

5.16.2 Even when compared to the most modest of take-away meals, €4.20 is a reasonable price for a three-course meal, which, in accordance with contractual provisions, should embrace the highest levels of nutritional principles. Based on the forgoing, the cost of a meal is considered reasonable from both a Government and client point of view.

5.16.3 This Office is not privy to the operator's costings and consequently cannot comment in depth as to whether the price of €4.20 per meal is fair from the Contractor's point of view. Nonetheless, it is being assumed that the price is also acceptable to the Contractor since this is the tendered bid. Secondly, given that the Contractor is delivering other material catering services to both the public and private sector, then it is probable that the Contractor's cost components to the Meals on Wheels Service relates to variable costs as fixed costs would have been already covered through the operator's other business activities.

5.16.4 Within this context, it can be deduced that while the price of a meal is reasonable for all parties, its value for money, however, is diminished through various counts of service delivery shortcomings, which negatively influenced customer satisfaction with the service.

5.16.5 **Recent Developments** - AACC is aware of the situation portrayed in the preceding paragraph and is in the process of preparing fresh tender specifications. This initiative will enable AACC to issue a new call for tenders when the effective period of the current contract elapses. Until such time, AACC sought to address some issues related to the quality of service delivery through an Addendum signed between the Parties, which became effective in November 2019.

5.17 Conclusions

5.17.1 The Meals on Wheels Service is an essential cog in the provision of community care for older persons. This service is intended to support older persons to remain living within a community environment, provides nourishment as well as fulfills the psychological and social needs offered by meal times. The price of a meal remains reasonable, despite the Government subsidy. Yet many clients terminated their service.

5.17.2 The ambiguity of contractual clauses and monitoring weaknesses diminish management's control over this service. As implied by customer surveys, contractual non-compliance translates itself into client frustration as older persons are never sure of delivery times. In some cases they have to make extra efforts involving flights of stairs to collect their meals from ground-floor levels. In other instances, the delivery is different to their meal selection.

5.17.3 On the other hand, delivering meals in an environment of congested roads and parking problems contribute to the decline in service quality. However, the operator could do significantly more – in terms of contractual provisions – to alleviate these logistical problems. The shortfall in the Contractor's resources deployed for the delivery of the Meals on Wheels Service breaches contractual provisions. The matter was, in part, resolved at an additional cost to AACC of around €95,000 (excluding VAT) to enable the service provider to improve the service delivery.

Chapter 6

Home Help Service

6.1 Introduction

6.1.1 The Home Help Service offers assistance to older people and persons with special needs in performing light domestic chores, shopping and preparation of light meals and is intended to complement family support.[34] This service enables older people and persons with disability and special needs to live as independently as possible in the community and assists them to improve their quality of life. The Home Help Service was first introduced in 1988 and by the following year, it was being offered all over Malta and Gozo.

6.1.2 The service is granted on the basis of social needs and/or medical problems and limitations, hence the eligibility and priority for the Home Help Service is as follows[35]:

a. All persons over the age of 60 especially those who are dependent on others due to medical or psychological conditions and older persons living alone and people who do not have any family support.

b. Independent older persons who have experienced an acute medical or psychological problem and are in need of temporary help in order to regain their independence.

c. Adult disabled persons registered with the Commission for the Rights of Persons with Disability.

d. Persons (and their carers) who are suffering from a terminal illness.

6.1.3 This service is against a weekly fixed contribution payment, as follows, which beneficiaries may opt to pay this contribution directly to the Welfare Committee:

a. A weekly fixed contribution of €2.33 is deducted from the pension of the beneficiary for a household with one beneficiary.

b. A weekly fixed contribution of €3.49 is deducted from the pension of one beneficiary for a household with more than one beneficiary.

c. A household with one beneficiary pays an extra weekly contribution of €1.16, while a household with more than one beneficiary will pay an extra weekly contribution of €1.75 if help in the preparation of a light meal is provided.

[34] Home Help Service, Annual Report Year 2018, page 3.
[35] Home Help Service, Annual Report Year 2018, page 3.

6.1.4 Each applicant is subject to an assessment by care professionals in order to ensure that the service is being provided to those persons who really need it. Valid applications are then considered by the Home Help Allocation Board and if approved, the Board indicates the number of weekly service hours allocated. This Board comprises a Chairman, a medical officer (doctor), a health professional (an occupational therapist or a physiotherapist) and a secretary.

6.1.5 The Board meets every two or three weeks. Various criteria on the allocation of hours of service to applicants guide the Board in their decisions. Generally, the Board allocates two hours of service weekly to most applicants. On enquiry, the Active Ageing and Community Care (AACC) contended that this state of affairs is mainly due to staff shortages and to cater for an increasing number of applicants.

6.1.6 Helpers employed with the AACC, as well as helpers employed directly by the Contractor on behalf of the AACC, deliver Home Help Services. As at end 2018, the Home Help Unit within the AACC consisted of 22 officers, that is an officer in charge, three administrative staff, 17 supervisors and one social assistant.[36]

6.1.7 In line with the objectives and scope of this performance audit, this Chapter discusses:

a. the vetting of applications,
b. contractual issues,
c. service delivery, and
d. service-related costs.

6.1.8 The discussion herein is subject to a cut-off date of end 2018. Nonetheless, wherever possible, the Chapter will present recent developments pertaining to this service.

6.2 AACC does not carry out any initial vetting on applications received

6.2.1 During 2018, applications received by the AACC for community services for older persons were not being vetted. In the absence of initial vetting, a number of applications were only found to be ineligible at assessment level. Furthermore, in a number of cases, when contacted by AACC, some applicants also indicated that they were no longer interested in utilising this service. This mainly resulted since applicants were not fully cognisant of all AACC services included in the application form and older persons were not fully knowledgeable of what these services entailed. Moreover, in circumstances where third parties, such as doctors or relatives, completed the application form on behalf of the older persons, there was a tendency to request all services listed in the application form. The lack of vetting leads to lost time and resources, which can be better utilised on the rest of eligible cases.

[36] Home Help Service, Annual Report Year 2018, page 3.

6.2.2 **Recent Developments** - AACC noted that the vetting process was introduced in June 2019. In addition, the application form has been modified to facilitate needs assessments and the subsequent vetting process. Furthermore, in 2019, a new manager was appointed to head the Home Help Unit. In order to expedite and render it more effective, the vetting process is now being carried out by a multi-disciplinary team, which also includes social workers. AACC has also provided training to its staff who are assigned Home Help assessment duties.

6.2.3 These initiatives are also intended to facilitate the Board's work in reviewing Home Help applications, in order to increase processing efficiency and reduce the number of outstanding applications. AACC further noted that during 2019, a representative of AACC was appointed to sit on the Home Help Board to immediately address any queries about applicants.

6.2.4 Moreover, applications pertaining to persons aged over 80 years are being fast tracked and assessed by a supervisor.

6.3 Expired Contract extended for three consecutive years without an issue for a call for tenders

6.3.1 On 7 January 2016, the Department of Contracts, on behalf of AACC, was a signatory to the Contract with Support Services Limited for the provision of Home Help Service in Malta. The Contract, which was for a one-year validity period, stipulated the provision of 4,500 weekly service hours, which could increase by 25 per cent or decrease by 15 per cent of the number of allocated hours. The Contract also stipulates the rate of €6.50 per hour excluding the Value Added Tax (VAT) for 2015 and at the rate of €7.05 excluding VAT for 2016. These rates prevailed for 2017 and 2018. AACC, in part recoups this fee through service users' contributions as outlined in paragraph 6.1.3.

6.3.2 Following the Contract signed in December 2015, up to the time of writing this Report, three further Addenda were agreed upon, as follows:

a. **Addendum 1 (signed 21 December 2016)** – Extended the Contract signed on 7 January 2016 by three months, from 8 January 2017 up to 8 April 2017.

b. **Addendum 2 (signed 31 July 2017)** – Extended the Contract by three months, from 8 April 2017 to 7 July 2017. The estimated cost of this extension amounted to €320,000.

c. **Addendum 3 (signed 3 March 2018)** – Extended the Contract up till the 7 January 2018. The estimated cost of this extension amounted to €960,000.

6.3.3 It is pertinent to point out the following issues and concerns regarding the extensions being provided to this Contract:

a. After the lapse of the first year of the Contract, the AACC did not proceed with a new tender for the Contract.

b. Addenda 2 and 3 were signed despite that the Contract extension time window had elapsed.

c. This situation breaches the Contract since, in total, the period covered by subsequent addenda elapsed one year as stipulated in clause 5.2.

d. Up to the time of writing this Report, the AACC is finalising its work regarding a new call for tenders.

6.4 The Contractor breached a number of contractual clauses

6.4.1 The Contractor was not fulfilling his contractual obligations, mainly when it came to employing enough people to serve the demand for the service. From the day an application is received by the AACC, it was taking an average of 130 days for the service to start.

6.4.2 Furthermore, when the service is temporarily suspended, such as in case of client hospitalisation, the helper is allocated to another household. Consequently, the former client would have the service curtailed until such time that the Contractor can deploy a replacement. This means that not only are there not enough helpers employed, but there is also lack of planning to ensure replacement of helpers is not delayed.

6.4.3 Another cause of concern relating to the turnover of helpers is the impact that this leaves on older persons. It is understood that older persons do not always welcome replacements since a relationship would have already been established between the two parties. The non-continuity of help is a contributory reason for service termination by clients.

6.5 Prolonged processes and customer satisfaction concerns influenced service effectiveness levels

6.5.1 In analysing the extent to which there was effective implementation of the Home Help Service, this performance audit reviewed various sources reflecting the degree of customer satisfaction as well as documentation maintained by the Home Help Unit within AACC. A case study comprising 30 client files was also undertaken to assess process efficiency in relation to the granting of this service.

6.6 As at end 2018, there was an increase of 237 beneficiaries receiving Home Help Service over the previous year

6.6.1 As at end 2018, the total number of beneficiaries receiving the Home Help Service amounted to 3,877. This amount constitutes an increase of 237 (6.5 per cent) beneficiaries over the previous year. Furthermore, during the same period, the number of households that received the Home Help Service amounted to 2,814. This resulted in an increase of 157 (5.9 per cent) households over the previous year.

6.6.2 The Contractor, as at end 2018, was providing the Home Help Service to 2,105 (74.8 per cent) out of the 2,814 households, while the AACC was delivering this service to the remaining 709 (25.2 per cent) households through direct labour. AACC contends that it is in the process of winding down the provision of service through direct labour. To this effect, AACC is not replacing its pool of staff upon retirement as it transfers the workload to the Contractor. Table 19 refers.

Table 19 - Home Help Household Beneficiaries (2018)

Year	Number of Households		Total number of Households	Total number of Beneficiaries
	Department	Contractor		
2017	783	1,874	2,657	3,640
2018	709	2,105	2,814	3,877

6.7 An average of 130 days elapsed from application to the commencement of the Home Help Service

6.7.1 A case study review, based on 30 client files, showed that on average it was taking 130 days until an applicant is provided with the Home Help Service. Table 20 shows that at every stage of the process (as indicated by A to E), the average time taken raises some concern, particularly since the prolonging of the commencement of services implies hardship on the older person who necessitate this service. The prolonged process with reference to stages A to D are the responsibility of the Home Help Unit.

Table 20 - Home Help Service Application Process (2018)

Process	30 Cases[37]	
	Cases	Average Days
A: From receipt of application at AACC until forwarded to Social Work Unit	27	25
B: Social Work Unit Assessment (prior to Board assessment)	26	72
C: Board review	22	18
D: From service approval until familiarisation visit	16	16
E: From familiarisation visit until helper's first visit	12	41
Total on process (A-E)	**12**	**130**

[37] Three cases out of 30 were not subject to the process analysis as the request for the Home Help service was aborted due to missing documents or client declined request.

6.7.2 Table 20 illustrates the following:

a. The declining numbers in the Cases column show how during the process, the number of clients either terminate their request for service, are deemed ineligible during the process or would not have gone through all the stages of the process.

b. Stage E shows that the average time elapsed since the 12 applicants forming part of the case studies received the service following the familiarisation visit (stage D) was 41 days.

i. Upon further enquiry, it transpired that the two cases who were to be provided the service through AACC directly averaged 12 days for service to commence (stages D to E). On the other hand, the remaining 10 beneficiaries who were to be provided the service through the Contractor averaged 46 days.

ii. The prolonging of the commencement of service, particularly after the AACC would have conducted a familiarisation visit to clients, implies that the Contractor is in breach of the contractual clause which obliges that service is to commence within five[38] working days after receiving request from the Contracting Authority.

iii. The Contractor is also in breach of an informal agreement with AACC whereby the three-week period being permitted for the commencement of service is also not being adhered to. The 10 case study files reviewed (as per point b.i above) showed that the Contractor, in two cases, deployed helpers after being furnished with the relative authorisation from AACC within 14 days, while the other eight cases had to wait between 23 to 111 days for the service to start.

6.7.3 **Recent Developments** - AACC contends that it is implementing initiatives towards shortening the period from receipt of application to the commencement of service. Moreover, AACC contends that during 2019 the Contractor increased his pool of helpers from 173 to 189.

6.8 5,684 hours of Home Help Service were not provided in 2018

6.8.1 Problems of households waiting for the new service commencement or continuation of service persisted throughout 2018. AACC issues a weekly reminder to the Contractor wherein it lists the clients who are still waiting for the service as well as drawing the Contractor's attention to allocate helpers to these cases at the earliest possible. Table 21 presents the monthly number of cases without Home Help Service and the respective total outstanding service hours.

[38] Home Help Contract, 4.4 – response time to allocate new service.

Table 21 - Outstanding Home Help Service (2018)[39]

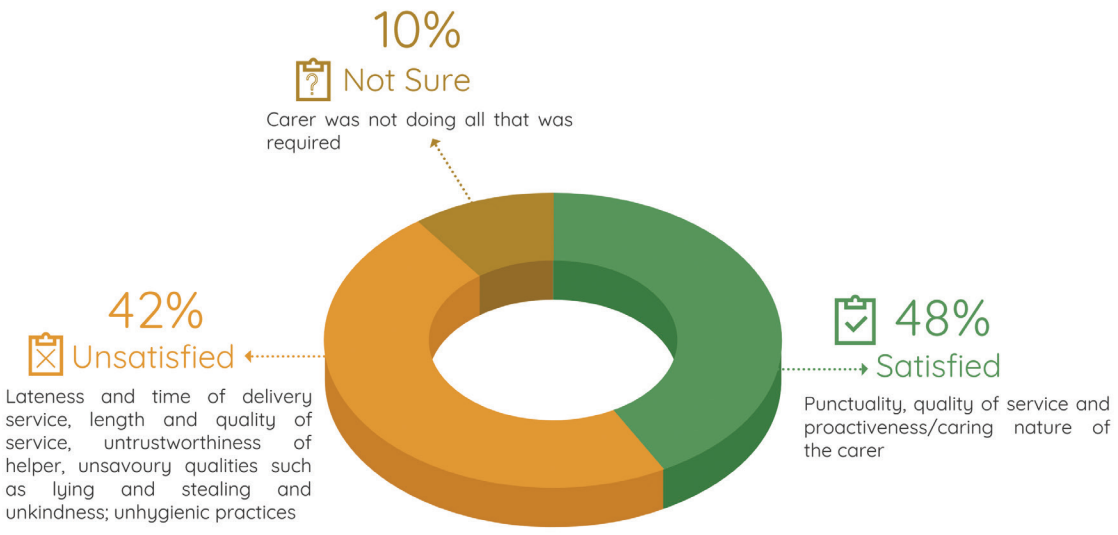
Month	New Cases Without Service	Break in Service Cases	Total Cases	Total Outstanding Hours
January	126	65	191	397
February	98	70	168	379
March	82	77	159	355
April	96	68	164	355
May	82	29	111	239
June	80	70	150	322
July	107	87	194	422
August	116	180	296	680
September	130	205	335	754
October	129	184	313	707
November	128	107	235	521
December	139	106	245	553

6.8.2 **Recent Developments** - AACC contends that, as at November 2019, the waiting list for this service has declined to 100.

6.9 An ACCC survey carried out in August 2018 indicates that less than half of the clients were satisfied with the Home Help Service

6.9.1 AACC's One-to-One Survey on Services carried out in August 2018 revealed that out of the 31 Home Help Service users who took part in the survey, only 15 (48.4 per cent) of the users were very satisfied or satisfied with the service being provided. On the other hand, three (9.7 per cent) users were unsure of their satisfaction level, while 13 (41.9 per cent) users were unsatisfied or very unsatisfied with the service received. Figure 3 refers.

Figure 3 - Home Help satisfaction survey (2018)



[39] Home Help Service, Annual Report Year 2018, page 15 and 16.

6.9.2 Further to the foregoing, the One-to-One Survey also offered respondents the opportunity to propose changes to the Home Help Service. The most frequently occurring comments are reproduced below:

a. clients are to be provided with more flexibility in the time of service,
b. the service should be completely free,
c. helpers should improve their behaviour through better manifestation of ethics, manners, motivation and wear the appropriate attire,
d. helpers should improve their quality of work, be more punctual, and have a better roster system,
e. helpers are to drive their clients to do their errands,
f. AACC to improve the supervision of the helpers, to train the helpers, and to provide relievers every time a helper is unavailable,
g. AACC should improve the paying system by clients, and
h. AACC should undertake a major overhaul of the Home Help Service.

6.9.3 In general, the issues raised by the One-to-One survey were corroborated by anecdotal evidence collated by the NAO during August 2019. Although neither the One-to-One survey nor anecdotal evidence is statistically representative, collectively, these exercises strongly point towards clients' dissatisfaction and increased expectations.

6.9.4 The foregoing implies the following:

a. Supply and demand for this service are not in equilibrium.
b. Helpers deployed to the Home Help Service need to be further trained on how to improve their relationships with older persons.
c. Clients may have information gaps about what to expect from this service.

6.9.5 **Recent Developments** - AACC contends that it has provided customer care training to its staff. In addition, in November 2019, AACC announced a new scheme, effective from January 2020, whereby clients can choose their own helpers. The Scheme entails that clients will receive a grant of €5.50 per approved hour and have their weekly contribution of either €2.33 or €3.59 in relation to this service waived.

6.10 The Contractor did not pay penalties for delays in providing the service

6.10.1 AACC imposed a total of €263,176 in penalties on the Contractor for delays or not providing the Home Help Service during 2018.[40] This amount is in addition to penalties amounting to €62,862 imposed in the previous year.[41]

[40] Home Help Service Annual Report 2018, page 13.
[41] Home Help Service Annual Report 2017, page 15.

6.10.2 During May and June 2017 many clients had their service suspended due to lack of helpers recruited by the Contractor. As from June 2017, the department also started to issue penalties in relation to break in service.[42]

6.10.3 AACC officials confirmed that as at the time of drafting this Report, the Contractor had not paid these penalties.

6.10.4 **Recent Developments** - AACC contends that its Finance Section is squaring the penalties due with the Contractor's charges. AACC envisages that the issue of the penalties referred to above would have been addressed by 2020.

6.11 The Home Help Unit does not maintain an aggregated record of complaints

6.11.1 The Home Help Unit within the AACC does not maintain an aggregated record of complaints received by clients. This Unit documents clients' complaints within the respective file, thus maintaining an audit trail. Nonetheless, AACC does not have strategic visibility of complaints received in terms of period, type of complaint, action taken and the period required to rectify matters.

6.11.2 **Recent Developments** - AACC noted that, since July 2019, a customer care Standard Operating Procedure (SOP) has been established wherein it is stipulated that all complaints are collated.

6.12 The Home Help Service costs less than €8 per hour

6.12.1 During 2018, AACC was delivering the Home Help Service for less than €8.00 an hour. These costs exclude the €69,299[43] incurred to assess the applicant's eligibility to receive this service. Table 22 refers.

Table 22 - Home Help Service cost (2018)

Home Help Service provider	Quantity of Beneficiaries[44]	Quantity Weekly Hours[45]	Quantity Yearly Hours	Total Salaries and Expenses[46]	Average Salaries and Expenses per Beneficiary	Average Salaries and Expenses per Hour
				€	€	€
The AACC helpers	964	1,935	100,620	759,747	788	7.55
The Contractor (Support Services Ltd.) helpers	2,913	4,996	259,792	2,033,369[47]	698	7.83
Totals	**3,877**	**6,931**	**360,412**	**2,793,116**	**720**	**7.75**

[42] Home Help Service Annual Report 2017, page 15.

[43] The average cost of €69,299.39 covering expenses, salaries, vacation leave, sick leave and training incurred by the Social Work Unit for work related to assessments of Home Help applications are not included in Table 22.

[44] Home Help Service Annual Report Year 2018, page 7.

[45] Home Help Service Annual Report Year 2018, page 9.

[46] Costs related to vacation leave, sick leave, public holidays and training by the Home Help Unit employees, amounting to €209,181 are excluded from Table 22.

[47] The amount of €2,033,369 includes payments of €1,685,418 to the contractor for providing the Home Help Service.

6.12.2 Table 22 shows that there is a marginal difference between the costs incurred for the provision of the Home Help Service through AACC's direct labour pool and the Home Help Contract. It is estimated that the former method of delivering this service costs €7.55 an hour, while the provision of the Home Help Service by the Contractor incurred a cost of €7.75 per hour. The foregoing raises the following issues:

a. The Home Help Service is a labour-intensive activity. Consequently, the most material cost component relates to personnel salaries.

b. The Contractor's rates, on the other hand, include a profit element. Given the similarities of the hourly costs with those of AACC direct labour provision, it is implied that the Contractor's main cost component – personnel remuneration – is at a lower unit cost than that of AACC employed staff.

c. The above two points suggest that the efficiency levels of the two approaches are at par.

d. There are no official statistics available to enable a comparison with the cost of the Home Help Services. Nonetheless, prima facie, the Home Help costs appear to compare well with prevailing market rates.

6.13 AACC is exploring ways to improve the Home Help Service

6.13.1 AACC acknowledges the concerns that influence the effectiveness of this service and are studying on how this service can be re-engineered. Within this context, AACC has already implemented an important initiative whereby applications pertaining to persons over 80 years do not need to be approved by the Home Help Board as eligibility is automatic. In addition to the measures outlined within this Chapter, other recently introduced initiatives include:

a. Immediate temporary Home Help Service is provided to older persons in emergency cases for two hours per week.

b. AACC supervisors are to increase monitoring initiatives, particularly through phone calls with the users.

c. An increase in the pool of assessors to improve the efficiency of the Home Help assessment process.

6.13.2 Furthermore, AACC envisages that the introduction of the new scheme that will be introduced as from January 2020, whereby older persons would be able to choose their own helpers and get refunded by Government, will address the efficiency and service quality shortcomings that prevailed during 2018.

6.14 Conclusions

6.14.1 During the period under review, AACC encountered difficulties in its contract enforcement function. The main point of contention related to the Contractor's inability to engage more helpers in line with contractual obligations. In turn, this caused a ripple effect on the efficiency and overall quality of service delivery. Despite the imposition of penalties (to date unpaid) in accordance with contractual provisions, the situation prevailed to the detriment of older persons who required this service. At this juncture, the question arises as to the reasons the Contractor is unable to engage the required staff to fully honour contractual obligations. The answer lies within a spectrum of economic variables ranging from the current favourable employment situation to one relating to the employment conditions offered to helpers.

6.14.2 AACC's action to address eligibility, efficiency and effectiveness related factors in the short-term is a step in the right direction. Similarly, the exploring of initiatives to remodel the Home Help Service in the medium term is also to be lauded. In view of its importance to older persons' independent living within a community setting, in due course, the NAO will be revisiting the progress registered through AACC's recent initiatives.

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NAO Work and Activities Report

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NAO Audit Reports

January 2019	An Investigation of Visas issued by the Maltese Consulate in Algiers
March 2019	Performance Audit: A Review on the Contract for Mount Carmel Hospital's Outsourced Clerical Services
June 2019	Joint Audit: An Evaluation of the Community Work Scheme
July 2019	Cooperative Audit: Are adequate mechanisms in place for the designation and effective management of Marine Protected Areas (MPAs) within the Mediterranean Sea?
October 2019	Information Technology Audit: The Effective use of Tablets in State, Church and Independent Primary Schools
October 2019	Follow-Up Reports by the National Audit Office 2019
November 2019	Report by the Auditor General on the Workings of Local Government 2018
November 2019	Performance Audit: An analysis of issues concerning the Cooperative Movement in Malta
December 2019	Report by the Auditor General on the Public Accounts 2018
December 2019	An investigation of contracts awarded by the Ministry for Home Affairs and National Security to Infinite Fusion Technologies Ltd