



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

REGULATION OF HOMECARE: Research Report

December 2021

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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About this report

Irrespective of the place where care is provided, whether in a nursing home, in residential care, in their own home or any other care situation, the Health Information and Quality Authority (HIQA) believes that vulnerable people should be supported to live their lives safely and to the fullest, receiving the best possible care and support.⁽¹⁾ With this view, HIQA has developed a research report on the regulation of homecare services at a timely junction to set out the context of homecare in Ireland. Various forms of homecare are in existence since the establishment of the 'home help' scheme under the 1970 Health Act. Like many other health and social care services, societal, economic, demographic and environmental influences have changed the way that homecare needs to be delivered. Society expects that there is a well-functioning health and social care system that meets the population's needs. Unfortunately, homecare in Ireland is not what it should be and over the last decade there has been a failure to address this deficit.

It is important to highlight that this report is not a criticism of homecare providers, the Health Service Executive (HSE) or of individual community healthcare organisations (CHOs) themselves. This report aims to deconstruct some of the complexities that exist within homecare services and set out some key areas for consideration. From HIQA's research, it is clear that homecare operates within a complex and convoluted intertwined network. While this report sets out some of these complexities, it also presents a snapshot 'as is' overview of homecare and details the evidence of what quality homecare should incorporate. It describes some international approaches towards the regulation of homecare and considers the concept of regulating this sector and what it will mean in practice in an Irish context. These areas are described and evaluated throughout this report and key areas for consideration are outlined at the end of this report.

Over the last number of years, HIQA has advocated that the homecare sector needs a complete overhaul and reformation given the uneven distribution of homecare services and the absence of a statutory footing. This position has also been voiced by many other organisations across the health and social care sphere. While it is encouraging to see The Programme for Government (2020)⁽²⁾ has committed to introducing a statutory scheme to support people to live in their own homes, HIQA believes that there is only one opportunity to get this right and is therefore advocating for an inclusive homecare scheme that protects all people who have either basic or complex needs and are receiving care in their own home.

Undoubtedly, the majority of homecare provision is situated within a low-level support sphere; however, society cannot forget about the people who have complex needs and who should be afforded the same level of protection. Indeed, such

individuals with complex needs will become more prevalent over the coming years if they choose to live at home. This is a choice of which they must be afforded.

Regulation is often instituted after system failures, a situation borne out in Ireland after the Leas Cross nursing home scandal in 2005. This initiated the establishment of HIQA as an independent health and social care regulator. While it cannot be inferred that regulating homecare will prohibit such issues from happening, HIQA believes that it will help drive standards, improve safety and bring about improvements in this sector. This is an opportune time to be decisive and prioritise this sector and ensure that irrespective of location, high-quality homecare is available to everyone who needs it. Furthermore, there needs to be a level of entitlement and protection for such persons in need, and homecare recipients and the public must be assured that homecare organisations are meeting certain standards and that there is legislation in place to ensure this is the case.

HIQA is ready to support the development of this sector and be the responsible regulatory authority; however, HIQA cautions that regulating homecare is only one cog of broader reform. For regulation to be successful, there is an urgent and critical need for multi-sector collaboration in this area to protect and provide assurances to people who receive services in their own home. Finally, homecare should be about quality, led by a person's needs, and integrated. It is from this position that HIQA will advocate, and this report is intended to support this narrative.



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Chief Executive Officer



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Chief Inspector of Social Services

December 2021

Executive Summary

Demographic changes over the last few decades have seen a significant increase in the importance of formal homecare.* As people age, they may face additional challenges to maintain independence and stay in their own home. The European Pillar of Social Rights has cited that everyone has the right to affordable long-term care services of good quality, in particular homecare and community-based services.⁽³⁾ From an international perspective, governments are attempting to minimise the demand for expensive residential places and acute care by offering alternative services. For that reason, homecare is regarded as an effective means of preventing hospital and residential admissions: in the main, it is also the preferred choice of care for older people.⁽⁴⁾ One of the most notable aspects of homecare is the international variance in its formation and delivery.^(5,6,7,8) For example, some countries rely heavily on informal care supplemented by formal homecare services, while others rely on cash incentive payments for families or friends to provide the majority of homecare.^(9,10) It is believed that the percentage of informal homecare provided in Ireland may be higher than the Organisation for Economic Co-operation and Development (OECD) average.^(11,12)

Homecare in Ireland is complex and, in part, indistinct. The origins of homecare can be traced back to the 'home help' scheme that came from the 1970 Health Act. Over the years, and through many different guises, homecare has developed into what it is today. Despite its 50-year history, it remains a discretionary but demand-led service where availability often outstrips supply. In broad terms, homecare can be funded publicly through the state body responsible for the health service in Ireland — the Health Service Executive (HSE) — or by private agreement between homecare providers and individuals or families.⁽⁸⁾ For people over the age of 65, homecare provided by the HSE is referred to as the 'Home Support Service'. The process for acquiring this service is set out in national guidelines and underpinned by a national tender. While this home support service is in the main provided to people over the age of 65, there are also various forms of homecare that are delivered to people with a disability and children with complex needs in their own home. For example, community healthcare organisations (CHOs)[†] are allocated annual funding to provide homecare services.

* Formal homecare is the term used in this review to describe paid care provided in a person's home. Unless otherwise stated, when homecare is referred to in this report it means formal homecare. Distinction will be made where there is reference to informal or other types of homecare.

† There are nine community healthcare organisations in Ireland. Community healthcare organisations provide a broad range of services that are outside of the acute hospital system and includes primary care, social care, mental health and health and wellbeing services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.

From a disability perspective, disability services enter into arrangements with homecare providers, either through Section 38 or 39 service arrangements or with providers contracted on an hourly basis. Therefore, in broad terms, homecare can be delivered by the HSE themselves or by provider organisations commissioned through tendering or a service agreement processes.

Quality assurance in homecare is underpinned by guidance and procedures published by the HSE⁽¹³⁾ and, in part, supplemented by voluntary standards.⁽¹⁴⁾ While private, voluntary and not-for-profit homecare providers are subject to monitoring by the HSE via a tendering and service agreement mechanism, the HSE in and of itself is not. This creates a situation where the HSE is not independent of the process. Furthermore, homecare providers that are not delivering homecare on behalf of the HSE (outside of tender or service arrangements) theoretically do not need to adhere to any standards.[‡] In this regard, there is no control over who can provide such services and how they are monitored. This is a very real and significant concern. Moreover, in conjunction with societal shifts, for example the ageing population,⁽¹⁵⁾ difficulties with recruitment and retention of social care staff^(10,16) and the occurrence and impact of COVID-19 in Ireland over the past 16 months,⁽¹⁷⁾ there is a fundamental need to provide a regulatory framework for the provision of homecare in Ireland. HIQA has advocated for the regulation of homecare services over a number of years. However, this is challenging as homecare operates in a complex context where there are interactions between the recipient of homecare, informal carers, homecare staff, provider organisations, the HSE and allied health professionals.

In line with national objectives, the Sláintecare policy⁽¹⁸⁾ is a plan that sets out to reform health and social care in Ireland. Central objectives contained within this plan include the need to ensure that there is an integrated universal, single-tiered health and social care system where people are provided with the “right care, in the right place, at the right time”.⁽¹⁸⁾ Fundamentally, this means that people with care needs should continue to live in their own homes and communities for as long as possible according to their wishes. In July 2020, the Health (Amendment) (Professional Homecare) Bill⁽¹⁹⁾ was published, is a clear signal of the approach towards the regularisation and quality improvement of homecare services in Ireland. This Bill has, in effect, been adjourned for 12 months (until October 2021)⁽²⁰⁾ to allow the Irish Government to consider the development of an appropriate bespoke regulatory framework. This work is ongoing and the Government is planning a programme of consultation and engagement over the coming months.

[‡] It is acknowledged that in many instances where a homecare provider is a member of a national organisation, they are audited by their organisation to ensure they are meeting certain standards.

This research report presents the current situation of homecare in Ireland. In Chapter 1, the report uses information supplied by the HSE regarding the provision of homecare for people in Ireland. It sets out the homecare that is provided to people over the age of 65, people with a disability and children with complex needs. It delineates what is formal homecare and uses evidence to identify discrete difficulties in the terminology and processes that exist. There is an abundance of definitions that have been reported. Indeed, as contextualised in this chapter, formal homecare in Ireland intersects both health and social care services. On one level, formal homecare can be defined as the assistance with activities and or instrumental activities of daily living. However, there are occasions where this intersects with more complex care and therefore it is not necessarily straight forward to deconstruct what is and what is not homecare. It is therefore the view of HIQA that formal homecare is a term that represents 'paid care that is provided in a person's home'. While this may seem overly inclusive, the strategy in Ireland is to provide integrated services that are closer to home. Subsequently, it may be naive to believe that, in the not so distant future, more and more complex care will be provided to people in their own homes. It would be prudent to ensure that this is considered from a regulatory perspective. This chapter also provides an overview of Government policy over the last few decades in respect of homecare and describes the type, funding assessment and delivery of homecare in Ireland.

Chapter 2 of this research report provides an overview of research undertaken by HIQA over the last eight months. This research aims to provide an overview of the current 'as is' picture of homecare in Ireland. In the first phase of the research, an online survey was distributed to homecare providers, followed up with focus group interviews. The results indicate that homecare providers are providing a range of services that cover a spectrum of care, from very basic support to complex care. Providers cited that they are struggling to employ and retain staff to work in homecare and reported that lone working[§] is a significant risk to providers of homecare services. The greatest reported risk to people receiving homecare services was described as those receiving a poor quality or unfulfilled service. This risk was associated with poor assessment processes, poorly implemented care plans, a lack of oversight and poor care in general. From an unfulfilled service perspective, this specifically related to continuity issues whereby homecare provision was interrupted by frequent carer changes, carer absence, missed homecare calls and an inability to provide care at the right time. Providers also cite areas that the regulation and standards for homecare should focus on. These are broadly categorised on the capacity and capability, and quality and safety dimensions of homecare services.

Three themes were identified in the focus groups:

[§] Lone workers are those who work by themselves without close or direct supervision.

- (1) positives of the homecare landscape;
- (2) what does not work well in homecare;
- (3) and what needs improvement.

Under the positives that exist in the current homecare landscape, participants identified governance and management and sectorial factors as real strengths. The analysis identified that there was a very strong sense of self-regulation that already exists in this sector and this was seen as a real asset of the current provision. Providers identified how they had robust processes, policies and procedures in place. These included vetting, monitoring of care, incident reporting and safeguarding processes. Providers also cited that they operated through a human rights framework that put the person at the centre of the homecare process. Regarding what does not work well in homecare, providers cited difficulties with staffing, timing of homecare, funding, availability of homecare and the assessment process as not working well at present. Providers of homecare services stated that these issues cause significant concerns for them and therefore negatively impacted the person in receipt of services. In the final theme, providers cited that there was a need to define homecare parameters, ensure equality, reduce inconsistency, embrace person-centred care, and to encourage advocacy. Providers also outlined solutions to help improve the homecare sector and these are outlined in this chapter.

Chapter 3 outlines a scoping review of the literature that was undertaken by HIQA to determine what constitutes quality in terms of formal homecare. Acknowledging that there is a severe absence of empirical literature concerning the impact and effects of regulation in homecare, this review conceives regulation as a quality improvement and assurance mechanism and constructed a systematic search to find literature relating to these concepts. A Donabedian framework⁽²¹⁾ (structure, processes and outcomes) was used to assist the synthesis and interpretation of the literature. Under the structural component of how homecare is organised and elements that form the homecare system, eight primary themes were identified, these include: collaborative work — formal and informal care, evidence-based guidance, health and safety, leadership and management, outcome measurement, person-centred care, service characteristics and workforce. Two primary themes were identified under the process component that identified the technical and interpersonal aspect of homecare. These related to quality of care and person-centred planning. From an outcome perspective, or the end result of homecare for the persons in receipt of services, health and wellbeing, person-centred care and support to service users were identified. The findings from this review suggest that the structures, processes and outcomes are mutually dependent and inseparable, meaning that without good structures, processes are compromised and as a result, outcomes are poorer for people in receipt of homecare services. Additionally, the concept of person-centred

care intersected all elements of this framework and subsequently there needs to be a person-centred ethos incorporated in all components of the homecare sector.

In Chapter 4, a review of the international approaches towards the regulation of homecare is reported on. This chapter is divided into predominantly English speaking countries and predominantly non-English speaking countries. Information relating to the regulation of homecare was ascertained through an online survey and desktop review. The review identified that in England, Scotland, Northern Ireland, Wales, Australia and Sweden homecare providers are registered by an independent regulator to provide homecare services. This means the regulator registers services and they are legally permitted to provide homecare services. In other countries, such as New Zealand, Finland, France, Germany and the Netherlands, there is an accreditation approach towards homecare where providers are permitted to provide homecare services. While there are similarities and differences regarding how homecare is regulated in all countries, it would appear that where decentralisation of services exists, the approach towards regulation is more fragmented and difficult to identify, particularly in predominantly non-English speaking jurisdictions. From an Irish perspective, learning comes from the English speaking jurisdictions insofar as the scope, reach and parameters of homecare are clearly set out and regulated accordingly. In England, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides a list of 'regulated activities' where providers need to determine which activities are relevant to the service they provide and register accordingly.

For example, if a homecare provider provides personal care services or both nursing and personal care services they must register the activity or activities separately with the Care Quality Commission (CQC). Therefore, providers are registered to provide regulated activities and assessed against these regulations accordingly. Importantly, across some jurisdictions, an outcomes-focused approach is adopted when monitoring and inspecting homecare services, and a holistic view of the person receiving care and support is emphasised. Having such a focus on patient satisfaction may ensure that inspections of homecare services are not restricted to a compliance versus non-compliance approach. Regarding the homecare workforce, the findings of this review identified that the registration and requirements of homecare workers was addressed in a number of jurisdictions. Wales, Northern Ireland and New Zealand are examples of where the homecare workforce falls under the regulatory framework. Legislation introduced has placed an emphasis on the homecare workforce, improving working conditions, wages and providing education and training.

Chapter 5 of this research report outlines the objectives of regulation in broad terms and aligns this to the sphere of homecare. It sets out what regulation tries to deliver based on three priorities:

1. to improve performance and quality of homecare
2. to provide assurance to people in receipt of homecare and to the public that minimally acceptable standards are achieved
3. to provide accountability both for levels of performance and value for money.

Additionally, this chapter draws on HIQA's experience as a regulator of health and social care over the last decade and calls on the Government to ensure that a detailed Regulatory Impact Assessment is undertaken by the Government to understand the impact and unintended consequences that imposing regulation on this sector may have. Reflecting on recent research undertaken by HIQA considering the concept of regulatory reform,⁽²²⁾ this chapter sets out the need to ensure that the impact of regulation on homecare services should be seen as an iterative process where its impact is regularly reviewed to determine its effectiveness once implemented and not necessarily in response to system failures. In the final stage of this chapter, HIQA set out different approaches towards regulation, detailing directive and external oversight approaches that are commonly used while detailing the responsive approach to regulation that HIQA currently use. This is a dynamic model in which persuasion and or capacity building are tried before escalation up a pyramid of increasing levels of sanction.

The discussion chapter of this report draws some conclusions from the preceding chapters, situated in the international evidence. Throughout, the HSE responses in chapter 1 and the findings from the research undertaken are evaluated in the context of homecare provision more broadly. HIQA concludes that there are currently three options available to the Government. These are:

- **Option 1:** The 'business as usual' scenario;
- **Option 2:** The 'directionless' or 'bandage' scenario;
- **Option 3:** The third option is the preferred choice. This is where there is a root and branch review of homecare — this will include concerned stakeholders and engagement of all stakeholders at national, CHO, service delivery and recipient level. A homecare framework will be developed that makes homecare available to everyone in need. Age is removed as a barrier to access, and homecare services are available from 'cradle to grave' in an integrated and needs-led fashion. Homecare includes services that support enablement and independence and provide services that maintain continuity. There is a clear funding framework to support this transition. Regulation in this scenario is one cog in the wheel of broader reform that seeks to drive quality in this sector.

Reflecting on these options, it is clear to see that Option 1 is not going to meet the needs of people who require homecare services, the end result of this is that people will be at risk. However, given the commitment in Sláintecare to implement a statutory scheme for homecare this option is unlikely. Additionally, Option 2, is also inherently risky as this will add to continued development of a complex system that will serve some people, but not all. This will be particularly acute for vulnerable populations if they are excluded from the scope of homecare regulation. In this option, homecare services will become more fragmented and disconnected. This is not aligned to Government strategy. While Option 3 will be costly and challenging, it will involve all concerned parties to work collaboratively and to deliver on their undertakings. There is a societal requirement to develop a homecare framework that makes homecare available to everyone if such services in a person’s home are required. Sláintecare has previously commented that the Irish health service was “facing extraordinary challenges” which required “an extraordinary response”.^(23,24) Option 3 will much provide wide-ranging long term benefits for people who require homecare services. Therefore, the cost of not doing this is incalculable.

HIOA recommends that homecare services need to be integrated and needs led, for age of access to be removed as a barrier, and services that support enablement and independence to be accounted for, ensuring the human rights of people in receipt of homecare are protected. While it is up to the Government to decide if more complex aspects of care will be included in the regulation of homecare, it should consider that health and social care services intersect frequently and are often integrated, and there is a strong argument that this will increase over the coming years with the move to more care in the community at the heart of the Sláintecare ethos.

This report concludes by outlining key areas for consideration that HIOA considers important for this sector. These key areas are described below in Table 1.0 and set out in full in Chapter 7.

Table: 1.0: Key areas for consideration in the homecare sector
Key area 1: A ‘root and branch’ review of homecare from the bottom up
Key area 2: Identify the scope and parameters of homecare
Key area 3: There is a need for homecare to be integrated and needs led
Key area 4: Quality is central to homecare
Key area 5: A national standardised assessment instrument is required
Key area 6: Investment in homecare workers is required

Key area 7: Funding for accessing homecare should be a statutory right

Key area 8: A universal methodology for commissioning disability homecare services should be developed

Key area 9: Homecare must be inclusive, continual and consistent

Key area 10: There needs to be a focus on information sharing using integrated ICT systems

Key area 11: Regulation should only be viewed as one component of broader reform and should not be burdensome

Key area 12: There is a need to focus on maintaining a standard across the homecare sector before driving quality improvement

Key area 13: There is a need to undertake an assessment of the effectiveness and cost-effectiveness of health technologies in homecare in the Irish context

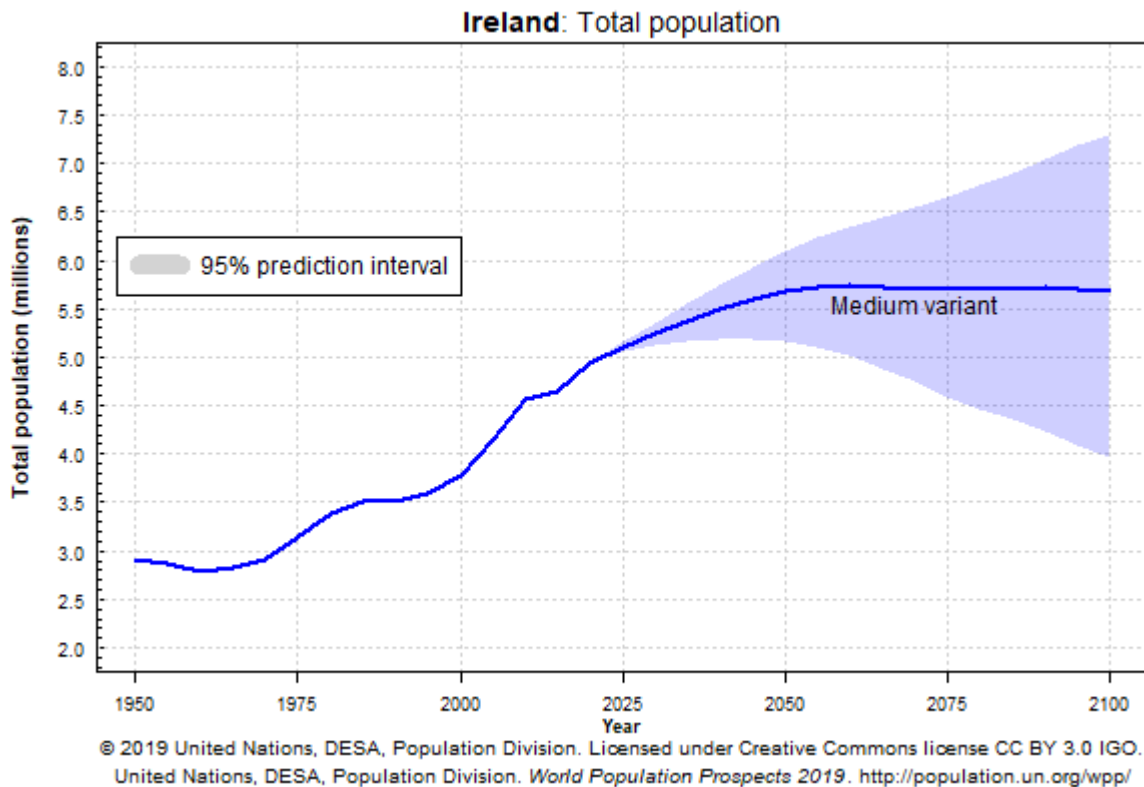
Introduction

The world's population is ageing. Over the last 20 years, Ireland has observed a significant growth in its population. Since 2000, Ireland's population has increased by 1.3 million to 4.9 million inhabitants.⁽²⁵⁾ This societal change is dissimilar to historical population transformations insofar as composition, with the proportion of older people now much higher than ever before. This transformation is driven by three primary influences: (1) fertility; (2) mortality, and (3) migration.^(15,25) The interplay between these factors has, in part, been referred to as the 'epidemiological transition theory'.^{** (26)} Essentially, fertility is declining, healthcare is improving and the cause of death is changing. For example, people are now living longer with high levels of chronic disease as opposed to dying at younger ages from acute illnesses. When the economic prosperity that Ireland has achieved over the last few decades is considered, this makes Ireland an attractive place to live, and influences net inward migration. These influences are indeed positive and welcomed; however, they place additional challenges on how public services function. Figure 1.0 illustrates the growth in Ireland population since the 1950s and provides an estimate of an interval in which our future population will fall. By 2030, Ireland's population is projected to be well in excess of five million people,⁽²⁷⁾ nearly a two million increase over 30 years.

The predicted change in the population is most starkly observed in the older and younger age groups. For example, from 2020 to 2050 it is estimated that the Irish population aged under 15 years will reduce by 12.9% from 1,029 (thousands) to 896 (thousands), while those over 65 will increase by 82.2% from 14.6 (thousands) to 26.6 (thousands).⁽¹⁵⁾ This demographic shift is important to consider from a number of perspectives. Firstly, while it cannot be considered normative that all older people will experience functional limitations that will result in them requiring health and social care services as they age, it is more likely to be the case. Secondly, inherent in this demographic shift, people with disabilities, and in particular people with intellectual disabilities, are now living longer (but still dying younger than the general population)^(28,29) and these individuals are more likely to have greater health and social care needs.⁽³⁰⁾ This suggests that they will utilise health and social care services at a greater frequency and at a younger age.^(31,32,33)

** Epidemiological transition is a theory which "describes changing population patterns in terms of fertility, life expectancy, mortality, and leading causes of death".⁽²⁶⁾

Figure 1.0: Ireland's total population (per millions) with a 95% prediction interval⁽²⁷⁾



Additionally, it will not be just older people or people with disabilities who may require increased health and social care services, other people may require services at, or for, a period of time in their lives from a supportive, rehabilitative or palliative perspective. Thirdly, the provision of care is changing and it is now accepted that institutional or residential-based care is not appropriate for everyone and that health and social care services should be accessible closer to home.⁽³⁴⁾ The public perception of what care should look like is also changing. In a number of reports, HIQA has set out various models of care that are being provided or will be provided in Ireland over the coming years;^(22,35,36) this demonstrates the need for more diverse integrated services in the future. Fourthly, despite an increase in population, it is important to illustrate that the average household size in Ireland has been declining for decades. Although it has now recently stabilised at 2.75 persons per household,⁽³⁷⁾ the ability of households to provide informal homecare to family members has been contracting over the last few decades. Finally, with a decline in younger age groups, there are fewer people paying taxes and this reduces the amount of revenue the Exchequer receives through taxation to fund public services.

The consequences of these changes are fundamentally important. From a general social policy perspective, Ireland is a liberal welfare state, meaning it takes a formal stake in the welfare and wellbeing of its population.⁽³⁸⁾ Section 7 of the Health Act

2004, (as amended) (hereafter referred to as the '2004 Act') states that the objective of the HSE is: "to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public".⁽³⁹⁾ Principally, the HSE is required by statute to manage or deliver, or arrange to be delivered on its behalf, health and personal social services.^φ In general terms, this provides the statutory basis for the provision of health and personal social services. However, the 1970 Health Act (as amended)^{††(40)} (hereafter referred to as the '1970 Act') under Chapter III 'General Medical Services', Section 61 'Home Help Service' states:

"61.-(1) A health board^{††} may make arrangements to assist in the maintenance at home of-

(a) a sick or infirm person or a dependant of such a person..."

In regards Section 61, it is apparent there is a significant gap as there is currently no statutory obligation on the HSE to provide 'home help' services in Ireland as it is referred to in the 1970 Act as a discretionary service.⁽⁴¹⁾ The 1970 Act sets out that the 'Health Board' may make arrangements through its 'home help' service to 'assist in the maintenance at home of...the sick or infirm...'. In this vein, the provision of home help (homecare) has been devolved locally without any legal obligation to provide or make available home help services.⁽⁴⁰⁾ From the 1970s until the mid-2000s, only a 'home help' scheme existed which primarily focused on domestic assistance. Through this pretext, and in the absence of a statutory obligation to provide home help services, the provision of homecare in Ireland has been identified as patchy and inconsistent where demand outstrips supply.^(41,42)

The absence of a statutory footing in Ireland has significant implications for those developing, procuring, delivering and most importantly, receiving homecare services.

^φ Health and personal services are broadly defined as all the services the HSE provides for the: 1) prevention, maintenance and diagnosis and treatment of illness, and 2) for the promotion of wellbeing and independence. It is delivered by the follow divisions:

- Acute hospitals
- Social care
- Mental health
- Primary care
- Health and wellbeing
- National Ambulance Service.

^{††} All the functions and or responsibilities of the Health Boards (to include those relating to home help service as it was called at the time under the 1970 Act) were transferred to the HSE under the 2004 Act.

^{††} Reference to 'Health Board' construed as reference to Health Service Executive (1.01.2005) by *Health Act 2004* (42/2004), ss. 56(a), 66, S.I. No. 887 of 2004.

In recent times, there is significant international interest in the provision of homecare services, driven by a societal desire to reduce the use of institutional or residential type services such as nursing homes and congregated settings^(8,43) and to increase the choice and quality of life of those who need support. The move away from institutional care to more focused community-led systems is well highlighted in the international literature.^(6,8) COVID-19 has also served to highlight the weaknesses in traditional forms of residential care for older people⁽⁴⁴⁾ (for example, the incidence of mortality and difficult living conditions experienced during pandemic times along with the move towards more medical type settings).^(44,45) Additionally, a recent report from the Office of the Ombudsman examined the appropriateness of the placement of people under 65 in nursing homes for older people.⁽⁴⁶⁾ This report cited a bias in favor of institutional care and identified a fractured funding model, stating that young people with living with disabilities are living wasted lives in nursing homes.^{§§} The Ombudsman stated that a statutory home support scheme will be necessary to address the current bias in favour of institutional settings. This, along with homecare generally being the preferred choice for place of care places a significant responsibility on Government to ensure it is fit for purpose and delivered in a sustainable way – internationally, this is regarded as a matter of urgency.⁽⁴⁷⁾

It is through this lens that the following research report sets out some of the real-world evidence regarding the formation and provision of homecare to help inform the regulation of homecare in Ireland.

^{§§} This report has highlighted that there are more than 1,300 people under 65 in nursing homes in Ireland. Additionally, the Ombudsman identified that he visited 28 people directly affected, of which, most of them said that they wanted to live at home but this request was not granted.

Chapter 1: Background of formal homecare and homecare policy and provision in Ireland

What is formal homecare?

It is important to firstly set out what this report means when it refers to formal homecare. *** In broad terms, formal homecare provides a range of services for those who need support due to deficits in functioning. The definition of formal homecare differs internationally; however, Kiersey and Coleman (2017)⁽⁴³⁾ has previously been guided, in part, by the definition proposed by Boerma and Genet (2012)⁽⁴⁸⁾ to generally mean:

any care provided behind someone's front door or, more generally, referring to services enabling people to stay living in their home environment. In some countries, "someone's front door" can include a home for the elderly. As regards the type of services, home care may refer to care given only by professionals or in combination with care given by a spouse or relative (personal care or housekeeping).

In their evidence review, Kiersey and Coleman (2017)⁽⁴³⁾ cite that homecare in Ireland is:

typically understood as home help services, which include cleaning, cooking and other light household tasks that a person is unable to do themselves due to old age or disability.

While this is a definition conveyed by the Department of Health (2018),⁽⁴⁹⁾ more recently, the Health (Amendment) (Professional Home Care) Bill 2020⁽²⁰⁾ has defined [formal homecare] 'Professional Home Care' as:

...services which are required to ensure that an adult person, that is, a person aged 18 years and over, can continue to live independently in their own home, and includes, but is not limited to the services of nurses, home care attendants, home helps, various therapies and personal care, and palliative care.

The former definition is extracted from an extensive review undertaken by the Law Reform Committee in 2011.⁽⁵⁰⁾ In Ireland, however, the term that is used by the HSE to define the foremost type of homecare services they provide is referred to as 'home support services' for older people. The HSE Home Support Service — formerly called the Home Help (until 2006) Service or Home Care Package Scheme (until

*** Unless otherwise stated, when homecare is referred to in this report it means formal homecare. The distinction will be made where reference is being made to informal or other types of homecare.

2018) — aims to support people to remain in their own homes for as long as possible and to support informal carers.

The Home Support Service (see Table 1.1) is theoretically narrower than the former definitions cited by Boerma and Genet (2012)⁽⁴⁸⁾ and the Health (Amendment) (Professional Home Care) Bill 2020.⁽²⁰⁾ In particular, the Home Support Service does not consider the professional services of nurses or various therapies and it does not include persons under the age of 18. Regarding professional services of nurses or various therapies, this role generally falls under the scope of primary care in the form of allied health professionals, public health nurses and community registered general nurses who are employed by the HSE to provide a range of healthcare services in the community. From this nursing care perspective, core nursing care is provided to diverse population groups, including:⁽⁵¹⁾

- Older people who live at home
- People who are chronically or acutely ill at home and people who are dying at home
- Children – infant welfare services, child health services and school health services
- Expectant mothers and mothers who have recently given birth
- People with disabilities
- People suffering social deprivation
- The Traveller community.

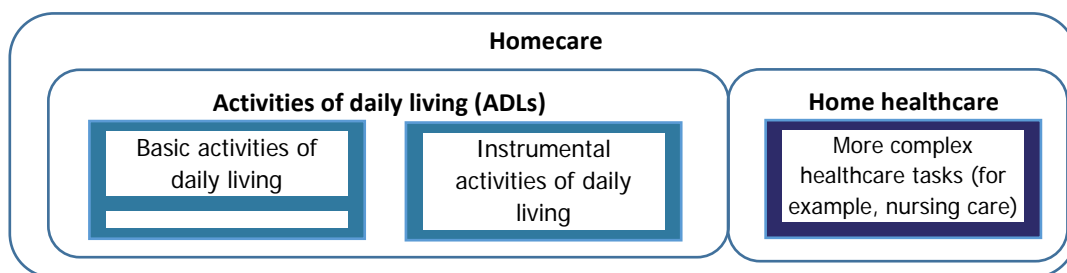
While this is currently the case, non-nursing staff in the form of healthcare assistants are sometimes employed to assist the public health nursing service. These staff provide personal care rather than nursing or domestic services but there is some overlap between what they do and what 'home support services' do.

While there are some areas of care that may overlap in the context of homecare, in the international literature 'home support services' are generally regarded as a 'shopping and mopping model' delivered through a 'time-and-task' commissioning process.⁽⁵²⁾ In Ireland, to add a further level of complexity, the HSE also provides or arranges to provide Intensive Home Care Packages (IHCPs). These are a more intense range of the same services that fall under Home Support Service; however, they are much fewer in number. Such packages provide complex care services to people with high-level care needs (up to a maximum of 56 hours a week). While these were initially developed for people with dementia back in 2014, they have evolved and are often provided where a person has major functional limitations and

may require high levels of personal care and potentially some form of nursing care.^{†††(53)}

Essentially, it would appear that some aspects of homecare in Ireland are placed within an intersection, as the range of activities provided in a person's home overlap with both health and social care services. This intersection has been discussed from a European context and is best illustrated by Guericke (2016)⁽⁵⁴⁾ in Figure 1.1 based on the work of Genet et al. (2012).⁽⁵⁵⁾

Figure 1.1: The intersection of homecare across health and social care in Ireland



Another area of homecare concerns the provision of homecare for people with a disability (see Table 1.1). This is a complex area, with diverse terminology and the scope and provision of homecare in this sector can involve homecare workers, personal assistants, personal budgets and the concept of supported living. Notwithstanding this, such services deliver care in one's home irrespective of the disguised terminology and this needs to be acknowledged.

For example, within disability services, personal assistance (PA) packages are delivered to an adult with capacity to direct their own service. They effectively direct their own service and employ and manage their own personal assistants to enable them to live independently. This form of package adds a level of complexity to homecare regulation as people in receipt of this package sometimes consider the service solely theirs with no reporting requirements needed. While a UK study has considered highlighted that personal assistants who are directly employed by service users may be more at risk of exploitation and abuse in the absence of regulation⁽⁵⁶⁾ it would be the view of HIQA that such an arrangement would not be subject to regulation as there is no provider organisation; however, there would need to be arrangements between the funder and the person who is receiving that package. Additionally, the HSE also provides or arranges for paediatric homecare packages, as shown in Table 1.1.

^{†††} The nursing care in this instance may be provided by the primary care team. However, if there is no capacity at this level it may be commissioned out to provider organisations (personal communication with the HSE).

It is from this perspective that these different definitions and levels of provision in the area of homecare make the interpretation of services difficult to disentangle. Equally, given the devolved nature of administration and provision, it is difficult to infer what is and what is not homecare. However, broadly speaking and when considered in its entirety, homecare in Ireland is multi-dimensional and multidisciplinary. Homecare mainly focuses on activities of daily living⁺⁺⁺ or instrumental activities of daily living^{sss} but it also may include services that go beyond these supports. Essentially, homecare serves to maintain the independence, autonomy, health and wellbeing of people, enabling them to remain in their own home. It should be integrated and needs led. Therefore, it is through this lens and for the purpose of this report that HIQA considers that formal homecare is:

‘A term that represents paid care that is provided in a person’s home’.

Notwithstanding these complexities, it is important to outline that the primary mode of homecare provision in Ireland is through informal homecare processes.⁽⁵⁷⁾ This means that homecare is provided in an unpaid capacity by family, friends or neighbours. The key difference between ‘formal’ and ‘informal’ care lies in the fact that no financial exchange occurs between a care recipient and an informal carer, therefore rendering it an informal service. To offset this, the Government makes certain incentives available to support the provision of informal care.^(58,59,60,61,62) Nonetheless, there is a strong recognition that formal homecare provision should complement informal care⁽⁵⁰⁾ given the significant financial cost it would have if it was to be funded directly by the Exchequer. There is a strong commitment by the Government and the HSE that home-based care should be maximised to support the important role of family and informal carers in order to allow people to remain at home for as long as possible.

While acknowledging the importance of informal care, there is some evidence to demonstrate that Ireland is heavily reliant on it, more so than other OECD member countries.^(8,11) To illustrate this, data from the Irish Longitudinal Study on Ageing (TILDA) suggests informal homecare accounts for 90% of all care provided,⁽¹¹⁾ whereas the OECD average has historically been cited at approximately 80%.⁽¹²⁾ This reliance, now and in the future, will contribute to further difficulties, because an ageing population will result in fewer people providing (or being able to provide) this informal homecare service. These difficulties may be particularly stark for people who live alone. In this regard, informal homecare is fundamentally important and therefore needs consideration alongside formal homecare more broadly.

⁺⁺⁺ Activities of daily living are supports relating to dressing, transferring, bathing or showering, support with eating, getting in or out of bed and toileting.

^{sss} Instrumental activities of daily living are supports relating to cooking a meal, doing household tasks (cleaning, laundry), shopping for groceries, making phone calls, managing money (for example, paying bills) and supporting medication administration.

Policy background

It is important to point out that there is no statutory entitlement to funding for formal homecare packages equivalent to the Nursing Homes Support Scheme (Fair Deal scheme)^{****(63)} for nursing homecare in Ireland.⁽³⁴⁾ This is in contrast to the political commitment that has been vocalised toward the statutory provision of homecare services over many years. The Law Reform Commission (2011),⁽⁵⁰⁾ Timonen et al. (2012),⁽⁵⁷⁾ Kiersey and Coleman (2017),⁽⁴³⁾ Sage Advocacy (2016),⁽⁶⁴⁾ National Economic and Social Council (2012),⁽⁶⁵⁾ Home and Community Care Ireland (2019)⁽⁴¹⁾ and the Houses of the Oireachtas (2019)⁽⁶⁶⁾ have all documented that the predominant policy in Ireland has been based on a commitment to enable people to live at home since the 1960s. Figure 1.2 outlines some key selected publications relating to relating to commentary regarding homecare in Ireland.^(19,41,43,50,65,67,68,69,70,71,72,73)

**** The statutory basis for the Nursing Homes Support Scheme is the Nursing Homes Support Scheme Act 2009, came into effect on the 1 July 2009. Under the 'Fair Deal' scheme, the applicant makes a contribution towards the cost of their care in the nursing home (the level of which is determined in accordance with the criteria laid down in the Act of 2009) and the State pays the balance of the cost of the applicant's care.

Figure 1.2: A selected overview of publication relating to homecare in Ireland



While the commentary is not disputed, it is reasonable to conclude that there has been a marked disconnect between the expansion of services and the development of homecare policy and legislation. The current homecare landscape is now defined by a situation where services have expanded in response to the population's health and social care needs in a fragmented, dispersed and disproportionate fashion. The

policies and oversight that should govern homecare have not maintained a similar degree of pace.⁽¹⁾ Despite this issue being highlighted on a consistent basis, there continues to be an independent absence of policy and regulatory oversight for the procurement, delivery and assessment of quality from public, private and non-governmental agencies providing formal homecare services in Ireland.^(50,64)

From a quality assurance perspective, the situation is also complicated, potentially as a consequence of the fragmentary and devolved approach towards the development and implementation of standards for formal homecare. For example, in 2008, the HSE agreed to develop national quality standards for formal homecare services. These, however, were drafted into two other sets of standards that were related to the tendering out of 'homecare packages' and to 'home help' services delivered directly by the HSE. During the subsequent years, the landscape continues to be complicated and difficult to contextualise fully and so HIQA engaged with the HSE to better understand homecare landscape fully.

Engagement with the HSE

Considering the above mentioned complexities outlined within the sphere of homecare, HIQA consulted with the HSE to set out what is the scope and reach of homecare services that are being provided to adults over the age of 65,^{†††} people with a disability and to children under the age of 18 years. In May 2021, HIQA issued a suite of questions to these services which broadly related to the scope, assessment, allocation, oversight, staffing and funding of homecare services. Additionally, specific questions were also asked to older people's and disability services relating to some issues outlined in Chapter 3 regarding the timing and provision of homecare services that were highlighted as problematic. The responses received by HIQA are considered through this research to bring a degree of coherence and understanding to the complication that exists across this sector.

Synthesis of the homecare landscape

Table 1.1 sets of a synthesis of the responses received from the HSE highlighting the typology of homecare provision. These are delineated into disability services, children's services and older people's services.

^{†††} Services for adults over the age of 65 are referred to as older people's services.

Table 1.1: Summary of responses from homecare providers

	Disability services	Children's services	Older people's services
Types of homecare	<p>Disability services are generally delivered on a person centred basis often on a social model of care sometimes into the community.</p> <p>Home Support provides personal and or essential domestic care and support to facilitate participation in social/leisure activities. It can include:</p> <ul style="list-style-type: none"> - Home Care Assistant Service: a personal care service which provides personal support including washing, dressing and other activities of daily living and facilitation in social and recreational activities. - Home Help: provides domestic type support but in many cases where a 	<p>Paediatric Home Care Packages (PHCP) are intensive packages of nursing care put in place to support families to care for their child with complex healthcare needs.</p> <p>The initiation of a paediatric home care package strengthen links between primary and secondary care, and provide additional support to parents, general practitioners and Public Health Nurses (PHNs) to manage Children with Complex Healthcare Needs (CCHN) closer to home. A range of services are now provided in the community to support CCHN to be cared for at home including PHCP which provide nursing support to children at home.</p>	<p>Home support services is defined as personal care and where appropriate, essential household duties relating to assessed needs of the individual client.</p> <p>The overall objective of the home support service is to:</p> <ul style="list-style-type: none"> • Allow people to remain at home in their communities for as long as possible by ensuring access to appropriate supports in primary care and community services, resulting in avoidance of unnecessary attendance at emergency departments and admissions to acute hospital. • Facilitate timely discharge from acute

	<p>Home Care Assistant is not available, the Home Help may also provide support of a personal nature.</p> <ul style="list-style-type: none"> - Home Support: is assistance provided to the family in terms of assisting with care and facilitating attendance at social activities. <p>Personal assistance is delivered to an adult with capacity to direct the service. Personal assistants are employed by the person with a disability to enable them to live independently.</p>		<p>hospital settings when admission does occur on a home first basis.</p>
<p>Formal homecare eligibility</p>	<p>Services are provided to children and adults with intellectual disabilities, autism and or physical and sensory disabilities through a range of providers. While the quantum of service available to meet demand is always a challenge, the service should be</p>	<p>The reach is the population aged under 18 with complex healthcare needs. This is a non-statutory service and access is based on the individual child’s clinical needs having regard to available resources and</p>	<p>Home support clients may require assistance in some or all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as identified by an individualised care needs assessment.</p>

	aligned to Sláintecare’s ambition for Integrated Services delivered – Right Care – Right Place - Right Time.	the competing demands for services.	Intensive Home Care Packages (IHCPs) – a more intense range of the same services as under HCP – much fewer in number (funded centrally therefore different to Home Support Service funding).
Definition of complex care	Disability services can be provided 24/7 but is not termed complex accordingly. Every package of support is defined on a bespoke basis. It could include significant nursing involvement, disability or public health. Complexity can be associated with prevailing risk around care and associated with interventions needing significant clinical governance. There are instances where a spectrum of service is procured from a specialist nursing care provider but ultimate oversight falls back to the HSE.	A definition has been developed of “Complex Needs” and a scoring tool outlined which is based on WHO’s ICF and functional difficulties. In this context “ Complex needs refers to one or more impairments which contribute to a range of significant functional difficulties that require the services and support of an interdisciplinary disability team ”.	A person with complex care needs may be defined as someone who requires a coordinated response from a number of different healthcare professionals or external agencies and a range of additional support services beyond the type and amount required by other members of a population. It does not specifically relate to the range of tasks that need to be provided for or the length of time taken to meet the person’s needs.
Provision of complex care	Complex care can come as part of a package of care including Home Support. Complex care is a	The framework of providers for nursing services for children with complex healthcare needs	Clients are deemed complex rather than home support being described as ‘complex’.

	<p>very broad consideration and aspects may be delivered jointly by disability and primary care services even within the secondary level. There are instances where a spectrum of service is procured from a specialist nursing care provider but ultimate oversight falls back to the HSE. Determination of supports is based on a combination of input from the person receiving the support, their family, the providers and the HSE typically including multidisciplinary assessment and sometimes including decision making with the Disability Manager and or Head of Disability.</p>	<p>(CCHN) in the home is the foundation on which the delivery of healthcare for CCHN both in the present and into the future.</p>	<p>Clients may be in receipt of a package of care where home support is just one component where supports may include a combination of services to include home support, health and social care services delivered across a spectrum of primary, secondary and tertiary services.</p>
<p>Funding of formal homecare</p>	<p>Funding is provided to CHOs in their annual budget and allocated to service provision accordingly. Disability services will then enter into arrangements with providers. This may be through Section 38 or 39</p>	<p>The service is funded by Government each year as approved in the HSE annual National Service Plan.</p>	<p>The Home Support Service is funded by Government to deliver a volume of service each year as approved in the HSE annual National Service Plan. It is a non-statutory service and access is based on</p>

	<p>service arrangements with providers or contracted on an hourly basis and invoiced accordingly. There may be some difference in services available in some areas with more resource dedicated to, for instance, residential service per head of population. Disability does not have a national tender framework in place with providers.</p>		<p>assessment of the person's needs and subject to the limit of funding available.</p>
<p>Process of care</p>	<p>People apply for services, are assessed and allocated hours either directly or through a Provider.</p> <p>There are arrangements on a pilot basis for personalised budgets whereby a number of approaches are being assessed for the allocation of funding to individuals to use to purchase supports.</p> <p>Where children receive services there is a requirement to have an adult family member present or</p>	<p>The process can be summarised as follows:</p> <ul style="list-style-type: none"> • Identification of need • Assessment of nursing needs • Submission of business case and assessment • Procurement of managed nursing service 	<p>In the context of current legislation, access to home support is based on assessed need and is not means tested. There are a number of steps in the process of accessing home support to include:</p> <ul style="list-style-type: none"> • Application/referral • Care needs assessment • Draft care plan/schedule of service • Decision on HSS application

	to have two staff present at all time		<ul style="list-style-type: none"> • Notification of outcome of application • Service delivery
Assessment of need	<p>Assessment of an individual's needs is conducted through standardised assessment instruments or locally developed tools. In some instances Providers complete assessments and deliver supports accordingly, in other instances, HSE Case Managers have a programme of assessment and allocation of hours with ongoing reviews dependent on need. The HSE is currently trialling two standardised assessment tools and also moving towards a statutory scheme across services which should bring greater consistency of approach.</p>	<p>Work was undertaken to adopt the NHS Northern Irish assessment tool and the Paediatric Community Assessment Tool (P-CAT) was rolled out to the CHOs following an education program in 2019. This tool is an essential component of assessment of nursing need.</p>	<p>Home Support clients are assessed using either an InterRai Assessment or a Common Summary Assessment Report (CSARs) pending the full implementation of InterRai nationally. InterRai assessment will replace, once fully implemented across the CHOs, the paper-based CSARs where it is currently in use. Community based staff, usually public health nurses complete the care needs assessments and in the case of referrals from acute hospitals, the care needs assessment may be completed by Discharge Co-ordinators or Medical Social Workers.</p>
Communication of assessment outcome	The outcome(s) of assessment are communicated in a variety of ways according to the person receiving supports		The outcome of the application for home support is notified to the applicant either verbally (if urgent) or

	<p>or to their primary carer where capacity is an issue.</p> <p>Communication with providers formally may be through the service arrangement process, incident reporting or ongoing informally.</p>		<p>issued in writing, usually within 10-days of the decision being made.</p>
Delivery of formal homecare	<p>There are a range of providers including;</p> <ul style="list-style-type: none"> • Voluntary providers • Lead agencies which offer supports through day or evening respite for adults and services for children. • Private providers • Through HSE direct provision by Older People's Services <p>Some national providers operating across all CHOs should deliver very similar services but there may be some differences between service providers.</p>	<p>Providers include:</p> <ul style="list-style-type: none"> • Lead agencies provide home support. (Also potentially for adults although this is sometimes returned as day or evening respite.) • Primary care (mostly nursing interventions) 	<p>Home support services may be delivered in a number of ways:</p> <ul style="list-style-type: none"> • Directly by the HSE • Voluntary not-for-profit services • Private for-profit services • Through a combination of the above
Monitoring of HSE homecare services	<p>The HSE monitor disability homecare/PA services through ongoing and regular engagement with the individual and their family so</p>	<p>The procured service providers provide governance of PHCP and the HSE at CHO level monitors the delivery of service. Each</p>	<p>HSE directly provided home support services are managed by Home Support Co-ordinators who have line responsibility for Healthcare</p>

	<p>that they are aware of processes like Your Service Your Say, The Confidential Recipient, safeguarding policies. The HSE ensure that an individuals' needs are met as per care and person-centred plans. The HSE also engage on a regular basis with advocacy organisations. It is important to note that HSEs capacity to monitor services intensively is finite due to resources.</p>	<p>CHO has a multidisciplinary governance group that oversees service delivery. At a national level HSE Primary Care operations has oversight of PHCP with clinical input as appropriate from paediatric nursing.</p> <p>Successful providers must enter into a service arrangement with the HSE. The service level agreement includes requirements on Quality and Safety, Service Delivery Specification, Performance Monitoring and other areas.</p> <p>At local CHO level a HSE key worker is identified for each package of care, the package reviews are carried out on a 6 monthly or annual basis by the HSE with the provider.</p>	<p>Support Assistants (HCSAs) assigned to their respective areas. There are 32 Home Support Offices across the CHOs. The HSE aims to deliver home support services in a standardised manner in accordance with the HSE Guidelines. HCSAs employed by the HSE are required to meet minimum eligibility requirements on recruitment and are required to undertake mandatory training programmes.</p> <p>Clients in receipt are reviewed on request or by regular review that is undertaken primarily public health nursing.</p> <p>The HSE operates a complaints policy that enables service users and/or their carers raise issues of concern.</p>
<p>Monitoring of HSE-commissioned homecare services</p>	<p>HSE defines the requirement for safeguarding and protection in the service arrangement. Delivery on this</p>		<p>Each approved home support provider has a service arrangement (SA) with the HSE and management and</p>

	<p>is through engagement with the provider through the service arrangement monitoring and reporting process. Service arrangements compel the provider to assure themselves and the HSE of their processes around quality, safeguarding and protection. They also stipulate that providers must adhere to HSE policies and procedures.</p>		<p>monitoring of SAs is undertaken at CHO level through regular engagements/meetings with each Provider. Providers are also obliged to provide key performance indicator (KPI) data relating to the following metrics: staff training and qualifications, attendance, service delivery, quantum of overall service delivery</p> <p>Procedures for non-compliance are detailed in the service arrangements.</p> <p>The HSE also regularly engages at national level with representative groups for both the voluntary private groups of providers.</p>
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Types of homecare

As can be seen from Table 1.1, there is a variation in the range of homecare that is provided across and within populations as reported by the HSE. However, as far as HIOA is aware, this is the first report that summarises the types of homecare provided across disability, children and older people's services in Ireland, while offering a definition of the types of care that are available. The findings from this fit in with a previous review by Timoney in 2018⁽⁷²⁾ who identified that the type and range of homecare services available are best defined as 'mixed'. It is also possible that homecare services are provided by the HSE and by private, voluntary or not-for-profit providers concurrently, in a hybrid fashion. On another level, there is also no control over who can provide homecare for people in Ireland. That is to say, if organisations are providing homecare outside of HSE funding, then they can in theory deliver any type of homecare. While this research focuses on homecare that is defined in Table 1.1, it also needs to be pointed out that other forms of homecare also exist, particularly palliative homecare which is provided by organisations that work off donations only and other charitable or voluntary organisations that provide services to people who may have very specific needs. It is expected this area will also expand, a situation seen in other areas of health and social care over the last decade.⁽³⁶⁾

Complex care in home services

Within homecare services, complex care packages may also be provided depending on needs and funding availability. However, the definition of complex care differs across services as outlined in Table 1.1. Disability services do not necessarily define complex care but cite it as a bespoke care provided that can include significant nursing involvement, disability or public health. Complex care for children refers to one or more impairments which contribute to a range of significant functional difficulties that require the services and support of an interdisciplinary disability team. In older people's services, a person with complex needs is someone who requires a coordinated response from a number of different healthcare professionals or external agencies and a range of additional support. In older people's services, the HSE identifies that complex does not specifically relate to the range of tasks that need to be provided for or the length of time taken to meet the person's needs, rather that the person is deemed complex. Overall, despite these differences, complex care generally refers to the involvement of specialist nursing care providers and or coordinated supports from multidisciplinary healthcare teams. The provision of complex care is implemented through frameworks of providers for children services, but also through primary, secondary and tertiary services across health and social care for other services.

Formal homecare eligibility

HSE-funded home support services are available to people aged 65 and over and who may need support to continue living at home. Other forms of homecare are available to children and adults with an intellectual disability, autism and or physical disabilities and for children with complex healthcare needs. From an older people's perspective, services may also be needed due to illness, disability or after a stay in hospital or following rehabilitation in a nursing home. In some cases, older people's services may be available to people younger than 65 who need support. For example, people with early onset dementia, a disability or palliative care needs. There are instances where people who do not fall into any of these criteria may be best served by having their needs met by a homecare service, and in this scenario, homecare may be made available through different funding mechanisms available within each CHO. The approach is varied and dependent on the available resources at the time.

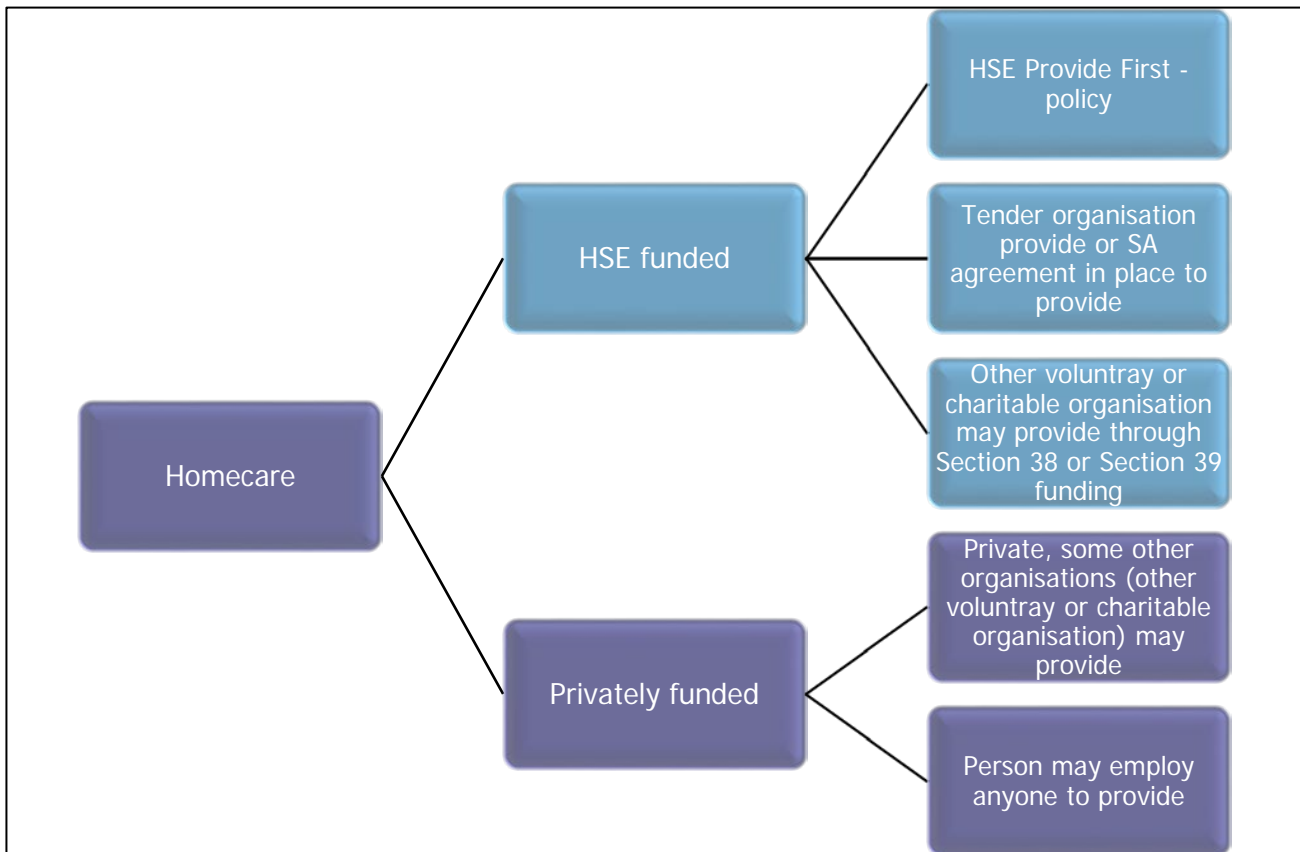
Funding of formal homecare

In order to contextualise the funding of formal homecare, 19 million homecare hours were funded in 2020. This has increased to just under 24 million homecare hours in 2021.⁽⁷⁴⁾ In total, this represents an increase from 10.5 million homecare hours since 2015.⁽³⁴⁾ The HSE informed HIQA that 23.67 million older person home support hours will be delivered to 55,675 people by the end of 2021, and this is inclusive of an additional five million hours funded under the Winter Plan 2020/2021.⁽⁷⁵⁾

In 2021, there are 235 people in receipt of the IHCP scheme and they will receive a proportion of 360,000 hours. From a disability perspective, there are in excess of three million hours provided for home support and over 1.7 million PA hours provided to adults who fall under their remit. Regarding children's services, as of May 2021 the HSE informed HIQA that there are 533 packages of care in place and the number of hours approved is approximately 18,000 per annum.^{†††} Notwithstanding this, it is important to set out that the process behind funding is dependent on what type of service is being provided. Given the variation that exists across the homecare sector, this is broken down in different homecare service types in Figure 1.3.

^{†††} The HSE has identified that the number of hours actually provided will be less than the 18,000 and is primarily impacted by changes in the condition of the child as well as the capacity of the parents to care for the child. COVID-19 has also impacted on the number of hours actually provided as at various stages of the pandemic some parents did not wish to avail of nursing services in the home.

Figure 1.3: Funding and homecare provision



Behind the allocation of these hours, the HSE has a clear process in place for funding the Home Support Service for older people. In the first instance, an application needs to be made to the respective community healthcare organisation (CHO). To determine eligibility, a person's individual needs are assessed to decide what supports they need. If a person is assessed as entitled to receive a home support service, then these supports will be provided by the HSE (this is the first choice), an external provider approved by the HSE or, in some cases, by an external provider where a service agreement has been specifically agreed. This is undertaken through a tender process and outlined in detail in the Home Support Service for Older People Tender 2018 Specification.⁽⁷⁶⁾ Recipients do not need a medical card to apply and their income is not assessed. In these instances, there are no associated costs and the service is free. In other situations where a recipient arranges additional homecare, over and above the level funded by the HSE, then recipients have to pay for this. There are also situations where people may also purchase private homecare in the absence of a formal entitlement or even without applying to the HSE for an assessment of entitlement. This may be through homecare agencies or, in some instances, private individuals. In some situations, tax relief of up to 40% is available on homecare fees.

Regarding the funding of homecare for disability services, there is no tender specification and the HSE informed HIQA that funding for homecare is provided to CHOs in their

annual budget and allocated to service provision accordingly. Disability services would then enter into arrangements with providers for homecare. This may be through Section 38 or 39 service arrangements with providers or contracted on an hourly basis and invoiced accordingly. Under the Health Act 2004, and particularly for Section 39 providers, the provider may identify need and deliver support accordingly and HSE may provide assistance to them for that purpose. For children's homecare services, funding is made available for children under the age of 18 with complex healthcare needs. This is a non-statutory service and access is based on the individual child's clinical needs having regard to available resources and the competing demands for services.

Assessment of need

The absence of legislation has also impacted upon the assessment of eligibility for HSE-funded home support services. The assessment of individuals applying for formal homecare is determined within each CHO and it has been reported that there is no standardisation of assessments used. Many inconsistencies also exist between various CHOs regarding the eligibility of services. Notwithstanding this, the HSE procurement guidance for older people identifies that in order to determine the type of services an individual requires, a care needs assessment must be undertaken. From a HSE perspective, this assessment is undertaken by a healthcare professional, typically a public health nurse, and it must indicate that home support is recommended. The current mode of assessment for older people is through the Common Summary Assessment Report (CSAR)^{§§§§(13)} pending the national implementation of the InterRai standardised assessment. For people with a disability, the assessment is undertaken using standardised or locally developed tools. The HSE is currently trialling two standardised assessment tools within disability services in order to improve consistency in assessment. Children's services have also made progress in implementing standardised assessment tools (see Table 1.1).

It is envisaged that a standardised approach to care needs assessment will facilitate a reduction of fragmentation allowing care planning, and policy decision-making to become effective, coordinated and provide maximum value for money.⁽¹³⁾ In the Department of Health's consultation regarding formal homecare, the SAT was viewed by professional bodies and organisations as integral to the homecare system.⁽⁴⁹⁾ Nonetheless, its implementation is slow. SAT was initially adopted in 2010 and piloted during 2016 and 2017, but it is yet to be fully implemented across Ireland.^{*****⁽⁷⁷⁾} In the context of privately commissioned or procured homecare (for example, those not funded by the

^{§§§§} The CSAR combines assessment information from various sources, creating a single, permanent and transferable report of the information relevant to a decision on an individual's care needs at a given point in time.

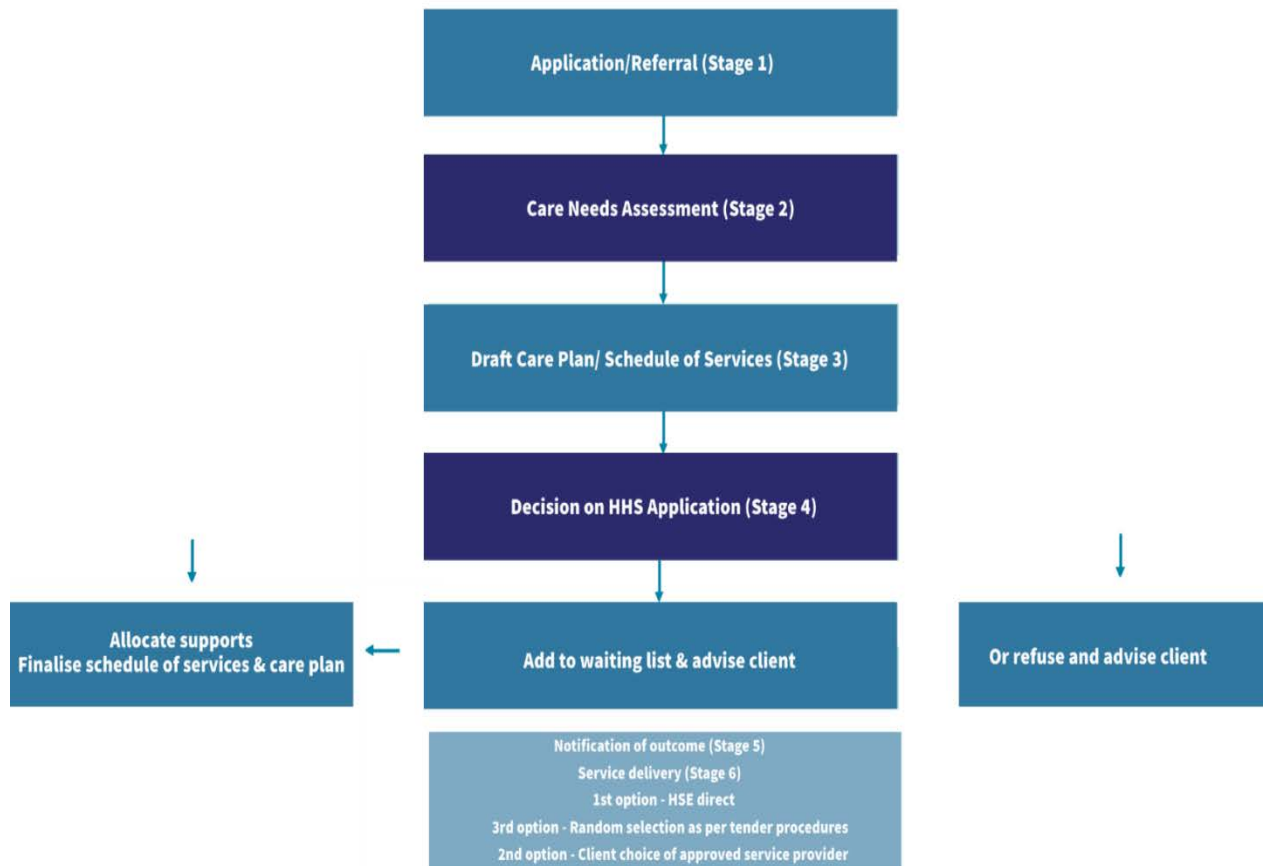
^{*****} In December 2020 the Government announced that funding had been secured for 128 interRAI assessors.

HSE), the assessment of need is not fully known; however, the Home and Community Care Ireland (HCCI) makes broad recommendations towards biological, sociological, psychological and spiritual assessment regarding a homecare recipients' assessment of need in their standards.⁽¹⁴⁾

Delivery of formal homecare

Despite the complexities regarding the provision of home support services for older people, homecare can be provided by or on behalf of the HSE in a number of ways, as outlined in Figure 1.4. Of importance, while the first option is that the HSE provide the homecare service, this is often not available due to the HSE not having the capacity. This is reported to be particularly the case in the East of Ireland. In the second option, the client can choose from a list of approved providers, and in the third instance a random selection of tender providers are chosen. The Home and Community Care Ireland (HCCI) (HCCI is an umbrella organisation representing a significant number of private homecare providers in Ireland) has highlighted some negative aspects to this process in older people's services, where they cite the 'random selection of homecare providers' where a 'fastest responder first' model is used as particularly inadequate.⁽⁴¹⁾ In this scenario, services are allocated on the basis of which service provider responds first after being emailed out a tender detailing the needs of a person requiring homecare.⁽⁴¹⁾ In addition to the process outlined below, private providers will have their own processes in place where people can pay them directly for homecare services provided. There is no control over what these processes can and cannot entail. However, in return, such costs can be offset for tax purposes by individuals. It is also entirely possible that people can purchase services from someone who may not be a provider of homecare services, but in a 'cash for care' or 'black market' agreement. This would be outside the scope of informal care as it includes a cash payment.

Figure 1.4 HSE-funded home support services process



Regarding disability service provision there is no national process (like older people’s services) and the delivery of homecare is through a mix of HSE direct provision, voluntary Section 38 and 39-funded service providers, and private providers. In children’s services, a procurement exercise was undertaken to put in place a framework of providers of nursing services for children with complex healthcare needs in the home. Essentially, when funding is approved for a new homecare package for a child, the local CHO area conducts a procurement exercise inviting each of the framework providers to apply to provide services for the child. The successful provider then enters into a service arrangement with the HSE.

Monitoring of homecare services

On the first tier, the HSE has *National Guidelines for the Standardised Implementation of the Home Support Service*.⁽¹³⁾ This sets out how the Home Support Service for older people operates as a single-funded service helping to streamline delivery and make the services easier to move through as assessed needs. On another tier, the HSE, through a tendering process for older people, has service specifications that are assessed against when deciding which non-governmental homecare organisations are to be awarded service contracts (this tender happened every two years since 2016, but was delayed for

2020 due to COVID-19). These service specifications, referred to as standards,⁽⁷⁶⁾ are founded on the *National Standards for Safer Better Healthcare* developed by HIQA in 2012.⁽⁷⁸⁾ Successful tenders, referred to as 'approved providers', are then monitored by the HSE through a 'Management and Monitoring of Service Arrangement'.⁽⁷⁹⁾

In disability services, the HSE monitors disability homecare services through ongoing and regular engagement with the individual and their family so that they are aware of processes like Your Service, Your Say, the Confidential Recipient, safeguarding policies. However, the HSE said they do not have capacity to monitor services intensively due to finite resources. In children's services, there is a comprehensive framework in place for both oversight and monitoring homecare packages as outlined in Table 1.1. Across the homecare sector, service agreements are commonly used. The service agreements broadly define requirements for safeguarding, protection, key performance indicators and governance agreements between the HSE and the provider. Generally, the monitoring and management of these service level agreements are undertaken at a CHO level.

To add another layer of complexity, the HCCI also introduced its own *National Standards for the Provision of Home Support Care Services* in 2012⁽¹⁴⁾ to try and bring some coherence and standardisation to homecare for its members. These have been periodically updated. The HCCI also audits its own members to ensure they are meeting its own standards. The consequence of this has resulted in some private homecare providers using many different approaches towards maintaining a quality assurance process. However, the situation is not entirely clear and there is an evident lack of clarity and understanding in this area.

Discussion

Notwithstanding some of the aforementioned difficulties, there has been a significant effort to develop a statutory framework for the provision of homecare in Ireland. Over the last decade, the Health (Professional Home Care) Bill 2012, the Health (Professional Home Care) Bill 2014 and the Health (Amendment) (Professional Home Care) Bill 2016 all lapsed with the dissolution of the Dáil and Seanad when a change in government occurred. Despite this, the Health (Amendment) (Professional Home Care) Bill 2020⁽¹⁹⁾ is currently in the second stage and has been adjourned for 12 months (until October 2021)⁽²⁰⁾ to allow the Irish Government to consider the development of an appropriate bespoke regulatory framework. The Government has agreed that homecare needs a statutory footing; however, disagree with the proposal to amend the Health Act (2007) (as amended) (the 2007 Act) to provide a legislative basis for this. Nonetheless, this along with Sláintecare's⁽³⁴⁾ commitment to increase the homecare provision budget is a clear signal of the Government's commitment to address the disconnect between legislation and 'real-world' homecare practices. Alongside this, the HSE has also made significant strides to try and develop processes to improve the homecare sector,

particularly for older people, over the last decade. Since the first tender for older people's homecare was commissioned in 2012, this was perceived as a significant stride to get the providers of homecare 'regulation ready'. These tenders have helped the sector to develop; however, it could be argued that they need to also include people with a disability as the current process appears to be inconsistent across CHO areas.

The drive to address this disconnect between policy and practice may potentially create some significant unintended consequences. Up to this point in time, the HSE has broadly focused on the concept of 'home support services', which is narrower than homecare as it does not consider complex care services or the professional services of nurses, various therapies, palliative care or clinical tasks that may be provided for in the homecare environment. HIQA has previously identified the difficulty it experiences where there is an absence of definition of what is meant by 'care' or 'care and maintenance'⁽⁸⁰⁾ within its remit for regulating designated centres under the 2007 Act. For example, other countries (such as England, Scotland and Northern Ireland) have provided a definition of care in their legislation, most often broken down into categories of personal or nursing care (referred to as regulated activities in England, for example). Therefore, HIQA believes that clarity is needed regarding what the Government considers homecare to be, especially as there are various elements that intersect health and social care across disability and older people's services, while children's complex care is a predominantly nursing service.

For example, from a disability perspective the HSE informed HIQA that there are instances where it procures services from specialist nursing care providers where people may have significant needs (for example, tracheostomy care, respiratory care [suctioning], percutaneous endoscopic gastrostomy feeding and bowel management). In addition, there are homecare services in the older people's sphere, particularly with IHCP, where people have high levels of needs. While IHCP does not fund nursing care as such, if nursing services are required at local CHO primary care level, nursing care may be contracted out to private providers if it does not have the capacity to deliver this. Therefore, it is accurate to conclude that there are instances where nursing and personal care are being provided by homecare providers in the person's own home. It is envisioned that this will become more widespread in the short to medium term as there is a new joint venture where the IHCP scheme is working along with a complex case home support team and disability services to facilitate complex discharges from acute settings to people's own homes.

Consequently, if homecare is limited to exclude the professional services of nurses, various therapies or palliative care, the Government must be clear on what protective measures are in place to provide assurances that people in receipt of such services are protected from harm. For example, difficulty may arise if a provider is providing both personal and nursing care, but is only regulated for the personal care activity.

Additionally, the underpinning ethos that services should be integrated and based on need should to be a reinforcing factor within this consideration.

From a policy perspective it is also clear that there are many issues regarding homecare that require close attention. A number of these issues are broadly concentrated on the incoherent, or absence of, standardisation or quality assessment of homecare across public, voluntary or not-for-profit and private homecare services. The lack of 'equally applied' (public vs other providers) standards complicate this further. Additionally, issues with commissioning, procurement and assessment of the quality of formal homecare provision create an environment which is not wholly independent, as the HSE has conflicted roles as a service provider, commissioner and 'proxy-regulator' of homecare.⁽⁶⁶⁾

The lack of independent oversight — such as regulation — does not provide assurances to the public, people in receipt of homecare or their families, and this is a significant concern. Most importantly, before any of these issues can be addressed, it is critically important that the scope of homecare is clearly operationalised, but consideration is also given to what impact this definition may have on the trajectory of service provision.

Plain language summary of Chapter 1

With improvements in healthcare, a growing population, and people living longer, more people will need more support as they age in the future. Many people would prefer to age and be cared for in their own home. Most of the homecare in Ireland is provided by family, friends or neighbours. If formal homecare is required, this is delivered by the HSE or by a private, voluntary or charitable organisation. The HSE calls this 'home support services for older people'. However, home support is not the same as homecare, as it does not include professional services or therapies, such as nursing care. Other types of homecare are available to people who might have an intellectual disability, autism and or physical disabilities and for children with complex healthcare needs. In this report, homecare is used to describe 'paid care that is undertaken inside a person's front door'.

In Ireland, there is no legal requirement to provide homecare. Although there are some controls on the providers that deliver publicly-funded homecare, there is no regulation, or independent oversight, or homecare in Ireland. There are also no national standards that the HSE, private, voluntary or charitable providers need to meet in order to provide a homecare service. As well as this, how an individual's needs are assessed in order to receive homecare differs. This needs to be made consistent across all providers of homecare.

HIQA has significant concerns about the current situation of homecare in Ireland. There are no assurances to the public, people receiving homecare or their families, that homecare is safe and of good quality.

Efforts are underway by Government to ensure that all homecare services meet a clear level of quality. Regulation will provide fair and improved homecare services for everyone, giving the people receiving homecare greater levels of protection and confidence in the service. However, it is very important that homecare is clearly defined and understood by everyone first.

Chapter 2: Current 'as is' picture of the private homecare landscape in Ireland

Background

Chapter 1 identified the complexities that exist surrounding the terminology, provision and oversight of homecare services in Ireland. It is clear that the landscape is difficult to understand and the parameters and variability are potentially wide ranging and fragmented. From a HSE perspective, the National Guidelines and Procedures for the Standardised Implementation of the Home Support Service (HSS Guidelines)⁽¹³⁾ clearly set out the arrangements for the management and engagement of the funded home support service for older people. However, it appears that the provision of homecare services are much wider than 'home support services' or, if this is not wholly accurate, then they are being described in this way by many providers. This is evidenced by many homecare providers offering personalised, one-on-one care in the areas of rehabilitation, re-enablement, diabetes, palliative or end-of-life care, arthritis, Parkinson's disease, live-in homecare, dementia care, companionship, concierge and post-surgery care. While this is a non-exhaustive list, it illustrates the complexity of how the language and services used in this sphere of care may give rise to misinterpretation. That is to say, it is not clear on what homecare is and what homecare is not.

Considering this, Chapter 2 presents HIQA's research to better understand the scope and breadth of homecare services and to determine the difficulties and challenges service providers face. HIQA carried out an online survey and focus group interviews with service providers and relevant stakeholders who advocate on behalf of people who may require homecare services.

Methodology

This was not a national engagement, rather a very specific point in time scoping exercise. In December 2020, HCCI distributed an online survey to its mailing list of homecare providers on behalf of HIQA. This list included both HCCI members and non-HCCI members such as voluntary and not-for-profit agencies. HCCI is the national membership organisation for companies that provide a managed formal homecare service in Ireland. This survey was broad in nature and asked questions relating to the range of services private and voluntary homecare providers offer, the difficulties they encounter, and the areas they consider that standards and regulation should focus on in Ireland. Respondents were also invited to identify people who may be interested in taking part in a focus group interview. The survey also identified some areas that the focus groups would concentrate on.

Approach towards analysis

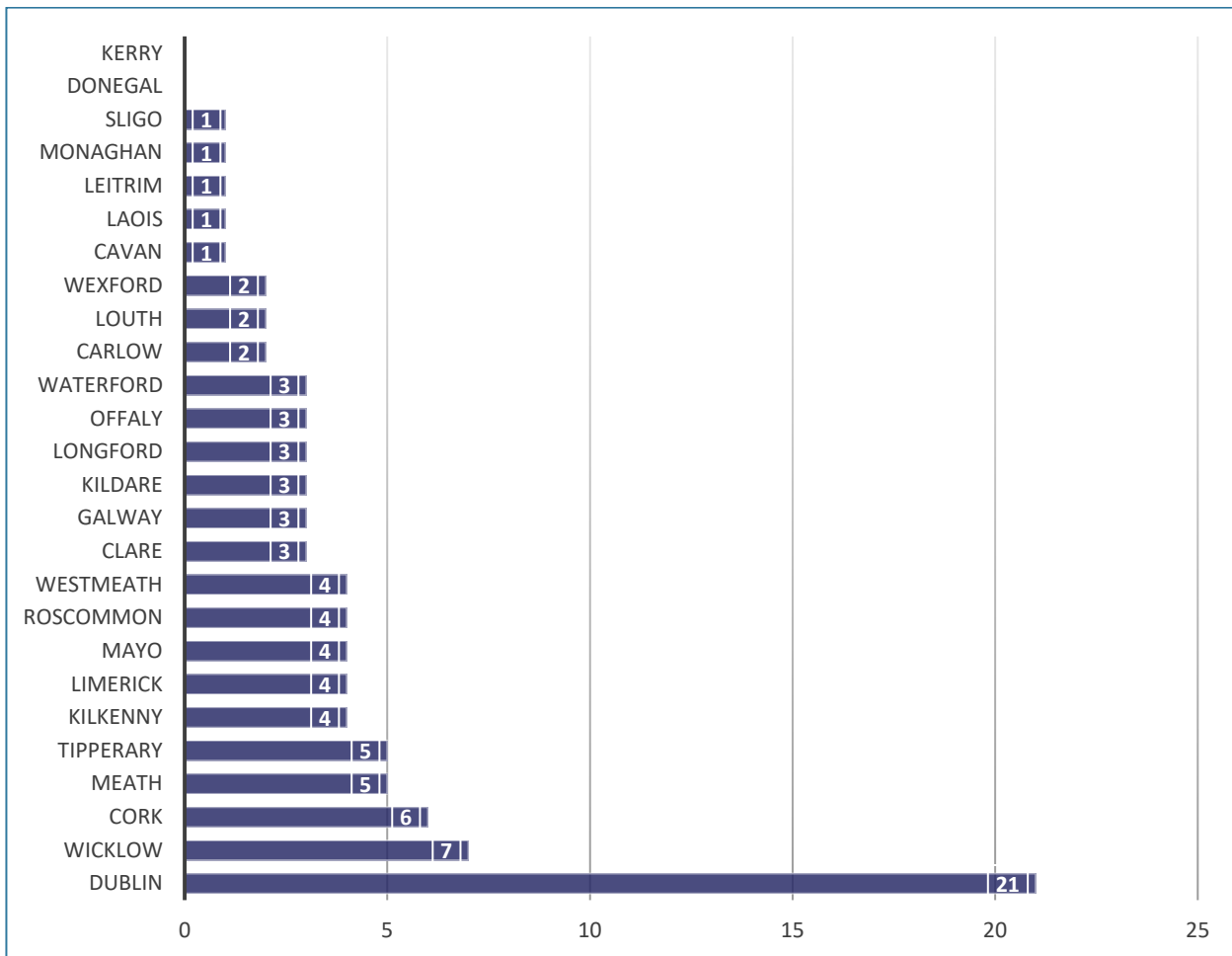
Simple descriptive statistics were used to describe participants' responses. As there was wide variability in the range and size of services who responded, medians and interquartile ranges (IQR) were used to describe the data. This gives a more accurate overview of central tendency, thus describing the respondents more appropriately.⁽⁸¹⁾ In order to analyse open-ended text, all responses were imported into a Microsoft Excel file. These responses were coded into higher-order categories and counted quantitatively.⁽⁸¹⁾ From this, the frequency of responses were reported on in a hierarchical fashion and, for ease of interpretation, word clouds were used to describe the free-text data to provide context. For questions relating to disability, the term disability was aligned to the Disability Act 2005 (as amended)⁽⁸²⁾ to mean: "a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the Irish State or to participate in social or cultural life in the Irish State by reason of an enduring physical, sensory, mental health or intellectual impairment."

Six focus groups were held in February and March 2021. A total of 42 organisations expressed an interest in participating. An interview schedule was used to guide the focus groups. As the aim of this research was to understand the landscape of homecare from a delivery perspective, rather than to reconcile conflicting definitions of a problem, thematic analysis was conducted.⁽⁸³⁾ This was seen as a practical way to organise and present the findings from the focus groups.

Survey results

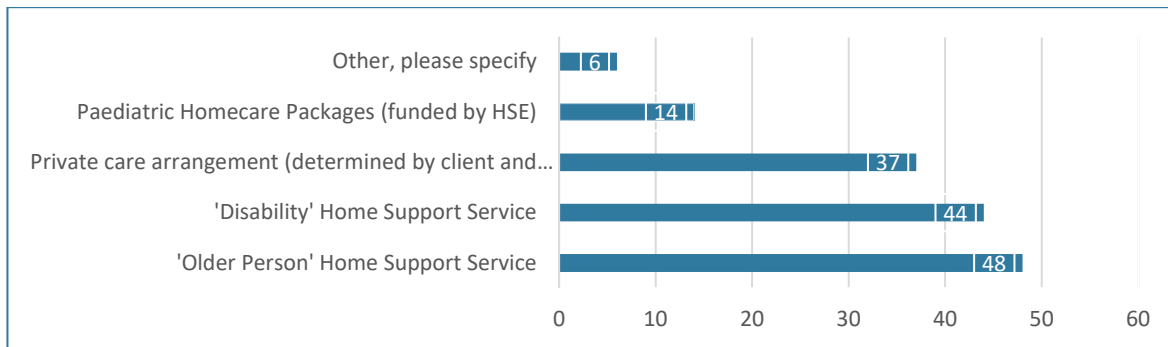
In total, 49 responses were received from homecare providers. Of these, 73% (n=36) were private homecare providers and 27% (n=13) were voluntary, charitable or not-for-profit homecare providers. Almost all (98%) responses were from HSE-approved home support providers for older people and, where this was not the case, the homecare provider had a specific service-level agreement to provide homecare services on behalf of the HSE. Seven responses reported they provided services throughout all of the Republic of Ireland. Figure 2.1 demonstrates the geographical overview of services provided by respondents.

Figure 2.1: Geographical overview of the self-reported provision of homecare based on respondent responses (n=49)



Thirty-six respondents (73%) reported that they provide services to all age ranges of people who require homecare services, whereas 11 (22%) respondents provide services to adults (18–64 years) and older people (65 years and older) only. Less than five respondents reported that they provide services to older people only (65 years and older). All respondents reported that they provide services for people with a disability. Eighty-six percent (n=42) of respondents identified that they provide Intensive Home Support Packages (IHSP), while 49% of respondent identified that the provide Consumer Directed Homecare (CDHS) (n=24). Forty-two respondents (86%) reported that they provide services on a 24/7 basis if required, while seven respondents (14%) reported that they provide services on a seven-day basis but not at night-time. The frequency of ‘type of services’ provided are broken down in Figure 2.2.

Figure 2.2: Frequency of provided homecare service (n49)



Other, please specify includes responder services, meals on wheels, reablement services,^{††††} mental health homecare, private physiotherapy services, day service, autism services

Given the variation in the scope of what constitutes homecare identified in Chapter 1, respondents were asked to identify any other homecare service they provided in addition to the services previously outlined. These findings are displayed in a word cloud in Figure 2.3. As seen from the data, there is significant variation in what 'homecare' service providers provide, or what they consider homecare services to be. This is perhaps indicative of the difficulties with terminology and language used in this sector.

Figure 2.3: Word cloud outlining services provided by homecare providers



Respondents reported supporting a median of 285 (IQR 159-850) homecare clients, which ranged from 50 to 8,000. When larger providers were excluded from analysis (for example, nationwide providers), this median reduced to 60 (IRQ 145-500) ranging from

^{††††} Reablement is a person-centred approach that helps individuals to learn or re-learn the skills necessary to be able to engage in activities and or occupations that are important to them.

50 to 3,500. Similar variances were identified when respondents identified how many 'whole-time equivalent' homecare staff they employ. A median of 60 (IQR 35-100) staff were reported, ranging from 10 to 2,000. Again, excluding larger providers, the median remained the same at 60 but the range was reduced (IQR 10-900). It was difficult to infer how many staff were employed in a clinical capacity.^{****} For example, clinical staff would include qualified nurses or other healthcare professionals who must register with a professional body or regulator and who are providing tasks that cannot be delegated. Out of 42 (86%) responses, only seven respondents (14%) did not employ any clinical staff and the remainder of respondents did.^{sssss} Overall, the majority of staff employed were non-clinical. If employed staff were clinical, they only made up a small percentage of the providers workforce (range of >1% to 20%). This was evident insofar as 38 (78%) of all respondents reported that they did not undertake any clinical tasks that can only be undertaken by registered health and social care professionals.

Of interest, 11 respondents who identified that they provided clinical services, did so for paediatric homecare packages (in 10 out of 11 responses), for disability homecare packages (in 8 out of 11 responses) in older persons home support services (in 5 out of 11 responses) and in private care arrangements which are determined by the client and provider (in 4 out of 11 responses). Relating to older people's home support services and private care arrangements, the fact that a number of providers report that they provide clinical services is perhaps a manifestation of some of the contextual issues outlined in Chapter 1.

Challenges associated with providing homecare services

In order to gauge how homecare providers find providing different aspects of homecare, a five-point Likert scale ranging from 'very difficult' to 'very easy' was used. These findings are presented as aggregated data in the form of a Heatmap in Table 2.1.

^{****} This was identified as those undertaking nursing, physiotherapy or occupational therapy tasks that cannot be delegated to another homecare worker.

^{sssss} In the most recent tender for older persons it outlines that the service provider must ensure that there is a management structure and clinical governance oversight in place, including clear lines of accountability, which enables the service provider to deliver services effectively on a 24/7 basis. This information including contact details is communicated to all relevant parties – client, provider staff and HSE.

Table 2.1: Heatmap representing aggregate responses on difficulty of providing different aspects of homecare services

How difficult do you find the following activities:	Very				Very easy
	difficult	difficult	Neutral	easy	
Employing and retaining personnel to work in homecare	18 (36.73%)	25 (51.02%)	5 (10.2%)	0 (0%)	1 (2.04%)
Ensuring homecare workers have the competency to undertake the allocated work	1 (2.08%)	9 (18.75%)	24 (50%)	13 (27.08%)	1 (2.08%)
Providing supervision to homecare workers	1 (2.04%)	8 (16.33%)	21 (42.86%)	16 (32.65%)	3 (6.12%)
Assessing environmental risks, such as risks posed in people's homes (for example, slips and falls), to those providing homecare services (for example, risk of injury)	1 (2.04%)	6 (12.24%)	21 (42.86%)	16 (32.65%)	5 (10.2%)
Ensuring the homecare environment is safe for homecare workers to undertake their role	0 (0%)	13 (26.53%)	20 (40.82%)	13 (26.53%)	3 (6.12%)
Evaluating the services that homecare workers provide to homecare clients	1 (2.04%)	3 (6.12%)	20 (40.82%)	22 (44.9%)	3 (6.12%)
Implementing care planning and ongoing assessment of the needs of the client	0 (0%)	4 (8.33%)	19 (39.58%)	20 (41.67%)	5 (10.42%)
Evaluating the effectiveness of care planning and assessment	0 (0%)	3 (6.38%)	24 (51.06%)	17 (36.17%)	3 (6.38%)
Monitoring and auditing the quality and safety of the homecare services you provide	0 (0%)	6 (12.24%)	26 (53.06%)	14 (28.57%)	3 (6.12%)
Ensuring the appropriate documentation and recording of the services you provide	0 (0%)	7 (14.29%)	23 (46.94%)	17 (34.69%)	2 (4.08%)
Ensuring those receiving homecare services are protected from harm (for example, risk of abuse)	2 (4.17%)	8 (16.67%)	25 (52.08%)	12 (25%)	1 (2.08%)

Note: Red indicates most responses and green indicated the least responses

As can be seen from the data, employing and retaining personnel to work in homecare has been reported as the principal issue that causes the most amount of difficulty for homecare providers. Almost 88% percent (n=43) of homecare providers found this

difficult or very difficult. Twenty-seven percent of respondents (n=13) reported experiencing difficulties in ensuring that homecare environments are safe for homecare workers. This was the second most prominent difficulty described by respondents. Apart from the employing and retaining of homecare staff, more than 25% of respondents found all the other tasks posed as 'easy' or 'very easy' (range: 27.08% to 52.09%). Nonetheless, across the majority of questions posed to respondents, the heat map identifies that most responses were congregated around the 'neutral' response. This tendency to report a neutral position cannot be extracted or accounted for. However, it is possible that this large amount of neutral responses are a result of: the presence of social desirability bias, ambivalence (balance of positive and negative affect) and or indifference (lack of either affect) about the difficulty associated with the questions posed indicating that:

1. Respondents answered in a manner that will be viewed favourably
2. Respondents have identified these issues as a potential issue and have mitigated for it so they are neutral as to the difficulty now, or
3. Respondent do see this as an issue and therefore are neutral regarding the difficulty.

What do you consider to be the greatest risk to people delivering and receiving homecare services?

In the next stage of analysis, the following open-ended questions were analysed:

- 1) What do you consider to be the greatest risk to people delivering homecare services?
- 2) What do you consider to be the greatest risk to people receiving homecare services?

Providers cited lone working as being the greatest risk to people delivering homecare services, with 19 respondents identifying this as a concern. Some examples provided related to inappropriate or challenging behaviour by people in receipt of services, boundary issues and risk of abuse or allegations of misconduct. In addition, COVID-19 and other communicable diseases, staff turnover, financial pressures of service providers and health and safety issues relating to staff wellbeing were identified as the top five risks identified by respondents. Respondents also cited poor governance as being a significant risk for people delivering homecare services. Finally, a lack of clarity surrounding commissioning of services was also reported as a significant risk insofar as homecare providers cannot offer care staff guaranteed contracts due to the nature of the homecare commissioning process. Figure 2.4 outlines a hierarchical representation of the greatest risks identified and a word cloud provides examples of the examples provided by respondents.

The greatest reported risk reported in relation to people receiving homecare services was described as being a poor quality or unfulfilled service (n=23). This specifically related to

poor assessment processes, poorly implemented care plans, a lack of oversight of homecare and poor care in general. From an unfulfilled service perspective, this specifically related to continuity issues whereby homecare provision was interrupted by frequent carer changes, carer absence, missed homecare calls and an inability to provide care at the right time and across all regions of Ireland. While this is potentially related to the underfunding of services, the underfunding of services was identified as a distinct category (n=16) insofar as respondents identified that people were at risk because the HSE did not fund enough services, or when they did, it was not enough to meet a person's need. Furthermore, it was also highlighted that there was no funding for preventative homecare packages. The risk of abuse and safeguarding (n=14) was also frequently cited as a significant risk. This generally related to physical, psychological and financial abuse. Respondents cited people who used homecare services as being very vulnerable and identified the lack of standardisation and regulation (n=8) as being a significant risk for this vulnerable population. Issues regarding recruitment and training (n=11) were also seen as a risk and this broadly centred on recruiting poor quality staff and a lack of appropriate training and supervision, environmental issues (n=7) such as slips, trips and falls. COVID-19 and other communicable diseases (n=6) were also highlighted as a significant risk to people receiving homecare services. Figure 2.5 outlines a hierarchical representation of the greatest risks identified and a work cloud provides examples of the examples provided by respondents.

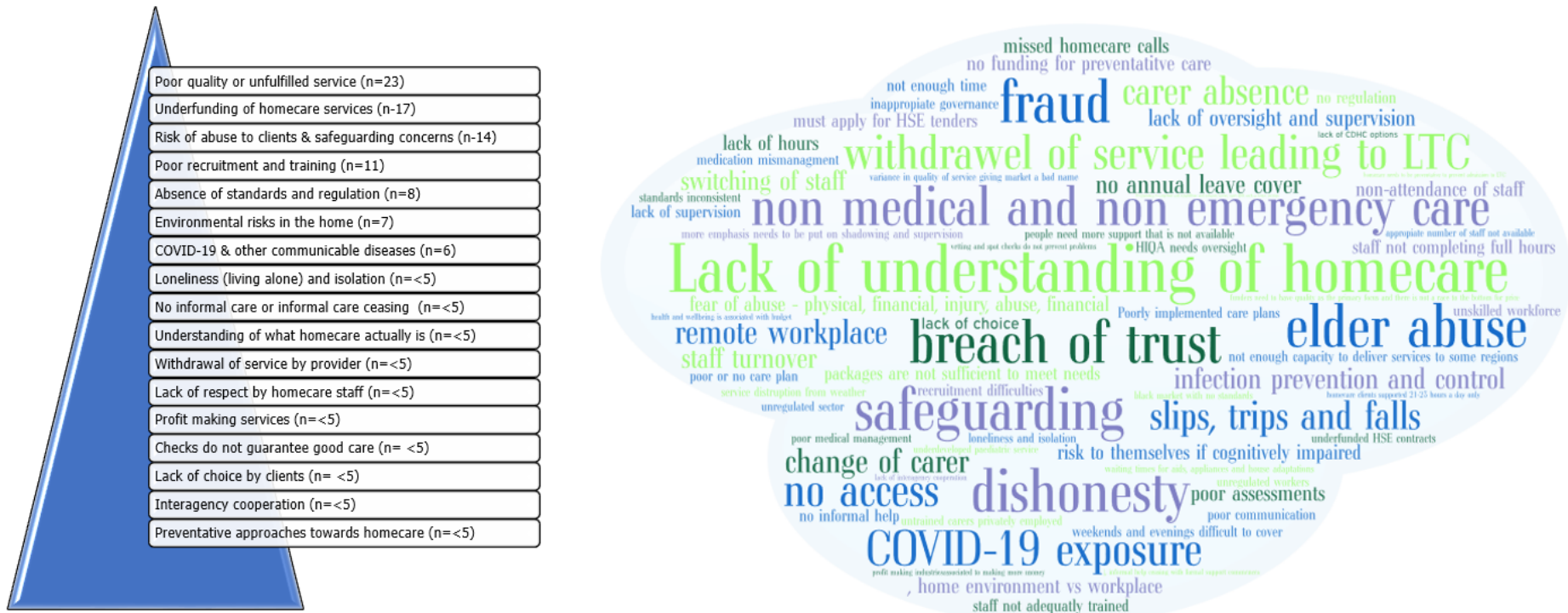
Figure 2.4: Categories identified as being the greatest risk to people providing homecare services (response n=48)

Lone working (n=19)
COVID-19 & other communicable diseases (n=11)
Staff turnover (n=10)
Financial pressures on homecare providers (n=9)
Health & safety issues for staff delivering homecare (n=7)
Unsafe houses (n= <5)
Issues with screening, training & career progression (n=<5)
Not enough allocated time to provide support (n=<5)
Governance (variation in governance by providers) (n=<5)
Commissioning problems (lack of clarity) (n=<5)
Vulnerability of staff (fear of blame) (n=<5)
Poor care plans (n=<5)
Not having tools (e.g hoists) to complete tasks (n=<5)
Medication mismanagement (n=<5)
Lack or no access to public transport (n=<5)
Lack of regulation in the sector (n=<5)
High dependency of homecare clients (n=<5)
Expectation of what homecare services can provide (n=<5)
Discrimination towards staff (n=<5)



* Note: The categories are presented in this figure are presented in hierarchical order above 'n=5' with lone working being the most frequently identified risk

Figure 2.5: Categories identified as being the greatest risk to people receiving homecare services (response n=48)



* Note: The categories are presented in this figure are presented in hierarchical order above 'n=5' with poor quality or unfulfilled service working being the most frequently identified risk

Free-text responses

In the final stage of the survey, respondents were asked what they thought homecare regulation and national standards should focus on. These free-text responses (n=48) were condensed and are outlined in Table 2.2. These responses are organised across three themes: Quality and safety, Capacity and capability, and Government, HSE and regulator considerations. This demonstrates the need for a provider to have capacity and capability in order to provide a safe and high-quality service. It also highlights the interdependent and interconnected nature of homecare and emphasises the importance of robust systems and processes with appropriate oversight. This is in line with HIQA's other programmes of inspection and monitoring under the 2007 Act. Regarding the 'Government, HSE and regulator considerations', these were outside the scope of the other two themes, but nevertheless, they are determined as important considerations in the context of developing regulation and standards in the area of homecare.

Table 2.2: Respondents view of what regulation and standards should focus on

Quality and safety	Capacity and capability	Government, HSE and regulator considerations
<ul style="list-style-type: none"> ▪ Advocacy is available 	<ul style="list-style-type: none"> ▪ Appropriate infrastructural links. For example, there are links in with local HSE governance structure, such as Community Healthcare Network 	<ul style="list-style-type: none"> ▪ Align to current HIQA <i>National Standards for Safer Better Healthcare</i>⁽⁷⁸⁾
<ul style="list-style-type: none"> ▪ Apprenticeship model of staff development – for example, learning on the job and attaining a QQI qualification in a certain timescale 	<ul style="list-style-type: none"> ▪ Carers should be supported and provided with supervision and guidance 	<ul style="list-style-type: none"> ▪ Ensure privately commissioned care does not negatively impact (for example, reduce) HSE homecare hours
<ul style="list-style-type: none"> ▪ Care needs to be compassionate 	<ul style="list-style-type: none"> ▪ The service provider undertakes routine inspections of service provision 	<ul style="list-style-type: none"> ▪ Ensure there is regulatory balance
<ul style="list-style-type: none"> ▪ Care needs to be effective 	<ul style="list-style-type: none"> ▪ Roles of people involved should be clarified 	<ul style="list-style-type: none"> ▪ Regulation should avoid unnecessary operational bureaucracy that may inflate costs that are not funded
<ul style="list-style-type: none"> ▪ Carers need to be competent to deliver services 	<ul style="list-style-type: none"> ▪ Service provider ensures that there is an appropriate delivery of homecare services 	<ul style="list-style-type: none"> ▪ Be explicit on what the scope of homecare involves
<ul style="list-style-type: none"> ▪ Ensure that there are proper processes for risk assessment and risk management 	<ul style="list-style-type: none"> ▪ Ensure that there are appropriate governance structures (includes clinical) and good systems in place 	<ul style="list-style-type: none"> ▪ Consider the registration of healthcare workers
<ul style="list-style-type: none"> ▪ Clients and carers needs to be protected 	<ul style="list-style-type: none"> ▪ Relevant to service provision, policies and procedures are in place and accessible 	<ul style="list-style-type: none"> ▪ Define what homecare is – this needs to be broad

<ul style="list-style-type: none"> ▪ Clients need to be treated as an equal and having dignity upheld 	<ul style="list-style-type: none"> ▪ There are processes in place to learn from errors and from when things go wrong 	<ul style="list-style-type: none"> ▪ Ensure regulation and standards are achievable
<ul style="list-style-type: none"> ▪ Clients should have choice 	<ul style="list-style-type: none"> ▪ Processes are in place for how information is used or shared 	<ul style="list-style-type: none"> ▪ Ensure regulated entry into system
<ul style="list-style-type: none"> ▪ Flexibility needs to be built in to services 	<ul style="list-style-type: none"> ▪ Hold appropriate insurance to provide services 	<ul style="list-style-type: none"> ▪ Ensure appropriate funding systems exist for providers
<ul style="list-style-type: none"> ▪ Homecarers should be paid a wage that is in line with HSE staff and receive travel time 	<ul style="list-style-type: none"> ▪ There are appropriate controls and processes in place if technology is used 	<ul style="list-style-type: none"> ▪ Ensure that there are appropriate homecare hours in place to provide a commissioned service – a governance model is required between contracting authority and provider to allow for this and also to enable flexibility and choice in care planning
<ul style="list-style-type: none"> ▪ Homecare should be person centred 	<ul style="list-style-type: none"> ▪ There are appropriate use of resources 	<ul style="list-style-type: none"> ▪ The role of the public health nurse is defined
<ul style="list-style-type: none"> ▪ Staff undertake a bespoke 'homecare qualification' – set educational requirements 	<ul style="list-style-type: none"> ▪ There needs to be a contract between the client and service provider for services provided 	<ul style="list-style-type: none"> ▪ Uphold carer rights and provide protection for carers
<ul style="list-style-type: none"> ▪ There is an overall focus on quality and safety 	<ul style="list-style-type: none"> ▪ Have processes and contingency plans in place to manage staff turnover 	
<ul style="list-style-type: none"> ▪ The should be a focus on improving quality of life 	<ul style="list-style-type: none"> ▪ Staffing levels are appropriate and safe for the levels of services provided 	
<ul style="list-style-type: none"> ▪ The should be a focus on medication management 	<ul style="list-style-type: none"> ▪ The service provider has a register of all carers 	
<ul style="list-style-type: none"> ▪ Ensure that there are appropriate safeguarding processes in place 	<ul style="list-style-type: none"> ▪ Have leadership and management systems and processes in place that are fit for purpose and effective 	
<ul style="list-style-type: none"> ▪ There needs to be a transparent complaints process 	<ul style="list-style-type: none"> ▪ There is safe accident and incident reporting systems and processes 	
<ul style="list-style-type: none"> ▪ Provide training, education and continuous education (development) for staff - clinical professionals such as nurses or allied healthcare professionals are employed to provide clinical oversight of training 	<ul style="list-style-type: none"> ▪ Service provider conducts internal auditing 	

<ul style="list-style-type: none"> ▪ There needs to be consistency and continuity – for example, being provided care (client) and providing care (staff) 	<ul style="list-style-type: none"> ▪ Undertake vetting and reference checks and have appropriate recruitment and human resource processes in place 	
<ul style="list-style-type: none"> ▪ There should be a focus on carer wellbeing 	<ul style="list-style-type: none"> ▪ The provider has a process in place for maintaining the quality of scheduling and matching homecare clients and staff 	
<ul style="list-style-type: none"> ▪ There should be a focus on customer experience 	<ul style="list-style-type: none"> ▪ There needs to be care plans that are properly implemented, reviewed and evaluated – this should include advance care planning 	
<ul style="list-style-type: none"> ▪ There should be a focus on dementia 	<ul style="list-style-type: none"> ▪ There should be multidisciplinary involvement 	
	<ul style="list-style-type: none"> ▪ Ensure that services are only responsible for the quality and safety of care provided whilst visiting and providing that service 	
	<ul style="list-style-type: none"> ▪ Ensure provider has a regional presence to provide local oversight 	
<ul style="list-style-type: none"> ▪ Shared decision-making is inherent across all decisions 		

Focus group results

Six focus groups were held with 34 participants. These represented private providers (n=13), not-for-profit, charitable and non-governmental organisations who provide homecare (n=16) and other organisations which advocate on behalf of homecare provision for various populations (n=5). Each focus group lasted approximately two hours and all data was transcribed into a Microsoft Word Document. Firstly, the raw data was read a number of times in order to become familiar with the data. Initial codes were then generated using line-by-line coding techniques. From this, themes were generated which grouped data that focused on similar topics. These themes were then reviewed, defined, and ordered into themes, sub-themes and categories. These themes were validated by a second researcher who attended the focus groups to ensure they were reflective of the focus groups. In total, three themes were identified:

- (1) positives of the homecare landscape;
- (2) what does not work well in homecare;
- (3) and what needs improvement.

These thematic analyses are outlined in tables 2.3, 2.4 and 2.5.

Theme 1: Positives of the homecare landscape

When discussing the current positive facilitators to the provision of homecare, governance and management, and commitment to client groups were identified as sub-themes. The thematic analysis is outlined in Table 2.3.

Self-Governance and Management

The analysis identified that there was a very strong sense of self-regulation that already exists in this sector. This was self-reported as a real strength in current provision by respondents. Providers identified how they had robust processes, policies and procedures in place. These included vetting, monitoring of care, incident reporting, safeguarding processes and operating through a human rights framework that puts the person at the centre of the process. This was reported across all types of providers:

Voluntary or not-for-profit provider: "All staff have QQI or FETAC training, competency assessments, ongoing training, COVID-19 training, mandatory training, PCC training, clear guidance."

The oversight from the HSE tender was welcomed and the competency assessments that are currently in place through the HSE tender were also seen as positive. This was described by one participant who reported that regulation existed in theory, but it was not monitored consistently across CHOs:

Voluntary or not-for-profit provider: "should be known that sector is regulated in theory by tender, but it is not [sic] policed."

Commitment to client groups

Across respondents, there was also a strong sense of commitment towards providing services that meets the needs of their client groups. For example, providers identified that they ensured that staff had the proper training, and they were appropriately matched with the client. While undertaking quality assurance visits, providers ensured the client was satisfied with the service being provided. There were significant sectorial elements that supported this commitment too in the form of informal care givers; this is the concept of spontaneity and meeting residents' needs at that point in time relative to their needs. In addition, providers were also committed to providing a variety of work to their staff as this was considered to be conducive to staff retention and better outcomes for clients. Interestingly, the impact of COVID-19 was also identified as having some positive impacts on the homecare landscape. This was an interesting finding as COVID-19 had facilitated an increased amount of communication and dialogue between service providers and the HSE examining what was being provided and by who.

The concept of 'more useful' hours was identified as a real benefit. This was explained by a private provider who reported:

Private provider: "One positive of COVID-19 is that many agencies.....they did take a look at what was happening. The hours were changed in certain situations. Some people went back with less hours but maybe more useful hours. They're looking at the carers working geographically."

Participants also identified that they were aware the HSE has 'no choice' but to use the systems that were available to them. They said that while these were inconsistent across every CHO, and not ideal, they knew these systems worked. In their opinion, the HSE would continue to use them despite their inconsistencies. This was voiced by providers who were operating in multiple CHOs.

Table 2.3: Positives of the homecare landscape

Theme	Subtheme(s)	Categories
Positives of the homecare landscape	Self-governance and management	<ul style="list-style-type: none"> ▪ Self-regulation ▪ Vetting ▪ Doubling up ▪ Incident reporting ▪ Monitoring/spot checks ▪ Clear policies and procedures ▪ Annual review ▪ Clinically led ▪ Safeguarding processes ▪ CMS (logging in) system ▪ Client matching ▪ Carer and liaison supervisors ▪ Auditing by industry ▪ Competency assessments ▪ Human rights based approach ▪ HSE meetings ▪ Shadowing ▪ Key performance indicators (KPIs)
	Commitment to client groups	<ul style="list-style-type: none"> ▪ Commitment ▪ Spontaneity ▪ Informal care ▪ COVID-19 increased need to evaluate hours being provided ▪ Variety of work for staff ▪ HSE use system they know works ▪ Positive culture

Theme 2: What does not work well

Four sub-themes were identified under the second theme that discussed what is not currently working well in homecare provision. The thematic analysis is outlined in Table 2.4.

Ability to retain staff

One issue that was reported to have a detrimental impact on homecare services was the difficulties of retaining staff. Appropriate (or lack thereof) remuneration was frequently raised by participants who referenced a European Union (EU) ruling in Spain referred to as the 'TYCO Case'. This was described by providers as a ruling in which staff without a fixed or regular office (in particular homecare workers) were entitled to be reimbursed for time spent travelling. Certain providers reported that they are not in a financial position to offer this form of reimbursement, which left them with a sense of inability in retaining their staff. One provider said:

Voluntary or not-for profit provider: "This is applied to HSE carers but not [sic] others. HSE get travel time, others don't."

In relation to staff, the level of complexity in the role and level of skills needed in carrying out the role of a home carer on a daily basis was acknowledged. One advocate highlighted that homecare is a difficult job to do and that there is an inaccurate belief that the role becomes easier following formal training:

Advocate: "Training and expectation that anyone can do this job, but not is not true. There's a lot to the job."

These concerns show that there is a two-tier system regarding staffing and most providers (particularly private providers) felt in competition with the HSE for homecare staff. Such providers felt that HSE staff experienced better work conditions and pay (such as reimbursement for mileage and paid travel time), despite doing the same job. This competition was frequently cited as a problem, with some providers essentially believing that they trained staff and prepared them to eventually work for the HSE. Additionally, limited career progression opportunities and hourly employment outside of HSE providers was also described as a significant issue. One private provider described this as follows:

Private provider: "If you want to recruit and retain you have to have an in house system for career development....needs a constructed development plan. At the same time, HSE is advertising roles with better salaries... [We] can't keep up with HSE."

The difficulty in retaining staff and funding in order to retain them was described by participants as inseparable and this was articulated by one voluntary provider when asked about staffing:

Voluntary or not-for-profit provider: "How many hours do you have? Cut to chase. Funding is a big issue and it has been for over 20 years. Now we have a surplus of funds but we have a shortage of carers. Money doesn't matter if there are no carers. Staffing is an issue. Two issues for homecare: availability/retention/recruitment of carers and insurance."

Finally, the concept of 'continuity' of staffing was identified as difficult to achieve. This was seen as difficult due to the transient nature of staffing, particularly where staff worked increased hours. For example, in many instances the homecare workforce was described as a workforce which did not work full-time hours. On one level this flexibility suited their lifestyle; however, it was also reported that it was difficult as it often negatively influenced social welfare payments and therefore working in homecare for some people was seen as not being financially beneficial. These inconsistencies across providers' ability to retain staff were identified as having a knock on effect on the level of care provided to people in receipt of homecare services. One private provider gave the following example:

Private: "It's hard for an employment point of view. We have care staff that are receiving different types of social welfare benefits...if they work for 30 minutes they can lose benefits. They are willing to provide care but why would they if they then lose payment. It'll impact staff. There's so many areas that need to be looked at."

Funding and tenders

A dominant concept relating to funding was the concept of 'pots of money' which was frequently voiced by all providers. 'Pots of money' referred to funding streams that were diverse and irregular. This was seen particularly for disability services where service agreements exist rather than tender agreements. In these situations, it was reported that there is no aligned funding system across CHOs which also impacts on commissioning of services. One private provider explained this as follows:

Private provider: "The problem is if there's a lot of pots for the funding. If homecare don't have the funding, they will pass us on to older persons even if they person is under 65. The majority of the funding is there. The most amount of hours you can get is 21 hrs. Anything else over 21 hours turns into an intensive care package, which takes 6 weeks [and] can take up to 13/14 weeks to be approved. But the HSE will keep reviewing it so that they can reduce it. If you have two kids (in the same family with disabilities), they might be getting funding from two separate places..."

Inconsistent or 'drip fed' funding was also cited as a significant issue for many providers. They explained that they were unable to plan for the future of their services as the homecare budget could be cut, which they reported had already been experienced in previous years. Providers referred to this as 'short-termism' and one provider called for multi-annual funding in the belief it would help in the planning of services but would also help maintain an appropriate level of staffing:

Private provider: There is a need for multiannual funding model to allow [for] planning. Every provider I know of can't get the carers they need.

The issue of 'zero hour' tenders was also raised by participants as a problem. This refers to service providers' funding becoming cut when a person in receipt of homecare goes into hospital. Providers highlighted that this happens in every sector except for the residential nursing home sector, again demonstrating inconsistent practices in relation to organisation, funding and the difficulty in retaining staff. The following dialogue sets out this issue between some participants:

Private provider: "Carers do not get paid while the client is in the hospital".

Voluntary or not-for-profit provider: "I've brought this up before. HSE won't pay for carer and hospital for that client. We can't afford to pay carers for those lost hours. The HSE don't pay us if the carer doesn't do work."

Voluntary or not-for-profit provider: "There's huge inequality for staff. One week they have 40 hours and then client goes to hospital and carer only gets 10 hours. Two carers working together could be on two different terms and conditions/pay scale. The carers working for non-profit end up going straight to HSE for better money."

An additional pressure to the inconsistency and uncertainty of funding was the increase in service provision costs that service providers have experienced in recent years. An increase in insurance premiums and Pay Related Social Insurance (PRSI) contributions were highlighted as causing a real strain on homecare organisations who questioned their own financial viability moving forward. Some providers reported that this was amplified by insurance providers refusing to cover certain activities in light of COVID-19. This was reported as a concerning and limiting issue for providers. A discrete difference between providers was observed insofar as a voluntary provider reported that they had different demands placed on them. For example, one provider said:

Voluntary or not-for-profit provider: "Different standards of not for profit from private. If you're a not-for-profit providing homecare on behalf of the HSE and you up your rate or insurance rates go up, you might have to tap into your own [funding] reserves...[there are] different expectations for not for profit. A private provider wouldn't be asked to do that."

Finally, some providers reported that they do not receive the homecare tenders that are sent out to others,***** and even though some hours are granted, they may not be delivered due to a lack of capacity from providers. This leaves the person who requires homecare in a state of need. In addition, the concept of spilt packages, where many different homecare providers deliver a service to the same person, were also voiced as a concern by providers. One provider identified an example where a homecare client has 14 different calls with 13 different carers, a situation they cited as demoralising for the person in receipt of homecare. Similarly to spilt packages, spilt shifts were also seen as an issue that impacted on the coherence and continuity of care for persons in receipt of homecare services. This issue was reported by providers as a common occurrence across CHOs, especially during holiday periods such as Christmas when many staff took annual leave, resulting in a strain on resources to cover all required hours.

Time constraints of homecare

The timing of homecare was also identified as a sub-theme which negatively impacts on homecare services. On the whole, homecare providers told us that they had to 'be quick' and they were 'time poor' when providing services. This was driven by an increased tendency for some CHO areas to implement 30 minute home visits as part of tenders. Providers stated that this was prevalent where the person required two homecare staff (2:1 staffing) to support homecare clients. In such instances, the allocated hour was divided into two 30 minute visits (referred to by providers as doubling up). This was described as being difficult to implement from a care recipient, geographical and remuneration perspective. Providers voiced this in the following ways:

Private provider: "There is a huge increase in 30 minute calls. A 30 minute call, double that up. Our point of view, doubling up 30 minute calls - providing 2 or 3 a day- is so difficult to keep up with as a provider, almost impossible. It looks good in figures - we provided so many hours in homecare, we're rushing in and rushing out. It doesn't make sense... [There is] a huge growth in this 30 minute and doubling it up. This double up is causing issues."

Private provider: "There's just not enough time anymore, [we] have to be quick but the client[s] aren't getting what they need."

Providers also explained that these time constraints meant that visits were very task based, not person centred and were potentially undignified or disrespectful for the person in receipt of care. Providers felt they were failing to meet the holistic needs of their homecare clients. One provider identified that very little can be done in 30 minutes. Another important consideration identified was that the timing of these calls was also impacting on the ability of providers to be able to meet the needs of homecare clients.

***** This may be because the homecare organisation is on a different tier of homecare providers that is established based on the most recent tender for older adults.

For example, providers identified that in the majority of assessments they received, the requested hours were very similar and therefore providers really struggled at peak times. This resulted in providers questioning their ability to provide person-centred care in 30 minutes. One provider identified that:

Private provider: "There's no consistency with scheduling of hours with rural areas. not thinking about the travel time. There are five providers in one little village I know of."

It is important to also highlight that this timing issue was reported by one provider as not impacting on disability services as much as older people:

Voluntary or not-for-profit provider: "...isn't really an issue [in sensory and physical], unlike older persons services, as there is longer time spent caring for same patients."

Notwithstanding this, these issues regarding the timing and time constraints of homecare provide a reality of what providers of homecare are describing the current 'as is' picture is of homecare in Ireland.

Inconsistencies in assessment

From an assessment viewpoint, the situation is equally complicated. While participants acknowledged that the SAT (Single Assessment Tool) is the preferred choice of assessment and this will eventually be implemented for older people, it was reported that different CHOs used different assessments and different documentation. One participant who works across many CHOs described their experience:

Voluntary or not-for-profit provider: "The assessment used is different in different areas. CSAR, it's a great tool.... We get the referral, but with very little information [provided]."

From an advocacy perspective, it was highlighted that assessment of needs is equally complex from a familial perspective, insofar as:

Advocate: "There's someone who knows they need care and others think they don't. Then there's people that think they need more time. Assessment is very clinical. We need to do it another way. It's medical because it's the PHN [public health nurse] dealing with the assessments. There's some that are good with the holistic aspect. Who should process it? Philosophical role of the state, is it a bit laissez faire attitude, it's how we're thinking about it."

Alongside this, the issue of limited information was a key theme across the discussion regarding assessments. Different CHOs supplied various amounts of information on an assessment that was sent out to tender. Some providers received comprehensive

information regarding the services needed, while others received limited information. Data protection and General Data Protection Regulations (GDPR) were cited as one reason for limited information. However, providers stated that there were very real risks that were not being communicated to them as a result of GDPR. An example of this was outlined by one provider who described a client who was an inpatient in hospital and receiving 2:1 staffing at all times. However, no risks in relation to this were identified to the homecare organisation when they went to assess the person in their home. One provider said that what is currently not working in homecare provision combines all the issues discussed above, and therefore reflects a summary of what service providers are currently facing.

Private provider: "there is a service level agreement but there's no tender for disability, some of the needs in 16-65. If disability don't [sic] have money they go to older and vice versa. It's a bit difficult. Disabilities now, are very complex and they are reducing the length of time that they'd be giving support [to persons]. Everything is being driven towards tasks across disability and older persons. When you look at face to face, then risk, health and safety (physical environment, adult children with mental health issues, dog etc), complex issues. It can be very complex and [you] need to be on top of it. You don't get that information [risk assessment] when you start out with a client. You're only going out there to do the shower, or make the meal. That's fine in theory, but in Ireland it's not possible. They may say that...someone needs a hoist, we will bring in two people, and we'll only pay for an hour (two people to cover that hour). Usually in disabilities there's a family member to support. That means that the family member has to be there during the hour. The lack of information is all about GDPR. We're very careful about GDPR, and protecting client's data. We would find that in the beginning, before the packages came into being, the HSE were getting experience. The 2018 tender has been extended to another year because of COVID. Going back to clients booking care themselves... They might have a comfortable background and they're now waiting until [they're] hospitalised to get the package. There's no means testing. For the vast majority of people [they] just need a bit of help, if someone else is there."

Table 2.4: What is not currently working well in homecare provision

Theme	subtheme(s)	Categories
<p>What is not currently working well in homecare provision?</p>	<p>Ability to retain staff</p>	<ul style="list-style-type: none"> ▪ Travel time/mileage and TYCO case ▪ Undocumented workers ▪ Limited career opportunities ▪ Social welfare payments restrictive ▪ Low level support/supervision ▪ Hourly employment ▪ Competition ▪ Continuity ▪ Availability
	<p>Funding and tenders</p>	<ul style="list-style-type: none"> ▪ Reactive services ▪ Easier access of homecare from hospital ▪ CHO inconsistency with [allocation of] funding ▪ Use of own funds ▪ Short-termism/drip fed budgets ▪ Private vs Vol / NfP differences ▪ HSE vs other rates of pay/terms and conditions ▪ Zero hour tenders ▪ Tender not sent to all providers ▪ Different pots of money in each CHO ▪ Hours granted but not delivered ▪ Insurance premiums/PRSI ▪ Legacy rates/hours costing money
	<p>Time constraints of homecare</p>	<ul style="list-style-type: none"> ▪ Loneliness ▪ Split packages ▪ Geography ▪ 30 minute visits ▪ Respect and dignity ▪ Same appointment times

		<ul style="list-style-type: none">▪ Task based
	Inconsistencies in assessment	<ul style="list-style-type: none">▪ Waiting lists▪ GDPR▪ Referrals not highlighting risk(s)▪ Hospital vs homes (2:1)▪ Old assessments▪ Multi-assessments▪ Different care plans▪ Poorly communicated▪ Different assessments and documentation▪ Lack of detail

Theme 3: What needs improvement

Four sub-themes were identified under the final theme related to improving homecare provision. These were: improving person-centred care, defining homecare parameters, balancing regulation with reducing bureaucracy and eliminating 'faster finger first' for tenders. The thematic analysis is outlined in Table 2.5.

Improving person-centred care

There was a recognition and consensus among participants that there needs to be improvements regarding person-centred care. Participants cited the need for increased impetus regarding continuity of care, choice, consent, human rights, safety and communication.

Additionally, while it was also acknowledged that informal care and the involvement of homecare recipients' families in their care is of paramount importance, there is a need to ensure that the recipient's rights and choices are at the forefront of all decisions. One voluntary provider articulated this:

Voluntary or not-for-profit provider: "From a human rights perspective when reviews are taking place there is a huge work emphasis on families- but we're not looking at the rights for the individual user. What the 'kids' want can be different from the parent, or [the] same goes for older people. It has to focus on the individual and not the family. Family needs to take second place to service user."

Proposals for improving person-centred care were divided into two categories of advocacy. The first was a need for advocacy from a service-level perspective which should focus on developing regulations and standards and advocating against crippling insurance premiums. The second category was a need for advocating for the improvement of people's care through a human rights-based approach. This means advocating for bespoke models of care that meet the needs of individuals and continuing to educate and promote person-centred choices, while facilitating the successful navigation of services offered for clients and their families. While this is currently present in the sector, participants said that it is absolutely critical that these issues are consistently advocated for.

Defining homecare parameters

In the first instance, providers identified that there is an increasing complexity and diversity in the services offered by them. This needs to be defined and the parameters of homecare delineated. Across the six focus groups the following terminology was used by providers to describe the services they provide:

- home help,
- home support for older people,

- home support for people with a disability,
- person assistance living services,
- disability home support,
- disability personal assistant,
- dementia homecare,
- children's homecare services,
- nurse-led services,
- nursing care services,
- complex care services,
- day services,
- and palliative care.

The complexity of homecare provision was highlighted by the description of specific service agreements providers had with the HSE. These agreements covered service provision for both children and adults. One private provider explained that they now offer homecare to children with complex needs and this form of service provision is now becoming more prominent:

Private provider: "The kids could be in hospital for years, but HSE have now allowed for homecare companies to provide complex care in their own home caring for babies with tracheostomies, on ventilators, IV drips etc."

In addition to this, another provider identified that they now have a clinical care department due to the increasing complexities of health care services they provide within homecare:

Private provider: "I would have a clinical care department – CNM (Clinical Nurse Manager) 3, CNM2 and CNM1, Staff nurses go to people's homes to provide care. They would be much larger than our homecare packages. A lot more hours. Mostly with children and some with adults. For example adults with spinal injury. These would be individually tendered."

Balancing regulation with reducing bureaucracy

The introduction of regulations within homecare was raised as an opportunity to improve homecare. One advocate spoke positively about the introduction of regulation, but felt that it should focus on the parameters of homecare and how best to support carers on an individual level. They also cautioned that regulation may result in additional bureaucracy within the setting.

Advocate: "There's a risk on [sic] too much focus on regulations. How light touched can the regulations be? Regulations should look at what homecare is, the work force and funding then... Lots of individual carers that are on their own and

can't get supports. [There is] no professional body they can turn to at the moment. Focus on the supports and what the needs [of service providers] are."

Other providers reported that there was a clear need for improvements in the homecare sector more broadly. However, they wanted a functioning system without the burden of bureaucracy. It was reported that some providers had left the sector because of this:

Voluntary or not-for-profit provider: "There's been a lot more bureaucracy, a lot of great care providers aren't bureaucratic and couldn't keep up and left."

When discussing the introduction of regulation, participants stated that regulations need to be applied fairly to all types of providers. In relation to auditing services, some providers felt that the HSE does not audit themselves, while the auditing of non-HSE homecare providers was inconsistent and fragmented. A further inconsistency highlighted which could be addressed by the introduction of regulations is the implementation (or lack thereof) of service user agreements. One provider highlighted that homecare clients do not currently receive a 'service user agreement':

Voluntary or not-for-profit provider: "Do you realise that no service user have ever been given what should be expected from homecare - don't physically get an agreement. The expectations of care is not in the care plan."

Ending 'fastest finger first' for tenders

Improvements were also highlighted with regard to equality and consistency in the allocation of tenders and service provision. Providers clearly expressed that at times they felt they were treated as 'differently', as they were only offered tenders that the HSE could not cover. Providers called for a 'fair deal' scheme for homecare that would be similar to the residential nursing home scheme which provides financial support to people who need long-term nursing home care.

Providers referred to an issue they called 'fastest finger first' (a hybrid of the term referred to by HCCI as 'fastest respondent first').⁽⁴¹⁾ This is where homecare providers are required to respond to a tender in the fastest possible time in order to secure it once it has been sent out by the HSE via email. This creates multiple issues particularly when providers accept clients with limited assessments or information available regarding the clients' needs:

Private provider: "each CHO, decide a package of care, in some areas it's the first person that gets back ("Fastest finger first") rather than who will have the best solution for the client. In other CHOs [they] do wait and see who has the best package to meet client's needs. 'We're a business. The priority of why we're accepting packages should be best solution for the recipient'."

Another provider voiced additional concerns about the fastest finger first process:

Private provider: "It's the fastest finger first [way] that we are procuring, which is complete nonsense. It goes against HIQA standards. Goes against all the principles of the eight standards. How it is procured - it takes the eye off of quality. That's the way I see it. Yes we're part of it, I'm just saying that in our area there's 20 plus providers and its fastest finger first. Not [sic] the best providers always get there first. Yet we're all deemed the same. We went through tender process, we showed how we operate. [There are a] number of excellent providers and number of others whose standards aren't to the same level as others."

Some providers explained that they were unable to participate in the 'fastest finger first' process due to IT data protection measures in place, such as firewalls. One provider claimed that some providers remove these security systems so that they can receive the tender quicker than other providers, who are practicing protecting data measures in accordance with GDPR. This disclosure raises significant causes for concerns in relation to data protection practices among providers.

Table 2.5: What needs improvement?

Main theme	subtheme(s)	Categories
<p>What needs improvement?</p>	<p>Improving person-centred care</p>	<ul style="list-style-type: none"> ▪ Continuity ▪ Care vs cost ▪ Consent ▪ Choice ▪ Human rights ▪ Safety ▪ Family vs. client wishes ▪ Bespoke models of care ▪ Can person centered care be delivered in 30 min? ▪ Time to communicate
	<p>Defining homecare parameters</p>	<ul style="list-style-type: none"> ▪ Children’s homecare services ▪ Home support for older people ▪ Disability home support / PA Service ▪ Increasing complexity ▪ Extended services ▪ Nursing led or nursing care ▪ Medical vs. social model ▪ Provision of complex care ▪ Accountability and clinical oversight ▪ Home help
	<p>Balancing regulation with reducing bureaucracy</p>	<ul style="list-style-type: none"> ▪ Funding to allow same conditions as HSE ▪ Allocation of funding e.g. hospital vs homecare ▪ HSE do not audit themselves ▪ Bureaucracy ▪ Service user agreement ▪ Policy implementation ▪ Vol / NfP restrictions on private homecare ▪ Fair deal scheme for homecare

	Ending fastest finger first for tenders	<ul style="list-style-type: none">▪ Equality for tenders▪ Providers treated differently▪ Assessment and allocation▪ Equally applied rules for all providers

Discussion

Summary of findings

This qualitative piece explored the facilitators and barriers to homecare service provision, as well as highlighting areas for improvement. Service providers discussed their strengths in provision, outlining the high standards self-governance and management within their respective services. Mechanisms that facilitated these high standards were reported as vetting, monitoring of care, incident reporting, safeguarding processes and operating through a human rights framework. Providers also articulated their strong sense of commitment to their service users.

In contrast, providers described many barriers to providing homecare services to the best of their ability. These barriers were an inability to retain staff, difficulties with funding and tenders, time constraints in homecare and inconsistencies in assessment. Providers of homecare services informed HIQA that these issues cause significant concerns for providers and therefore negatively impacted the person in receipt of services.

Finally, participants offered insightful solutions as to what would improve the provision of homecare. These were the need to define homecare parameters, improve person-centred care, balance the implementation of regulations with increasing bureaucracy, and eliminating the 'fastest finger first' approach for securing tenders.

Findings are discussed in the context of current literature and experiences of homecare provision in other countries in order to determine if these experiences are unique to Ireland. This is undertaken using the Donabedian Model to categorise the structure, processes and outcomes of homecare.⁽⁸⁴⁾

Structure

Participants offered nine solutions to improving the structure of homecare provision. Many of these related to structures that would help retain staff. They suggested that there is a need to make homecare appear as a long-term career, a need to allow for self-rostering between clients and carers, a need to alleviate the lone working aspect if possible and also a need to reduce staff caseloads while increasing their time allocations with individual clients. Many of these suggestions focused on reducing time constraints and pressures experienced by staff. These suggestions are consistent with previous research which has outlined how staff⁽⁸⁵⁾ struggle to create responsive care environments due to time constraints, but compensate by employing tactics such as leaving time outside (not discussing time constraints with clients), working on different paths simultaneously (initiating and performing different tasks at the same time) and postponing tasks. However, these tactics may contribute to temporal risks such as rushing with travelling to homes in between visits.⁽⁸⁶⁾

Facilitating self-rostering and reducing caseloads would alleviate some of these risks and contribute to a more person-centred form of service provision. Participants also articulated that homecare workers should be enticed to view their employment as a long-term career.⁽⁸⁶⁾ Previous literature has described conditions of homecare employees as sub-optimal with poor communication, minimal support, guaranteed hours, low wages, unsafe work environments and travel time not paid identified as central issues.⁽⁸⁷⁾ ^(88,89,90) Larsson et al. (2018) also outlined that leadership is an important component to support the process of improving the employment conditions of homecare workers, which may entice them to stay in their roles on a long-term basis.⁽⁹¹⁾

The development of policy and implementation of regulations were also offered as a solution to improving services; however, it was caveated with a need to keep bureaucratic practices to a minimum. There is currently a gap in research in relation to the implementation and benefits of regulation in homecare services. However, one Dutch study⁽⁹²⁾ investigated the perceived added value of, and barriers to, a newly developed regulatory framework. The study identified that regulating care networks added value to services as this promoted person-centred care. However, this study also highlighted that the implementation of regulation takes time and collaboration across all services involved. It also recommended that regulatory bodies give more consideration to measures taken by care providers to assess the ability of clients. Within this research, service providers also felt that means testing should be introduced to decide if recipients are financially able to resource their own homecare. This would allow resources to be allocated more equitably.

Collaboration was also highlighted as an important aspect of homecare provision, with providers articulating that collaboration between families, informal and formal careers is needed, as well as collaboration between organisations in terms of assessment and information sharing. Again, these issues have been previously mentioned in international literature citing that informal caregivers must be involved in health interventions in order to reduce adverse events⁽⁹³⁾ and to negotiate processes that take the whole homecare arrangement into account⁽⁹⁴⁾ and reduce passivity that can develop.⁽⁹⁵⁾ Successful homecare is dependent on collaborations between the care recipient, families, hospital (if applicable) and the homecare service.⁽⁹⁶⁾

Process

Service providers highlighted a potentially unique issue within homecare services in Ireland when they stated that there is a need to change the view that admission to hospital is the fastest way to procure a homecare package. It was felt that this may be given priority due to the current pressures on hospitals and risks of contracting illness upon admission such as COVID-19. A shift is needed from the view that admission to hospital is the fastest way to procure homecare. This issue highlights how the absence of policy or regulation is affecting how homecare services are sought. Service providers also

stated that the use of geographical homecare routing should be considered. This is where workers would provide care in certain geographical locations with responsibility for the timing and delivery of services they can perform within their working hours and that area. This would alleviate temporal risks associated with the constraints of homecare working currently experienced such as timing of services, rushing with travelling and travelling to clients' homes.^(97,98) Previous literature has highlighted that implementing solutions such as these may be difficult as leaders have less opportunity to organise, structure and immediately address problems which may negatively impact homecare services due to 'direct vs distant' roles.⁽⁹⁹⁾

Participants highlighted that goal-focused care that encompasses the care recipients' views should be prioritised in homecare provision. In order to achieve this, standardised assessment tools must be adopted to achieve consistency and measure outcomes incrementally.^(100,101,102,103,104,105,106) The use of goal-focused assessments has also been shown to improve quality of life for care recipients upon referral for homecare services.^(107,108) These forms of assessment also support a person-centred structure to services and may help alleviate the 'fastest finger first' practice or securing tenders without the service considering its ability to meet the needs of service users. Service providers also articulated that, as part of this assessment process, early interventions should also be considered as part of service provision. Providers described this as providing effective early support to individuals who are assessed as having low-level needs. This in turn would help to reduce the subsequent need for more intensive homecare supports or admission to residential care by implementing early interventions.

Outcomes

In terms of outcomes, service providers suggested one solution for homecare reform in that there needs to be a mantra where 'you do yourself out of a job'. In other words; increase independence through preventative measures which will reduce long-term homecare provision. As previously stated, preventative care through promoting preventative measures (such as the risk management of falls) has been cited in the literature. In order to achieve this form of care and an improvement in quality of care, homecare workers must be afforded more time with their clients⁽⁹⁸⁾ and be less restricted by the tasks that delegated to them.⁽¹⁰⁹⁾

Overall, the following were identified in different guises as proposed solutions to improve the homecare sector. These are outlined in Table 2.6.

Table 2.6: Proposed solutions for the provision of homecare services

Donabedian Category	Solution Offered	Description
Structure	A roadmap for the trajectory of services	The development of a policy document that details the trajectory of homecare in the short, medium and long term.
Structure	Statutory scheme for homecare	A statutory scheme for the regulation of homecare with a clear funding model.
Processes	Goal-focused care	An approach to care that uses the recipients' priorities, or goals, to drive what kind(s) of care are appropriate for that person.
Structure	Means testing	Means testing should be introduced to decide if recipients are financially able to resource their own homecare. This would allow resources to be allocated more equitably.
Structure	Less clients and more time	Providers were clear that they needed more time with less clients to provide person-centred care.
Processes	Early Intervention	The provision of early intervention where low level needs are identified and effective early support is provided to individuals would help to reduce the subsequent need for more intensive homecare supports or admission to residential care.
Structure	Self-rostering	Homecare workers could work alongside the client and/or clients' family to organise their own work schedules. This would allow a more person-centred approach in line with the wishes and needs of the recipient.
Structure	More policing	The current policing of providers was identified by themselves as 'patchy' and they welcomed more policing to ensure equality and equity.

Outcomes	Do yourself out of a job	Some providers said there needed to be a mantra where 'you do yourself out of a job', in other words; increasing independence through preventative measures which will reduce long-term homecare provision
Structure	A shift in focus from nursing homecare	Nursing homecare should not be seen as the final option and there needs to be a concerted effort to provide homecare where it is more appropriate than nursing care. This should also be looked at retrospectively (this means that there may be people who could live at home but are currently living in nursing homes).
Structure	Information sharing	There needs to be superior processes in place to support information sharing between organisations, specifically in regards to assessment of need and in order to eradicate "fastest finger first".
Structure	Make it a career	There is a need to make homecare a long-term career to entice people to work and stay in this sector in order to sustain services.
Processes	Avoiding hospital as a procurement option for homecare	A shift is needed from the view that admission to hospital is the fastest way to procure homecare. The avoidance of hospital must be a high priority given the potential exposure to associated risks of admission and current strains on service provision within hospitals.
Processes	Geographical Routes	The use of geographical homecare routing should be considered. This is where workers provide care in various geographical locations and routes, and are responsible for the timing and delivery aligned to estimated travel times as well as the number of services they can perform within their working hours.

Limitations

It is important to consider limitations of this research when interpreting the overall findings. Firstly, despite a variety of service provider groups consulted, this research was conducted to create a current 'as is' situation and may not be indicative of the opinions of all service providers across the country. The perspectives of the HSE and those in receipt of care were not included in this research piece, however this was not the scope of the research piece. In order to facilitate person-centred care, it is vital to consider the views of care recipients. It is recommended that a further root and branch review should be conducted to include these important perspectives. In addition, bias may have been introduced by the sample, as they were limited to participants who responded to requests and were motivated to engage in the discussion surrounding homecare.

Conclusion

This research was conducted to provide an overview of the current landscape of homecare services in Ireland. From a HSE perspective, the *National Guidelines and Procedures for the Standardised Implementation of the Home Support Service* (HSS Guidelines)⁽¹³⁾ clearly set out the arrangements for the management and engagement of the funded home support service for older people. However, homecare provision is wider than 'home support services'. This was identified by participants who took part in this research. Service providers discussed their strengths in provision, outlining that there are high standards of self-governance and management within their respective services, while also discussing barriers that inhibited their services and areas where they felt improvements could be made. There was also a general consensus that there is a need to reform homecare services which may include the introduction of regulations.

Plain language summary of Chapter 2

There are differing ideas in how homecare is understood and what services are offered in Ireland. HIQA carried out an online survey to better understand how homecare is organised, funded and run. The survey asked about the sorts of services private and voluntary homecare providers offer, the difficulties they face, and areas they think that standards and regulation should focus on in Ireland. HIQA also held focus groups with providers of homecare services and some interested parties to explore these questions in more detail.

Service providers said that they were good at applying self-governance and management. They also said they were committed to the people they provide services to. Service providers stated that they found certain aspects of homecare difficult to manage, such as keeping their staff, trying to secure tenders and funding, and the differences in how assessments of people needing care were conducted.

Participants in this research also made suggestions that would help them to improve homecare. These included defining what is meant by homecare services, improving

person-centred care, finding a balance between regulations and unnecessary administration, and getting rid of the fastest reply approach for tenders.

This research provided views from some participants; however, not all homecare providers may agree with everything that was discussed. Also, this research did not include the views of people who receive homecare services. Despite this, there was general agreement that homecare services need to reform, and that introducing regulation may help this happen.

Chapter 3: International scoping review of what constitutes quality in the provision of homecare services

Background

Chapter 1 described the current landscape regarding the provision of formal homecare services in Ireland, setting out the complexities that exist in the current formal homecare environment. Notwithstanding this, as regulation is a policy tool that drives quality and quality improvement, it is important to understand what constitutes quality in terms of the provision of homecare. As detailed above, there is a significant reliance on 'informal homecare' in Ireland. In the main, homecare is provided informally and supplemented by formal 'home support' services. While this can partly be attributed to a legacy left over from a familial and communitarian philosophy, it is also a manifestation of expanding services⁽⁵⁷⁾ in response to the needs of the population. However, as identified throughout Chapter 2 which are many positives that exist in the homecare sector, there are many challenges, particularly from a quality improvement perspective.

Subsequently, this chapter consists of an international scoping review undertaken by HIQA to determine what constitutes quality in terms of the delivery of formal homecare. This scoping review aimed to map existing evidence concerning the regulation of homecare to inform national policy for the forthcoming regulation of homecare in Ireland. Regulation is a key policy instrument used by governments for quality improvement, supporting the achievement of policy objectives.⁽¹¹⁰⁾ Acknowledging there is a severe absence of empirical literature concerning the impact and effects of regulation in homecare more broadly,^(10,43) this review sees regulation as a quality improvement and assurance mechanism.⁽¹¹¹⁾ In this vein, this review sought to map the empirical evidence on:

'the quality of service and protection of person(s) in receipt of formal homecare i.e. through regulation, monitoring, quality improvement to include recipients of, and carers providing formal homecare services'.

Given the size and coverage of this review, a Donabedian^(84,112) lens is applied (structure, processes and outcomes) to assist synthesis when charting the data.

Methods

Scoping reviews are a relatively new methodology that are becoming a common approach for synthesising research evidence, despite there being no definite procedure or reporting guidelines.⁽¹¹³⁾ This study employed the Arskey and O'Malley five-stage methodological framework for conducting scoping reviews which is now one of the most widely used frameworks.⁽¹¹⁴⁾ It includes: (i) Identifying the research question; (ii) Identifying relevant studies; (iii) Study selection; (iv) Charting the data; and (v) Collating, summarising and reporting the results.

Identifying the research question

The research question was defined by HIQA's Regulation Directorate. To establish the concept of formal homecare, the Genet et al. (2011) broad definition of formal homecare was adopted, meaning; 'professional care provided at home [for adults and children]'.⁽⁸⁾ In terms of context, all European countries were included along with Australia, Canada and New Zealand. This is to reflect logistical and comparable health and social care systems to Ireland. As stated above, the principal aim of the study was to synthesise the empirical evidence surrounding the quality of service and protection of people in receipt of formal homecare, that is to say the regulation, monitoring, quality improvement and assurance, including service users and carers providing formal homecare services.

Identifying relevant studies

This scoping review identified, retrieved and evaluated published peer-reviewed empirical articles that focused on the provision of formal homecare services. Studies published between 2010 and 2020 were included to reflect the previous systematic review that was undertaken by Genet et al. (2011)⁽⁸⁾ in this area which reviewed research until 2010. In July 2020, a search of seven databases was completed (CINAHL, PubMed, PsycInfo, Social Care Institute for Excellence (SCIE), Embase, SocINDEX and Scopus). Searches were conducted according to each database's subject heading terminology and thesaurus functionality. An example of a database specific search set is outlined in Table 3.1.

Table 3.1: Example of database specific search terms (CINAHL)

Limiters - Published Date: 20100101-20201231 Narrow by Subject Geographic: - Canada Narrow by Subject Geographic: - Australia & New Zealand Narrow by Subject Geographic: - Continental Europe Narrow by Subject Geographic: - UK & Ireland Narrow by Subject Geographic: - Europe Search modes - Find all my search terms S22 AND S23 AND S24 S22 AND S23 AND S24 S22 AND S23 AND S24 S22 AND S23 AND S24 S22 AND S23 AND S24 S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 S7 OR S8 OR S9 OR S10 OR S11 S1 OR S2 OR S3 OR S4 OR S5 OR S6 Inspection* Monitoring* guidance or oversight (MH "Quality Assessment") OR (MH "Quality of Nursing Care") OR (MH "Quality Assurance") OR (MH "Quality Improvement") Best practices* Quality* Standards* "standard" regulati* (MH "Rules and Regulations/ST/LJ") (MH "Government Regulations+/ST/LJ") Wellbeing* Independence or independent or autonomy* Assistance or Aid Support* Home maker* Home help* Domiciliary care* Homecare* Homecare Servic* (MH "Home Health Care") OR (MH "Home Nursing, Professional") OR (MH "Home Visits") OR (MH "Homemaker Services") OR (MH "Home Nutritional Support") OR (MH "Community Health Services")

Study selection

All retrieved articles were imported into Covidence and independently reviewed for completeness by two researchers. Titles and abstracts were then reviewed for suitability

according to inclusion and exclusion criteria. Table 3.1 identifies the inclusion and exclusion criteria applied to this study. We included children in this review; however, given the sheer breadth of the literature, we excluded 1) medical procedures or medical maintenance carried out in the person’s home (for example chemotherapy or advanced medical procedures); 2) palliative care (for example end of life management) and 3) technology based assessments for monitoring (for example the use of monitoring aids). Principally, the reason that these were excluded was due to the sheer volume of evidence that would require distinct reviews in these three areas. Studies that were identified as relevant were subject to full text screening and again these were screened by two authors. Any article with a missing abstract was also retained for further screening. Two authors screened all full text articles until a consensus was reached as to whether they met inclusion criteria.

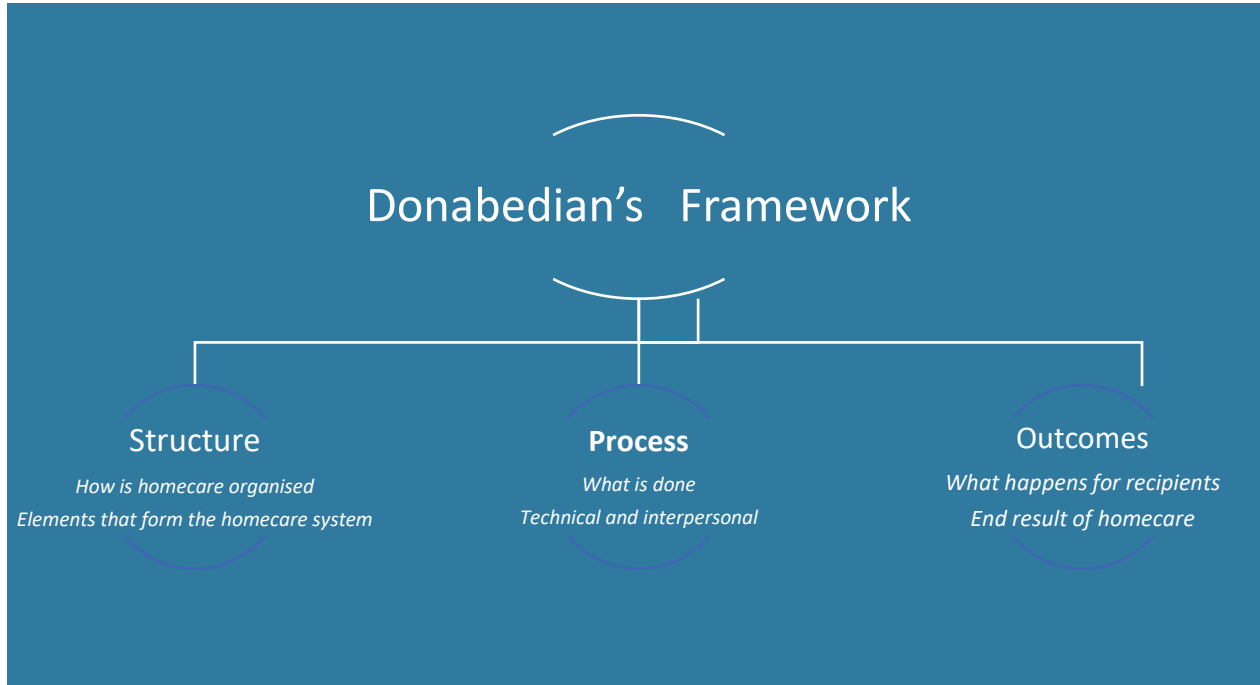
Table 3.1: Articles were included if they met the following criteria	
Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> ▪ Must be in English ▪ Must relate to formal homecare or domiciliary services ▪ Must be in Europe, Canada, Australia, New Zealand ▪ Must focus on quality of service and protection of people in receipt of health or social care i.e. regulation, monitoring, quality improvement or terms with a focus in this regard or must relate to staff providing formal homecare services ▪ Can cover children and adults ▪ Do not include protocols, reviews, opinion pieces or books ▪ Must be from 2010-present 	<ul style="list-style-type: none"> ▪ Not related to formal homecare - i.e. paper specifically relates to a medical procedures or medical maintenance carried out in the persons home ▪ Exclude palliative care ▪ Exclude technology-based assessments for monitoring ▪ Outside of the countries reported ▪ Not focused on quality of service or protection of people who receive homecare services ▪ Studies before 2010 ▪ No peer reviewed research ▪ Conference abstracts / books or opinion pieces

Charting the data

Data was abstracted by a single researcher and reviewed by a separate researcher before being imported into Microsoft Excel. This file contained the author, year, country, study aim or focus, methodology and sample size. In order to conceptualise the concept of quality, the study’s findings were aligned to the Donabedian’s framework for contextualising quality.⁽²¹⁾ This included structures, processes and outcomes. In the interpretation, the structure refers to the physical and organisational characteristics of homecare (for example, organisational systems or elements that form the system); the

process refers to the care delivered (for example, personal care or services, or treatment delivered); and, the outcome refers to the effect of this on the homecare recipient. This structure is demonstrated in Figure 3.1.

Figure 3.1: Donabedian's framework aligned to homecare



Collating, summarising and reporting the results

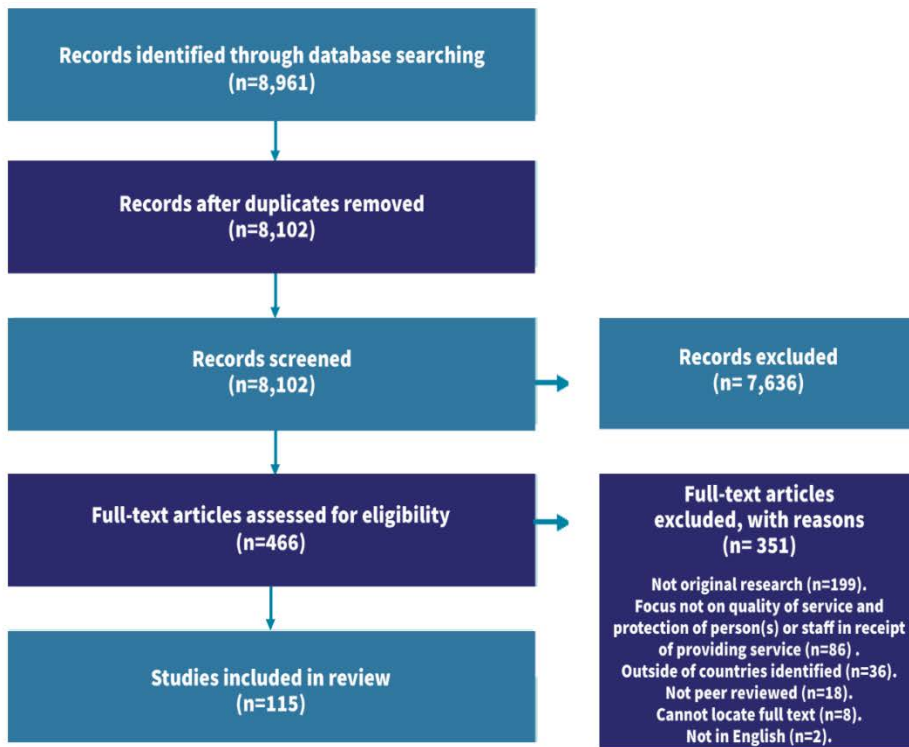
An interactive, deductive approach was adopted through the use of thematic analysis. In line with a deductive approach, the three main themes of structure, process and outcomes were selected and informed by Donabedian's framework. Sub-themes were then identified by conducting line by line coding on the summaries that were extracted into Microsoft Excel. These sub-themes were assigned to the themes of structure, process and outcomes and a taxonomic tabular method was used to report these results. This included Donabedian's framework, theme, subtheme, study methodology (quantitative, qualitative, mixed or multi-methods).^{†††††}

Results

Figure 3.2 summarises the studies that were included in this review. The search identified 8,961 references with 8,102 remaining following the removal of duplicates in Covidence (CINAHL n=2,470; PubMed n=396; PsycInfo n=801; Social Care Institute for Excellence (SCIE) n=359; Embase n=4,617; SocINDEX n=97; Scopus n=221).

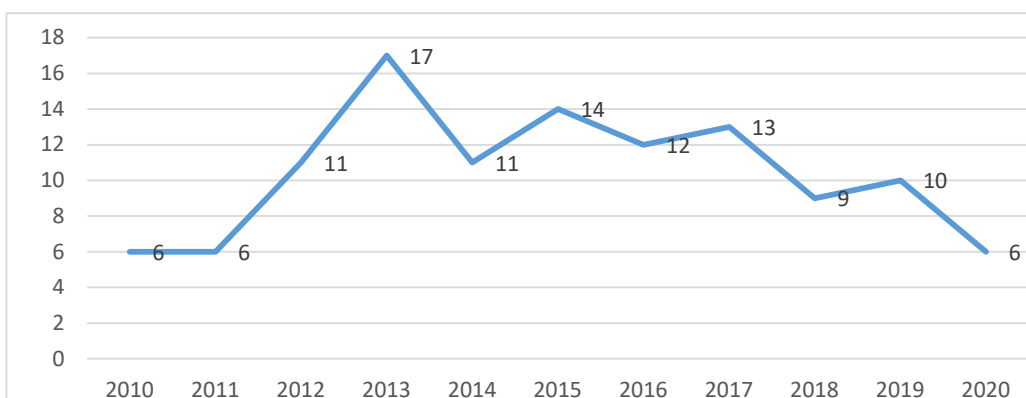
^{†††††} A supplementary Excel file that further details the characteristics of included studies is available upon reasonable request.

Figure 3.2: Flow chart of study identification



This review examined 466 full-text articles for inclusion and from this, 115 articles were deemed to be eligible to include. Figure 3.3 identifies the spread of publication by year.

Figure 3.3: Number of studies included in this scoping review, by year of publication



Methodological design

Fifty-three studies used a quantitative research design, 51 studies used a qualitative research design and 11 studies used a multi or mixed methods design. One Irish study⁽¹¹⁵⁾ described its paper as an audit; however, as it used inferential statistics it has

been included as a quantitative research paper. The majority of studies' primary data sources were from homecare workers across the structure (n=22) and process (n=10) domains, and from homecare recipients in almost all the studies (n=15) included under the outcome domain, as demonstrated in Table 3.2.

Table 3.2: Sources of data from selected studies

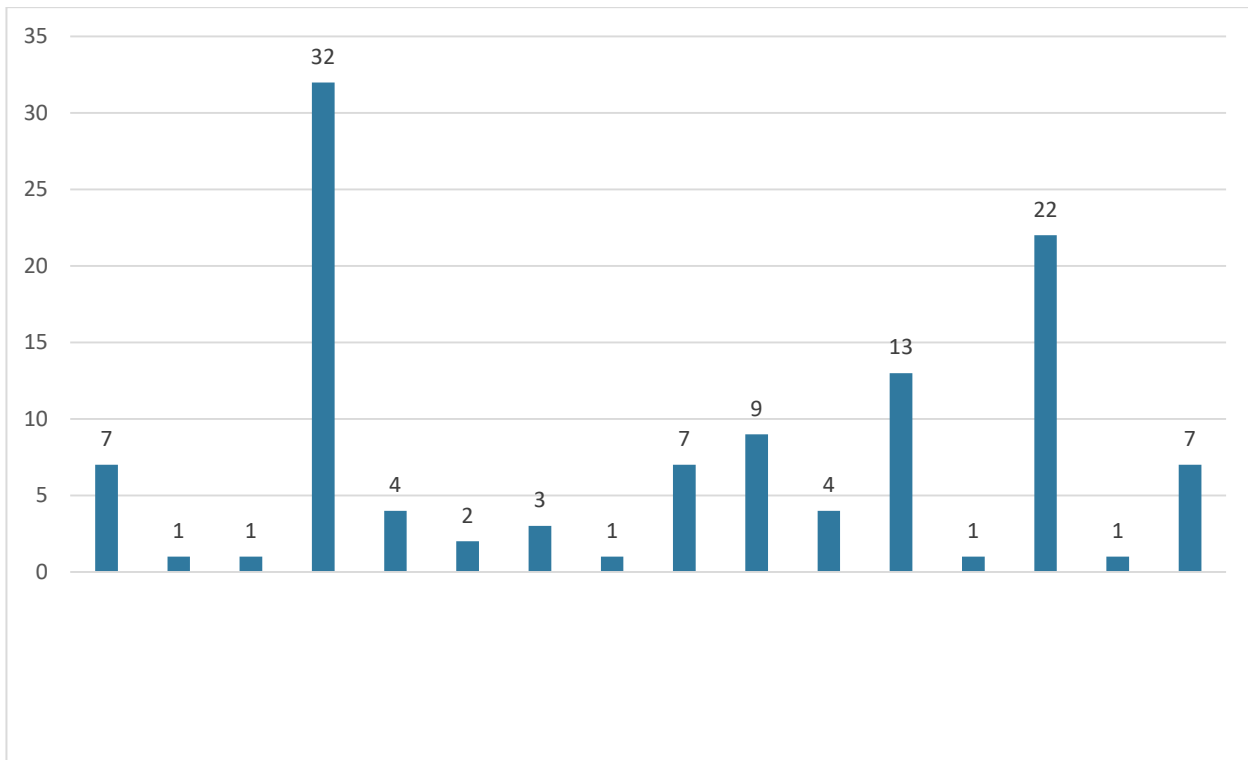
Source of data	Structure (n/%)	Process (n/%)	Outcome (n/%)
Homecare workers	22 (31.9)	10 (33.3)	
Secondary data	14 (20.3)	1 (3.3)	
Homecare providers	6 (8.7)		
Client Assessment / charts	5 (7.2)		
Homecare recipients	4 (5.8)	7 (23.3)	15 (93.7)
Clinicians or experts	2 (2.9)	1 (3.3)	
Homecare managers / leaders	2 (2.9)	1 (3.3)	
Homecare workers and homecare recipients	2 (2.9)	4 (13.3)	
Family care givers	1 (1.5)		
Carers and homecare recipients	1 (1.5)	1 (3.3)	
General population	1 (1.5)	1 (3.3)	
Healthcare professionals	1 (1.5)	2 (6.6)	
Homecare organisations, homecare recipients and / or homecare workers	1(1.5)		1 (6.3)
Homecare providers, homecare workers and homecare recipients	1 (1.5)	1 (3.3)	
Homecare recipients and homecare providers and inspectors	1 (1.5)		
Homecare recipients and relatives	1 (1.5)		
Homecare workers and managers	1(1.5)		
Homecare workers, family care givers and homecare recipients	1(1.5)		
Homecare workers and family carers	1(1.5)		
Homecare workers or homecare managers and stakeholders	1(1.5)	1 (3.3)	
Homecare workers, homecare providers and unions	1(1.5)		
Total	69 (100)	30 (100)	16 (100)

Geographical spread

Of the 115 studies included in this review, 32 were from Canada, 22 from Sweden, 13 from Norway and the remainder of countries included in the review accounted for less

than 10 studies each as shown in Table 3.4. Where data originated from multiple countries (n=7), this is referred to as a multi-country study.

Figure 3.4: Number of studies included in scoping review, by country or data of origin



Thematic findings

The following sections present the results of this scoping review through Donabedian's framework for contextualising quality. The thematic analysis identified eight themes under the structural domain, two themes under the process domain and three themes under the outcome domain. Person-centred care was seen to intersect all three domains. An information graphic (Figure 3.5) details the themes and subthemes generated from the thematic analysis. Table 3.3 sets out the taxonomic approach towards the generation of these themes along with the methodological approaches generated by the included studies.

Figure 3.5: Infographic reflecting the themes and subthemes generated from the thematic analysis

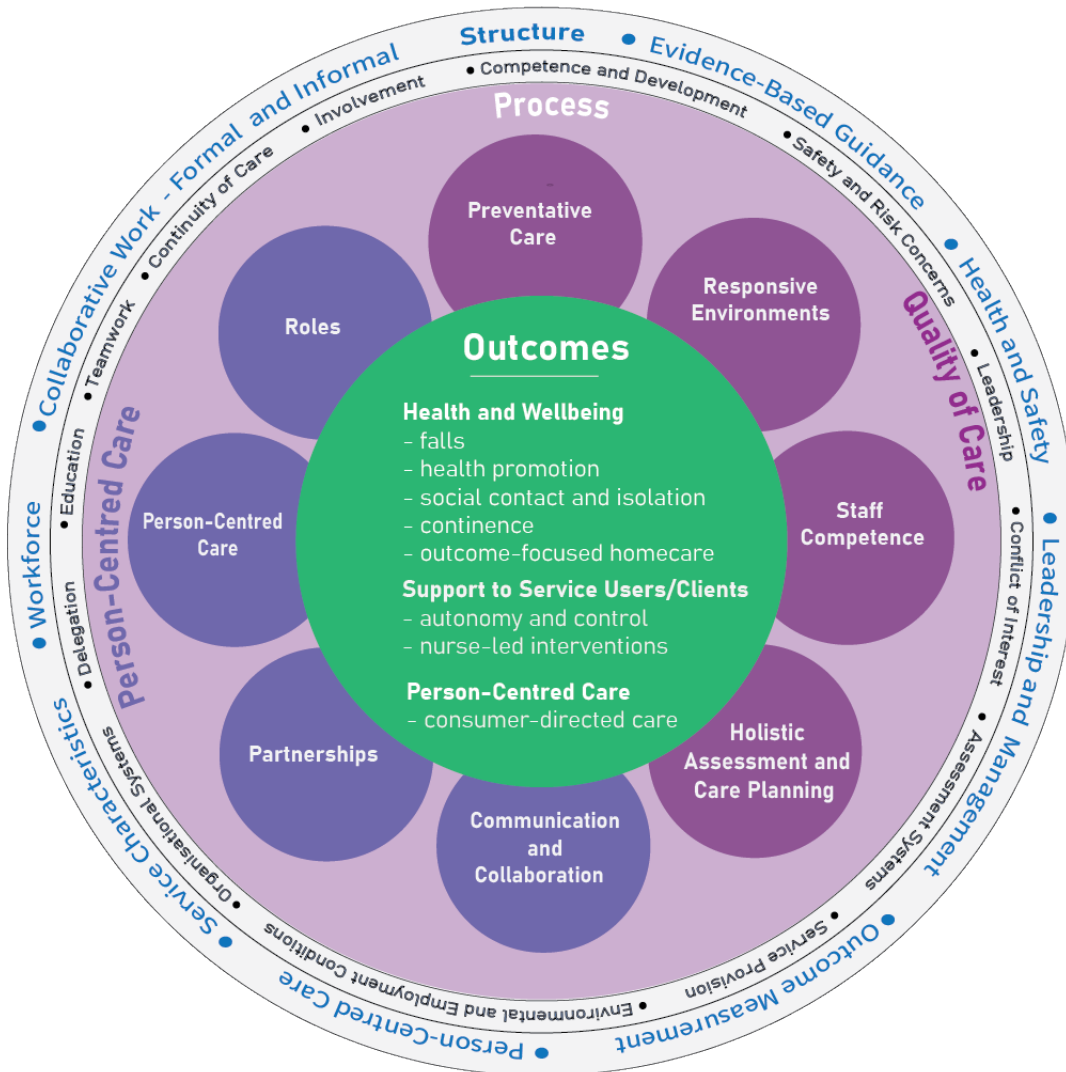


Table 3.3: Taxonomic summary of studies relating to the structure, process and outcomes of homecare

Structure Primary Theme	Sub theme	Studies	Quantitative Methods n=53 (study description)	Qualitative Methods n=51 (study description)	Mixed or Multi Method n=11 (study description)
Collaborative work - formal and informal care	Involvement - person centred and informal carers	(6,93,94,95,96,116)	Retrospective cohort design (n=1),	Interviews using grounded theory approaches (n=2) and descriptive qualitative designs (n=2)	Data from 30 European countries / including policy documents and interviews (n=1)
Evidence-based guidance	Evidence-based care	(117,118)	Cross-sectional design (n=1)	Interviews using grounded theory design (n=1)	
Health and safety	Safety & Risk concerns	(97,98,119,120,121,122,123,124,125,126,127,128)	Cross-sectional design (n=1), Cohort study design (n=1), Delphi study design (n=1), Randomised stratified sample design (n=1), Secondary analysis (n=1), Retrospective cohort study design (n=1)	Interviews using descriptive qualitative designs (n=2), Interviews not specified (n = 2)	Interviews and documentary analysis (n=1), Interpretive description methodology and participatory photographic methods (n=1)
Leadership and management	Leadership	(129) (99) (130)	Cross-sectional design (n=2)	Focus group interviews using exploratory qualitative research design (n=1),	
	Conflict of interest	(131)		Interviews using a phenomenological design (n=1)	

Outcome measurement	Assessment systems	(100,101,102,103,104,105,106,132,133)	Cohort study (n=1), Cross-sectional design (n=2), Secondary analysis (n=2), Randomised control trial (n=1), Prospective longitudinal and cross sectional design (n=1)	Interviews using descriptive qualitative designs (n=1), Interviews not specified (n=1), multiple case study (n=1)	
Person-centred care	Person-centred care	(134)	Cross-sectional / cross country design (n=1)		
Service characteristics	Service provision	(7,135,136,137,138)	Cross-sectional design (n=2), Secondary analysis (n=3)		
	Environmental conditions	(90,91,139,140,141)	Interviews using an explorative and a descriptive approach (n=1)	Participant observation (n=1), Interviews and observation not specified (n=1)	Convergent parallel mixed methods design (n=1), Interview and questionnaire design (n=1)
	Employment Conditions	(56,87,88,89,90)	Cross-sectional design (n=1)	Focus group interviews using descriptive qualitative designs (n=1), Focus group interviews using an exploratory descriptive design (n=1),	Semi-structured interviews generating qualitative and quantitative data (n=1)
	Organisational systems	(9,47,92,142,143)	Cross-sectional design (n=1), Secondary analysis (n=1),	Participant observation and semi structured interviews using an ethnographic design (n=1), Interviews using descriptive qualitative design (n=1),	

				interviews using an exploratory design (n=1),	
Workforce	Delegation / Task Shifting	(144), (145) (146) (147) (148)	Secondary analysis (n=1)	Interviews using descriptive qualitative designs (n=4),	
	Education / training & Oversight	(149,150,151,152,153)	Cross-sectional design (n=3),	Interviews informed by a mixed feminist philosophy (n=1)	Mixed method convergent parallel design (n=1)
	Team work	(154)		Interviews using a phenomenological design (n=1)	
	Continuity of care	(155,156)	Cross-sectional design (n=1)	interviews using an exploratory design (n=1)	
	Competence & Development	(157,158)	Cross-sectional design (n=1)	Interviews using a hermeneutic design (n=1)	
Process Primary Theme	Sub theme	Studies			
Quality of care	Preventative care	(115,159,160,161,162)	Secondary analysis (n=1), Quasi-experimental post-test-only design (n=1), Cross-sectional design (n=1)	Focus group interviews using an exploratory design (n=1), focus group interviews using a descriptive qualitative design (n=1),	
	Responsive environments	(85,163,164,165)	Secondary analysis (n=1), Cross-sectional design (n=1)	Interviews using descriptive qualitative design (n=1), participant observation informed by feminist and	

				anthropological theory (n=1)	
	Staff competence	(166,167,168,169,170,171,172)	Cross-sectional design (n=1)	Interviews using descriptive qualitative design (n=1), interviews using a single case study (n=1)	Participant observation / interviews and auto-ethnographic methods used (n=1), Unspecified (n=1), Observation, interviews, diary notes, surveys and literature reviews (n=1), explorative, qualitative mixed-methods design (n=1)
	Holistic Assessment & Care Planning	(173,174,175,176,177)	Delphi study design (n=1)	Focus group interview using a descriptive qualitative design (n=1), interviews using an exploratory design (n=1), focus group interviews using an exploratory and descriptive qualitative design (n=1),	Pre- to post-implementation design (n=1),
Person-centred care	Roles	(178,179)	Cross-sectional design (n=1)	Qualitative interviews (n=1)	
	Partnerships	(161,180,181)	Quasi-experimental post-test-only design (n=1)	Interviews using a descriptive qualitative design (n=2),	
	Communication & Collaboration	(182,183)		Focus group interview using a descriptive qualitative design (n=1), Audio recordings of naturally occurring	

				conversations using a descriptive qualitative design (n=1)	
	Person-centred care	(109,184,185)	Cross-sectional design (n=2)	Focus group interview using a descriptive qualitative design (n=1),	
Outcomes Primary Theme	Sub theme	Studies			
Health and wellbeing	Falls	(186,187)	Quasi-experimental design (n=1), Pretest-post-test design (n=1)		
	Health Promotion	(188,189)	Longitudinal study design (n=1)	Interview using a descriptive qualitative design (n=1)	
	Social Contact & Isolation	(190)	Cross-sectional design (n=1)		
	Continence	(191,192)	Cross-sectional design (n=1), Cohort study design (n=1)		
Person-centred care	Outcome focused homecare	(107,108,193,194)	Longitudinal study design (n=1), randomised controlled trial (n=2), retrospective pre/post-intervention design (n=1)		
	Consumer directed care	(195)		Interviews using an exploratory and descriptive qualitative design (n=1)	
Support to service users/clients	Autonomy & Control	(196,197,198)		Interviews using a hermeneutical approach (n=1), Observations and	

				interviews using a single case study design (n=1), interviews and observations using a grounded and reflective ethnographic approach (n=1)	
	Nurse-led interventions	(199)	Randomised controlled trial (n=1)		

Structure themes

Collaborative work - formal and informal care

Six studies identified the importance of collaborative partnerships between formal and informal care in homecare. Buscher et al. (2011)⁽⁹⁴⁾ describe the relationship between 'formal and informal' care as two different perspectives that need to engage in negotiation processes that take the whole homecare arrangement into account. Blais et al. (2013)⁽⁹³⁾ reviewed 1,200 homecare chart files in Canada. Through this review, they outlined that informal caregivers may contribute to the occurrence of adverse events and suggest that informal caregivers need to be involved in the creation of health interventions to reduce the incidence of adverse events. Homecare was also seen as organisationally driven⁽⁹⁵⁾ where there appears to be a philosophy of 'doing for clients' instead of promoting independence. Therefore, there was a need to ensure informal carers and formal carers worked together to reduce passivity. In their study, ⁽⁶⁾ make reference to countries across Europe where informal care is more prevalent than the involvement of governments in homecare delivery. However, Castor et al. (2018)⁽⁹⁶⁾ (child study) outline that successful homecare is dependent on tripartite collaboration being created and maintained between the family, the homecare service and the hospital.

Evidence-based guidance

Chaves et al. (2010)⁽¹¹⁷⁾ identified that protocols used in pressure ulcer care in homecare do not ensure that practice is in accordance with current scientific knowledge. Their Dutch study identified that although protocols exist in homecare, these may not be evidence based and this has the potential to negatively impact on care. They call for a consistent, standardised approach with a systematic implementation of regulations. Another concept of evidence-based practice is the 'phases of spread' model discussed by Ploeg et al. (2014).⁽¹¹⁸⁾ This model outlines how to spread models of evidence and best practice in homecare. In their study, the implementation of best practices (falls prevention, pain management, and management of venous leg ulcers) is optimised through the application of the 'phases of spread'. These stages include ensuring that organisations:

1. commit to change
2. implement best practices on a small scale
3. adapt locally
4. spread best practices internally to multiple users and sites.

These stages were facilitated by leading with passion and commitment, sustaining strategies, and seeing the benefits of the strategy once implemented correctly.

Health and safety

One of the most significant findings of this review is the extensive health and safety risks that exist in homecare, particularly in the unregulated homecare sector.⁽¹²⁰⁾ Twelve studies identified a multitude of risks that are broadly multi-dimensional and intersectional.⁽¹²⁷⁾ The delivery of care in the 'home' amplifies risks. Sears et al. (2013)⁽¹²⁵⁾ identified in their study (using a stratified randomised sample) that 13.2 of every 100 homecare cases were exposed to adverse events, of which 33% were preventable. They defined an adverse event as an event that causes 'an unintended injury or complication which results in disability, death or increased use of health-care resources and is caused by health-care management'. These increased risks in health and safety were corroborated by a further cohort study⁽¹²³⁾ which identified environmental hazards in 91% of homes (n=959) where people were in receipt of homecare (mean of 3.3 risks per individual). In two further studies, falls and medication-related incidents^(121,126) were cited as highly prevalent and Tariq et al. (2015)⁽¹²⁶⁾ report that the use of incident data (for example, on falls and medication incidents) may improve client safety. This is aligned with Ross et al. (2014)⁽¹²⁴⁾ who have developed notifiable incidents in their Delphi study – this broadly includes injury (related to inappropriate care planning), disease, adverse reaction, infection, serious incident relating to standards, theft, retention of objects and practicing outside the scope of competence.

Furthermore, Tong et al. (2016)⁽¹²⁷⁾ had similar findings to Craven et al. (2012).⁽⁹⁷⁾ Both studies were conducted in Canada in which Tong et al. (2016) conducted qualitative interviews with clients and family care givers. Craven et al. (2012) conducted qualitative interviews with homecare workers only. Despite this difference in samples, both studies identified "physical (musculoskeletal, injuries falls, communicable disease etc.), spatial (home environment, space, dangerous neighbourhood, pets, hazards) and interpersonal (interactions between client and family impacting on emotional, psychological and social wellbeing) safety concerns in homecare settings".⁽⁹⁷⁾ In addition to these, Craven et al (2012)⁽⁹⁷⁾ also highlighted temporal (timing of service, rushing with travelling and travelling to clients homes) risks" (p.528).

A reoccurring theme in the literature also identified the 'transient', 'lone' and 'remote' nature of homecare. According to Jackson et al. (2019), these 'invisible journeys' are associated with safety risks, and health and economic costs.⁽⁹⁸⁾ Safety was also viewed through the lens of the potential exposure to violence and harassment that homecare staff may also experience⁽¹¹⁹⁾ when lone working and their inability to undertake appropriate risk assessment due to lack of time, equipment and resources.⁽¹²²⁾ From a risk-protective perspective, Sun et al. (2017)⁽¹²⁸⁾ identified that higher levels of therapeutic self-care ability can be a protective factor against the

occurrence of adverse events, which therefore signals this an avenue for exploration in reducing adverse events and risks to homecare workers.

Leadership and management

Three Scandinavian studies identified how important leadership is in homecare. In Norway, Berland et al. (2012)⁽¹²⁹⁾ identified that a lack of functional leadership in homecare compromised patient safety. They also detailed specific management responsibilities that are co-dependent, such as lack of routines and failure to update procedures. This study also emphasised that management need to listen to nurses and be more aware of the dilemmas they experience. Lundgren and colleagues (2016) investigated leadership factors in homecare settings and reported that within homecare, leaders have less opportunity to organise, structure and immediately address problems which may negatively impact homecare services due to 'direct vs distant' roles.⁽⁹⁹⁾ However, to achieve a good working environment, leaders must focus on 'support from superior' (that is, express appreciation and support), 'empowering leadership' (encourage staff to participate and speak up and develop staff), 'human resource primacy' (reward staff for a job well done) and 'control of decisions' (that is, promote collaboration and involvement in decisions).⁽⁹⁹⁾ In this vein, Westerberg and Tafvelin (2014)⁽¹³⁰⁾ identified that a transformational leadership style is associated with more positive job satisfaction and better staff wellbeing, which in turn improves the quality of homecare. A separate discrete concept that branches from the leadership and management theme identified that homecare workers may experience a conflict of interest⁽¹³¹⁾ in balancing the interest of the homecare recipient's right to self-determination against external role demands. This means that homecare workers need to ensure they work within certain parameters, but they also need to be conscious of the rights and choices of homecare recipients. Breitholtz et al. (2013)⁽¹³¹⁾ identified that staff need to be supported in their ethical reflection.

Outcome measurement

Nine studies reported on various aspects of assessment systems and how they can support opportunities for decision making from a service or policy level perspective. Of which the following studies reported on a suite of interRAI tools.

(100,101,102,103,104,105,106)

The interRAI Health Care version is a standardised instrument that provides a reliable, person-centred assessment system that informs and guides comprehensive care and service planning in community-based settings. The findings suggest that these instruments offer numerous opportunities to influence patient-level clinical decision-making and organisation level quality improvement initiatives, and flag quality potential quality issues. However, their implementation can be burdensome

and homecare providers find using assessment tools difficult.⁽¹³³⁾ Firbank (2010)⁽¹³²⁾ and Firbank (2012)⁽¹³³⁾ considered quality improvement from homecare providers' perspectives and identified that smaller homecare providers have difficulty handling comprehensive assessments without external support. They further outlined that providers most in need of monitoring and improving the quality of services may also be least likely to voluntarily adopt and institutionalise quality improvement.

Person-centred care

One large descriptive cross-country design concerning eight European countries from the "RightTimePlaceCare" project⁽¹³⁴⁾ identified that in most European countries, people with dementia receive generic care that is rarely adjusted to their needs. This highlights a disconnect between service provision and use which could be improved through restructuring the delivery of care holistically around the individual.

Service characteristics

Nineteen studies discussed service characteristics in the context of the quality of service and protection of people in receipt of formal homecare. From a European organisational perspective, Van Eenoo et al. (2018)⁽⁹⁾ identified six models of homecare that range from a "(very) strong focus on patient-centred care delivery, a high availability of specialised care professionals, and a strong focus on monitoring of care performance to a very limited focus on patient-centred care delivery, little or no availability of specialized care professionals, and a strong focus on monitoring care performance". When considering best practice, Van Eenoo et al. (2016)⁽⁴⁷⁾ identified that researchers and policy-makers should take full account of local and national care contexts alongside international evidence.

Service characteristics on an operational level may also hinder best practice and what is best for the client as Strandås et al. (2019)⁽¹⁴²⁾ outlined in their study. They described how nursing staff they interviewed admitted to deviating from pre-defined tasks which they felt were based on economic reasons that devalued their patients rather than a person-centred healthcare approach. Likewise, Watkinson-Powell et al. (2014)⁽¹⁴³⁾ described the lack of recognition that food provision (resulting in malnutrition) receives in homecare, citing organisational barriers and budget cuts as a causative factor. In terms of regulation, a qualitative Dutch study⁽⁹²⁾ investigated the perceived added value of, and barriers to, a newly developed regulatory framework. They identified that regulating care networks (multiple care providers, formal and informal, and organisations that are involved in long-term care for frail people living independently) added value to services as this framework put the person at the centre of care and at the forefront of multiple providers. However, while such benefits were identified (for example, collaboration and the recipient being at the centre of the process and speaking to inspectors) significant barriers

were cited such as time and cooperation. This study also recommended that regulatory bodies give more consideration to measures taken by care providers to assess the ability of clients. This directly relates to the concept of service provision where Guinaldo et al. (2013)⁽¹³⁵⁾ highlighted issues with the inappropriate use of homecare and Holm et al. (2017)⁽¹³⁶⁾ identified that allocation systems need to be fair and subject to review. Kitchen et al. (2011)⁽¹³⁷⁾, Riedel et al. (2016)⁽⁷⁾ and Vecchio (2013)⁽¹³⁸⁾ all outline that diverse systems of homecare need to be developed that are geographically equitable with clear referral pathways.

From a service characteristic perspective, the working conditions of homecare employees were identified as precarious with poor communication, minimal support, guaranteed hours, low wages and travel time not paid identified as central issues.⁽⁸⁷⁾ Three studies of homecare workers in Canada cited similar themes for homecare workers job satisfaction and intention to remain employed (for example: having autonomy, flexible scheduling, reasonable and varied workloads, supportive work relationships, and receiving adequate pay and benefits were reasons to remain employed).^(88,89,90) Similarly, a UK study highlighted that staff who are directly employed by service users may be more at risk of exploitation and abuse in the absence of regulation.⁽⁵⁶⁾ Employee conditions are also likely to be influenced by homecare conditions where intimate care and moving and handling have been highlighted as a challenge due to ill-adapted environments^(139,140) and where 'dirty workplaces' pose risks.⁽¹⁴¹⁾ Larsson et al. (2018)⁽⁹¹⁾ outline that criteria for a safe working environment need to be developed in order to prioritise safety at work and that leadership is an important component to support this process.

Workforce

Continuity of care is a prerequisite for quality in homecare.^(155,156) However, an individual recipient of homecare has few consistent carers, and ensuring the continuity of care for all recipients is difficult for homecare managers. This can create a paradox, where homecare managers are in conflict with the professional standards in which they must balance the person's wellbeing with the wellbeing of their staff. The concepts of 'delegation'⁺⁺⁺⁺⁺ or 'task shifting'^{SSSSS} may increase continuity, but comes with caveats. While delegation in homecare has been associated with increased autonomy and reinforcing the intrinsic rewards of care work,⁽¹⁴⁴⁾ it is also associated with blurred responsibilities⁽¹⁴⁵⁾ due to accepting delegation (unquestioned or involuntary delegation) that may be outside of a care

+++++ In broad terms delegation is a process by which a healthcare professional who has legal authority to perform a task transfers that authority to another person.

SSSSS Task shifting refers is the name now given to a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications.

worker's scope of competence.^(146,147,148) This is particularly true where there is no defined scope of practice.⁽¹⁴⁸⁾

Hasson and Arnetz (2011)⁽¹⁵⁸⁾ identified that opportunities for competence development may be difficult in homecare due to the isolated nature of the work. Despite this, they also report that staff need to develop competencies regarding interactions and activities offered to older homecare recipients in order to improve and maintain quality. Additionally, Debesay et al. (2014)⁽¹⁵⁷⁾ described the diverse homecare population that now exists and outlined a need for cultural competence training, greater awareness of rehabilitative choices and care surrounding death and dying. This review highlights a need for standardised education,⁽¹⁵¹⁾ training and oversight⁽¹⁴⁹⁾ with a particular focus on dementia^(149,150,153) and mental health issues.⁽¹⁵²⁾ Morgan et al. (2006)⁽¹⁵³⁾ outlined that educational programmes should be aligned with perceived needs and warned that basing education solely on typical activities in homecare may be ineffective. The workforce theme is perhaps embodied by a single child study⁽¹⁵⁴⁾ which identified that in order to provide a child-centred service, there is a need for close collaboration and good team work.

Process

Quality of care

Aspell et al. (2019)⁽¹¹⁵⁾ identified that services and supports need to be personalised and cognitive specific in order to keep people with dementia and cognitive impairments living at home for longer. In three other studies, there was an emphasis on preventative care through promoting independence⁽¹⁶⁰⁾ and focusing on preventative measures as opposed to treatment (for example, the cause of falls as opposed to their management)⁽¹⁵⁹⁾ and aged-related health issues.⁽¹⁶²⁾ In terms of improving the quality of responsive environments, Bagchus et al. (2015)⁽¹⁶³⁾ called for creative ways to facilitate the expression of needs and wishes of people in receipt of homecare. Another study using a participant observation approach⁽⁸⁵⁾ identified how care workers struggle to improve these responsive environments due to time constraints. However, staff compensate for this by employing certain tactics such not discussing time constraints with care recipients, individualised routinisation, working on different paths simultaneously (initiating and performing different tasks at the same time) and postponing tasks. These tactics and their consequences on care workers are outlined by Bijnsdorp et al. (2019)⁽¹⁶⁴⁾ who refer to caregiver burden⁽⁸⁶⁾ and state that in order to uphold quality, it is important that healthcare professionals make sure partner caregivers receive adequate and timely support.

In terms of technical competencies, there is a broad consensus that homecare staff need to be multi-skilled. They must be skilled in 'illness work, everyday life work, life-changing work, relation work, discretion work, information work and articulation

work'.⁽¹⁶⁷⁾ They must also be culturally competent and responsive to sexuality,⁽¹⁶⁹⁾ have a good level of emotional intelligence and social skills,⁽¹⁷¹⁾ and be able to detect early deterioration in frail older patients.⁽¹⁷²⁾ Swedberg et al. (2013)⁽⁸⁶⁾ referred to a competence gap where home healthcare assistants performed advanced care without formal training or support, which creates risks for both their client and themselves. The home healthcare assistants in this study articulated feeling trapped in the home setting. They described poor supervision and a disconnect to the patient care system as causative factors of these increased risks. De Witt and Ploeg (2016)⁽¹⁶⁸⁾ make reference to home healthcare professionals' describing that they 'do the best we can', but feel they are 'walking the tightrope' regarding meeting professional responsibilities despite constraints and boundaries related their professional roles. Two other studies have addressed competence evaluation [Nursing Older People-Competence Evaluation Tool (NOP-CET)]⁽¹⁶⁶⁾ and rehabilitative competence development ('Stay Active at Home' training programme).⁽¹⁷⁰⁾ The NOP-CET showed good validity and reliability as a measure of community-based nursing staff competence and the 'Stay Active at Home' training programme is described as a promising programme that will help equip workers with the necessary knowledge, attitude, skills and social and organisational support to deliver day-to-day services at home from a more rehabilitative perspective. In a further Delphi style study, Monsen et al. (2011)⁽¹⁷⁶⁾ developed evidence-based standardised care plans (EB-SCP) [available online] for use internationally to improve homecare practice. Using the care plans intends to reinforce excellence in care, and other studies have identified the critical need for holistic assessment (based on consent and collaboration), care planning of hygiene care,⁽¹⁷³⁾ pain assessment [in dementia],⁽¹⁷⁴⁾ oral care⁽¹⁷⁵⁾ and medication management⁽¹⁷⁷⁾ in homecare.

Personal-centred planning

Johnasson et al. (2017)⁽¹⁸⁴⁾ and Kazemi and Kajonius (2015)⁽¹⁰⁹⁾ both identified the importance of using a person-centred and user-orientated approach towards meeting the person's needs. A separate study by Sundling and colleagues (2020)⁽¹⁸⁵⁾ reported that person-centred responses from care workers were associated with the way distress was expressed by older persons. For example, emotive responses received a person-centred response from staff, whereas regular repetitive behaviours did not. Equally, they found that intercultural differences in communication may also be related to the level of person centeredness offered by homecare workers. Poor communication and collaboration were also found to impact person centeredness. For example, a study by Håkonsen et al. (2019)⁽¹⁸²⁾ regarding nutritional care, identified that poor collaboration and communication obstructed optimal clinical decision-making. Additionally, Kristensen et al. (2017)⁽¹⁸³⁾ identified that communication during homecare visits can mainly be task orientated with

greater attention paid to physical needs as opposed to existential needs, and therefore called for improved person-centred communication.

Partnership was also identified as a key aspect of person-centred care planning. Gregory et al. (2018)⁽¹⁸⁰⁾ deconstructed this concept in their qualitative study and understand it as being treated as an equal, being involved in decision-making, and making contributions which impact on healthcare and health systems. They also refer to invisibility which is seen as the opposite of partnerships. Matscheck et al. (2020)⁽¹⁸¹⁾ also references user involvement as being an integral part of 'support in daily living', but suggests that having less detailed plans (including rules and restrictions) may facilitate better partnerships. In a quasi-experimental study McWilliam et al. (2014)⁽¹⁶¹⁾ found that having a concrete, process-focused, guided conversation script fostered an empowering and health-promoting partnering experience over time as opposed to the usual approach to in-homecare interaction. Another aspect of person-centred planning relates to the concept of roles. Funk (2013)⁽¹⁷⁸⁾ refers to formal homecare as supplementary, with family being primary providers. Funk advocated that formal homecare should not try and substitute, but rather endeavour to be flexible representing the 'responsibilisation' of support. Finally, regarding preferences, a German study⁽¹⁷⁹⁾ identified preference towards the type of person 'old age' individuals want to support them. Being kind, understanding, punctual, reliable, having enough time for conversation and having an orderly appearance were principally identified characteristics. Some individuals did identify a preference for the same language but having the same cultural background was less important.

Outcomes

Health and wellbeing

From a health and wellbeing perspective, homecare should have a health promotion philosophy.⁽¹⁸⁸⁾ Burton et al. (2015) identified the benefits of physical activity and its relationship with health and wellbeing. This study demonstrated that older people recognise physical exercise is good for them; however, the focus should be on their activity levels through an activity they enjoy rather than on exercising.⁽¹⁸⁸⁾ Another study⁽¹⁸⁹⁾ identified a strong relationship between homecare recipients who scored high on two health measures (Methods for Assigning Priority Levels and Changes in Health, End-Stage Disease, Signs and Symptoms) as being more likely to be admitted into long-term care or dying. They call for comprehensive, frequent, pre-emptive reviews and suggest this may highlight the need for an intensive care coordinator approach. Concerning falls in homecare, one study using a quasi-experimental design determined that home help services interventions did not have any impact on fall-related hospitalisations.⁽¹⁸⁶⁾

Poorer outcomes for people in receipt of homecare were also associated with urinary incontinence.⁽¹⁹²⁾ In their Swiss study, John et al. (2014)⁽¹⁹²⁾ identified that if a homecare recipient had urinary incontinence and was then admitted to hospital, they are more likely to have longer lengths of stay and a higher mortality rate. The mortality rate increased in line with the incidence of urinary incontinence. For example, the hazard ratio (HR) range increased from HR:1.5 for one episode of urinary incontinence per week to HR:4.2 for daily urinary incontinence compared to no urinary incontinence. A further study⁽¹⁹¹⁾ stated that despite homecare agencies claiming they adopt quality systems to improve urinary incontinence, a cross-sectional analysis found no associations between these quality systems and the urinary incontinence process or patient outcomes. Social contact and isolation were identified as key concerns for older people. Dale et al. (2020)⁽¹⁹⁰⁾ found that perceived social provisions was high in a Norwegian study of 242 people aged over 75 years. This is in contrast to the widely held belief that older people are often isolated. However, social desirability may have an impact on findings. Nonetheless, reduced social provisions was related to increased amount of homecare, and the authors report that being in receipt of homecare may work as a strategy to gain more social contact.

Person-centred care

While different terminology may be used across different geographical jurisdictions, this review found that where homecare was outcome focused, or consumer directed (more person centred), then more favourable outcomes were reported. In a longitudinal UK study, Gethin-Jones (2012)⁽¹⁹³⁾ identified a greater improvement in subjective wellbeing in a comparison group receiving outcome-focused care versus traditional task-focused homecare. This subjective wellbeing was also found to remain even with physical decline. A randomised control trial⁽¹⁹⁴⁾ that focused on restorative homecare (a person-centred approach towards the restoration and maintenance of older people's physical function) also identified a significant improvement in health-related quality of life (measured by the Short Form 36 [SF36] Health Survey) in a control group receiving task-focused homecare. Additionally, Parsons et al. (2012)⁽¹⁰⁸⁾ and Parsons and Parsons (2012)⁽¹⁰⁷⁾ explored the concept of 'goal setting' in homecare. They found that where a goal facilitation tool was used in the assessment of an older person's needs on referral for homecare, then a significant improvement in quality of life was observed. Furthermore, they underlined the importance of facilitating older people to set goals. This is seen as an important person-centred approach towards developing support plans. Alongside this, Russell et al. (2020)⁽¹⁹⁵⁾ have explored the experiences of people receiving a homecare package. They found effective consumer-directed care is reliant on being charged reasonable fees, having continuity of care workers, having person-centred care, having support from family or advocacy and community engagement.

Support to service users

The concept of autonomy and control is central to upholding the rights of people receiving homecare. Faeø et al. (2020)⁽¹⁹⁶⁾ detailed that maintaining control and autonomy over one's own life was fundamental for people with dementia. However, they define that there are fine margins between whether specific care interventions are supportive or infringing, and this may have a detrimental impact on autonomy and control. Glasdam et al. (2013)⁽¹⁹⁷⁾ advanced this further and highlighted that homecare support may create a dilemma between being institutionalised and maintaining one's own private life in a person's own home, particularly if regulatory and healthcare systems and processes impact on a person's own way of living. Another aspect to this issue concerns being viewed as a 'human' and not a 'case'.⁽¹⁹⁸⁾ Liveng (2011)⁽¹⁹⁸⁾ considered this further and identified that homecare recipients want to be seen as competent to make their own decisions, to be heard, respected and understood. In terms of overseeing homecare support,⁽¹⁹⁹⁾ supporting the concept of health promotion and disease prevention interventions with multiple home visits using a holistic suite of approaches facilitated this.

Interpretation of results and discussion

In Ireland, there is a fundamental need to provide a statutory basis for the regulation of homecare. This review has highlighted the multi-dimensional and intersectional complexities that exist in the sphere of homecare. Given the dearth of empirical evidence examining the concept of regulation of homecare, this review has attempted to map some of the issues concerned with homecare structures, process and outcomes through a Donabedian lens. Structures, processes and outcomes are mutually dependent and inseparable, meaning that without good structures, processes are compromised and as a result, outcomes are poorer. These concepts are the foundation of quality healthcare,⁽²¹⁾ and are determined to be necessary for improving performance and quality.⁽²⁰¹⁾ Therefore, these findings can help inform governmental policy in respect to establishing parameters for the regulation of homecare in Ireland, and in other jurisdictions more broadly.

The review identified eight primary themes under the structural lens, two primary themes and eight sub themes under the process lens, and three primary themes under the outcomes lens of Donabedian's framework. Of particular note, the person-centred care theme intersects with each aspect of the framework, identifying its critically important nature in care, and representing the global person-centred philosophy that homecare must take across all domains. The spread of retrieved evidence is consistent with the development of homecare insofar as Canada is observing shifting philosophies to provide care 'closer to home',⁽²⁰²⁾ whereas in Eastern Europe, homecare is not yet fully developed.⁽⁷⁾ Additionally, the type and range of empirical evidence identified was largely comparable across the structural

and process lens, but more orientated towards a quantitative methodology across the outcome lens. Given the scoping review methodology employed,⁽¹¹⁴⁾ the methodological quality of included studies was not determined. However, to the best of the researcher's knowledge, only peer reviewed studies have been included. It is important to highlight that although the provision of homecare services differ in terms of geographical location,⁽⁴⁷⁾ distribution, market privatisation and decentralisation of formal services in some countries,⁽⁸⁾ the evidence is generally coherent and largely aligned.

In summary, there is a severe lack of empirical research regarding regulation in homecare. While some studies have made reference to regulation or called for regulation in varying degrees (or varying aspects),^(6,47,98,122,147,152,181,195,198) only Verver et al. (2018)⁽⁹²⁾ reported on how the Dutch Health and Youth Care Inspectorate tested a regulatory framework focusing on care networks around older adults living independently. They do however, caution against its implementation given the substantial time and resource investment, notwithstanding that it puts older adults at the centre of the regulatory activity.

This review signals that from a structural regulatory oversight perspective, there is a critical need for providers to embody a person-centred philosophy where recipients of care and informal carers are an integral component of formal homecare.⁽⁹⁴⁾ Essentially, it would appear that the collaborative partnerships between informal and formal care are fundamental to the success of homecare, and this relationship needs to be maintained. The evidence identified in this review describes that there also needs to be strong leadership with robust governance and management arrangements in place, supported by clear lines of oversight and accountability. A concerning finding in this review indicates that there appears to be an extremely high tolerance to risk in the homecare sector. Whether this is known or unknown to service providers was not explored in this review. However, it must be noted that the risks identified in this review are multi-dimensional and intersectional as they encroach on all identified structural themes.^(97,98,119,120,121,122,123,124,125,126,127,128) In this regard, the concept of safeguarding the wellbeing of recipients of homecare is also critically important. Direct inferences can be taken from these findings that highlight the importance of safeguarding the wellbeing of people who use homecare services more broadly.

In terms of service characteristics and workforce development, the precarious employment conditions of homecare workers is a fundamentally important issue to address. There needs to be oversight in terms of working conditions, supervision and support,⁽⁸⁷⁾ but also from a competency,^(157,158) educational⁽¹⁵¹⁾ and task shifting perspective.⁽¹⁴⁶⁾ Continuity of homecare can only be consistent with such interventions. It is also acknowledged that the use of assessment systems shows

substantial promise and this needs further consideration from an implementation perspective.

In terms of processes, this review focused on homecare being preventative and responsive, where staff have the competence to assess, plan and deliver care that is grounded in evidence. Promoting independence⁽¹⁶⁰⁾ and focusing on preventative care⁽¹²⁹⁾ are cited as central to achieving this. However, it is important to note that homecare workers are often time restricted⁽⁹⁸⁾ and task orientated⁽¹⁰⁹⁾ which is incongruent with independent, preventative homecare services. Homecare workers' lack of technical competence has also been identified as a significant concern. Even though homecare workers have described that they do the best they can,⁽¹⁶⁸⁾ this does not necessarily translate into the most appropriate care actions. Therefore, there is an urgent need to guarantee that there are appropriate supports in place to ensure homecare staff have appropriate training and support that is proportionate with the range and reach of services they provide.^(86,167) In parallel, there is a need to ensure that the homecare provided is embodied in a partnership that focuses on communication and collaboration,⁽¹⁸³⁾ transparent roles and responsibilities⁽¹⁷⁸⁾ in a person-centred approach.⁽¹⁸⁵⁾

From an outcome perspective, it is imperative that homecare does not infringe on the autonomy and control of the person in receipt of homecare. Liveng (198) deconstructs this further to state autonomy and control should encompass being heard, respected, understood, regarded as competent and decisive in one's own home, and accepted and identified through one's life. There are tentative links to suggest that this may be achieved through using outcome-focused, consumer-directed or goal setting methodologies.^(107,108,193,195) Furthermore, there is some weight towards suggesting that nurse-led interventions⁽¹⁹⁹⁾ positively influence health-related quality of life. This theoretically gives more clinical oversight towards the creation of homecare provision. Equally, high-risk areas of concern such as urinary incontinence,⁽¹⁹²⁾ falls,⁽¹⁸⁷⁾ and other serious and notifiable incidents,⁽¹²⁴⁾ may be a mechanism towards which a regulator may determine the quality of outcomes for people in receipt of homecare. It is important to highlight that despite these being indicators of quality on their own, they are diminished unless they are subject to continual evaluation and review largely due to the changing needs of people in receipt of homecare services.

Finally, from an outcome perspective and in the context of regulating homecare, it is important that the outcomes that are important to the person receiving homecare are at the core of service provision. For example, outcomes such as quality of life⁽²⁰³⁾ and satisfaction with homecare⁽²⁰⁴⁾ should be considered as a core purpose of the service that is being provided.

Limitations

The main limitation that needs to be considered is the lack of empirical evidence on the regulation or effectiveness of homecare. This review has taken a pragmatic viewpoint and conceptualised regulation as a quality improvement instrument through a Donabedian lens. Therefore, despite highlighting the necessary areas that homecare regulation should address, this review cannot fully occupy the absence of such evidence. Furthermore, due to the volume of evidence this review has excluded the role of technology, palliative care and medical procedures or medical maintenance carried out in a person's home. It is important that such areas are considered in any regulatory framework that is developed in line with the scope of homecare regulation.

Health technology is vastly used in homecare for a variety of reasons; however, due to the volume of evidence available it was excluded from this scoping review. Nevertheless, its use and impact on homecare must be recognised, as it is a vital component to consider within the development of homecare regulation. Any development of a homecare regulatory framework must be agile to adapt in line with the inevitable advancements of health and assistive technology. An in-depth review would be required to comprehensively assess the role of technology in homecare provision in order to determine how to proceed with developing an appropriate regulatory framework (Appendix 1.1 includes further evidence on the use of health technology in homecare).

It is important that the use of technology in homecare is further considered from an Irish context as it has received increased attention over the past two decades as the feasibility of its implementation has grown.^(205,206,207) Within homecare, health technology can reduce complications associated with chronic conditions⁽²⁰⁸⁾, reduce hospital readmissions and length of admissions, reduce visits to outpatient services and reduce costs associated with home-based services for chronic disease patients.⁽²⁰⁹⁾ However, the evidence supporting these benefits is mixed.^(205,210)

Facilitators for the successful implementation of health technology are evident in several systematic and scoping reviews. These include collaboration between all 'actors' in the process of care,⁽²⁰⁷⁾ the use of a participatory approach when designing health technology, and facilitating access to supports for informal carers.⁽²¹¹⁾ Barriers to the implementation of health technology have been cited as; the low level of 'smart home readiness' in older people's homes,⁽²⁰⁵⁾ costs associated with implementation,^(209,212) perceptions of health technology⁽²⁰⁷⁾ and a lack of solid evidence base needed to inform practice.^(207,210,211)

Conclusion

The Government of Ireland is preparing to develop a bespoke regulatory framework that would provide the statutory basis for the regulation of professional homecare in Ireland. This review has taken a pre-emptive position by identifying the areas that need to be considered when regulations are being drafted through a Donabedian framework. This framework can also be used by other jurisdictions to map areas for consideration from a regulatory perspective.

This review has highlighted that homecare structures, processes and outcomes are co-dependant, intersectional and multi-contextual. In this vein, providers of homecare and regulators alike need to apply a person-centred philosophy at each strand of the framework. In doing so, there is a more realistic opportunity for enabling the structures and processes to deliver better outcomes for people in receipt of homecare services.

Plain language summary of Chapter 3

The structures, processes and outcomes of homecare rely on each other. Without good structures, processes are compromised and as a result, outcomes are poorer for people receiving homecare services. It is important that person-centred care is considered at all stages of the homecare process. Homecare should be about quality and the following elements should all be considered as being very important in providing homecare:

Structure: Involvement – person-centred and informal carers; safety and risk concerns; leadership; conflict of interest; assessment systems; service provision; environmental conditions; employment conditions; organisational systems; delegation or task shifting; education, training and oversight; team work; continuity of care and competence and development.

Processes: Preventative care; responsive environments; staff competence; holistic assessment and care planning; roles; partnerships and communication and collaboration.

Outcomes: Falls; health promotion; social contact and isolation; continence; outcome-focused homecare; consumer-directed care; autonomy and control and nurse-led interventions.

Chapter 4: International approaches towards the regulation of homecare

Introduction

Chapter 3 found that the structures, processes and outcomes within the homecare sphere are mutually dependent and inseparable. This means that without good structures, processes are compromised and as a result, outcomes are poorer for people receiving homecare services. Additionally, the concept of person-centred care intersects all elements of this framework and there needs to be a person-centred philosophy incorporated at all components of the homecare sector. This chapter identifies international approaches towards the regulation of homecare.

Research identified in Chapter 3 also signalled which jurisdictions would be included in this review. As many countries do not use English as their first language, this chapter is divided into [predominantly] English speaking and [predominantly] non-English speaking jurisdictions. The substantial bulk of evidence was retrieved from online sources from English speaking countries. It is important to note that regulatory approaches and mechanisms are diverse and there is no simple way to compare like-for-like characteristics. Rather, this chapter broadly describes how different jurisdictions regulate homecare. However, due to a significant amount of sources being in languages other than English, this restricted the scope of what could be achieved and reported.

Methodology

In the first instance, international authors whose research was included in the scoping review in Chapter 3 were invited to participate in an online survey. The survey asked questions relating to the regulation of homecare; more specifically it asked:

- 1) Is homecare regulated in the jurisdiction you are answering on behalf of?
- 2) If homecare is regulated, then how is it regulated?
- 3) What tasks are provided for within homecare?

The online survey was issued in November 2020. In parallel, a desktop review of English speaking jurisdictions identified in the scoping review were conducted. This two-pronged approach aimed to maximise the breadth of evidence that would be retrieved from each country. From the desktop review perspective, the following questions were asked:

- 1) Is homecare regulated?
- 2) How is homecare regulated? (including work carried out by the regulator if appropriate)

3) What type of tasks are provided by homecare providers that are regulated?

Findings

Seven out of 23 jurisdictions contacted responded with information regarding homecare. These were Denmark, Finland, France, Germany, Greece,^{*****} the Netherlands and Sweden. As these countries were all [predominantly] non-English speaking, with limited English resources, these findings are presented only in a descriptive format. To mitigate the non-response from English speaking countries, Australia, Canada, England, New Zealand, Northern Ireland, Scotland and Wales were specifically targeted for inclusion in the desktop review. These findings are set out below.

Regulation of homecare services in English speaking jurisdictions

England

Is homecare regulated?

The Health and Social Care Act 2008 specifies the Care Quality Commission (CQC) as the independent regulator of health and adult social care in England.⁽²¹³⁾ CQC regulates treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).⁺⁺⁺⁺⁺ Homecare agencies are the most common services providing care in a person's home.⁽²¹⁴⁾ CQC also regulates:

- Mobile doctors and phone or online advice services that operate in-homecare services
- Homecare services provided for children
- Supported living services which refer to a person living in their own home and receiving care and or support in order to promote their independence; enabling the person to be as independent and autonomous as possible.
- Extra care housing services. These services cover a variety of arrangements and consist of purpose built accommodation (services and facilities are shared) with different amounts of care and support provided. CQC regulates the care provided, but not the accommodation or facilities.
- Shared lives where care and or support is provided by individuals, couples and families who have been trained for that role by the service registered with CQC. The service is only regulated by CQC.⁽²¹⁵⁾

^{*****} Greece was excluded from the review as the response provided was not aligned to the needs or objectives of this research.

⁺⁺⁺⁺⁺ In England and Wales, services that provide personal support (IADL) activities only are not regulated, however if a service is regulated to provide personal care, personal support services will be reviewed during inspection.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out a broad range of regulated activities.⁽²¹⁶⁾ A ‘service provider’^{*****} must register with CQC for each of the regulated activities they carry out, for example personal care and nursing care. Regulated activities are set out in Table 4.1.

Table 4.1: Regulated activities as set out in the Health and Social Care Act 2008 Regulated Activities 2014 in England	
<ul style="list-style-type: none"> ▪ Personal care 	<ul style="list-style-type: none"> ▪ Management of supply of blood and blood-derived products
<ul style="list-style-type: none"> ▪ Accommodation for people who require nursing or personal care 	<ul style="list-style-type: none"> ▪ Transport services, triage and medical advice provided remotely
<ul style="list-style-type: none"> ▪ Accommodation for people who require treatment for substance misuse 	<ul style="list-style-type: none"> ▪ Maternity and midwifery services
<ul style="list-style-type: none"> ▪ Treatment of disease, disorder or injury 	<ul style="list-style-type: none"> ▪ Termination of pregnancies
<ul style="list-style-type: none"> ▪ Assessment or medical treatment for persons detained under the Mental Health Act 1983 	<ul style="list-style-type: none"> ▪ Services in slimming clinics
<ul style="list-style-type: none"> ▪ Surgical procedures 	<ul style="list-style-type: none"> ▪ Nursing care
<ul style="list-style-type: none"> ▪ Diagnostic and screening procedure 	<ul style="list-style-type: none"> ▪ Family planning services

Type of work carried out by the regulator

CQC registers care providers and monitors, inspects and rates services. It publishes inspection findings, naming the provider and including performance ratings, which can help people choose care. There are specific Care Quality Commission (Registration) Regulations 2009 (Part 4 and 5) that relate to the registration and ongoing monitoring of those who carry out regulated activities.⁽²¹⁷⁾ These regulations broadly relate to a service’s statement of purpose, notifications, fees, financial position and other regulations bespoke to the carrying out of a specific activity. Additionally, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3, Section 1), sets out requirements relating to persons carrying on or managing a regulated activity as follows:⁽²¹⁶⁾

***** A service provider can be an individual, a partnership or an organisation. Examples of organisations are companies, charities, NHS trusts and local authorities.

- Regulation 4: Requirements where the service provider is an individual or partnership
- Regulation 5: Fit and proper persons: directors
- Regulation 6: Requirement where the service provider is a body other than a partnership
- Regulation 7: Requirements relating to registered managers.

Registration: Before a care provider can carry out a health or adult social care regulated activity, such as personal care, they must register with CQC and demonstrate that they meet legal requirements, such as fundamental standards of quality and safety. Information provided by applicants allows CQC to make judgments about:

- Whether they are suitable
- Whether there are enough staff and whether they have the right skills, qualifications and experience
- The size, layout and design of the places where they intend to provide care
- How effective their policies, systems and procedures will be
- How decisions will be made.⁽²¹⁸⁾

Every registered provider must pay fees every year; these fees cover costs of registration, changes to registration and CQC's activities associated with monitoring, inspecting and rating services.⁽²¹⁹⁾ CQC's registration team includes 'Experts by Experience', who are people with personal experience of care.⁽²²⁰⁾ Once a service has registered with CQC, they continuously get monitored. There is no registration requirement for individual homecare workers, nor is there any requirement for staff to be fully qualified before they begin working.

Monitoring and inspecting: Up until the beginning of the COVID-19 pandemic, CQC broadly carried out three types of inspections; announced, themed or responsive. It used a variety of methods to collect information on service providers including:

- information from historical inspections and how issues were addressed, statutory notifications, provider information return (this is a form that asks the provider to give key information about the service, what the service does well, and the improvements that they plan to make)
- observations through home visits (not always, but with consent if they are to take place)
- speaking to relatives

- communication with people providing and people who receive services (this can also include Experts by Experience who communicate with the person in receipt of services)
- contact with the local authority safeguarding and commissioning teams to ask for their views about the service
- reviewing care plans and staff files.

Homecare providers are assessed against the fundamental standards of care.⁽²²¹⁾ These standards of care are set out in Section 2 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), as shown in Table 4.2. It is determined that care must never fall below these. Where care does fall below these standards, appropriate enforcement action is taken by the CQC. These came into force for all health and adult social care services from the 1 April 2015.

Table 4.2: Regulations relating to the fundamental standards of care as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended)

Regulation	Theme
▪ Regulation 8	General Regulation
▪ Regulation 9	Person-centred care
▪ Regulation 10	Dignity and respect
▪ Regulation 11	Need for consent
▪ Regulation 12	Safe care and treatment
▪ Regulation 13	Safeguarding service users from abuse and improper treatment
▪ Regulation 14	Meeting nutritional and hydration need
▪ Regulation 15	Premises and equipment ^{§§§§§§}
▪ Regulation 16	Receiving and acting on complaints
▪ Regulation 17	Good governance
▪ Regulation 18	Staffing
▪ Regulation 19	Fit and proper persons employed

^{§§§§§§} 'Premises' and 'equipment' are defined in the regulations. The definitions make sure that the term 'premises' does not apply to the person's own accommodation where accommodation is not provided as part of their care and treatment. In addition, 'equipment' does not include equipment at the person's own accommodation, where it is not provided as part of their care or treatment.

<ul style="list-style-type: none"> ▪ Regulation 20 	Duty of candour
<ul style="list-style-type: none"> ▪ Regulation 20A 	Requirement as to display of performance assessments.

CQC asks five key questions of all services it regulates, including homecare agencies. These are underpinned by key lines of enquiry (KLOEs) to help the regulator to answer the five key questions.⁽²²²⁾ These are outlined in Table 4.3 as follows:

Table 4.3: CQC’s five key questions and key lines of enquiry	
Key questions	Key lines of enquiry
Are they safe?	<ul style="list-style-type: none"> ▪ Safeguarding and protection from abuse ▪ Managing risks ▪ Suitable staff and staff cover ▪ Medicines management ▪ Infection control ▪ Learning when things go wrong
Are they effective?	<ul style="list-style-type: none"> ▪ Assessing needs and delivering evidence-based treatment ▪ Staff skills and knowledge ▪ Nutrition and hydration ▪ How staff, teams and services work together ▪ Supporting people to live healthier lives ▪ Accessible premises ▪ Consent to care and treatment
Are they caring?	<ul style="list-style-type: none"> ▪ Kindness, respect and compassion ▪ Involving people in decisions about their care ▪ Privacy and dignity
Are they responsive to people’s needs?	<ul style="list-style-type: none"> ▪ Person-centred care ▪ Concerns and complaints ▪ End of life care
Are they well-led?	<ul style="list-style-type: none"> ▪ Vision and strategy ▪ Governance and management ▪ Engagement and involvement ▪ Learning, improvement and innovation ▪ Working in partnership

CQC has embedded a human rights-based approach in its regulatory framework since 2014. Key human rights-based principles are applied to its five key questions when reviewing health and social care services. These principles are based on the FREDA principles of Fairness, Respect, Equality, Dignity, and Autonomy. CQC has additionally added two principles to its human rights-based approach to regulation which include 'human rights article of right to life', and 'staff rights and empowerment'.⁽²²³⁾

After each inspection, CQC produces a report. In most cases, the inspection reports include ratings showing the overall judgment of the quality of care. The reports include: 1) findings of the key questions outlined above, 2) a description of both, good practice concerns found, 3) clearly present any evidence about breaches of regulations, and 4) recommendations to help the care provider improve their rating.⁽²²⁴⁾

There are four ratings that CQC gives to services:

- Outstanding: The service is performing exceptionally well
- Good: The service is performing well and meeting CQC's expectations
- Requires improvement: The service is not performing as well as it should and CQC has told the service how it must improve
- Inadequate: The service is performing badly and CQC has taken action against the person or organisation that runs it.⁽²²⁵⁾

A rating is given for each of the five key questions, and also an 'overall rating'. Each homecare agency, by law, must display the rating assigned in their premises and also on their website.⁽²²⁶⁾ CQC may take action if it finds that a homecare agency is not meeting the fundamental standards of care. CQC may issue a fine or formal warning and, in some extreme cases, take action to close the agency.⁽²²⁶⁾

In March 2020, routine inspections were paused due to COVID-19 and activities focused on where there was a risk to people's safety. CQC continued regulating, but instead focused on developing some new monitoring tools including the Emergency Support Framework.⁽²²⁷⁾ The Emergency Support Framework was put in place to allow inspectors to understand where the greatest risks were in terms of managing the impact of COVID-19, and has been continuously adapted since the onset of the crisis. In Spring 2021, CQC published *Our Strategy from 2021*; setting out how CQC will be 'smarter' in how it regulates.⁽²²⁸⁾ One such method includes a collaborative, digital-first approach with virtual inspections; this is being piloted among willing homecare providers in 2021.

Type of homecare tasks provided by services

Regulated homecare services are those that are registered with CQC to provide the regulated activity of 'personal care'. The 2014 Regulations defines 'personal care' as:⁽²¹⁶⁾

- (a) **Physical assistance** given to a person in connection with: eating or drinking, toileting, washing or bathing, dressing, oral care, or the care of skin, hair and nails, or
- (b) The **prompting**, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.⁽²²⁹⁾

It is possible that providers can be registered to provide both personal and nursing care as a regulated activity (and or other regulated activities). The Regulations 2014 (UK) define 'nursing care' as any services provided by a nurse and involving:⁽²¹⁶⁾

- (a) the provision of care, or
- (b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to the nature and the circumstances in which they are provided, do not need to be provided by a nurse.

Exemptions can apply to the regulated activity of 'nursing care'. For example, if a provider was regulated to provide the regulated activity referred to as the 'treatment of disease, disorder or injury', they would not need to register the 'nursing care' activity as they would be registered by virtue of providing the 'treatment of disease, disorder or injury' (TDDI).

Northern Ireland

Is homecare regulated?

The Regulation and Quality Improvement Authority (RQIA) is the independent body that regulates and inspects the quality and availability of Northern Ireland's health and social care services. RQIA was established in 2005 under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.^(230,231) Under this legislation, domiciliary care is defined as:

"An undertaking which consists of or includes arranging the provision of prescribed services in their own homes for persons who by reason of illness, infirmity, disability or family circumstances are unable to provide any such service for themselves without assistance."⁽²³²⁾

The Department for Health, Social Services and Public Safety (DHSSPS) defines domiciliary care as:

“the range of services put in place to support an individual in their own home. These services may involve routine household tasks within or outside the home, personal care of the client and other associated domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.”⁽²³³⁾

RQIA’s remit over domiciliary care is underpinned by:

- The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003⁽²³¹⁾
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007⁽²³⁴⁾
- The Domiciliary Care Agencies Minimum Standards (2011).⁽²³⁵⁾

The regulations and minimum standards for domiciliary care agencies focus on ensuring that people using the services provided are protected and the care is quality assured. They apply to both independent and statutory providers of domiciliary services, supported accommodation services (providing personal care in addition to housing support services) and intentional communities (where personal care is an aspect of service provision).⁽²³²⁾ The regulations for domiciliary care agencies were published by the DHSSPS in accordance with Article 23 of the Order, which sets out the range of areas for which regulations may make provision. These include the management, staff, premises, financial position and conduct of health and social care establishments and agencies. The regulations concerning domiciliary care agencies are broadly outlined in Table 4.4. Article 38 of the Order gives powers to the DHSSPS to publish minimum standards that the RQIA must take into account in the regulation of establishments and agencies.

Table 4.4: The Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Regulation 3	Prescribed services	Regulation 18	Provision of information to service users
Regulation 4	Expected undertakings	Regulation 19	Disclosure of information
Regulation 5	Statement of purpose	Regulation 20	Identification of workers
Regulation 6	Service user’s guide	Regulation 21	Records
Regulation 7	Review of statement of purpose and service user’s guide	Regulation 22	Complaints
Regulation 8	Fitness of registered provider	Regulation 23	Assessment of quality of services
Regulation 9	Appointment of manager	Regulation 24	Improvement plan
Regulation 10	Fitness of registered manager	Regulation 25	Fitness of premises
Regulation 11	Registered person – general requirements and training	Regulation 26	Financial position

Regulation 12	Notification of offences	Regulation 27	Notice of absence
Regulation 13	Fitness of domiciliary care workers supplied by an agency	Regulation 28	Notice of changes
Regulation 14	Conduct of agency	Regulation 29	Appointment of liquidators etc.
Regulation 15	Arrangements for the provision of prescribed services	Regulation 30	Death of registered person
Regulation 16	Staffing	Regulation 31	Compliance with regulations
Regulation 17	Staff handbook	Regulation 32	Offences

Since 2015, there is compulsory registration for all social care workers, including homecare workers, with the Northern Ireland Social Care Council (NISCC). The NISCC is the regulatory body for the social care workforce in Northern Ireland. Registered social care workers are required to comply with the NISCC Standards of Conduct and Practice for social care workers at all times. These consist of two sets of standards:

- Standards of conduct that describe the values, attitudes and behaviours expected of social care workers in their day-to-day work.
- Standards of practice that outline the knowledge and skills required for competent practice.

Type of work carried out by the regulator

RQIA carry out the following functions:

- **Registration:** Compliance with the regulations is mandatory and non-compliance with some specific regulations is considered an offence. RQIA must take into account the extent to which the minimum standards have been met in determining whether or not a service maintains registration or has its registration cancelled, or whether to take action for breach of regulations.
- **Inspection:** RQIA inspections take place on site at the agencies office. RQIA reports on four domains and look for evidence against the indicators outlined on Table 4.5.⁽²³⁰⁾

Table 4.5: RIQA’s four domains of inspection

Domain	Indicators
Is care safe?	<ul style="list-style-type: none"> ▪ There are, at all times, suitably qualified, competent and experienced persons working in the service in such numbers as are appropriate for the health and welfare of service users. ▪ The service promotes and makes proper provision for the welfare, care and protection of service users. ▪ There are systems in place to ensure that unnecessary risks to the health, welfare or safety of service users are identified, managed and where possible eliminated. ▪ The premises and grounds are safe, well maintained and suitable for their stated purpose.
Is care effective?	<ul style="list-style-type: none"> ▪ The service responds appropriately to and meets the assessed needs of the people who use the service. ▪ There are arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to service users at appropriate intervals. ▪ There are robust systems in place to promote effective communication between service users, staff and other key stakeholders.
Is care compassionate?	<ul style="list-style-type: none"> ▪ There is a culture/ethos that supports the values of dignity and respect, independence, rights, equality and diversity, choice and consent of service users. ▪ Service users are listened to, valued and communicated with, in an appropriate manner. ▪ There are systems in place to ensure that the views and opinions of service users, and or their representatives, are sought and taken into account in all matters affecting them.
Is the service well led?	<ul style="list-style-type: none"> ▪ There are management and governance systems in place to meet the needs of service users. ▪ There are management and governance systems in place that drive quality improvement. ▪ There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. ▪ The registered person/s operates the service in accordance with the regulatory framework. ▪ There are effective working relationships with internal and external stakeholders.

RQIA inspection reports reflect findings from inspections; therefore, are not a comprehensive review of all strengths and areas for improvement in a service. Specifically, when RQIA inspects a domiciliary care agency (either conventional or supported living services), the aim is to engage with relevant stakeholders as set out in the regulations. While this is currently a remote and blended approach due to COVID-19, RQIA has and can perform home visits to people's homes who are in receipt of domiciliary support once consent is granted. More specifically RQIA:

- reviews previous inspection outcomes and information received about the service since the previous inspection
- seeks the views of the people who use the service and or their representatives
- talks to managerial and other staff on the day of the inspection
- talks to trust commissioners and professionals, where appropriate
- examines a range of records including policies, care records, incidents and complaints
- provides feedback on the day of the inspection to the person in charge on the outcome of the inspection; and
- provides a report of inspection findings and outlines any areas for quality improvement where failings in compliance with regulations and or standards are identified.⁽²³⁰⁾

Enforcement Actions: RQIA may take enforcement action if it 1) identifies non-compliance with regulations and or standards, or 2) it identifies concerns about a particular service, in order to ensure the safety, wellbeing and protection of those using the services.⁽²³⁶⁾

Type of homecare tasks provided by services

Under the 2007 Regulations, Regulation 3 describes prescribed services that domiciliary care agencies may undertake. These are:

- (a) personal care; and
- (b) assessment of the need for such care.

Personal care includes the provision of appropriate assistance to promote rehabilitation, assistance with physical or social needs, and counselling; it does not include any prescribed activity.^{*****} Nursing care services do not come under the remit of domiciliary or supported living. If nursing care is provided in the home, it is a distinct service regulated under the Nursing Agencies Regulations (Northern Ireland) 2005.⁽²³⁷⁾

^{*****} No description of prescribed activity given in the order.

Scotland

Is homecare regulated?

Homecare services, referred to in Scotland as 'care at home', are available without charge to all adults who have been assessed by the local authority as eligible for these services. The Regulation of Care (Scotland) Act 2001 established regulatory mechanisms and a legal framework for the care sector, including homecare. The main aim of the Regulation of Care (Scotland) Act 2001 was to improve the quality of social care services. According to the Act, an independent commission must register and inspect all care services against national care standards. In 2010, the Scottish Commission for the Regulation of Care was dissolved and a new body, the Care Inspectorate, was established under the Public Services Reform (Scotland) Act 2010;⁽²³⁸⁾ it has been regulating the care sector since April 2011. All services providing personal care and personal support to people in their own homes must register with the Care Inspectorate as a 'support service - care at home'. Where there is a personal and private arrangement (for example, personal assistants), or where the care is provided by a hospital as part of its continued healthcare service, this does not have to be registered with the Care Inspectorate.⁽²³⁹⁾

The Care Inspectorate regulates providers of homecare using the Health and Social Care (HSC) Standards (2017).⁽²⁴⁰⁾ The HSC Standards were introduced under section 50 of the Public Services Reform (Scotland) Act 2010⁽²³⁸⁾ and section 10H of the National Health Services Scotland Act 1978. The HSC Standards are underpinned by principles such as dignity and respect, compassion, inclusion, responsive care and support, and wellbeing. They set out what people should expect when using health, social care or social work services in Scotland. They aim to provide better outcomes for everyone and to ensure that individuals are treated with respect and dignity and that the basic human rights we are all entitled to are upheld. They are reported under the following outcomes:

- I experience high-quality care and support that is right for me
- I am fully involved in all decisions about my care and support
- I have confidence in the people who support and care for me
- I have confidence in the organisation providing my care and support
- I experience a high-quality environment if the organisation provides the premises.

The Scottish Social Services Council (SSSC) regulates the social care workforce in Scotland by requiring all social service workers, including home support staff, to register with it. The SSSC supports professional development of staff, publishes national codes of practice, and may revoke an individual's registration status if acceptable standards in conduct and practice are not upheld.

Type of work carried out by the authority

Registration: By law, care services in Scotland must be registered with the Care Inspectorate.⁽²⁴¹⁾ Just over half (51%) of registered providers are from the voluntary sector, 34% are private sector and 15% of services from local authorities and NHS boards.⁽⁴³⁾ In 2020, the Care Inspectorate published a guide for registering care services; this outlines the process of registration for care recipients in a home or community setting.⁽²⁴¹⁾ Before starting the registration process, applicants have to complete an application form and pay a fee. Information provided at this stage allows the Care Inspectorate to assess:

- the fitness of the applicant and manager of the proposed care service
- the premises in which the proposed care service will be provided are fit to be used for that purpose
- the proposed service will make all the adequate provisions for the health, welfare, independence, choice, privacy and dignity of everyone using the service.⁽²⁴¹⁾

The application process includes answering questions on how applicants plan to regulate and evaluate their homecare services in the future, and it also seeks information on how they plan to involve staff and service users in this process.⁽⁴³⁾ The final step in registering a care service is the assessment process (financial, information they provided, reference checks, a Protection of Vulnerable Groups (PVG) scheme record check is also carried out and also checks on the people involved with managing the care organisation).⁽⁴³⁾

Inspection and monitoring: Prior to COVID-19, inspections were carried out on homecare providers annually to ensure standards are adhered to. Specific complaints are investigated separately.⁽⁴³⁾ These inspections may involve visiting people who receive a service (once permission is received) or speaking to them on the phone, sending out questionnaires to recipients of care and relatives, and speaking to staff providing care. The Care Inspectorate takes into account the HSC Standards when carrying out its inspections and quality assurance functions, and when making decisions about the registration of care and health.⁽²⁴²⁾ It monitors and inspects all care services against quality frameworks which were developed in line with the standards, informed by a human rights and wellbeing-based approach. The same frameworks are also incorporated into self-assessment forms, in order to allow providers to use the same quality indicators that inspectors use when undertaking their own self-evaluation and quality assurance. In recent years, the Care Inspectorate has been changing the way it inspects the quality of care and support to reflect the 2018 standards. As such, the Care Inspectorate has shifted its focus from compliance (what services are

doing to meet various standards, procedures and targets) to an overall approach that supports services to improve.

Since the COVID-19 pandemic, the Care Inspectorate made changes to the way it inspects care services. These changes, made as a result of the Coronavirus (Scotland) (No. 2) Act, place particular focus on infection prevention and control, wellbeing and staffing in care settings. This means carrying out targeted inspections that are short, focused and carried out with colleagues from Health Improvement Scotland and Health Protection Scotland, to assess care and support during this time.⁽²⁴³⁾

Enforcement action: The Care Inspectorate sets out areas for improvement if providers are not meeting the standards and these are published in the inspection report. It also rates services from 1 to 6 where 1 is unsatisfactory and 6 is excellent. Where the Care Inspectorate finds that a care service is not operating according to the standards it expects, it has the powers to:

- make recommendations
- make requirements
- take enforcement action which may lead to the service's registration being cancelled if required improvements are not made
- apply to the sheriff for emergency cancellation of the service's registration
- attach a condition to the registration of the service.⁽²⁴⁴⁾

The Care Inspectorate also encourages all care providers to have comprehensive safe recruitment policies, having background checks, references, and ensuring that employees are registered under the Protecting Vulnerable Groups scheme. Homecare workers must hold a relevant qualification or be working towards gaining one that relates to the work they do. Since 2020 it is mandatory that all homecare workers should be registered with the Scottish Social Services Council (SSSC).⁽²⁴⁵⁾+++++

Type of homecare tasks provided by services

Homecare services in Scotland include services provided to people in their own homes or in supported accommodation, sheltered housing or elsewhere. It also includes those services traditionally referred to as 'day care' whether they are provided in the home, in a care setting or elsewhere. It covers services provided or

+++++ SSSC Registration is mandatory for the following Adult Social Care roles: Manager of a Housing Support Service, Manager of a Care At Home, Service Manager of a Care Home for Adults, Manager of an Adult Day Care Service, Practitioner in a Care Home for Adults, Supervisor in a Care At Home Service, Supervisor in a Care Home for Adults, Supervisor in a Housing Support Service, Support Worker in a Care Home for Adults, Support Worker in a Housing Support Service, Support Worker in a Care At Home Service, Social Worker, Student Social Worker

purchased by a local authority, services provided by health bodies which are not part of core NHS functions. It does not include services provided by an individual through direct arrangements with the recipient. Homecare services provided under the free personal and nursing care scheme may include:

- Personal hygiene – bathing, shaving, oral hygiene and nail care
- Personal assistance – assisting care recipients to get in and out of bed, ensuring the correct use of medical devices and mechanical or manual aids, assisting with prostheses and dressings
- Continence management – toileting, catheter or stoma care, skin care and laundry and bed changing
- Food preparation and dietary services – assisting with meal preparation and special dietary needs
- Equipment and adaptation – supplying equipment and adapting the home of the client to help with immobility and to make tasks such as bathing, walking up and down stairs and general mobility around the care recipient's home easier
- Simple medical treatment – administering medication, applying creams and lotions, changing simple dressings, oxygen therapy.⁽⁴³⁾

People who are eligible for care at home services in Scotland include older people (aged over 65), children and young adults with disabilities, adults with learning or physical disabilities, adults dependent on alcohol or illegal substances and people with HIV or AIDS. People being discharged from hospital may also be eligible for home support for up to 28 days following discharge.⁽⁴³⁾

The Social Care (Self-directed Support) (Scotland) Act 2013 has allowed clients to have more control and choice over the social care and support they can obtain. The Act has made it compulsory for all local authorities to offer prospective service users the following options:

- To receive a direct payment from the local authority
- To choose a preferred care provider and the local authority will organize the required services
- The local authority can both choose and arrange the care provider and services for the care recipient
- A mix of all options above can be used.⁽⁴³⁾

Wales

Is homecare regulated?

Local authorities have a statutory responsibility for planning and commissioning social care in Wales. The majority of domiciliary care funded by a local authority in

Wales is delivered either by the independent or voluntary sector, who the local authority commissions to meet the needs of eligible individuals. Care Inspectorate Wales (CIW) is the independent regulator of social care and childcare in Wales. It regulates homecare, referred to as domiciliary support services.⁽²⁴⁶⁾ The following legal documents give CIW the power to register and inspect these services:

- Social Services and Well-being (Wales) Act 2014 which gives powers to review the way in which local authorities discharge their social services functions.
- Regulation and Inspection of Social Care (Wales) Act 2016 which gives powers to register and or inspect providers of social care services in Wales.⁽²⁴⁷⁾

The Regulation and Inspection of Social Care (Wales) Act 2016⁽²⁴⁸⁾ defines a domiciliary support service as the:

the provision of care and support to a person who by reason of vulnerability or need (other than vulnerability or need arising only because the person is of a young age) is unable to provide it for him or herself and is provided at the place in Wales where the person lives (including making arrangements for or providing services in connection with such provision).

A number of regulations followed on from the Regulation and Inspection of Social Care (Wales) Act 2016 including:

- The Regulated Services (Registration) (Wales) Regulations 2017
- The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.

The Regulated Services (Registration) (Wales) Regulations 2017 set out the information required by an applicant or by a service provider for application of registration. In particular, it details the information required to be included in a statement of purpose for each place in relation to which service is to be provided. CIW inspects domiciliary support services against the Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) Regulations 2017.⁽²⁴⁹⁾ The regulations set out the general requirements on a service provider in relation to the standard of service that must be provided. The intent of the general requirements is to ensure that service providers put in place governance arrangements to support the smooth operation of the service and to ensure that there is a sound base for providing high-quality care and support. In Part 11 of the regulations, there is direct reference made to domiciliary support services (regulation 40, 41 and 42) and these set out:

- a 'schedule of visits' which delineates the time allowed for each visit and the time allowed for travel between each visit

- the offer to domiciliary care workers on non-guaranteed hours contracts the choice of alternative contractual arrangements.

The regulations also set out the duties placed on the designated responsible individual in relation to a regulated service.

Statutory guidance was issued by the Welsh Ministers under section 29 of the Regulation and Inspection of Social Care (Wales) Act 2016. This guidance sets out how providers and people designated as a responsible individual for a regulated service may comply with the requirements imposed by regulations made under section 28 of the Act. Providers and people designated as responsible individuals must have regard to this statutory guidance which is intended to help them understand how they can meet the applicable requirements within the regulations. CIW uses this guidance to inform decisions about the extent to which registered providers are meeting those requirements, and when considering whether to take enforcement action. Where the regulations are bespoke to domiciliary support services, this is clearly articulated in the regulations and statutory guidance. It is important to highlight that this guidance should not be considered exhaustive as there may be other ways that service providers and responsible individuals can show that they meet each component of the regulation.⁽²⁴⁹⁾

Type of work carried out by the authority

Registration: CIW registers and inspects domiciliary support services, which are defined as a service that provides care and or general support in people’s own home.

In Wales, from April 2020 all domiciliary care workers have to register with Social Care Wales. There is currently professional guidance on what is expected from domiciliary care workers published by Social Care Wales and the CIW may take this guidance into account in its work.⁽²⁵⁰⁾

Inspection: CIW has two types of inspections; full (planned as part of inspection schedule) and focused (carried out when concerns are raised or with the aim to follow up on areas of improvement identified at previous inspections).⁽²⁵¹⁾ Routine inspections are carried out every 18 months, early inspections at 12 months and priority inspections at six months if necessary. Inspectors may visit people receiving domiciliary support services.⁽²⁵²⁾

The following four themes in Table 4.6 are considered during inspections:⁽²⁵²⁾

Table 4.6: Themes considered during inspections	
Core theme	What inspectors evaluate
Wellbeing: the wellbeing of individuals receiving care and support.	<ul style="list-style-type: none"> ▪ the extent to which outcomes are being achieved.

<p>Care and support: the quality of care and support staff provide.</p>	<ul style="list-style-type: none"> ▪ the degree to which people receive a high-quality service. This reflects best practice, care and support provided by staff who have the appropriate knowledge and skills and supports people to achieve the best possible outcomes.
<p>Environment: the physical setting in which care and support is provided. (This theme does not apply to regulated service that do not provide accommodation).</p>	<ul style="list-style-type: none"> ▪ the degree to which outcomes for people are supported by surroundings that are safe, clean, accessible, comfortable, welcoming, well-maintained, stimulating, and suitably equipped and furnished.
<p>Leadership and management: organisational arrangements for the provision of care and support.</p>	<ul style="list-style-type: none"> ▪ the degree to which organisational arrangements provide assurance for the delivery of high quality services, by motivated staff in a well led and managed service.

CIW is planning to introduce a new framework for inspections of domiciliary support services and a new approach to writing the reports, which will allow it to provide a clear outcome-focused approach to inspection.⁽²⁴⁶⁾

Enforcement action: In line with its enforcement procedures, CIW operates a graduated approach to secure improvement. Where it has concerns or has identified non-compliance to the regulations, it takes action to secure improvement. However, if serious, multiple or persistent non-compliance is identified, it may restrict the care a provider can deliver or ultimately, prevent the provider from operating altogether. Where there is significant impact on wellbeing and risk of harm, the graduated approach may not be appropriate; in this instance the CIW would take immediate enforcement action.^(252,253)

Type of homecare tasks provided by services

Broadly speaking, domiciliary care services in Wales are considered within three categories:

- **Maintenance** – for example, supporting people to keep active and alert; supporting people with mobility and or physical health; maintaining quality of life, hygiene; continuing social contacts and keeping safe.
- **Change (improvement)** – for example, supporting people to increase physical ability, achieve higher morale and or more positive mood state, increased confidence, more social and community contact, maintaining finances in order, having a healthier environment, reduced risks and so on.

- **Comfort and dignity at end of life** – for example, ensuring that health, social, psychological and emotional, spiritual and religious needs and wishes are respected, and any advance care plans are followed where possible.

There are certain exclusions that outline what a domiciliary support service is not, as set out in Section 87 of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017. For example, it is not a domiciliary support service if:

- the service is provided by an individual without the involvement of an undertaking acting as an employment agency or employment business
- it is wholly under the direction of the person receiving the care
- it is provided in a care home or other accommodation, for example, in a hospital
- it is the provision of nursing care by a registered nurse or by a Local Health Board to meet needs which are related to the needs of individuals for nursing care. ++++++

Australia

Is homecare regulated?

The Aged Care Act 1997⁽²⁵⁴⁾ is the main law that covers aged homecare for people in Australia. It sets out the legislation for funding, regulation, approval of providers, quality of care and the rights of people receiving care. Homecare for older people in Australia is regulated by the Aged Care Quality and Safety Commission (the Commission). The Aged Care Quality and Safety Commission Act 2018 (the Act)⁽¹⁹⁴⁾ establishes the Commission and enables the Minister to make rules prescribing matters for carrying out or giving effect to the Act. The Aged Care Quality and Safety Commission Rules 2018⁽¹⁹⁵⁾ give operational effect to the processes of the Commission from January 2020. The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government; they conduct homecare investigations, and determine compliance requirements (such as sanctions) to be imposed on providers. The Aged Care Legislation Amendment (Single Quality Framework Consequential Amendments and Transitional Provisions) Act 2019 amended the Aged Care Quality and Safety Commission Rules

+++++ There are services which are nursing care services and these are registered as nursing agencies with Health Inspectorate Wales. As part of registering services, CIW assesses the service's statement of purpose against what the service is planning to provide. CIW requests for services to detail:

- the range of health or care needs the service will provide support for, including any specialist services/care provision
- how they intend to provide the service and also detail the care and support the service offers and to whom
- information on the numbers and qualifications of staff.

2018 as part of the transitional arrangements giving legal footing to the 2019 *Aged Care Quality Standards*.⁽²⁵⁵⁾

The Commission defines homecare and home services as:

- **Homecare:** Care consisting of a package of care and services provided in a non-residential care setting
- **Home service:** means
 - (a) a homecare service
 - (b) a flexible care service through which short term restorative care is provided in a homecare setting
 - (c) a home support service.

Homecare for people with disabilities is funded by the National Disability Insurance Scheme (NDIS), and is often called NDIS care. This is governed by the NDIS Act 2013. This includes personal care, and supports for independent living. The National Disability Insurance Scheme Agency, or NDIA, is the Commonwealth agency responsible with delivering NDIS care.

Type of work carried out by the Commission

The Commission assesses and approves applicants to provide homecare services under the Aged Care Quality and Safety Commission Act 2018 (Act).⁽¹⁹⁴⁾ The Commission ensures that if providers deliver government-subsidised 'homecare package services', then they must meet certain responsibilities. They must meet the eight legislated 2019 quality standards: *Aged Care Quality Standards*⁽²⁵⁵⁾ as follows:

- Standard 1. Consumer dignity and choice
- Standard 2. Ongoing assessment and planning with consumers
- Standard 3. Personal care and clinical care
- Standard 4. Services and supports for daily living
- Standard 5. An organisation's service environment
- Standard 6. Feedback and complaints
- Standard 7. Human resources
- Standard 8. Organisational governance.

Providers must also be transparent about the fees they charge, and use funds appropriately in a consumer-directed care approach. This means that providers give people choice, flexibility and control over the types of services they receive, how services are provided, who provides the services and when the services are provided.

The Commission applies a risk-based regulatory approach and risk assessments are continuously undertaken to assess the level of risk of home service providers. Compliance is checked through a mix of quality assessments, reviews and consumer feedback. Depending on how serious a non-compliance issue is, the provider will be given one of the following actions and agree to a plan and a time frame to fix the issue:

- areas for improvement: where a provider does not meet the Aged Care Quality Standards, the Commission will give them a direction to make improvements. It will assess at a later date if these improvements have been made.
- non-compliance notice: where a provider is not meeting requirements and is not providing the care and services required by law, they may receive a non-compliance notice. The notice indicates the significant problems to be addressed. If action is not taken within the agreed time, a sanction may be given.
- notice to agree: §§§§§§§§ this occurs where the Commission is satisfied the provider's non-compliance poses an immediate and severe risk to the safety, health and wellbeing of those receiving care.
- sanction: where there is continued non-compliance, the Commission may impose a sanction. The sanction revokes the provider's approval to deliver aged care.

The quality of NDIS care and support is monitored by an independent agency called the NDIS Quality and Safeguards Commission. Services are monitored against the NDIS practice standards. Service providers under the NDIS must be registered with the NDIS Quality and Safeguards Commission, and home support service staff must comply with the NDIS code of conduct. The NDIS Commission operates within each state or territory in Australia.

Types of homecare tasks provided by services

Secondary legislation, referred to as Quality of Care Principles 2014,⁽²⁵⁶⁾ sets out what homecare providers can deliver insofar as they also need to meet the quality standards.^(256,257) Various homecare provisions are legally permitted to be delivered as long as the approved provider and recipients agree, and the approved provider is able to provide the care and services within the limits of the resources available.

§§§§§§§§ Where providers non-compliance has resulted in the Commission considering revoking their approval to deliver care through a sanction, the Commission may – in certain circumstances – first issue the provider a 'Notice to Agree' before sanctioning.

These tasks are described as 'care services', 'support services', 'clinical services' and 'exclusions'. Table 4.7 outlines these tasks.

Table 4.7: Care services that an approved provider of a homecare service may provide using homecare package funding (from the Quality of Care Principles 2014)⁽²⁵⁶⁾

Care services	Personal services	Personal assistance, including individual attention, individual supervision and physical assistance, with: (a) bathing, showering including providing shower chairs if necessary, personal hygiene and grooming, dressing and undressing, and using dressing aids; and (b) toileting; and (c) dressing and undressing; and (d) mobility; and (e) transfer (including in and out of bed).
	Activities of daily living	Personal assistance, including individual attention, individual supervision and physical assistance, with communication including assistance to address difficulties arising from impaired hearing, sight or speech, or lack of common language, assistance with the fitting of sensory communication aids, checking hearing aid batteries, cleaning spectacles and assistance in using the telephone.
	Nutrition, hydration, meal preparation and diet	Includes: (a) assistance with preparing meals; and (b) assistance with special diet for health, religious, cultural or other reasons; and (c) assistance with using eating utensils and eating aids and assistance with actual feeding, if necessary; and (d) providing enteral feeding formula and equipment
	Management of skin integrity	Includes providing bandages, dressings, and skin emollients
	Continence management	Includes: (a) assessment for and, if required, providing disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances and enemas; and (b) assistance in using continence aids and appliances and managing continence

	Mobility and dexterity	<p>Includes:</p> <ul style="list-style-type: none"> (a) providing crutches, quadruped walkers, walking frames, walking sticks and wheelchairs; and (b) providing mechanical devices for lifting, bedrails, slide sheets, sheepskins, tri-pillows, and pressure relieving mattresses; and (c) assistance in using the above aids
Support services	Support services	<p>Includes:</p> <ul style="list-style-type: none"> (a) cleaning; and (b) personal laundry services, including laundering of care recipient's clothing and bedding that can be machine-washed, and ironing; and (c) arranging for dry-cleaning of care recipient's clothing and bedding that cannot be machine-washed; and (d) gardening; and (e) medication management; and (f) rehabilitative support, or helping to access rehabilitative support, to meet a professionally determined therapeutic need; and (g) emotional support including ongoing support in adjusting to a lifestyle involving increased dependency and assistance for the care recipient and carer, if appropriate; and (h) support for care recipients with cognitive impairment, including individual therapy, activities and access to specific programs designed to prevent or manage a particular condition or behaviour, enhance quality of life and provide ongoing support; and (i) providing 24-hour on-call access to emergency assistance including access to an emergency call system if the care recipient is assessed as requiring it; and (j) transport and personal assistance to help the care recipient shop, visit health practitioners or attend social activities; and (k) respite care; and (l) home maintenance, reasonably required to maintain the home and garden in a condition of functional safety and provide an adequate level of security; and (m) modifications to the home, such as easy access taps, shower hose or bath rails; and

		<p>(n) assisting the care recipient, and the homeowner if the home owner is not the care recipient, to access technical advice on major home modifications; and</p> <p>(o) advising the care recipient on areas of concern in their home that pose safety risks and ways to mitigate the risks; and</p> <p>(p) arranging social activities and providing or coordinating transport to social functions, entertainment activities and other out-of-home services; and</p> <p>(q) assistance to access support services to maintain personal affairs</p>
	Leisure, interests and activities	Includes encouragement to take part in social and community activities that promote and protect the care recipient's lifestyle, interests and wellbeing
Clinical services	Clinical care	Includes: <p>(a) nursing, allied health and therapy services such as speech therapy, podiatry, occupational or physiotherapy services; and</p> <p>(b) other clinical services such as hearing and vision services.</p>
	Access to other health and related services	Includes referral to health practitioners or other related service providers
Excluded items	Excluded items	<p>The following items must not be included in the package of care and services provided under section 13:</p> <p>(a) use of the package funds as a source of general income for the care recipient;</p> <p>(b) purchase of food, except as part of enteral feeding requirements;</p> <p>(c) payment for permanent accommodation, including assistance with home purchase, mortgage payments or rent;</p> <p>(d) payment of homecare fees;</p> <p>(e) payment of fees or charges for other types of care funded or jointly funded by the Australian Government;</p> <p>(f) home modifications or capital items that are not related to the care recipient's care needs;</p> <p>(g) travel and accommodation for holidays;</p>

		<p>(h) cost of entertainment activities, such as club memberships and tickets to sporting events;</p> <p>(i) gambling activities;</p> <p>(j) payment for services and items covered by the Medicare Benefits Schedule or the Pharmaceutical Benefits Scheme.</p>
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Types of home support services that are provided to younger people with disability through the NDIS Scheme include:

- personal care to help with showering or dressing, or help preparing meals and cleaning
- supports to access social, civic and community activities and keep up informal support networks with family, friends and carers
- therapy including allied health supports (for example, occupational therapy, speech pathology and physiotherapy)
- specialised equipment for someone who has an ongoing problem with some activities, which are not part of the homecare package or which may be provided in the treatment of a medical condition, and
- modifications to make a person’s home accessible.

Canada

Homecare in Canada has observed unprecedented growth since the 1980s. This is largely due to hospital restructuring; changing policy focus to provide healthcare services ‘closer to home’; consumer choice to ‘age at home’; primary healthcare renewal and new approaches to chronic disease management that include proactive homecare services.⁽²⁵⁸⁾

The Government of Canada outlines that homecare services may include:⁽²⁵⁹⁾

- nursing
- personal care such as help with bathing, dressing, and feeding
- physiotherapy
- occupational therapy
- speech therapy
- social work
- dietitian services
- homemaking
- respite services.

Homecare services are not publicly insured through the Canada Health Act in the same way that hospital and physician services are.⁽²²⁹⁾ In Canada, most home and community care services are delivered by provincial, territorial and some municipal

governments with the federal government providing funding support through transfer payments for health and social services. Therefore this desktop review has focused on Ontario, as it is the most populous region of Canada.

Is homecare regulated?

Publicly-funded homecare is provided for by the Homecare and Community Services Act, 1994.⁽²⁶⁰⁾ The purpose of this Act is to ensure that a wide range of community services is available to people in their own homes and in other community settings to ensure alternatives to institutional care exist. Since April 2021, publicly-funded homecare is controlled by Home and Community Care Support Services (HCCSS). There are 14 HCCSSs in Ontario and their role is to plan, integrate and fund local healthcare, as well as deliver and coordinate home and community care. Under the Local Health System Integration Act 2016, a HCCSSs-funded health service provider is defined as an agency that has a service accountability agreement with the HCCSSs. This accountability agreement holds the agency accountable for delivering healthcare services to patients, clients, and or family members and caregivers. Regulated health professionals working in the sector are governed by the Regulated Health Professionals Act.⁽²⁶¹⁾

Type of work carried out by the authority

The Patient First Act (2016) provides each HCCSS with the responsibility to manage the health service providers it funds through a service accountability agreement. This includes the authority to issue policy or operational directives, engage in or permit an audit or operational review, appoint investigators to report on the quality of the management, care and treatment provided within health services, and to appoint a supervisor for a health service provider (excluding hospitals and long-term care homes).

The Resident Assessment Instrument-home care⁽²⁶²⁾ is a standardised homecare indicator tool created by Health Quality Ontario to measure 'long-stay' patients' health status and it is recommended that the tool be used every six months by service providers as a performance measure. The instrument encompasses 12 measurable ***** indicators which are presented in Table 4.8:

***** There are currently 20 homecare indicators recommended, however only 12 are currently measurable. The other eight indicators will require further development by Health Quality Ontario.

Table 4.8: Homecare services indicators Ontario Canada⁽²⁶²⁾

Measurement area	Indicator	Reporting level	Data source
Client involvement in care plan	Percentage of homecare clients who felt involved in developing their care plan	Provincial HCCSS Service provider	Client and Care Giver Experience Evaluation Survey
Communication (client – provider)	Percentage of patients that report that their provider explained things in a way that was easy to understand	Provincial HCCSS	Client and Care Giver Experience Evaluation Survey
Satisfaction	Percentage of homecare clients who were satisfied with their care from both care coordinators and service providers	Provincial HCCSS Service provider	Client and Care Giver Experience Evaluation Survey
Informal Care Giver Distress	Percentage of long-stay homecare clients whose primary informal caregiver expressed continued feelings of distress, anger or depression over a six month period	Provincial HCCSS Service provider	Homecare Reporting System
Wait-time Between Approval and First Visit (Nursing Services and Personal Support Services)	Wait time for a client between application for homecare and approval for nursing services/personal support services (new clients only)	Provincial HCCSS	Homecare Database
Wait-time for Approval of Homecare Services (Nursing Services	Wait time for a client between approval for nursing services/personal	Provincial HCCSS	Homecare Database

and Personal Support Services)	support services and the first homecare visit	Provider	
Health System Use at the End of Life	Percentage of palliative care clients with an unplanned emergency department visit during their last 30 days of life	Provincial HCCSS	National Ambulatory Care Reporting System
Emergency Department Visit	Percentage of new homecare clients who had an unplanned emergency department visit within 30 days after acute hospital discharge	Provincial HCCSS	National Ambulatory Care Reporting System
Hospital Readmission	Percentage of homecare clients experienced an unplanned readmission to hospital within 30 days of discharge from hospital	Provincial HCCSS	Discharge Abstract Database
Case Management	Percentage of homecare clients whose case manager helped them get the services they needed	Provincial HCCSS	Client and Care Giver Experience Evaluation Survey
Pain	Percentage of clients who complained or showed evidence of pain at a higher frequency compared to their previous assessment	Provincial HCCSS Service provider	Homecare Reporting System
Functional Status	Percentage of homecare clients whose physical functioning (Activities of Daily Living (ADL)) improved	Provincial HCCSS Service provider	Homecare Reporting System

Despite the authority placed on HCCSSs and the implementation of the Resident Assessment Instrument by Health Quality Ontario, an audit conducted in 2015 by the Office of the Auditor General of Ontario highlighted that monitoring of contracted service providers' performance needs improvement. The report found that HCCSSs audited did not assess service providers for meeting client outcomes, did not always apply corrective action when service providers underperformed, and did not consistently conduct site visits to service providers.⁽²⁶³⁾

Types of homecare tasks provided by services

HCCSSs are responsible for deciding who receives homecare, the level of care that is required and for how long. If they decide a person is eligible to receive homecare, they can theoretically receive the following activities in their home as set out in Table 4.9.

Table 4.9: Homecare services available in Ontario Canada⁽²⁶⁴⁾

Healthcare professionals	<ul style="list-style-type: none"> ▪ nursing care – including help to take medications, change bandages and clean wounds, recover from an injury or health problem, check your health, create a care plan ▪ physiotherapy – including help for back pain, mobility problems, blood circulation, pain relief and relaxation ▪ occupational therapy – including help to make day-to-day activities easier and make it easier to move around in your home ▪ speech and language therapy – including stroke recovery for seniors who have difficulty speaking or understanding speech ▪ social work – including help for caregivers to cope and manage stress, help for families to address conflicts ▪ healthy eating – including help to assess eating habits and create a healthy eating plan ▪ home healthcare supplies – including dressings, walking aids, braces, cushions
Personal care	<ul style="list-style-type: none"> ▪ washing and bathing ▪ mouth care ▪ hair care ▪ preventative skin care ▪ routine hand or foot care ▪ getting in and out of chairs, vehicles or beds ▪ dressing and undressing ▪ eating

	<ul style="list-style-type: none"> ▪ toileting ▪ taking you to appointments
Homemaking	<ul style="list-style-type: none"> ▪ house cleaning ▪ doing laundry ▪ shopping ▪ banking ▪ paying bills ▪ planning menus ▪ preparing menus ▪ caring for children
Family-managed homecare	<p>For greater flexibility and choice, if eligible, a person can receive funding directly to pay for homecare services. They are responsible for the related administrative tasks, such as finding, hiring and paying for the service providers, but they also have the freedom to choose their provider, direct how they care for them or their loved one and set a schedule that best works for you.</p> <p>This programme is available for the following people with homecare needs:</p> <ul style="list-style-type: none"> ▪ children with complex medical needs ▪ adults with an acquired brain injury ▪ home-schooled children with qualifying healthcare needs ▪ those in extraordinary circumstances
End-of-life care at home	<ul style="list-style-type: none"> ▪ nursing and personal care ▪ medical supplies, including low-cost medication for seniors through the Ontario Drug Benefit Plan ▪ tests ▪ hospital and sickroom equipment ▪ transportation to other health services ▪ help to manage pain ▪ home hospice services – including in-home visits and respite care by trained volunteers

New Zealand

Homecare services are referred to as home and community support services (HCSS) in New Zealand. Homecare services in New Zealand are publicly funded and are provided by service providers under contracts with government agencies. The government agencies include the Ministry of Health Disability Support Services, District Health Boards (DHBs), Accident Compensation Corporation (ACC), or the

Ministry for Social Development, depending on the needs of the person receiving services. Typical HCSS include help with personal care and household management that can help a person to maintain independence, quality of life and stay at home for as long as they can participate in their community. People who use HCSS can be grouped according to their funding arrangement:

- DHB funds homecare services for people with health needs, including older people (aged 65 and over), people with long-term medical conditions, and those requiring short-term care following discharge from hospital
- The Ministry for Health directly funds homecare services for people with physical, intellectual or sensory disabilities
- The ACC funds homecare services for people recovering from injury, or living with the long-term effects of injury.

Individuals must meet eligibility criteria and have their needs assessed to receive homecare services. For people with disabilities and older people this is undertaken by a Needs Assessment and Service Coordination organisation (NASC). NASC arranges for:

1. Needs assessments
2. Service planning and co-ordination
3. Resource allocation within a defined budget.

From this, NASC then identifies which services or supports individuals are eligible for and which of the supports and services are funded. NASC then facilitates these services and supports to commence. The NASC service makes contact yearly or whenever needed if a person's needs change. Figure 4.1 outlines how the process works, although this relates to older people (generally over 65) who have age-related needs, it is broadly representative of the process.

Figure 4.1: Process for obtaining publicly funded homecare in New Zealand



Referrals for a needs assessment are by self-referral or by a doctor, community health worker, family member or a friend, providing the person who needs the assessment has given consent. The person who carries out the assessment is a trained health professional who assesses the following:

- level or types of support wanted and needed
- involvement of family or whānau
- support received from health professionals, for example doctor, physiotherapist
- eligibility for support (community services card)
- cultural needs
- where to refer for more help, for example a more in-depth assessment with a specialist or therapist.

Is homecare regulated?

There is no legislative regulatory framework or requirements that govern this sector in New Zealand; however, the Code of Health and Disability Services Consumers' Rights (1996) governs and protects the delivery of home support. The Health and

Disability Services (Safety) Act 2001 underpins the certification of healthcare services in New Zealand. The Act places a duty on health and disability service providers to take responsibility in providing safe services and to continuously improve the quality of service provision.⁽²⁶⁵⁾ This legislation describes the setting of standards and the certification of listed services against these standards. While homecare services are not explicitly listed under this legislation, it may be included under a service that is 'provided to people with disabilities or people who are frail (whether because of their age or for some other reason), for their care or support or to promote their independence.'⁽²⁶⁵⁾

It is well documented in New Zealand that while there is a national assessment and coordination framework and tool, there is considerable variation in how homecare is assigned to consumers due to a lack of consistency across providers and available services.⁽²⁶⁶⁾ HCSS providers that hold a contract with the Ministry of Health, a DHB and or the ACC must be certified against the the *Home and Community Sector Standards (2012)*.⁽²⁶⁷⁾ These standards are used to outline what people receiving support in a home or community setting can expect from the services they receive and the minimum requirements to be attained by organisations. The standards focus on enablement and their overarching aim is to provide support to people facing challenges to fully participate in everyday life, to maintain or increase independence, live in their own home, participate in their communities, and fulfil the roles they value.

The 2015 Director General's Reference Group report on in-between travel highlighted a number of issues faced by HCSS in New Zealand. These included increased demand on services and lack of funding; inconsistent and fragmented services; a lack of focus on person-centred care; lack of regularisation and training of the workforce, and inconsistent quality improvement processes. Currently, the National Framework for Home and Community Support Services (HCSS)⁽²⁶⁸⁾ is being implemented and this will provide guidance for DHBs for future commissioning, developing, delivering and evaluating HCSS to improve national consistency and quality of care. Its key principles are:

The key principles underpinning the framework are:

- Person directed
- Connected
- High quality and safe
- Flexible
- Equitable
- Responsive to Māori
- Cost effective and sustainable.

The core focus will be on ensuring services:

- 1) deliver nationally consistent assessments,
- 2) support planning,
- 3) enable focus,
- 4) deliver integrated, competent and supported workforce,
- 5) deliver clinical oversight,
- 6) deliver optimum use of natural supports,
- 7) are culturally competent,
- 8) are performance focused.

Full implementation is planned for 2022.

Type of work carried out by the authority

Conformity assessment bodies (CABs) (also referred to as designated auditing agencies) audit and certify providers of HCSS that have a contract with the Ministry of Health to provide services. The HCSS providers must demonstrate that they are complying with the *Home and Community Support Sector Standard* in order to obtain certification. The Ministry of Health (2017) Auditing Requirements: Home and community support sector standard⁽²⁶⁹⁾ sets out:

- The types of audits conducted:
 - Certification audit valid for three years
 - Verification audit (expanding service or change in service site is valid for three years or alters existing certificate)
 - Surveillance audit (monitoring that occurs within the period of certification).
- The levels of attainment based on a continuous quality improvement model:
 - Fully attained
 - Partially attained
 - Unattained
 - Not applicable.
- The rigorous certification decision process which takes place over two stages:
 - A team leader experienced in auditing homecare services conducts a systematic peer review of the audit report. The peer review includes associated audit evidence (that is, field notes, workbooks or tools) where a report is ambiguous. The peer reviewer must be independent of the original audit. After the peer reviewer has completed the peer review, the conformity assessment body recommends either certification or delaying certification pending completion of corrective action requirements.

- An Independent Assessment Committee, made up of two funder representatives, conducts an independent review of the audit report and decides whether to endorse the decision to award certification. The Independent Assessment Committee has seven working days to respond to and provide feedback on the audit report.

In some cases, providers are certified against the Health and Disability Services Standards.⁽²⁷⁰⁾ In such instance providers must include additional evidence that they are implementing standards relevant to home and community support services.

These cases include where:

- HCSS are provided as part of a larger organisation's services and that larger organisation is certified to use the same management
- The provider uses the same quality and risk management systems across its organisation
- Home and community support services can be identified within the management, quality and risk management systems.⁽²⁶⁹⁾

Types of homecare tasks provided by services

The Ministry of Health outline that the following tasks are delivered as part of their homecare services:

Household management may include help with:

- preparing meals
- washing, drying or folding clothes
- house-cleaning, vacuuming and tidying up.

Personal care may include help with:

- eating and drinking
- getting dressed and undressed
- getting up in the morning and getting ready for bed
- showering and going to the toilet
- getting around your home.

Regulation of homecare services in non-English speaking jurisdictions

Denmark

Is homecare regulated?

The provision of social care and homecare in general in Denmark is dissimilar to other western European countries. While homecare is regulated by primary legislation, the Ministry of Health is responsible for establishing the overall framework for the provision of health and elderly care.⁽²⁷¹⁾ At regional level, there

are five regions and at local level there are 98 municipalities. The 98 municipalities are fully responsible for public governance, provision, delivery and financing of elderly care in Denmark, including homecare.⁽²⁷²⁾ Therefore, it is the responsibility of each municipality to set quality standards and carry out inspections in homecare. The inspection reports are published online in Danish. Homecare agencies are also subject to quality risk inspections by the Danish Patient Safety Authority. It is therefore problematic to accurately describe their regulatory approaches. However, at a higher level, a biannual survey is conducted among elderly people (aged 67 and over) who receive either care in their own home.

The homecare sector in Denmark is publicly funded and delivered to older adults (66 years and older) and people with a disability (physical, sensory and intellectual disability). Some older people are offered a 'voucher' system, where they get half an hour every week for services of their own choice. In general terms, homecare services are targeted at elderly people who live at home but are unable to manage everyday life on their own.

Types of tasks provided for within homecare

Homecare falls into two categories: practical help and personal care. Table 4.11 outlines the primary tasks undertaken by homecare services in Denmark.

Table 4.11: Tasks provided by homecare services in Denmark
Doing household chores (laundry, cleaning)
Help with dressing, including putting on shoes and socks
Bathing or showering
Help with eating, such as cutting up food
Help getting in or out of bed
Help using the toilet, including getting up or down
Nursing care

Homecare services may also include food services based on an assessment of individual need. Another fundamental aspect of homecare services in Denmark is centred on the principle of self-reliance, which is realised through the concept of reablement.⁽²⁷²⁾ In practice, this means that homecare services are focused on restoring, maintaining and improving mental and physical functionality. The reablement scheme is limited in time and adjusted to the individual needs and capabilities of the elderly.

Finland

Is homecare regulated?

Homecare in Finland is regulated by primary legislation.⁽²⁷³⁾ Municipal social and healthcare services are prescribed by legislation covering social welfare, primary

healthcare, specialised medical (hospital) care and informal care support. Social welfare for older people is made up of social and health services, and income security. The Ministry of Social Affairs and Health is responsible for the running of services for older people. It determines the course of service development, draws up legislation and oversees the implementation of reforms. The Ministry also monitors service standards through the National Supervisory Authority for Welfare and Health and the Regional State Administrative Agencies. The legislation concerning homecare does not entitle people to homecare services on the basis of age but according to need.⁽²⁷⁴⁾ This need is assessed using the interRAI assessment instruments.⁽²⁷⁴⁾

Both public and private homecare is available in Finland. Public homecare is the most common way to take care of older people at home. If people choose private homecare, public homecare can grant service vouchers for these individuals. These are granted according to homecare criteria for auxiliary services (hygiene, sauna or outdoor recreation).

The government also directs the policy on social and healthcare client fees through legislation. The purpose of the policy is to ensure that the fees are kept at a reasonable level and they are not an obstacle to using social and healthcare services. There are a number of acts in Finland that outline the rights of people receiving healthcare and social services that all influence quality of homecare.

How is homecare regulated?

Valvira is Finland's national supervising authority on social welfare and it cooperates with six regional administrative agencies that have primary responsibility on supervising social care in their own region. All six agencies have similar duties in fields like healthcare and social welfare, but they differ in actual geographical scope of jurisdiction. Accreditation is mandatory and a condition for public reimbursement.⁽²⁷⁵⁾ Valvira handles welfare-related supervisory cases when they are of nationwide importance and matters of principle; other complaints are handled by the six agencies. Valvira publishes a national supervisory programme every three years and sets out the programme of work. For example, it looked at service structure, service availability and service content and quality in various health and social care settings from 2016-2019, including in homecare. Additionally, agencies are required to analyse the effectiveness of their own actions by factors such as the changes in the end result of a service to help drive improvement. This are numerous pieces of legislation in Finland that that promotes the right of social welfare clients to quality care and to good treatment in Finland. These broadly focus on professionals to have the necessary education and training, as well as be familiar with the area of their work and the quality service provided.

Types of tasks provided for within homecare

In response to HIQA's survey, Table 4.12 identifies the primary tasks undertaken by homecare services in Finland.

Table 4.12 Tasks provided for by homecare services in Finland
Providing a hot meal, for example cooking
Doing household chores (laundry, cleaning)
Support taking medication
Help with dressing, including putting on shoes and socks
Help with walk across a room, for example transferring
Bathing or showering
Help with eating, such as cutting up food
Help getting in or out of bed
Help using the toilet, including getting up or down
Nursing care
Other: taking older people outdoors (not every day)

In addition to this, nursing care is also provided. This was described as nurses activating and rehabilitating clients through an individual care plan. Examples were provided insofar as nurses would support walking indoors with mobility aids or doing other training to maintain functioning, older people doing own breakfast with nurses. This is perhaps difficult to disentangle as homecare services, and home nursing care is combined in many municipalities with homecare and this is supplemented by additional support services.⁽²⁷⁶⁾

France

Is homecare regulated?

The provision of homecare in France is very complex as it involves several levels of governance through the state, regions, departments and municipalities. Overall, the government defines national health and social policies through legislation, and different territorial levels are involved in managing and funding the two sectors.⁽²⁷⁷⁾ Homecare is partly regulated for two primary reasons. Firstly, public and private sectors coexist, with three types of service providers — public social services, non-

profit organisations, and private companies. Each type of service has its own regulations. Secondly, part of the French funding system of long-term care is based on public funding through a system of 'cash for care' and co-payments and this can create 'black markets' that are out of reach of regulation. Therefore, homecare services in France can be seen as fragmented in terms of its legal framework. The absence of a unique regulatory framework is seen as an obstacle to structuring both service provision and employment within the sector. Different (often overlapping) collective agreements co-exist; with the collective agreement referring to the private sector being less protective of employee rights than that of non-profit organisations or public services. This is described as being an ongoing issue and there appears to be a three tier system regarding homecare employees according to activities performed:⁽²⁷⁸⁾

- 1) Domestic cleaners (aides ménagères) who in practice often also provide personal care and have no formal qualifications
- 2) Homecarers (aides à domicile) who provide personal care as well as domestic cleaning and consider their jobs to cover a wide range of activities
- 3) Personal care assistants (auxiliaires de vie à domicile) who have specific qualifications and present themselves as professional carers having specific skills.

How is homecare regulated?

Notwithstanding this, formal homecare is delivered by public and private providers who receive an agreement from the French local authority called the Département. At national level, the government develops national legislation and regulation for access, quality and efficiency of all type of homecare. At the regional level, France's Regional Health Agencies are responsible for regulating homecare. Homecare providers are accredited (such as, formal homecare providers operating under a quality management system) and from this the service is entitled to payment for provided services. If services are in breach of rules then they can have their licence to provide services revoked.

Types of tasks provided for within homecare

In response to HIQA's survey, Table 4.13 identifies the primary tasks undertaken by homecare services in France.

Table 4.13 Tasks provided for by homecare services in France
Providing a hot meal, for example cooking
Doing household chores (laundry, cleaning)

Shopping for groceries
Managing money (for example, paying bills)
Making phone calls
Support taking medication
Help with dressing, including putting on shoes and socks
Help with walk across a room for example, transferring
Bathing or showering
Help with eating, such as cutting up food
Help getting in or out of bed
Help using the toilet, including getting up or down

A distinction should be made between tasks depending on nursing homecare services in France. Nursing services or personal care delivered by nursing services are not subject to the same regulation as homecare delivered by homecare workers.

Germany

Is homecare regulated?

In Germany, homecare is also called 'outpatient care' ('Ambulante Pflege') and it is regulated by Social Code SGB XI.⁽²⁷⁹⁾ This provides the regulatory framework guiding all statutory insurance schemes. Germany has specific compulsory care insurances for long-term care, including homecare. Individual needs are assessed and varying levels of financial support (ranging from 1-5) are made available if a person is assessed as needing homecare. The fixed amount of benefit is determined by law and is paid by the long term care (LTC) insurances. People can then 'buy' formal homecare services up to this level. In case they need or want more services, they have the options to pay for these themselves. In LTC, people can choose between care-in-kind or cash benefits or a combination of both. Formal homecare in terms of supporting medical treatments is funded by the sickness insurances after a physician's prescription. They are provided as formal services only (no cash benefits available) and co-payments do not occur in this area.

How is homecare regulated?

The MDK (Medical Board of the Health Insurances) oversees the quality assurance procedure in homecare services. Homecare agencies have to meet certain structural standards in an accreditation process if they are permitted to operate in the homecare sector. These include:⁽⁴³⁾

- Competence of personnel: their training and ability to assess, treat, and communicate with the clients
- Timeliness: timely access to care and coordination
- Continuity: coordination.

Homecare agencies are assessed by the regional Medical Review Boards for care deficits. There is a regulatory framework which defines specifically identified performance indicators. The performance indicators are known as 'transparency criteria'. There are annual inspections alongside continuing to follow up on complaints pertaining to the quality of homecare services. The results of these quality checks are published in transparency reports. The homecare service is awarded a score based on the outcomes of the inspection. The score ranges from 1 (excellent) to 5 (insufficient). The annual inspections are undertaken by a team comprising a qualified community worker, a registered nurse and an administration employee.

Types of homecare tasks provided by services

An ambulanter Pflegedienst (German for homecare nursing provider) employ nurses as well as other homecare workers (nursing assistants, people providing domestic care and others). There are around 14,500 provider organisations all over the country. Typically, in German homecare services, the professionals providing nursing care are qualified nurses, the professionals providing personal care are fully qualified nurses for the aged, and the professionals providing domestic care are home helps who require a training period ranging from three months to one year. Accreditation at provider level necessitates that homecare staff are suitably qualified and are paid adequate wages.

In response to HIQA's survey, Table 4.14 identifies the primary tasks undertaken by homecare services in Germany:

Table 4.14 Tasks provided for by homecare services in Germany
Providing a hot meal, for example cooking
Doing household chores (laundry, cleaning)
Shopping for groceries

Making phone calls
Support taking medication
Managing money (for example, paying bills)
Help with dressing, including putting on shoes and socks
Help with walk across a room, for example, transferring
Bathing or showering
Help with eating, such as cutting up food
Help getting in or out of bed
Help using the toilet, including getting up or down
Nursing care

Netherlands

Is homecare regulated?

There have been significant changes in the health and social care system and since 2015 there has been a drive to promote self-sufficiency and independence. The regulation of homecare in the Netherlands is complex, borne in part from the multiple stakeholders who are involved in its provision. For example, it is important to distinguish that the term homecare in the Netherlands does not refer to all care that is received in a home situation. Municipalities are responsible for ensuring that people are able to live independently and participate in society for as long as possible. This is set out in the Social Support Act.⁽²⁸⁰⁾ This broadly refers to all domiciliary care, encompassing activities such as house cleaning, buying groceries, and cooking. However, medical, nursing and personal care do not fall under the term homecare. These activities are covered under the Healthcare Insurance Act.⁽²⁸¹⁾ Therefore, it is becoming more common for clients to be provided services in their home by multiple providers. Although the Dutch Health and Youth Care Inspectorate (IGJ) guards the quality and safety of care, enforcing laws, scientific guidelines and field standards in the Netherlands, the IGJ does not have one responsible authority to address the regulation of homecare due to the complex web of involvement in homecare. This is further complicated as the same organisation may be providing both forms of services to people in their home, but funded and controlled by two different pieces of legislation.

Is homecare regulated?

Firstly, under the Care Providers (Accreditation) Act (WTZI),⁽²⁸²⁾ all organisations that provide care must be accredited. Accredited care providers are allowed to provide care that is covered by health insurance or that falls under the Chronic Care Act. Care providers that meet a specific scheme's quality requirements may carry its quality mark. Care providers also must satisfy several legal requirements. For example, they must:⁽²⁸²⁾

- deliver responsible care that meets the quality standards set by the relevant medical and professional associations
- make sure that only care professionals who are registered under the Professions Act to carry out certain regulated procedures
- discuss patients' care plans with them
- provide for patient participation
- have a complaints procedure in place
- account for their quality management in annual reports.

The IGB then supervises care providers who offer care at home under these pieces of legislation. From a care in the home perspective, this concerns nursing and care of people at home by the district nurses as the basic homecare is the responsibility of each municipality. This may concern a short period of intensive care, such as during a recovery period after surgery in the hospital or people who are ill for a long time and need nursing or care for a longer period of time. The primary focus of the IGB is to ensure that the client is at the centre of all the care and that they receive good and safe care at home. The client is central to their supervision. There is an assessment framework; however, this is only available in [Dutch](#). The inspectorate looks at five themes:

1. Client central: does the patient have control over his situation? Are the wishes of the client the starting point for the care he receives?
2. Integrated care: how does the cooperation between district nurses and informal carers work, between the district nurses themselves and between the district nurses and other care professionals?
3. Safety: for example medication safety, but also a safe care relationship with the patient and a safe performance of technical nursing activities.
4. Professional autonomy of the district nurse: attention to the coordinating role in the team, the assessment, the substantive management and how the intakes proceed.

5. Focusing on quality: how does the homecare institution support district nurses so that they can do their job properly?

In addition to the normal supervision of the district nursing, the district nurse and homecare institution may also have to deal with the inspection in other ways, such as:⁽²⁸²⁾

- **Supervision of incidents**
The homecare institution is obliged to report incidents such as violence, a calamity and dismissal due to malfunctioning to the inspectorate. The institution is then asked to conduct an investigation
- **Supervision of new homecare providers**
A new homecare institution for nursing and care can be visited as part of the supervision of new care providers
- **Supervision of care networks**
The inspectorate can also visit in the context of supervision of care networks.⁽⁹²⁾

In addition, the inspectorate pays thematic visits, such as for infection prevention.

What tasks are provided for within homecare?

In response to HIQA's survey, domestic homecare was identified as being 'homecare' and any further tasks beyond that were considered distinct from homecare, for example nursing care, and therefore regulated by the IGB.

Sweden

Is homecare regulated?

In Sweden, services are governed at three levels: national, regional and local. At a national level, the government governs through legislation, policy plans, state subsidies and supervision through the Health and Social Care Inspectorate (IVO). Homecare in Sweden, referred to as 'home help', is granted by social services under the Social Services Act.⁽²⁸³⁾ This Act governs most of elderly care in Sweden, such as nursing homes. Sweden is unusual insofar as the legislation governing homecare and other elderly care for that matter is based on a 'goal orientated framework' law that sets out a right to services, however it does not set out specific regulations.⁽²⁸⁴⁾

How is homecare regulated?

There is a long history of very little regulation and control in homecare services⁽²⁸⁵⁾ with some commenters arguing that stricter regulation may be a threat to the quality of care.⁽²⁸⁶⁾ Monitoring of homecare services is the responsibility of the State and local authorities, with the government responsible for ensuring that the provision

and organisation of homecare services is adequate and in line with regulatory criteria set out in the Social Services Act 2001 (SSA).⁽²⁸³⁾ One such broad regulation is the management system for systematic quality work which sets out that providers delivering services under the SSA (among others) should ensure that their work is systematically and continuously developing and ensuring the quality of such activities.⁽²⁸⁷⁾

The Health and Social Care Inspectorate (IVO) was established in 2013 as the government agency responsible for supervising healthcare, social services and activities under the Act concerning Support and Service for Persons with Certain Functional Impairments. The IVO grants permits to providers to deliver services and considers:

1. whether the service can be run with good quality and safety
2. if a service looking after people who are vulnerable and at risk, the competence of the staff and the person who is responsible for the service are very important indicators
3. the service's quality and management system, premises and other features.

The IVO also may investigate complaints if they are raised about the quality of services and use this information for ongoing monitoring.

Types of homecare tasks provided by services

Homecare consists of help and support to an individual in their own home or equivalent, so that the person can continue to live at home. Homecare is the term for a collection of services granted by social services according to Chapter 4, Article 1 of the Social Services Act (SoL). These may be:

- non-personal services, such as cleaning or shopping.
- personal care, such as hygiene or help at mealtimes. Emotional and social support is also regarded an important aspect of the service.
- certain other types of homecare services are available that do not entail significant contact with the eligible person (for example, social care alarms, delivery of meals, collecting and delivering laundry, and so on) are not subject to authorisation.

In response to HIQA's survey, Table 4.15 identifies the primary tasks undertaken by homecare services in Sweden.

Table 4.15 Tasks provided for by homecare services in Sweden

Providing a hot meal, for example, cooking
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Doing household chores (laundry, cleaning)
Shopping for groceries
Support taking medication
Help with dressing, including putting on shoes and socks
Help with walk across a room, for example, transferring
Bathing or showering
Help with eating, such as cutting up food
Help getting in or out of bed
Help using the toilet, including getting up or down

Additionally, basic medical tasks can also be included in homecare services. For example, it was reported in the literature that this may include insulin injections and treatment of wounds.⁽²⁸⁴⁾ However, this is delivered through a separate assessment process.

Discussion

The review of homecare across English and non-English speaking jurisdictions identified many similarities and differences regarding how homecare is regulated. It would appear that where decentralisation of services exists, the approach towards regulation is more fragmented and difficult to identify. It is important to consider that due to language barriers, where it is difficult to get information in English along with variations in homecare terminology, omissions are possible. This review has sought to outline the broad principles of predominantly non-English speaking jurisdictions only.

Homecare is generally embedded within legislation across jurisdictions. Examples include Wales where homecare is regulated against a framework put in place under the Regulation and Inspection of Social Care (Wales) Act 2016, and in Scotland where free personal and nursing care is a statutory entitlement outlined and defined in legislation for those who need it, and monitored against national standards. Embedding similar legislation in Ireland will strengthen the regulation of home support services and provide legal footing for the sector.

In England, Scotland, Northern Ireland, Wales, Australia and Sweden, homecare providers are registered by an independent regulator to provide homecare services. This means the regulator registers services and they are legally permitted to provide

homecare services. In other countries such as New Zealand, Finland, France, Germany and the Netherlands, there is an accreditation approach towards homecare where providers are permitted to provide homecare services. An additional safeguard used in Wales concerns the use of regional registration. This means that services are registered on a regional perspective, whereby if there are concerns surrounding the provision of care, sanctions or restrictions may not be applied on a national basis.

The registration and requirements of homecare workers was addressed in a number of jurisdictions. In Wales, Northern Ireland and New Zealand, homecare workforce falls under the regulatory framework. Legislation introduced has placed an emphasis on the homecare workforce, improving working conditions, wages and providing education and training. In Wales, the Regulation and Inspection of Social Care (Wales) Act 2016 introduced steps to improve the quality of care and support provided by the homecare workforce, by requiring an increase in the separation between travel and call time and limiting the use of zero hour contracts. Homecare workers must also register with Social Care Wales which has set out detailed requirements necessary for to register. Registration is flexible and there are different options for training and registration. In contrast in England, there is no registration requirement for homecare workers, nor is there any requirement for staff to be fully qualified before they begin working. It is documented that up to two thirds of homecare staff do not have the basic qualifications which are expected to be completed by all paid carers. Registration and qualification requirements of homecare staff should be clarified. With the nature of homecare being largely unsupervised work, the regulation of its workforce can serve to enhance the competency of care workers and quality of care delivery.

From an Irish perspective, the English speaking jurisdictions provide learning in how the scope of homecare is set out. In England, the concept of regulated activities is set out where providers need to determine which activities are relevant to the service they provide. For example, nursing care means any service provided by a nurse involving either:⁽²⁸⁸⁾

- the provision of care
- the planning, supervision or delegation of the provision of care, other than any services which, by their nature and the circumstances in which they are provided, do not need to be provided by a nurse.

And the regulated activity of personal care involves:⁽²⁸⁸⁾

- supporting people in their homes (or where they are living at the time) with things like washing, bathing or cleaning themselves, getting dressed or going to the toilet.

While there are many other regulated activities under the Health and Social Care Act 2008 Regulations 2014,⁽²¹⁶⁾ the concept of regulated activities would appear to be a very serviceable way forward. In theory, this would mean that there would be homecare providers providing both nursing and personal care services, or just personal care services under a regulated activities regime. This may provide a mechanism to help 'future proof' the concept of moving services left in an attempt to provide more advanced services closer to home.⁽³⁴⁾ From a regulation perspective, this would mean that the regulator would maintain a register to identify who was legally entitled to provide regulated services or activities and they would be inspected to ensure they are safe to do so. There also appears to be a similar mechanism in Australia where 'care', 'support', 'clinical' and 'excluded tasks' are clearly set out.

Alternatively, in Wales and Australia, the distinction is not fully made between homecare tasks. The Care Inspectorate Wales (CIW) can register homecare services that provide nursing services as long as this is outlined in their 'statement of purpose' and they have the capacity and capability to deliver them. This could be viewed as a pragmatic approach towards personalisation, as the provider of care can potentially increase service provision in line with a person's needs, and CIW register services in accordance with their updated statement of purpose. In Australia, while their regulations provide legal footing for homecare services, they do not specifically outline the scope of tasks involved in these services. Again this may provide flexibility in terms of what types of care can be provided in the home, allowing the care worker to adapt care delivery as a person's needs arise during visits.

Exclusions to the scope of services may also produce challenges. In Scotland, nursing care is not a registerable activity with the Care Inspectorate, and is often not within the scope of services provided to a person receiving care in their own homes. Not having nursing care included in the scope of services may be restrictive and introduce challenges. Additionally in England, household tasks are excluded from the scope. This may not fully support the wellbeing and quality of life of the person receiving the service. Therefore, this is potentially one of the most important issues to consider from an Irish perspective. If homecare does not include the provision of tasks that extend to activities of daily living and instrumental activities of daily living then there needs to be provisions put in place to protect the rights of people who receive such services.

On a final note, regulators use varying mechanisms to inspect homecare providers. Across jurisdictions, an outcomes-focused approach is adopted when monitoring and inspecting services, and a holistic view of the person receiving care and support is emphasised. Having such a focus on patient satisfaction may ensure that inspections of homecare services are not restricted to a compliance versus non-compliance approach. Methods of assessing this include visiting a person's home. If this is to be

the case in Ireland, then there needs to be significant consideration and consultation on how this should be developed and how it is likely to infringe on the person in receipt of services.

Plain language summary of Chapter 4

HIQA sent surveys to people who are knowledgeable about homecare services in different countries and states. HIQA wanted to answer three questions:

- 1) Is homecare regulated in the country/jurisdiction?
- 2) How is homecare regulated?
- 3) What type of tasks are provided by homecare providers that are regulated?

As only seven out of 23 states responded, HIQA also carried out an online review of these countries. The results show that many countries use different mechanisms to regulate homecare, such as registering or certifying services. However, in order to regulate this sector, it is important that homecare tasks are fully defined and understood. For example, whether homecare include nursing care, or assistance with dressing and shopping in a person's home. Ireland needs to consider how people receiving all these different types of services in their own homes are protected. Regulating these activities, or having a statement of purpose that shows an organisation had the capacity and capability to provide certain services would be beneficial.

Chapter 5: Regulatory considerations for the regulation of homecare in Ireland

The previous chapters have identified the complexities that currently exist within the homecare sector in Ireland. Its development, albeit fragmented and in response to changing societal needs, has resulted in a homecare landscape that is devoid of commonality across community healthcare organisations (CHOs). This is potentially putting people who receive and provide services at risk. While Chapter 4 outlined a range of international approaches towards the regulation of homecare, it is important to highlight that once regulation is imposed on a sector, while it should have positive consequences, it can also have some unintended consequences.

Chapter 2 of this report identified that homecare providers in Ireland are providing services to a range of people, with a variety of different needs. These services have developed in tandem with the changing health and social care landscape. This is almost certainly a result of the aforementioned issues that surround the use of terminology, driven by funding issues and the provisions set out for 'home help' in the 1970 Act.⁽⁴⁰⁾ Nonetheless, there is a strong argument that there will be a significant drive for homecare services from people, particularly in the aftermath of the impact of COVID-19, and this needs to be taken into account.

Chapter 3's international review of what constitutes quality within a Donabedian lens is largely aligned with the majority of risks identified by service providers and named issues that regulation and standards should focus on. While these are important and reinforce the need to regulate this sector — and offer a starting point for the direction of the development of regulations and standards in homecare — it is also essential to illustrate and set out the impact that regulation will potentially have on homecare in Ireland.

Therefore, this chapter will briefly outline the objectives of regulation in broad terms, aligned to the sphere of homecare. It will broadly consider the impact that regulation may have on the homecare sector and it will set out what HIQA may consider to be an appropriate regulatory approach toward the regulation of homecare services in Ireland. This is underpinned by drawing on HIQA's experience of being a statutory regulator of social services since 2009.

Objectives of regulation

From a social care perspective there have been significant enhancements in the provision of services over the last few decades. While it is well highlighted that there are many issues with the current state of homecare in Ireland, there are undoubtedly many excellent examples of homecare provision. However, the fact remains that the homecare landscape is unbalanced and precarious. There is also a complete absence

of any oversight of providers who do not provide HSE-funded services. Over the last number of years competition in this sector has soared and as a result it has been reported that a 'black market'^{††††††††††} now exists in different guises.^(289,290)

Therefore, in the absence of a regulated system, independent assurances cannot be provided to people who receive services and the public more broadly that they will receive a quality service and will be protected from harm.⁽²⁹¹⁾ Unfortunately, regulation is nearly always brought in as the result of previous failures,⁽¹¹⁰⁾ an experience also borne out in Ireland after the Leas Cross nursing home scandal.⁽²⁹²⁾ Essentially, regulation is necessary when voluntary arrangements are not enough to guarantee compliance with certain levels of performance that ought to be expected. This is where regulation is used by governments as a key policy instrument to achieve policy objectives.⁽²⁹³⁾ Regulation generally comprises of three key characteristics to:⁽²⁰¹⁾

- 1) provide direction for the regulated
- 2) determine the level of performance or compliance of the regulated
- 3) and use regulatory powers to bring about a positive change in performance of the regulated.

It is important to highlight that achieving good regulatory outcomes is not just dependent on having regulations; rather, it is a cooperative effort between the government, the regulators, the regulated and other concerned parties.⁽²⁹⁴⁾ From a homecare perspective, this means that through cooperative effort regulation sets out to deliver on three priorities (adapted from Sutherland and Leatherman (2006)⁽²⁰¹⁾:

- 1) to improve performance and quality of homecare
- 2) to provide assurance to people in receipt of homecare and to the public that minimally acceptable standards are achieved
- 3) to provide accountability both for levels of performance and value for money.

Deconstructing these three priorities would suggest that the philosophy behind the regulation of homecare is positioned within a social policy context. This means that the introduction of regulation stems from a perspective whereby homecare is seen as a fundamental right for all people and this should not be influenced by any other characteristic (for example, where someone lives or their bespoke or individual

^{††††††††††} HCCI (undated) cited in Timoney (2017)⁽⁷²⁾: "An important point to note about the 'black market' in homecare, is that it is not as we traditionally understand, with murky dealing happening in the back of vans. Black market homecare is often provided by people with the best of intentions - friends, relations and neighbours trying to do what they believe is the right thing. However, there is also the 'cash in hand' side of the business, where advertisements are answered by unknown people, with unknown qualifications. There are a large number of carers operating on the black market on a cash-in-hand basis. The issues for either type of care are significant. Black market carers are not paying taxes or properly trained or insured, leaving many people in vulnerable situations in the event of an issue arising."

needs). Nonetheless, despite being positioned within a social policy context, and accepting that it is the right thing to do, it is important to consider how advancing the objectives of regulating homecare will have both intended and unintended consequences. Subsequently, its impact needs careful and detailed consideration and engagement with concerned stakeholders.

Impact of regulation

The Government's commitment to regulating homecare indicates that, as a society, the cost-benefit relationship of regulating homecare versus not regulating homecare is warranted and appropriate. However, some homecare providers will find the transition to being regulated difficult and as a result they potentially will not meet the minimum requirements to be registered to provide homecare services. This is in line with HIQA's previous experience when the regulations governing nursing homes were implemented in 2009. While this will impact some homecare providers, it may also impact people who are in receipt of homecare services, whereby they are no longer able to receive a service from their preferred provider. Although this may prove to be less of an issue for HSE-funded services, it may significantly impact providers who do not provide any HSE-funded services. Consequently, this may increase the demand for homecare on providers who are registered to provide homecare services. However, it would also increase the demand for 'black market' homecare that is reported to exist in this sector.

When this is considered alongside the fact that provision of homecare is patchy and influenced by location,⁽⁴¹⁾ the first impact that regulation of homecare in Ireland could have is to reduce the number of providers in the market. While this must not be regarded as negative (for example, if it stops inadequate or unsafe providers from delivering homecare services) in the short term, the introduction of regulation in this sector may cause such an unintended consequence. Other unintended impacts may include:⁽¹¹⁰⁾

- 1) Providers only intend to meet the minimum requirements set by regulators thereby there is a lack of focus on quality improvement
- 2) Providers spend too much time on trying to demonstrate compliance.

It is very important that the regulation of homecare will be seen as a significant statutory instrument and therefore a detailed Regulatory Impact Analysis^{*****} (RIA) (screening and or full RIAs) is undertaken by the Government in line with the Department of An Taoiseach's Cabinet guidance. ⁽²⁹⁵⁾

***** A Regulatory Impact Analysis is an assessment of the likely effects of a proposed new regulation or regulatory change.

HIQA has previously commented on the importance of having effective regulations that are current and aligned to policy objectives.⁽²²⁾ The OECD is very clear on this and calls on governments to:⁽²⁹³⁾

Integrate RIAs into the early stages of the policy process for the formulation of new regulatory proposals. Clearly identify policy goals, and evaluate if regulation is necessary and how it can be most effective and efficient in achieving those goals. Consider means other than regulation and identify the trade-offs of the different approaches analysed to identify the best approach.

On another level, HIQA is also advocating that the impact of regulation in the homecare sector should not be considered as a linear process and RIAs should not be an end in themselves. Rather, the impact of regulation on homecare should be seen as an iterative process where it is regularly reviewed once implemented, to identify whether its:

- original objectives are still valid and or being achieved,
- regulation remain effective, and;
- objectives to be improved or removed in light of legal, economic or social changes are undertaken.⁽²⁹⁶⁾

These principles are outlined in a 2004 Government report the published a White Paper entitled 'Regulating Better, A Government White Paper Setting out Six Principles of Better Regulation'. Although this report is 17 years old, these principles remain very much to the forefront for effective regulation and must be considered as a cornerstone for the development and ongoing monitoring of regulation in the sector.

Regulatory approaches

Regulators can be defined as either deterrence or compliance focused.⁽²⁹⁷⁾ Walshe (2003)⁽¹¹⁰⁾ identified that deterrence orientated the regulator's view of the regulated as 'amoral calculators' — out to get what they can and will only comply if they are forced. Whereas, he reports that compliance-focused regulators develop a partnership to bring about improvements. Under this type of regulation, the regulated are seen as good and well intentioned, and likely to comply with regulations if they can. He concluded that in practice regulators usually need to use both these strategies.

Nonetheless, there are different processes that could potentially be used to regulate the homecare sector in Ireland if the legal provision was enacted to enable this to be the undertaken. Some of these approaches are outlined into directive approaches and external oversight approaches in a non-exhaustive list below (adapted from Sutherland and Leatherman (2006).⁽²⁰¹⁾ It is important to highlight that these

approaches are nuanced and often interconnected whereby regulators use different directive approaches together and within external oversight approaches.

Directive approaches

- **Target setting:** Homecare providers would need to provide a demarcated level of performance which would be linked to specific targets. These targets would be input, outcome, process and inequality targets. Targets would need to be measurable to ensure that performance could be measured by the regulator.
- **Performance indicators:** Homecare providers would need to provide a defined measure of performance that can be used to track performance over time. These indicators could be used with or without targets or standards to set goals and expectations.
- **Regulation setting:** Homecare providers would need to ensure the homecare services they provide are in compliance with accompanying regulations. Regulations are mandatory legal rules and, therefore, if the provider is found to be non-compliant with regulations they will be liable to enforcement proceedings.
- **Standard setting:** Homecare providers would need to ensure they provide homecare services to a required level, set out in standards, that the regulator would expect to observe. Standards are voluntary and therefore they cannot be enforced.

External oversight approaches

- **Accreditation:** This is considered to be "...an external evaluation procedure independent of healthcare organizations and their administrative bodies, conducted by professionals and concerning all operations and practices. Its purpose is to ensure that standards regarding safety, quality of care and treatment of patients are taken into account by the healthcare establishment".⁽²⁹⁸⁾ From a homecare viewpoint, this would mean that the provider is deemed competent by an body authoritative (provided there is the legal basis to perform this task) to provide homecare.
- **Certification:** The homecare provider would be deemed competent and assurances are given that they are capable of providing a safe service. This certification is voluntary, and could be provided through mechanisms such as the International Organisation for Standardization (ISO).
- **Licensure:** The World Health Organization defines licensing in a healthcare context as a: "process by which a government authority grants permission,

usually following inspection against minimal statutory standards, to an individual practitioner or healthcare organisation to operate or to engage in an occupation or profession".⁽²⁹⁹⁾ This would be a mandatory credentialing process for homecare services. Once approved, the service provider could provide homecare services to varying degrees that are set out.

- **Registration:** The homecare provider would need to register with the regulator to be deemed as an organisation who is registered to provide homecare services. They would need to provide evidence that they can meet a basic set of standards.
- **Inspection, review and audit:** The homecare provider would be subject to external oversight by inspection, review or auditing. These would be either onsite or offsite (or both), and would be dependent on the mechanism for which services were registered to provide services and on which directive approach they are being assessed against.
- **Enforced self-regulation:** This would mean that homecare providers would adhere to any directive published by the regulatory body (for example, codes of conduct, standards, regulations and so on). These bodies may not be inspected as such, but any directive can be enforceable by the regulatory body.

While these approaches signal different avenues that warrant exploration by the Government to develop a bespoke regulatory framework for Ireland, it is important to reflect on the work of Kiersey and Coleman (2017)⁽⁴³⁾ — based on the work of Genet et al. (2012)⁽⁵⁵⁾ — who categorise Ireland's current governance of homecare as *laissez-faire*, with weak involvement and no vision for homecare regulations, where eligibility criteria is often set by voluntary and private providers. Nonetheless, it is reasonable to also conclude that before the regulation of older persons' services in 2009, similar inferences could be made about that sector. In 2006, Professor O'Neill⁽³⁰⁰⁾ highlighted a number of issues in this sector at that time, including:

- failure of management to give sufficient weight to concerns expressed by interested parties
- weak policy, legislation and regulation
- deficiencies in funding
- the speed of growth in the private sector and capacity of the regulatory bodies to keep pace.

Over the last decade the transformation of this sector has been immense, and now all designated centres for older people along with designated centres for children

and adults with a disability are subject to regulation by HIQA. §§§§§§§§ (301,302) HIQA is a mature regulatory body that has adapted a transparent, proportionate and targeted approach to regulation, which is also responsive to the needs of service users. Therefore, it would be reasonable to build upon this approach if HIQA is going to regulate homecare in the future. Under its current programme of regulation, HIQA has adopted a responsive approach.

This approach was initially proposed by Ayres and Braithwaite in 1992, with responsive regulation seen as a dynamic model in which persuasion and or capacity building are tried before escalation up a pyramid of increasing levels of sanction.⁽³⁰³⁾ Responsive regulation means that the type, frequency and intensity of regulatory intervention is informed by an assessment of risk. Over the course of HIQA's work, this has meant that regulated services who persistently breach regulations or place people in receipt of services at risk of harm are identified quickly and face proportionate and meaningful sanctions. HIQA describes its responsive regulation as a risk-based approach. This risk-based approach is undertaken by building a composite picture of service providers through assessing different pieces of information, such as routine monitoring notifications, service user questionnaires, unsolicited information and inspection findings. The longer providers are regulated, the more intelligence HIQA builds about the services and this increases the predictive validity of HIQA's risk-based approach. Using this approach enables HIQA to:

- respond to risk proactively,
- prioritise its regulatory activities,
- organise its resources.

§§§§§§§§ HIQA also regulates special care units for children and medical ionising radiation under the following regulations:

- European Union (Basic Safety Standards for Protection Against Dangers Arising from Medical Exposures to Ionising Radiation) Regulations 2018 (SI 256/2018).
<http://www.irishstatutebook.ie/eli/2018/si/256/made/en/pdf>
- European Union (Basic Safety Standards for Protection Against Dangers Arising from Medical Exposures to Ionising Radiation) (Amendment) Regulations 2019 (SI 332/2019).
<http://www.irishstatutebook.ie/eli/2019/si/332/made/en/pdf>
- European Union (Basic Safety Standards for Protection Against Dangers Arising from Medical Exposures to Ionising Radiation) (Amendment)(No. 2) Regulations 2019 (SI 413/2019).
<http://www.irishstatutebook.ie/eli/2019/si/413/made/en/pdf>
- [Health Act 2007 \(Registration of Designated Centres\) Regulations 2017 S.I. No. 635 of 2017](#)
- [Health Act 2007 \(Care and Welfare of Children in Special Care Units\) Regulations 2017 S.I. No. 634 of 2017](#)
- [Health Act 2007 \(Care and Welfare of Children in Special Care Units\) \(amendment\) Regulations 2018 S.I. No. 108 of 2018](#)

This approach also ensures that regulated services are treated fairly and HIQA would also consider that regulated services have a positive experience as they are regulated in a consistent and proportionate manner. To do this, HIQA uses both regulations and standards to drive quality improvement. In simple terms, regulations are devised and introduced by the Minister for Health by means of a statutory instrument. Regulations can be legally enforced and all providers need to be in compliance with these. However, regulations set out the basic requirements for a service and can be regarded as a minimum level of quality and safety. As regulations only seek to meet minimum requirements, HIQA uses standards as a mechanism to further drive quality improvement. Standards set the bar for quality and safety higher than regulations. They are devised by HIQA through a process of research and consultation with a range of stakeholders and approved by the Minister for Health. Standards are not legally enforceable, but all providers should strive to meet the standards. In this vein, there is a very close relationship between standards and regulations — if a provider is not in compliance with the regulations, it will not be in compliance with the standards.

It is through this lens that HIQA advocates for a similar approach to the regulation of homecare in Ireland. That is to say, it would be a responsive approach⁽³⁰³⁾ using a risk-based strategy that is underpinned by specific regulations and standards. Within this approach, there would be a clear escalation and enforcement pyramid that helps bring about improvement in a transparent and proportionate manner (for example, from education and persuasion to prosecution or loss of licence to provide homecare).⁽³⁰⁴⁾

A further point relating to this concerns the powers of the regulator of homecare. HIQA and the Chief Inspector of Social Services^{*****} are of the firm view that whatever legislation underpins homecare, the regulatory powers must be agile and

***** As set out in the 2007 Health Act (as amended) the Functions of the Chief Inspector are to:

- (a) inspect the performance by the Executive of the Executive's functions under—
 - a. (i) sections 39 to 42 and 53 of the Child Care Act 1991 , and
 - (ii) section 10 of the Health (Nursing Homes) Act 1990 ,
- (b) establish and maintain one or more registers of designated centres,
- (c) register and inspect designated centres to assess whether the registered provider is in compliance with the— (i) regulations, and (ii) standards, if any, set by the Authority under section 8 (1)(b),
- (d) inspect special care units to assess whether the operator is in compliance with the— (i) regulations respecting special care units under the Child Care Acts 1991 and 2001, and (ii) standards, if any, set by the Authority under section 8 (1)(b), and
- (e) subject to written agreement between the Minister and the Minister for Justice, Equality and Law Reform, act as an authorised person for the purposes of section 185 of the Children Act 2001, as amended by the Criminal Justice Act 2006.

responsive for the regulator to be effective. HIQA has commented on this concern in detail in a 2021 publication on *The Need for Regulatory Reform*⁽²²⁾ and this has also been borne out in the courts.⁺⁺⁺⁺⁺ While there has been criticism in Ireland regarding the soft approach towards regulation;^(305,306) the overarching legislation needs to be agile to ensure that the regulator can respond in a proportionate manner to varying non-compliances and risks within services in line with the regulations. In the absence of this flexibility, the regulator can be perceived as weak when the fact is that the legal framework does not support the regulator to make certain decisions at particular times, or the decision becomes entangled in lengthy legal cases that dilutes the regulator's response.

At this stage it is too early to identify specific directive and external oversight approaches. Nevertheless, they would need to be clearly operationalised and guided by the Government in response to the following two questions:

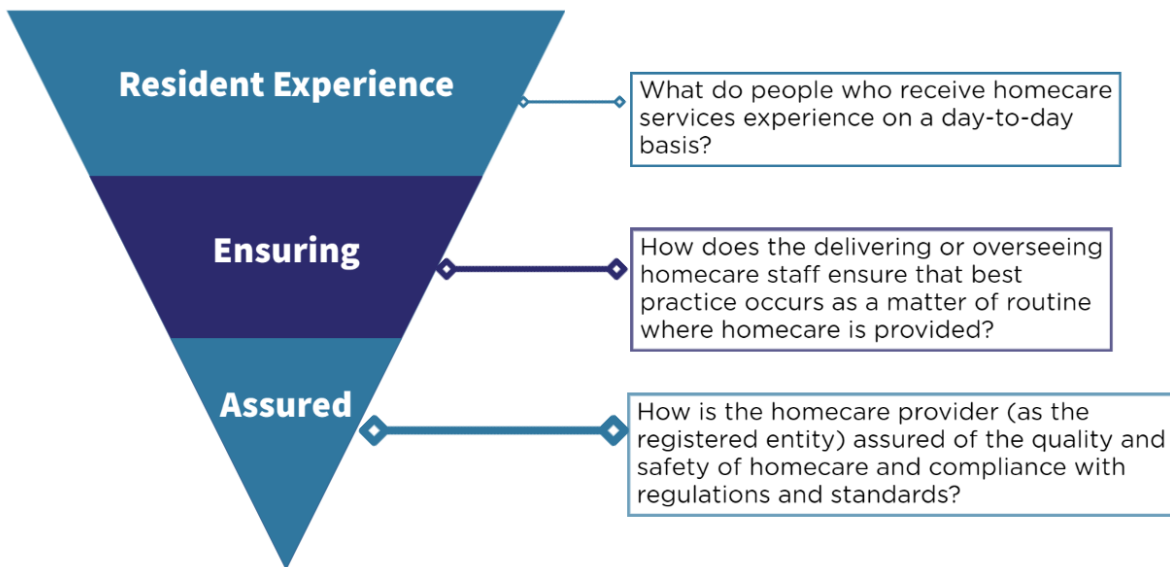
1. What is the scope and parameters of homecare?
2. What is the purpose of regulating homecare in Ireland?
 - a. Is it to ensure that all homecare providers are regulated to meet minimum requirements?
 - b. Is it to drive quality improvement and raise performance?
 - c. Or is it both?

Key considerations

From a regulatory perspective, the following key considerations need to be kept in mind. Firstly, once regulation is imposed on the homecare sector, there cannot be the 'carte blanche' attitude that regulation is the 'cure' to all the problems highlighted in this sector. Rather, regulation must be seen as one cog in the wheel of broader transformation and quality improvement to strengthen this sector. In essence, regulation is the third line of defence after the people delivering the service, and governance and management arrangements a service provider has in place to assure that the care is in compliance with any regulations and set standards. This needs to be embodied within a person-centred philosophy where the person in receipt of homecare is seen as an active participant, their voice is heard, and their day-to-day experience is at the centre of service provision. It is at this stage that regulation seeks to determine if people in receipt of care are protected by assessing against regulations and or standards (or any other mechanism that is instituted). Figure 5.1 outlines how this interrelates.

⁺⁺⁺⁺⁺ See *Silvergrove Nursing Home Limited vs Chief Inspector of Social Services and HIQA* [2019] IEHC 774.

Figure 5.1: Relationship between regulation and resident experience



Secondly, it is important that a full RIA is undertaken by the Government before any potential legislation that is enacted. This should have stakeholder engagement at the heart of the process and clearly define the objective, scope, content, role and influence that the regularisation of this sector will have. Thirdly, the directive and external oversight approaches should be associated with the specific approach towards regulation; that is to say that homecare is carefully defined and the objective of regulation is set out. Fourth, it is imperative that for regulation to function properly and to be effective then the regulators needs to have enforcement powers that are agile and responsive, while proportionate to the breaches of regulations they may face. If the regulator's powers are either too weak or too blunt, it will be difficult for the regulator to be proportionate while driving quality improvement in this sector. Finally, depending on the approach and scope towards the regulation of homecare, it is fundamentally important that a 'regulatory shock' is avoided, and providers are given an interim period to get accustomed with regulation and being regulated. In the first instance, HIQA would consider that the focus would need to be on service providers achieving minimum standards.

Plain language summary of Chapter 5

As homecare is not regulated in Ireland, providers who do not provide services on behalf of the HSE are not subject to independent monitoring or oversight. The Irish Government intends to commence regulation of homecare to provide assurances to the public homecare services meet the minimum requirements. Regulation would establish the quality and safety of homecare, and help to bring about change and

improvements where they are necessary. However, introducing regulation into a sector that has not previously been subject to regulation may have unintended consequences and it is important that these are considered.

Policy-makers should carry out a Regulatory Impact Assessment before legalisation is introduced to fully consider the impact of regulating homecare services. It is also important to remember that regulation will not solve all problems in the homecare sector. Instead, regulation is one tool that will support broader reform across this sector and must be considered alongside the people delivering the service (staff) and the provider's governance and management arrangements.

This chapter also highlighted that there are many approaches towards regulation. Some of these approaches are often connected, whereby regulators use a directive approach, such as setting minimum standards of care to be met, together and within an external oversight approach, such as inspecting to ensure a service is meeting the minimum standards.

This chapter also considered how HIQA's risk-based approach to regulation could be used in homecare services. This approach means the type, frequency and intensity of regulatory action would be informed by an assessment of risk in a service. Equally, when regulation is introduced it is also important that the regulator has enforcement powers that are swift, responsive and proportionate to risk. If these are either too blunt or too weak they may not be effective. Finally, it is important that providers are given time to get familiar with regulation and being regulated to help support them to achieve a minimum level of care. Once this is achieved, there can be a focused effort to drive improvements in this sector.

Chapter 6: Overall discussion

This report has provided a broad overview of homecare services, detailing its background in Ireland, the current as-is picture, what constitutes quality in homecare, international approaches towards the regulation of homecare, and regulatory considerations. This discussion chapter aims to draw some conclusions and focus on key areas highlighted within this report.

This report has identified that homecare operates within a complex network and an uncontrolled environment. This creates challenges for everyone involved in the process. Furthermore, the international approach towards regulation is atypical and influenced by decentralisation, varying demands, needs and funding systems. That is to say, the regulation of homecare is specific to the context in which it operates. While undoubtedly there is learning that can be taken from other jurisdictions and international evidence more broadly, it is equally important that policy-makers also take full account of local and national care contexts in order to develop a homecare system that is considerate of and aligned to the Irish context. The successful provision of homecare depends on the funder of homecare, the provider of services, homecare workers, informal carers, employers, and the person receiving homecare working together. Given that each of these stakeholders have differing perspectives, it is necessary to provide a statutory footing to serve as a quality improvement instrument along with a clear funding system to bring a degree of coherence and consistency to this sector. This is the foremost way to provide assurances to the public that the homecare system in Ireland meets the needs of those who avail of it, and is safe, effective and fit for purpose.

Irish society has experienced vast changes over the last few decades that have significantly impacted what people have come to accept as residents or citizens of Ireland. From a health and social care perspective, traditional residential and institutional nursing homecare for older people is generally not the principal way that older people want to live during their later years of life. Indeed, younger people, people with disabilities, people with palliative or chronic health and social care needs and people who may need periods of rehabilitation throughout their life want the choice of having care and support in their own home. Although, this has been a dominant theme for successive governments since the 1960s, this has been misaligned due to economic, social and political factors. In addition, there has been no all-encompassing framework concerning the funding and provision of homecare services for all people in need, across all regions of Ireland. Essentially, the development of homecare services has been uneven and responsive to short-term needs. In the absence of a statutory obligation to provide homecare, it has not been a priority in health and social care provision. Subsequently, the regulation of homecare in Ireland is a matter of critical importance and is set out in the

Sláintecare Implementation Strategy (2018) which commits to the introduction of a statutory scheme for home support services by 2021.

The HSE has made significant strides towards improving the delivery and oversight of homecare services over the last decade. For example, since 2011, the HSE has engaged voluntary, not-for-profit and private providers with the national tendering process for older people's services. In addition, since 2014 it has been working towards the streamlining of homecare services. The rationale behind this process was to streamline the services into the single home support service which would provide for a single application and assessment process. This aimed to provide clearer financial and activity reporting arrangements, and give greater accountability and transparency to the sector. Since 2018, the tendering process for older people's home support service has service specifications that are aligned to the *National Standards for Safer Better Healthcare*.⁽⁷⁶⁾ The HSE also has service arrangements with approved providers, and the management and monitoring of service arrangements is undertaken at CHO level through regular engagements and meetings with each provider. Providers are also obliged to provide key performance data relating to certain metrics that are called out under the service arrangements. Where providers are found to be not compliant with a service arrangements, this may result in their removal from the approved provider list. The work of the HSE over the last decade has been encouraging and has no doubt improved the homecare landscape. Nonetheless, the absence of regulation means that the HSE can only control the services it commissions, it is not independent of the process and without a statutory funding framework it is somewhat compromised in what it can provide in this demand-led but discretionary service.

Moreover, age is currently a restriction to access. There is no demarcated process for individuals who are under 65 and who do not have a disability to avail of homecare services. Indeed, for many people there are still difficulties, as highlighted by the Wasted Lives report,⁽⁴⁶⁾ insofar as institutional care was the only choice for many people in need of care who would have preferred to be supported in their own home. It is clear from Chapter 1 that there are issues regarding the provision of homecare. Issues surrounding terminology of what constitutes homecare and what is excluded adds to the complexity. As identified in Table 1.1 and detailed throughout this chapter, there are a number of definitions and interpretations of what homecare is. Essentially, homecare intersects both health and social care and therefore, there is a spectrum of tasks that may be provided for which may well increase in the future. This is an important factor to consider as the need for integrated and more complex care has been acknowledged and recognised in this report. This phenomenon was also voiced by homecare providers insofar as some do provide elements and packages of complex care to individuals on a service arrangement basis and to children with complex needs. This is not to say that all

homecare will be complex and require nursing care, rather it is drawing on a widely held view that was recently highlighted by the Nursing Home Expert Panel:

Contrary to traditionally accepted 'wisdom', there is increasing evidence to show that even those with significant dependency levels, including dementia, can be safely, and some would argue more appropriately, reside in domestic more 'homely' settings, always provided the required homecare supports are put in place.⁽³⁰⁷⁾

Furthermore, the HSE has highlighted that Paediatric Home Care Packages are intensive packages of nursing care put in place to support families to care for their child with complex healthcare needs. It is therefore important that consideration is given regarding the best way to ensure there is a level of oversight to these types of services that provide complex care, to adults, children, or both. If this is not from a regulatory perspective, then there needs to be a clear process of clinical governance and oversight detailing what this is, how it is to be administered and what assurances are provided that the services are safe and effective at a national level.

However, the fact remains that the current model of homecare has evolved from the 1970 Health Act, insofar as the 'home help service' was theoretically considered from a 'sick' and 'infirm' perspective. While the current 'home support service' does not cover nursing care for older people, there are instances where primary care commission out nursing care for some individuals to provider organisations, and in some cases, this may be the organisation that is also providing the homecare to these individuals. This would suggest that there needs to be a greater degree of alignment and understanding between both, and a clear need to delineate what homecare is and what it is not.

Notwithstanding this, HIOA firmly believes that homecare should be needs led and integrated, and calls on the Government to legislate for what tasks can and cannot be provided in the sphere of homecare regulation. If this is only to include the current provision of what is performed within the 'home support service' sphere, then this needs be outlined clearly. If this is the case, there needs to be a degree of caution expressed as this may lead to increased burden on providers. The HSE will not be independent of the process for complex care, which risks creating a two-tier system (for example, home support service are regulated but complex care services). It may also be very difficult to understand what this will look like in reality until after regulation is implemented. It is predicted that it will also be particularly difficult for providers to navigate the system. To illustrate this, a hypothetical scenario is provided in Table 6.1.

Table 6.1: An example of how homecare system may present

Homecare X is a private homecare company that operates across every CHO in Ireland. It provides homecare to adults and children, and has agreements with different CHOs under a tender arrangement to provide 'home support services' to 240 adults and another 36 adults with a disability under separate service agreements. Under different service agreements it also has a contract to provide IHCP to 26 adults across these CHOs. In 12 instances, it provides nursing care as the primary care team does not have the capacity to do this. It also provides complex care to 11 children under a separate agreement in six CHOs.

Due to the enactment of homecare legislation, Homecare X is now required to register as a homecare provider. This is because continuing to offer its homecare services without being registered would now be considered a criminal offence. However, this only relates to 'home support services', as complex care is excluded for the legislation.

In these instances the following may potentially happen:

Scenario 1: Homecare X decides it does not want to be subject to registration (or, (1) it does not meet the threshold to be registered, (2) or has its registration cancelled) and regulation so it decides to cease providing 'home support services' and focus solely on complex care. If the provider is successful in acquiring a contract with the HSE, there will then be monitoring arrangements in place by each CHO under a service agreement that is in place at that time. This will mean the provision of services will continue as is, and there is no protection from regulation. Essentially, this is not legislated for. The HSE is not independent of the process as it will remain both commissioner and regulator. Homecare X continues to provide complex homecare which is not regulated.

Scenario 2: Homecare X is going to continue to provide the same home support and complex care services. This would mean:

- 1) If the provider is successful in acquiring a contract with the HSE, there will be monitoring arrangements in place by each CHO under the tender and service-level agreements for the complex care. This will mean the current or future changes will stay in place and there is no protection or assurances to the public as they are not independently regulated. Essentially, this type of service is not legislated for. The HSE is not independent of the process as it will remain both commissioner and regulator.
- 2) Homecare X will need to be registered to provide home support services. The home support service will be regulated and inspected and assurances will be provided that Homecare X meets the minimum requirements for 'home support services' only. It will be liable to sanction up to and including cancellation of registration.
- 3) A two-tier system has been created in such a scenario as Homecare X continues to provide complex homecare, but rather than being regulated it is subject to HSE oversight. It is, however, regulated for the home support service it provides.

Although this is a hypothetical example, it does go some way to illustrate the multitude of issues that may arise if the intersection of health and social care services in a homecare scenario is not carefully thought out and legislated for. For example, how can these services be disentangled if they are being provided concurrently by providers?

In a regulated environment it is also reasonable to conclude that the full situation will not become clear until regulation has been introduced and embedded within the homecare sector. Additionally, a core objective of Sláintecare is to minimise the use of acute services in order to provide the 'right care, in the right place at the right time'.⁽³⁴⁾ In this vein, it would be sensible to consider how health and social care professionals have evolved over the years, and how they have taken on extended roles. For example, it is reasonable to say that the role of healthcare assistants has developed and grown.⁽³⁰⁸⁾ In a recent review, Drennan et al. (2018)⁽³⁰⁹⁾ outline that healthcare assistants are providing patient care in both inpatient and community settings. Although this is partly a consequence of nurses taking on extended roles, it is also the result of a greater demand for health and social care services and the need for the workforce to satisfy this. Therefore, it would be naive to believe that the scope and demand for homecare services that are provided will not expand in tandem.

Subsequently, it may be short-sighted to take the simplest approach and solely regulate for 'home support services' at this stage. This would result in a further need for regulatory reform to account for the demands of expanding services in the not-so-distant future. This may not be a judicious use of resources in the medium to longer term. Nevertheless, if this is to be the case, there is a responsibility on policy-makers to ensure there is a national clinical governance and monitoring framework that protects all people who have complex needs and who receive complex care in their own home.

Chapter 2 provided an overview of what constitutes quality in terms of the provision of homecare. From the scoping review of the literature, presented through a Donebedian lens, the structural components of how homecare is organised and elements that form the homecare system rely on eight primary themes. These include: collaborative work — formal and informal care, evidence-based guidance, health and safety, leadership and management, outcome measurement, person-centred care, service characteristics and workforce. These themes are considered integral elements that form the homecare system, and which also facilitate a high-quality provision of care.

This review highlights the need for collaboration between informal and formal carers, and the tripartite agreement between the provider of service, the person in receipt of services and the informal carer. This is especially important given the peripatetic

nature of the role and, as identified by a provider in a focus group, 'there is no nurses' station in the home'. This is also consistent with the concept and importance of leadership within the review which identified that leaders have less opportunity to organise, structure and immediately address problems which may negatively impact homecare services due to 'direct vs distant' roles.⁽⁹⁹⁾

The theme of evidence-based guidance was also identified in the review. Along with ensuring that practices are based on evidence, there is also a need to ensure evidence-based practices are embedded and implemented within services. That is to say, that while services may refer to idealistic evidence-based practice, it is another issue to 'bridge the divide' and implement these practices.⁽³¹⁰⁾ Within the regulation of homecare it is imperative that health and safety risks are fully identified. The multitude of risks that occur in homecare are broadly multi-dimensional and intersectional and cover physical, special and interpersonal risks.⁽⁸²⁾ Suffice to say, these are amplified in light of the 'transient', 'lone' and 'remote' nature of homecare. This was a consistent finding across the research as providers cited lone working as being the greatest risk when delivering homecare services. Subsequently, health and safety is fundamentally important in the sphere of homecare and the use of incident data or monitoring notifications may be an appropriate mechanism referenced in the review outlined in Chapter 2.

Placing this review in the Irish homecare context also illustrates the need to ensure that reliable assessment of need measures are used. The review found that InterRAI tools are a standardised instrument that provide a reliable, person-centred assessment system which informs and guides comprehensive care and service planning in community-based settings. It is encouraging that the HSE is using the Single Assessment Tool (SAT); an IT-enabled healthcare and social care needs assessment (InterRAI System[®]) as part of its current assessments. In the longer term, the HSE has committed to this practice by recruiting 128 interRAI assessors. However, it cannot be escaped that this process has now been voiced for the last 10 or so years. The HSE reports that the use of the InterRai assessment tools is generally more common in areas where pilot sites were established. Notwithstanding this, having such standardised data not only allows for reliable assessment at patient level, it also facilitates opportunities for decision-making from a service or policy level perspective and this is an important consideration from a strategic homecare standpoint.

From a service characteristic perspective, it is important to identify the spectrum of models of which homecare may operate in. In their European study Van Eenoo et al. (2018)⁽⁹⁾ identified six models of homecare that range from a:

“(very) strong focus on patient-centred care delivery, a high availability of specialised care professionals, and a strong focus on monitoring of care

performance to a very limited focus on patient-centred care delivery, little or no availability of specialised care professionals, and a strong focus on monitoring care performance”.

As a result, it is important that a balance is struck so that homecare in Ireland has a strong focus on patient-centred care delivery and also a strong focus on monitoring care performance. In order to achieve this, policy-makers will need to take full account of local and national care contexts and ensure there is a person-centred lens applied at all stages of homecare delivery (development, commissioning and procurement, delivery and monitoring). The concept of person centeredness was a central theme that dissected all structural, process and outcomes across this Donabedian framework. It is encouraging to see that is also the first theme in the most recent service specifications for the older people’s home support tender, whereby standard 1.1 recognises that the planning, design and delivery of services are informed by service users’ identified needs and preferences.⁽⁷⁶⁾ Consequently, HIQA considers that that definition of homecare should follow its interpretation of it as paid care provided inside a person’s front door, and that the philosophy of homecare should embody a needs led and integrated service where the person in receipt of services is central to all decisions that are made.

It has been highlighted across many aspects of this report that, first and foremost, there needs to be continuity and retention of staff. The issue of continuity was highlighted in the review,^(155,156) across the focus groups, and in the survey completed by providers as being very important. However, for a plethora of reasons, it was also identified as being difficult to achieve. In the questionnaire, the importance of continuity among the workforce related to issues whereby homecare provision was interrupted by frequent carer changes, carer absence, missed homecare calls and an inability to provide care at the right time and across all regions of Ireland. Essentially, continuity of care needs to be seen as an integral component of the workforce if care is to be truly person centred.

In order to achieve this continuity, it has been suggested that attention must be paid to both the management and delivery of care.⁽³¹¹⁾ Continuity in homecare ensures that trusting relationships are developed and consistent knowledge and practices are being applied across the entire workforce. It is important to learn from homecare services in other jurisdictions and, in doing so, acknowledge that the homecare sector in England has been described as fragile. This fragility has been highlighted by the large churn of homecare providers registering and deregistering, with around 500 agencies registering and 400 deregistering with the CQC each quarter.⁽³¹²⁾ The CQC identified that this situation not only adds to uncertainty for the sector as a whole, but the lack of continuity of care deeply affects people using the service.⁽³¹²⁾

Subsequently, it would also be prudent to consider that if there is not consistent homecare providers in the market, then continuity will be difficult to achieve in this sector due to the retention of the workforce. Equally, HIQA has voiced similar concerns regarding the financial viability of nursing home providers in recent times these issues are equally applicable to the homecare sector.⁽²²⁾ Alongside the concept of continuity, the notion of delegation, task shifting and competence in the workforce were seen as being important areas to address to ensure that homecare recipients are provided with a safe service. This comes to the fore when the intersectional nature of homecare is considered, whereby health and social care tasks interconnect.

The international review indicated there is a need for requirements and regulation in this area. In England, for example there is no registration requirement for homecare workers, nor is there any requirement for staff to be fully qualified before they begin working. In other jurisdictions (Wales, Northern Ireland, New Zealand), the homecare workforce falls under the regulatory framework and legislation places an emphasis on the homecare workforce, improving working conditions, wages and providing education and training. In Wales, the Regulation and Inspection of Social Care (Wales) Act 2016 introduced steps to improve the quality of the care and support provided by the homecare workforce by requiring an increase in the separation between travel and call time, and limiting the use of zero hours contracts.

This scoping review also identified the range of skills needed by the homecare workforce in order to facilitate quality in service provision. It is reasonable to conclude that homecare workers need rounded and balanced skills that cover 'illness work, everyday life work, life-changing work, relation work, discretion work, information and articulation work';⁽¹⁶⁷⁾ should be culturally competent and responsive to sexuality,⁽¹⁶⁹⁾ have a good level of emotional intelligence and social skills⁽¹⁷¹⁾, and be able to detect early deterioration in frail older patients.⁽¹⁷²⁾ The requirements for this level of skill clearly signals the investment that is needed in recruiting and maintaining good quality staff. Herein lies a particular challenge, as the remote and transient nature of this role, coupled with low pay and poorer terms and conditions, often means that working in homecare is not an attractive or viable career option.

The HSE has developed a competency framework in relation to minimum training requirements for staff and many organisations have strong training and development processes. However, HIQA advocates the need to make homecare a better career for people who work in this sector, where there are development and career opportunities to progress. The cost of not doing this may be detrimental to the sector moving forward.⁽¹⁷¹⁾ This needs a coordinated response from key stakeholders where a development and career pathway is mapped out and available for people who work in this sector.

In terms of processes in the sphere of homecare, there is a need to ensure that homecare is personalised, cognitive specific and has a focus on being preventative while promoting independence. These are key issues that were also discussed among the focus groups, as highlighted in Chapter 2. HIQA's interpretation of this finding is that there needs to be a proactive approach towards maintaining and supporting people who require homecare, particularly older people. For example, people with low level needs should be supported in their own home to minimise decline and eliminate the need for costly residential placements, often a scenario the person with low level needs does now want. While evidence supports the move towards this approach, some providers identified in the focus groups that older people felt they would receive homecare packages quicker upon discharge from hospital. This is a genuine concern as 'hospital-associated complications of older people' (for example, delirium, functional decline, hospital-acquired incontinence, falls, and pressure injuries) are more common in older people and associated with poorer outcomes.⁽³¹³⁾ It should be noted that the use of hospital admission to procure homecare packages may not impact on all CHO regions as there may be enough resources within the CHO area to support older people with low level needs in a timely manner. However, when resources are limited at local level and there are waiting lists, a prioritisation mechanism for allocating resources (services and supports) to approved applicants applies. Therefore, people with lower needs maybe overlooked and this in the longer term may be counterproductive.

From an outcome perspective, a health promotion philosophy and physical activity were seen as important factors of homecare provision. The evidence also signalled that frequent, pre-emptive reviews and intensive care coordinator approach may also improve outcomes for people receiving homecare. From a disability perspective, the HSE identified that it has case managers who undertake reviews and similar processes are currently in place with a key worker in children's services. For older adults, people in receipt of homecare are reviewed on request or on a regular basis primarily public health nursing. Some providers cited that this can be problematic, particularly in urbanised regions where public health nurses have large caseloads and this can lead to delays in reassessment.

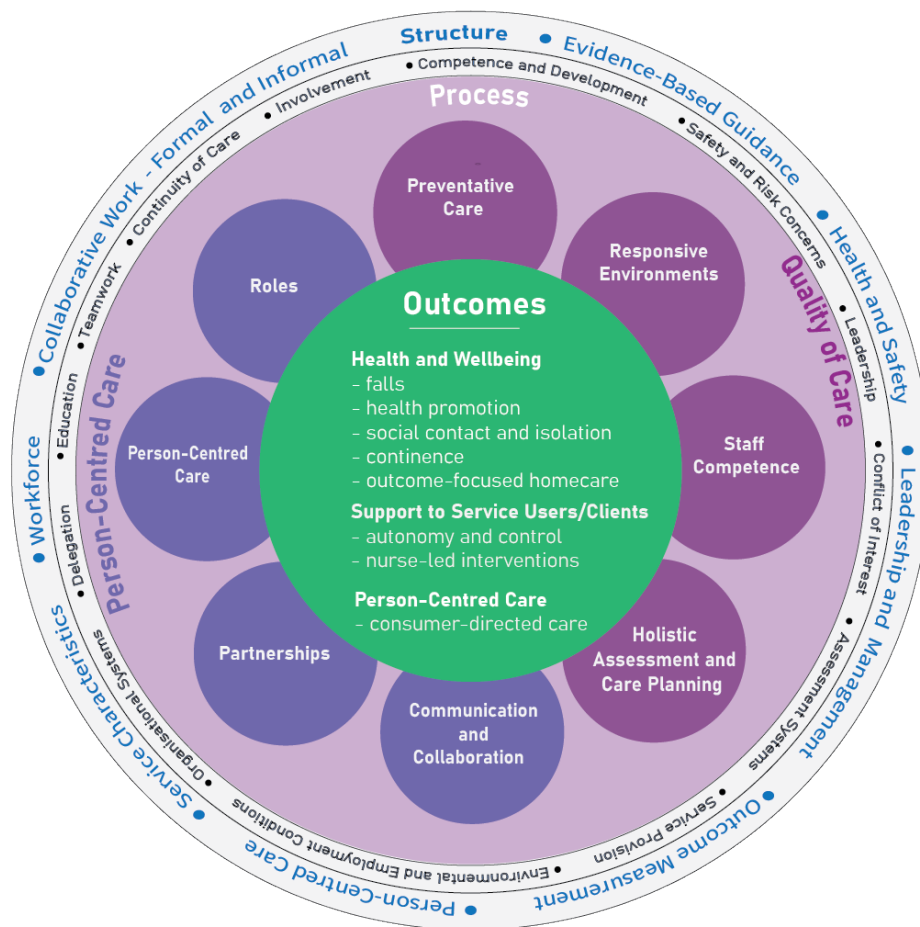
In relation to risk, falls were seen as a significant issue and it is widely acknowledged that falls are an important predictor of older adults becoming admitted to long-term care.⁽³¹⁴⁾ Interactions between the person, the environment and comorbid conditions make some individuals more prone to falls and subsequently the assessment of such needs is crucial. For example, a recent Canadian study found that a decline in ADLs, assistive device use for locomotion indoors, polypharmacy, and health conditions, such as dizziness or light-headedness, and Parkinson's disease, were associated with a higher rate of falls.⁽³¹⁵⁾ These

factors may signal a further sub-population of people who receive homecare that are at a greater risk of falls.

Furthermore, urinary incontinence was also associated with poorer outcomes when older adults were admitted to hospital. This would suggest the continence needs of homecare clients is a particularly important aspect of homecare from a medical, functional and social perspective, particularly as the prevalence of urinary incontinence is high in this population⁽³¹⁶⁾ and even more so increased for individuals who has chronic illness such as diabetes.⁽³¹⁷⁾ It was also determined that when homecare was outcome focused, or consumer directed (and care was more person centred), more favourable outcomes were reported. Aligned to this is the concept of autonomy and control, which must be seen as central to upholding the rights of people in receipt of homecare.

The findings from this review suggest that the structures, processes and outcomes of homecare are mutually dependent and inseparable. This means that without good structures, processes are compromised and as a result, outcomes are poorer for people in receipt of service provision. Additionally, the concept of person-centred care intersected all elements of this framework and subsequently there needs to be a person-centred philosophy incorporated at all components of the homecare sector. This is illustrated in the framework that has been developed and outlined in Figure 6.1.

Figure 6.1: Infographic reflecting the themes and subthemes generated from the thematic analysis



The survey findings suggest that providers are delivering services that intersect both health and social care. From the research outlined in Chapter 3, it is apparent that there are many positive aspects of the homecare sector. Providers of homecare services identified that they had a strong sense of self-regulation and providers who worked under tender and service-level arrangements had contracts with the HSE which had robust processes surrounding them. This was identified as a positive factor and illustrates the solid foundation on which providers will be prepared for regulation. In the focus groups, it was also evident that there was a real sense of commitment towards the people who were in receipt of services and spontaneity of provision was an important part of the role. Spontaneity of provision related to delivering a needs-led service. From interpreting these findings, it appears that it is not so much the existing processes that create problems, rather it is the inconsistent application of processes across different areas.

HIQA acknowledges that there are significant demands on health and social care services, and that such demands have been particularly acute throughout the COVID-19 pandemic, perhaps even more so for the homecare sector. For example, some evidence from England during the first COVID-19 peak (April 10 to 19 June 2020) identified that deaths of recipients of domiciliary care rose by 125% during that time period when compared against the previous three year average.⁽³¹⁸⁾ While this relates to the impact of COVID-19 on homecare in England, the Health Protection Surveillance Centre (HPSC) in Ireland were notified^{*****} of 366 laboratory confirmed cases of COVID-19 associated with home help or homecare services reported to the Computerised Infectious Disease Reporting System (CIDR) from March 2020 until 14 May 2021 in Ireland. Of these, a total of 32 deaths were reported.⁽³¹⁹⁾ Moreover, in the disability sector there is also some Irish evidence to suggest that staff who worked in independent settings during the pandemic (that is, where one person lives alone with support or shared living or live-in carer settings) and provide direct care had high levels of personal burnout,⁽³²⁰⁾ again illustrating the challenging environment that currently exists in this sector.

Four principal barriers to the implementation of homecare were identified in focus groups which were conducted with homecare service providers. First, the ability to retain staff in this sector was highlighted as a significant issue for providers, with this being most pronounced for private providers. This was also identified by providers in the survey as the most challenging issue for homecare provision. Providers explained that they felt they were in direct competition with the HSE to recruit and retain staff. The HSE has a policy to provide homecare in the first instance. However, it needs to be emphasised that if national policy focuses on keeping people in their own home, and a hybrid market model is needed to facilitate this (that is, tendering of services), then this is an area that needs immediate attention.

Dominant sub-themes related to this barrier focused on travel time, infrequent hourly employment and social welfare payment stipulations interfering with earning capability. Such factors were reported to be causing staff shortages and providers identified that staff are leaving this sector for other opportunities in order to obtain greater job security and better working conditions. In the most basic terms, homecare care staff are critical to delivering person-centred homecare services. As the scoping review identified, there is need to apply a person-centred lens across all aspects of homecare, with a particular emphasis on the importance of maintaining staff wellbeing. Kitwood, a pioneer in person-centred care, strongly advocated that

***** Information on whether each individual COVID-19 case is in receipt of homecare services or not is not collected during case interviews. Therefore, information included in this response was obtained from outbreaks associated with homecare services reported to the Health Protection Surveillance Centre (HPSC).

in order to improve the effectiveness of care, there needs to be a particular emphasis placed on developing staff wellbeing.⁽³²¹⁾

While the above-mentioned factors broadly relate to remuneration and working conditions, there is also a critical need to make homecare a viable career. This role has been identified as undesirable⁽¹⁷¹⁾ and in England there is an increasing trend towards high staff turnover.⁽³²²⁾ High staff turnover has also been reported in Ireland,⁽⁴¹⁾ highlighting that this is an area that needs addressing. On a final note, the focus groups also noted the undocumented workers or migrants who work in the homecare sector. Due to the current absence of regulation in the sector, there is a significant risk for these individuals themselves who are an absent voice from the homecare debate. There is also a risk of exploitation and discrimination due to their immigration status or lack thereof.⁽²⁸⁹⁾ While it is outside the scope of HIQA to comment on the legal routes towards addressing this problem, it needs to be considered as part of regulating homecare.

Secondly, although the concept of funding was raised as an issue, the Economic and Social Research Institute has identified that it is undertaking research regarding the implications of potential funding mechanisms (for example, Exchequer funding, co-payments, asset-testing) for the allocation of costs, distributional effects and demand for services.⁽⁷¹⁾ The findings of this review did highlight that the current funding model is described as not fit for purpose and providers largely called for a means testing approach towards funding. This issue of sustainability and being 'drip fed' budgets was cited as problematic and stifling for organisational development. 'Zero hour' tenders were also described as economically impractical for homecare providers. Rising insurance costs and increased PRSI contributions were additional factors identified as problematic for providers. When this is all considered through the guise of inconsistency and resources being available at CHO level, the current system for homecare is discretionary⁽⁴⁰⁾ and led by supply, which means that increased usage increases the pressure on budgets. It is therefore apparent why there needs to be a clear funding mechanism akin to the 'fair deal' scheme for nursing home care which provides financial support to people who need long-term care. This is an aspect that has been highlighted over the years.^(41,49,72)

Third, a prominent issue cited throughout the research and by providers was the time constraints imposed on homecare workers when completing their duties. It is important to highlight that the HSE uses 30 minute home visits and the decision to use these is based on care need assessments. Essentially, the timing is determined by the tasks to be completed which may range from full personal care, wellbeing checks or medication prompting. It is not within HIQA's scope to comment on their legitimacy. Rather it can be observed from all viewpoints insofar as 30 minute visits may be assessed as appropriate due to finite resources; there are challenges with staffing 30 minute home visit where the geographical location of recipients' homes

also play an important role; and people who are in receipt of services may have reduced social provisions⁽¹⁹⁰⁾ and therefore homecare affords social contact. In this regard, HIQA would urge further examination of the use of such visits in the form of service user satisfaction surveys (or similar methodologies) to delineate their validity. It may not be until the voice of the service user is heard that this can be objectively determined. Nonetheless, having a clear funding mechanism may also positively impact on this situation. Furthermore, there are also some very positive signs of collaborative working in this regard where COVID-19 has resulted in an increased amount of communication and dialogue between service providers, the HSE examining what is being provided by whom and the concept of 'more useful' hours was identified as a real benefit.

Fourthly, inconsistencies in assessment were reported by providers. It is recognised in the sector that there are different assessments used across different services (refer to Table 1.1). From a disability perspective, there are bespoke arrangements around the country for assessments of individual needs either through standardised assessment instruments or locally developed tools. This may be appropriate given the heterogeneous needs that span the spectrum of disability. However, the HSE is currently trialing two standardised tools to use in these areas. From an older persons' perspective, various assessments are used as highlighted throughout this report. While different documentation was cited as problematic, one central point made by providers described how they are often provided with different levels of information from assessments that range from 'very limited to very comprehensive'.

Data protection and General Data Protection Regulations (GDPR) was cited as one reason for limited information. The HSE has clear processes in place regarding tendering services for older people. In the standard operating procedure⁽³²³⁾ for older persons services, the HSE states that emails to approved providers must supply adequate information on duties required in each case. In each case this should include the name or initials of the client, address of the client, summary of assessed need and details of required service including days, times number of support staff required. HIQA recommends that this area be examined further in order to reduce the levels of risk for all involved in the provision of, and those in receipt of homecare.

The concept of 'fastest finger first', ^{§§§§§§§§§§(41)} was identified by providers in the focus groups as an issue that is causing concern. This needs to be deconstructed

§§§§§§§§§§ This is the same as a term described in the 2019 HCCI report ⁽³⁵⁾ (fastest responder first) whereby homecare providers under the older people's tender process have to respond the fastest get the work.

from two perspectives. On one level, the HSE has a process in place where the tender process is being used for older people's home support services whereby:

- 1) if a client does not specify a Tier 1 ***** approved provider using the client choice form, the HSE will email all Tier 1 approved providers. Provided that a Tier 1 approved provider responds within the time frame contained in the email with a named home support staff member, that Tier 1 approved provider shall be awarded the contract for service to the client.
- 2) in the event that no Tier 1 approved provider responds within the HSE timeline, having applied the above approach, the HSE will then email all Tier 2 approved providers. If a Tier 2 approved provider responds within the time frame contained in the email with a named home support staff member, that Tier 2 approved provider shall be awarded the contract for service to the client unless a Tier 1 provider has responded in the intervening period, with a named home support staff member. In this case, the Tier 1 provider will be awarded the contract for service to the client.
- 3) if no Tier 1 or Tier 2 approved provider responds within the HSE timeline, the HSE may make contact with service providers who met standards, but who opted not to join Tier 2. The HSE will require any such providers to complete a service arrangement. In each case, the HSE will email all approved providers (Tier 1 and Tier 2 approved providers who were notified of the service requirement) to advise that the service requirement has been filled.
- 4) the successful provider will be provided with the outcome of the care needs assessment and a copy of the care plan or home support plan detailing care needs along with a schedule of service (or agreed with the client) detailing time(s) and day(s) of service delivery or tasks.

On another level, this needs to be considered from the provider's perspective. The HSE do not set official time limits for responding and within point 1 identified above, they identify that the time frame is contained in the email that is sent to providers. The wording in the standard operating procedure outlines:⁽³²³⁾

It is recommended that each CHO would arrange a standard time (or times) each day (for example, 11am and or 2pm) when emails requesting HSS will issue to approved providers. This will help to ensure greater levels of responses from providers. In general, response times will be determined by

***** Following a tender process, the HSE has appointed home support providers to deliver home support approved as part of the home support service. These are referred to as Tier 1 and Tier 2 providers.

HSE Service Managers on the basis of the individual case. Response times will not normally exceed and will generally be less than 24 hours.

Notwithstanding this, providers have identified that if they take more than five minutes to respond, they tend to find the packages are gone and there is a rush to reply. Within the focus group discussions, one provider cited that some organisations take off 'firewalls' so they receive emails quicker and therefore can respond faster. While this cannot be validated, if accurate, it raises significant concerns and reinforces the critical need to regulate this sector. Additionally, such a methodology is potentially incongruent with scheduling and rostering staff (a situation identified by HCCI)⁽³²⁴⁾ where it is likely to impact on the ability retain staff. Finally, it is worth noting that the fundamental purpose of homecare is to meet the needs of the recipient. While it is appreciated that there needs to be a process in place, if this is negatively impacting on providers, then the effectiveness of the approach needs to be evaluated.

Before highlighting recommendations that were emphasised by providers and advocates in this research, the learning from the international approaches toward the regulation of homecare and the concept of regulating homecare within an Irish context are broadly considered. Internationally, the approach to towards maximising the effectiveness of formal homecare is to maintain and support informal homecare as much as possible⁽⁴³⁾ and this is well described in the evidence.⁽⁶⁾ In Ireland, this is also a key component of Government and HSE policy, and a particular cornerstone of the Older Persons home support services as outlined by the HSE to HIQA.

Chapter 4 identified the various approaches towards the regulation of homecare in different jurisdictions. There are different approaches towards the regulation of homecare across the United Kingdom. For example, while each country uses a registration-type approach and various aforementioned approaches toward monitoring and inspection of providers who are registered to provide homecare services, different terminology is used. In Northern Ireland, domiciliary care is regulated under the Domiciliary Care Agencies Regulations (Northern Ireland) 2007,⁽³²⁵⁾ and under these regulations prescribed services cover personal care and the assessment of the need for such care. In England, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out a broad range of regulated activities.⁽²¹⁶⁾ Providers need to determine which activities are relevant to the service they provide and register accordingly to the CQC. In the context of homecare, regulated home care services are those that are registered with CQC to provide the regulated activity of 'personal care' which includes physical assistance and prompting. As England uses a regulated activity approach, it is possible that providers can be registered to provide both personal and nursing care as a regulated activity (and or other regulated activities). The Regulations 2014 (UK) define 'nursing care' as any services provided by a nurse and involving:⁽²¹⁶⁾

- (a) the provision of care, or
- (b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to the nature and the circumstances in which they are provided, do not need to be provided by a nurse.

Personal care is then defined as:

supporting people in their homes (or where they are living at the time) with things like washing, bathing or cleaning themselves, getting dressed or going to the toilet.

In contrast to Northern Ireland, both in England and Wales, services that provide personal support (IADL) activities only are not regulated. However, if a service is regulated to provide personal care, personal support services will be reviewed during inspection.

In Chapter 5, the concept of regulatory approaches was evaluated. This concluded that achieving good regulatory outcomes is more than having a regulated environment. It is a cooperative effort between the government, regulators, the regulated and other concerned parties.⁽²⁹⁴⁾ As identified previously, regulation is a quality improvement instrument that is often implemented as the result of previous failures and therefore it is imperative that the objectives of regulation are clearly understood in a general sense and from a homecare standpoint. Essentially, regulation is intended to improve the performance and quality of homecare, provide assurances that minimum standards are met and provide accountability for level of performance and value for money.⁽²⁰¹⁾ However, before regulation is introduced to this sector, it is imperative that the Government undertakes a detailed Regulatory Impact Assessment to determine the positive and negative effects of proposed homecare regulation. The importance of this in informing an evidence-based approach to policy-making cannot be understated.⁽²⁹⁴⁾

When regulation is introduced to this sector, it will undoubtedly result in some unintended or ill-wanted consequences. A significant unintended consequence is that it may destabilise the market, where some providers may find the transition to being regulated difficult. As a result, they potentially will not meet the minimum requirements of registration to provide homecare services. Providers who engaged with the focus groups self-reported they have good governance and management processes in place, and when coupled with the HSE processes they operate within, there is solid foundation to work from. Nonetheless, as the current market model is a hybrid system, a reduction in providers may negatively impact this sector. The current HSE approach towards monitoring means that each CHO area has a service-level agreement with providers. This is an important consideration for the regulation of homecare sector given the large organisations that operate across the sector in

every CHO area. Essentially, there would need to be delineated regulatory regions where homecare providers would be licenced to operate in. There could then be provisions where compliance is related to each specific area.

Furthermore, making homecare regulation effective needs to be at the forefront of policy-makers' minds. The regulations need to be seen as a dynamic tool that are frequently evaluated to determine that the original objectives are valid, are being achieved and are fit for purpose in the environment they are imposed upon.⁽²⁹⁵⁾ If the development and implementation of regulation of this sector is considered as a linear, once-off restructuring and formulation of homecare, then this will be incongruent with the evidence supporting 'better regulation' in this area.^(293,294,295)

The approach towards regulation is also an important element of the regulatory framework, that is to say; how will homecare providers be regulated in practice. Chapter 5 identified some directive and external oversight approaches towards regulation. However, it is too early to identify specific directive and external oversight approaches that may be used other than to identify that HIQA currently uses a responsive approach to regulation.⁽³⁰³⁾ Essentially, this means that the type, frequency and intensity of regulatory intervention is informed by an assessment of risk. In effect, where registered providers persistently breach regulations or place people in receipt of services at risk of harm, they are identified quickly and face proportionate and meaningful sanctions. HIQA calls this a risk-based approach. Having a clear escalation process underpinned by an enforcement pyramid also helps bring about improvement in a transparent and proportionate manner (for example, from education and persuasion to prosecution or loss of licence or registration to provide homecare).⁽³⁰⁴⁾

Another consideration that needs to be examined and communicated clearly concerns the use of regulations and standards and how they will operate in a regulated environment. For example, regulations are the minimum requirements that are set out in law, while standards are the quality improvement tool to drive continuous quality improvement. In real terms, HIQA uses regulations to ensure that providers meet the minimum levels of acceptable criteria that are set out in legislation, while standards – while also legally enforceable – are used to drive continuous improvement. From a standards perspective, HIQA has recently developed a set of principles that will be used as HIQA's standards development framework to underpin all future national standards for health and social care services.⁽³²⁶⁾ These principles work together to achieve person-centred care and support. The principles are:

- a human rights-based approach,
- safety and wellbeing,
- responsiveness, and

- accountability.

The development of these evidence-based principles provides a unique opportunity to incorporate consistent and meaningful principles throughout legislation, regulations and standards. For transparency and consistency, HIQA advocates that the underlying principles should be embodied and consistent through the legislation, regulations and standards pertaining to homecare.

Furthermore, it is also HIQA's view that in order to minimise the 'regulatory bang' that the environment may experience, there should be a focus on meeting regulations in the medium term, while standards can be used to drive improvements in this sector. It would be naïve to introduce a system that may be difficult to adhere to from outset for some providers who have never being regulated before. Notwithstanding this, many providers will excel when they are regulated.

Finally, this report has addressed many areas relating to the provision of homecare. As identified throughout the scoping review and more broadly, the concept of person-centred care needs to be embodied throughout the homecare process, from the development of homecare right through to delivery and evaluation. Regulation must be used as a tool to ensure that people in receipt of homecare services have a positive experience on a day-to-day basis, and where this is found not to be the case, action can be taken to remediate this. Regulation must also ensure that those delivering or overseeing the delivery of a homecare service ensure that good practice is routine. It must also provide assurances to the person in receipt of homecare and the public more broadly that homecare is of high quality and safe.

Therefore, HIQA believes there are three options available in regards homecare:

1. **Option 1:** The first option is a 'business as usual' scenario. Here, the current landscape continues where there is uneven distribution of services across Ireland and people remain underserved, in need and potentially at risk of deterioration. However, given the commitment in Sláintecare to implement a statutory scheme for homecare this option is unlikely.
2. **Option 2:** The second choice is a 'directionless or 'bandage' scenario where homecare continues on the same trajectory. This is where the HSE continues to develop and expand services in line with the needs of the population. In this scenario, the types and processes of homecare outlined in Table 1.1 become more convoluted and complex and some groups of people in receipt of homecare are afforded a level of protection offered by regulation, but not all. Many people remain underserved with national variation and the development of more complex processes will not be sustainable in the short

to medium term. There will be increased risks to many people using homecare as a result.

3. **Option 3:** The third option is the preferred choice. This is where there is a root and branch review of homecare — this will include concerned stakeholders and engagement of all stakeholders at national, CHO, service delivery and recipient level. A homecare framework will be developed that makes homecare available to everyone in need. Age is removed as a barrier to access, and homecare services are available from 'cradle to grave' in an integrated and needs-led fashion. Homecare includes services that support enablement and independence and provide services that maintain continuity. There is a clear funding framework to support this transition. Regulation in this scenario is one cog in the wheel of broader reform that seeks to drive quality in this sector.

The first option is unsafe. While there are significant strides towards the development of a statutory framework for homecare, this needs to be viewed through the lens of the last decade. Essentially, the history of introducing regulation to this sector since the publication of the report into homecare from the Law Reform Commission in 2011 can only be described as inconsistent at best.⁽⁵⁰⁾ Nonetheless, given the commitment in Sláintecare to implement a statutory scheme for homecare this option is unlikely. The second option is unsustainable and unaffordable in the long run. If potentially vulnerable populations are excluded from the scope of homecare regulation this will not serve the needs of all people in receipt of homecare. This path will lead to more complex systems and processes that will impact homecare providers and subsequently homecare recipients. This will result in a situation where the provision of homecare is fragmented and disconnected. The third option is the right choice, but as outlined in Sláintecare this is also the most challenging. This requires a complete review and, where necessary, an overhaul of the homecare sector. This will be driven by the inclusion of all key stakeholders, at all levels across the sector through national engagement. Regulation in this scenario is one cog in the overall system reform, a reform that needs to apply a person-centred perspective across all elements of the homecare sector. In this scenario homecare is integrated and needs led and it is responsive to the needs of people who require this service. In the longer term this affords a greater level of protection for those who require homecare and has the ability to respond to the changing health and social care landscape into the future.

While this research has taken a high level review towards examining the 'as is' picture of homecare and considering the international evidence relating to the quality of homecare, there are some important findings that can be considered as recommendations. These are outlined in Chapter 7.

Chapter 7: Key areas for consideration

HIQA sets out below a range of areas that need to be considered. These key areas have been developed based on, and informed by the review of evidence as described throughout this research report. It is important that these key areas are reflected on alongside this report in its entirety as it covers a wide spectrum of factors that are interconnected within the homecare sector. HIQA advocates that adequate deliberation and resources are given to these recommendations as they are critically important to reform and shape the homecare sector as a matter of critical importance.

Key area 1: A 'root and branch' review of homecare from the bottom up

A 'root and branch' review of homecare should be undertaken across all CHOs by the Government. Such a review must include all key stakeholders with service user involvement at its core. This review should fully evaluate homecare from the 'bottom up', critically reviewing homecare through all its appearances and functionality and distinguish:

- 1) How is homecare meant to operate at the individual CHO level?
- 2) What is actually happening at the CHO level?
- 3) What works well at the CHO level?
- 4) What does not work well at the CHO level?

Actions from this 'root and branch' review should be used to develop targeted solutions to improve and develop the homecare landscape and provide a roadmap of homecare services into the future.

Key area 2: Identify the scope and parameters of homecare

The complexity of homecare and homecare terminology needs to be reduced and the scope and parameters of homecare clearly set out. The intersection of 'activities and instrumental activities of daily living' and health and social care needs of homecare recipients needs to be defined. This may include, but is not limited to, the services of homecare workers, nurses and various therapies. If it is determined that homecare does not include tasks that are provided to people in their home that are considered from a complex, therapy or nursing perspective, then there needs to be a national clinical framework and governance structure that ensures people who are in receipt of such services are protected.

This will go some way to providing assurances to service users and the general population that these services are safe and fit for purpose.

Key area 3: There is a need for homecare to be integrated and needs led

A concentrated effort is required by all to ensure that current and future homecare services are integrated, led by needs and where age is not a barrier for inclusion. That is to say, homecare should meet the needs of the person and it should be delivered in an integrated way that improves the delivery, quality and continuity of services, where there is a better flow of information and resources are targeted and used appropriately.

Key area 4: Quality is central to homecare

Homecare must be of good quality and people in receipt of homecare enjoy a good quality of life that upholds their human rights. To ensure this it should apply a person-centred lens and focus on, but not be limited to, the following structures, processes and outcomes relating to:

Structure: Involvement – person-centred and informal carers; safety and risk concerns; leadership; conflict of interest; assessment systems; service provision; environmental conditions; employment or recruitment conditions; organisational systems; delegation and task shifting; education, training and oversight; team work; continuity of care and competence and development

Processes: Preventative care; responsive environments; staff competence; holistic assessment and care planning; roles; partnerships and communication and collaboration

Outcomes: Falls; health promotion; social contact and isolation; continence; outcome-focused homecare; consumer directed care; autonomy and control and nurse-led interventions.

Key area 5: A national standardised assessment instrument is required

The assessment of needs for accessing homecare should be based on a universal assessment. The introduction of InterRAI System[®] is welcomed; however, this has been ongoing for over a decade now — in 2011 the Law Reform Commission⁽⁵⁰⁾ welcomed the proposed adoption by the Health Service Executive (HSE) in 2010 of the interRAI suite of tools — and this needs to be implemented consistently as soon as possible. Additionally, the implementation of a consistent assessment or suite of assessment of needs to be employed across the disability sector.

Key area 6: Investment in homecare workers is required

There is a crisis in the homecare workforce and this is potentially going to get worse unless urgent action is taken. The conditions in which homecare staff work

needs to be improved. Without a competent workforce the future of high-quality homecare is not achievable. A detailed review is required to:

- 1) examine the recruitment and retention issues in this sector. This should include, but not be limited to, migrant or undocumented homecare workers, zero hour contracts, working patterns, terms and conditions, lone working and the impact of working in homecare and how it influences and social welfare.
- 2) identify what is required to make homecare a viable career option.
- 3) develop a framework to maximise the development opportunities for homecare staff.
- 4) examine the feasibility of recognising homecare as a profession.

The cost of not doing this will have longer term implications on the homecare sector.

Key area 7: Funding for accessing homecare should be a statutory right

While reference is made throughout this report to the development of a funding system similar to the 'fair deal' scheme, HIQA believes that irrespective of the methodology and approach that is decided upon, there is a statutory right to access funding for homecare for people who are in need. This should be based on need, rather than the resources available to the CHO, or a person's age or disability status.

Key area 8: A universal methodology for commissioning disability homecare services should be developed

Funding is provided to CHOs in their annual budget and allocated to service provision accordingly. As such, disability services will then enter into either Section 38 or 39 service arrangements with providers, or contract on an hourly basis and invoiced accordingly. This is different in both older people and children's homecare services. There needs to be a standardised approach toward development of a universal tender.

Key area 9: Homecare must be inclusive, continual and consistent

The market model for the delivery of homecare for people is through a hybrid arrangement. The best outcome for people receiving homecare is that there is consistency and continuity. This needs to be considered in the development commissioning, procuring and delivery of services. The current situation where organisations are competing with the HSE is not sustainable.

It is acknowledged that there is a need to have a process in place for the commissioning of homecare services. It is also acknowledged that it is not the first avenue for commissioning homecare services. However, a system where services are allocated on the basis of which service provider responds first after a tender is emailed out detailing the needs of a person requiring homecare need to be reviewed. This approach is frequently used and incongruent with the concept of quality.

Key area 10: There needs to be a focus on information sharing using integrated ICT systems

Meeting a homecare recipient's needs in a safe and personalised manner is dependent on collaboration, good communication and data sharing. Therefore, there is a critical need to examine the digital interoperability between the commissioners of homecare services and the providers of homecare to ensure that the initial agreement to provide homecare is based on shared and up-to-date health and social care information.

Key area 11: Regulation should only be viewed as one component of broader reform and should not be burdensome

Regulating homecare must be seen as one component of reforming the homecare sector. If regulation is seen as a 'cure' to all issues that this sector experiences, then regulation will not be effective in driving improvements in this sector. Rather, it could erode the public's trust in the ability of regulation to bring about change. When regulation is introduced to this sector, it should not be burdensome whereby resources are redirected from the provision of person-centred homecare.

Key area 12: There is a need to focus on maintaining a standard across the homecare sector before driving quality improvement

There is a critical need to reduce the 'regulatory shock' to the sector. Therefore, HIQA calls for a graduated approach towards the implementation of regulation to allow the sector time to implement the regulations and focus on meeting the regulatory requirements. When national standards are implemented in the homecare sector to drive quality improvement, support tools should be developed to assist in the implementation of these standards.

Key area 13: There is a need to undertake an assessment of the effectiveness and cost-effectiveness of health technologies in homecare in the Irish context

The use of health technology can have positive impacts in homecare settings. However, in some reviews the evidence that supports these findings is not strong.

It is important that accurate and reliable evidence is presented to determine direct and intended effects of technology, as well as its indirect and unintended consequences. An assessment of the effectiveness and cost-effectiveness of health technologies in homecare provision in the Irish context should be undertaken by a competent body, for example HIQA.

Chapter 8: Limitations of this research

The findings from this report need to be considered in the context of the following limitations. The first limitation concerns the small sample of providers that engaged in the survey and focus groups in order to provide the current 'as is' picture of homecare in Ireland provided in Chapter 2. As this research was conducted in order to provide a snapshot of current 'as is' picture, the voice of care recipients were not heard and not all homecare providers in Ireland took part. As a result, despite the coherence and consensus identified across the research, it is not possible to generalise the findings to all providers across the country. As acknowledged throughout this report, it is also imperative that the voices of care recipients are included in further research in order to ensure a person-centred approach across the reform of the homecare sector. It is also important to point out that these findings are presented from a participant perspective and not an assessment of this sector by HIQA.

Secondly, the international scoping review of what constitutes quality in homecare provision implemented exclusion criteria due to the sheer breath of literature available in relation to homecare provision. Three aspects to homecare provision were excluded from the search strategy: medical procedures or medical maintenance carried out in the person's home, palliative care and the use of technology in homecare. This may have introduced bias to the review, however it was considered that these three areas would require independent reviews in and of themselves in order to fully explore their impact on quality in homecare services. A further exclusion was placed on countries where studies were conducted. This may also have introduced further bias; however, countries were selected on the basis of their similarities to Ireland in how they operate health and social care services. Notwithstanding these limitations, the findings from this review was coherent with the general evidence and well situated from an international perspective.

Finally, Chapter 4 provided a review of the international approaches towards the regulation of homecare. Again, this chapter restricted the review to specific English and non-English speaking countries which may not offer the entirety of how homecare is regulated internationally. Furthermore, the inability to interpret some information due to language barriers may also inhibit the ability to get a true reflection of the homecare environment in that jurisdiction. However, countries were selected on the basis of their similarities with Ireland in terms of health and social care provision and, in the main, they offered a degree of learning and understanding from an Irish context.

Chapter 9: Overall conclusion

The Government of Ireland is preparing to develop a bespoke regulatory framework that would provide the statutory basis for the regulation of homecare. This report aimed to provide an overview of homecare provision in Ireland through summarising the current landscape of homecare policy and conducting research with providers to offer an overview of service provision. It also conducted a scoping review of what constitutes quality in homecare and summarised the international approaches to homecare provision while making recommendations that need to be taken into account when regulating homecare services in Ireland.

It is evident that homecare operates in and under complex conditions influenced by funding, availability and geography. While there are many positive aspects that exist in the homecare sector, such as self-reported high standards and self-governance, there are also many challenges. These challenges are becoming more acute, and it is expected that this will continue to be the case, particularly when moving forward to deliver health and social care in line with Sláintecare philosophy of the 'right care, right place, right time'. Despite the commentary since the 1960s being focused on providing care at home or closer to home, the time is now. It is imperative that homecare is reformed as a matter of priority as the current ageing population places more demands on health and social care to be provided in home settings.^(205,206,207)

Within this report, there was a general consensus among providers that there is a need to reform homecare services which may include the introduction of regulations and standards. When considering the introduction of regulation, providers of homecare and regulators alike need to apply a person-centred philosophy at each strand of the framework. In doing so, there is a more realistic opportunity for enabling structures and processes to deliver better outcomes for persons in receipt of homecare services. Ireland can learn from other English speaking jurisdictions in relation to how homecare is clearly defined and the concept of 'regulated activities' which may provide a mechanism to facilitate moving services closer to a person's home as the population continues to age.

While this report sets out some key issues in relation to homecare, of which regulation is one vital aspect, it must not be viewed as the only solution for homecare services reform. Rather, regulation should be viewed as a component for improving services together with collaboration between people delivering services and those in receipt of services, and providers' ability to provide assurances that care is in compliance with any regulations and set standards. This needs to be embodied within a person-centred philosophy where the person in receipt of homecare is seen as an active participant, their voice is heard and their day-to-day experience is at the centre of service provision.

Appendix 1: The use of health technology in homecare

Health technology in homecare

Due to the changing demographics and an ageing global population, there is a need for health reforms and cost saving mechanisms which will include an increased move from inpatient care to care within people's homes in the community.^(205,206) The use of health technology may offer a solution to this change in care provision. Health technology is defined by the World Health Organization (WHO) as "the application of organised knowledge and skills in the form of medicines, medical devices, vaccines, procedures and systems developed to solve a health problem and improve quality of life".⁽³²⁷⁾ Its use in homecare settings has received increased attention over the past two decades as the feasibility of the implementation of these types of medical supports has grown.⁽²⁰⁷⁾ Currently, health technology offers solutions to issues within homecare such as informal caregiver burden, shortage of skilled staff and an increasing demand for long-term care in private residences.⁽²⁰⁶⁾

Health technology is a broad term and includes interventions that use information communication technology (ICT), sensors, electronic health records (EHR), monitoring, assistive devices, e-learning, educational technology, decision support, tracking and personal medical records (PMR) as well as many others.⁽²⁰⁶⁾ Health technology is used for a variety of reasons in homecare; however, due to the volume of evidence available it was excluded from this scoping review. Nevertheless, its use and impact on homecare services and provision must be recognised. It is important that an area such as this is considered in any regulatory framework that is developed in line with the scope of homecare regulation.

The benefits of health technology in homecare

The benefits of health technology in homecare have been cited in several reviews. Meystre et al. highlighted that tele-monitoring as a health technology has been shown to reduce complications associated with chronic conditions by offering efficient follow-up and providing a virtual system of monitoring patients.⁽²⁰⁸⁾ In addition, Gaikwad and Warren's systematic review added that health technologies, especially telehealth, can help reduce hospital readmissions, length of hospital admissions, and also reduce visits to outpatient services. There is also some evidence to suggest that telehealth can reduce costs associated with home-based services for chronic disease patients.⁽²⁰⁹⁾ Peeters et al.'s scoping review also highlighted that the use of health technology can have positive impacts in homecare settings, specifically in relation to patients' self-care and self-management⁽³²⁸⁾. However, they also stated that the evidence to support these findings was not strong. A more recent systematic review by Ten Haken et al. also cited that the use of health technology in homecare can have positive impacts on patients and their

families as they can increase a patient's independence, enhance overall health and improve overall quality of life.⁽²⁰⁷⁾

Despite these benefits, it has also been noted that the evidence in relation to the benefits of health technology in homecare settings is mixed. Palmdorf et al.'s systematic review of the use of health technology at home for people with dementia advised that a broad evidence base on the benefits and risks of technologies for users is vital in order to promote their use. It is also needed to support the transition of health technology from research of their uses to their acceptance and use in homecare settings.⁽²¹⁰⁾ Liu et al. also similar concerns in their systematic review of home health monitoring for older adults.⁽²⁰⁵⁾ They stated that there is no evidence that the use of such technologies helps to address health-related quality of life, or falls prevention and that the evidence on the benefits of health technology for conditions of COPD is conflicting.⁽²⁰⁵⁾

The risks of health technology in homecare

The biggest risk posed by the use of health technology in homecare is patient safety. Historically, medical and health technologies were designed for use in hospital settings, which means that factors such as human, environmental and technological factors needed to be taken into account when using technologies in a homecare setting.⁽²⁰⁷⁾ In their scoping review, ten Haken et al.⁽²⁰⁷⁾ emphasised the importance of maintaining patient safety when using health technologies. They outlined that more education is needed in order to improve awareness and understanding on the correct use of technology by both formal and informal carers.⁽²⁰⁷⁾

A further scoping review highlighted the risk of the inappropriate use of health technology by investigating the use of health technology within organisations in order to improve homecare work environments and staffing issues.⁽³²⁹⁾ This review highlighted four categories in which health technology was used from an organisational perspective: organisation change, education and training, digitisation and work scheduling.⁽³²⁹⁾ This review found that the use of technology was focused on changing superficial issues and behaviours rather than addressing complex issues among staff such as burn out and gender inequality.⁽³²⁹⁾ This raises the issue that the adoption of health technology should be carefully considered before its implementation.⁽³³⁰⁾

Facilitators for health technology implementation

When discussing how best to facilitate the implementation of health technology, ten Haken et al.⁽²⁰⁷⁾ called for more collaboration between all 'actors' in the process of care. This means increased levels of supportive communication and continuity between formal and informal carers in order to successfully implement health technology safely.⁽²⁰⁷⁾ Successful implementation of health technology would also

strengthen collaboration between informal and formal carers. A further facilitator for implementation of health technology is the use of a participatory approach that includes homecare staff when identifying needs and designing health technology initiatives.⁽³²⁹⁾ Studies have demonstrated that involving homecare workers in this is an important facilitator for the success of an intervention. This inclusion works twofold in that it would increase homecare workers' understanding of the technology and also would help in resolving issues experienced by homecare workers on a regular basis.⁽³²⁹⁾ In terms of informal homecare workers, access to support from healthcare workers and formal carers would enable them to take more responsibility in using health technologies and facilitate more independent self-care for patients.⁽³²⁹⁾

Barriers to health technology implementation

One significant barrier to the implementation of health technology is the low level of 'smart home readiness' in older people's homes.⁽²⁰⁵⁾ Liu et al.'s systematic review of health monitoring systems in older people's homes found that readiness for smart technologies is low and that there is a limited number of studies that have investigated health technologies in natural homecare environments.⁽²⁰⁵⁾ Further reviews which have explored the barriers to the implementation of health technology in homecare have cited costs as a significant issue.^(209,212) In relation to telehealth, the financial and time costs involved in the implementation of intervention, licensing and reimbursements have been cited as barriers affecting the adoption of this type of health technology in homecare.⁽²⁰⁹⁾ Peeters et al. also stated in their systematic review that the financial benefits of video communication in comparison to traditional visits did not outweigh the costs of the initial implementation and maintenance involved in video communication.⁽²¹²⁾ The perception of health technology from all involved in homecare settings also impacts its implementation. In ten Haken et al.'s systematic review, several health technologies were not perceived as user-friendly and some home medical devices did not meet the needs of individuals with physical or sensory deficits.⁽²⁰⁷⁾

An additional factor which inhibits the implementation of health technologies is a lack of a solid evidence base to inform evidence-based practice. Ten Haken et al.'s scoping review found that of the systematic reviews included in their review, many of them concluded that there are not enough high-evidence studies available ⁽²⁰⁷⁾. Palmdorf et al.'s review of health technology for people with dementia also outlined these concerns. They stated that the studies included in their review were case studies with small sample sizes which resulted in limited findings about effects or feasibility of the technologies studied.⁽²¹⁰⁾ These small studies may be as a result of the difficulty in conducting research in homecare settings, due to homecare workers and patients spread out geographically despite working in or availing of the same service.^(210,329)

Regulation of health technology in homecare

Despite the vast use of health technology in homecare settings, its role in homecare has yet to be regulated alongside homecare provision services. Health technology has become an important part of homecare provision and it is envisaged that its role will grow as technology develops and an ageing population places more demands on healthcare.^(205,206,207) As a result, health technology is a vital competent to consider within the development of homecare regulation. A further consideration is the ever changing and developing landscape of health technology. Any development of a homecare regulatory framework must be agile to adapt in line with the inevitable advancements of medical interventions and technology. An in-depth review would be required to comprehensively assess the role of health technology in homecare provision in order to determine how to proceed with developing an appropriate regulatory framework.

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