Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

REGULATION OF HOMECARE:
Research Report (abridged)

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.

This abridged research report outlines the main areas of interest that are contained in HIQA's full research report on homecare. The full research report should be read in its entirety to fully recognise the complexities that exist in the homecare sector.

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.

Phelim Quinn
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 — 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

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 of the process. Furthermore, homecare providers who 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

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through the HSE and its funded agencies to people in local communities, as close as possible to people's homes.

‡ 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.

framework. This work is ongoing and the Government is planning a programme of consultation and engagement over the coming months.

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 naïve 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 and this wasfollowed 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

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

standards for homecare should focus on. These are broadly categorised on the capacity and capability, and quality and safety dimensions of homecare services.

Three global themes were identified in the focus groups:

(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 (or other 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 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 sets 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 uses. 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 at CHO level – this includes all stakeholders at national, CHO, service delivery and recipient level. A homecare framework is developed that makes homecare available to everyone in need. Age is removed as an access requirement, and homecare services are available throughout life (where necessary) in an integrated and needs-led fashion. Homecare includes services that support enablement and independence and they maintain continuity. There is a

clear funding framework to support this transition. Regulation in this scenario is one cog of broader reform that seeks to drive continuous quality improvement 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 potentially vulnerable populations if they are excluded from 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 difficult, 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" "an extraordinary response".[23] 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.

HIQA recommends that homecare services need to be integrated and needs led, for age of access to be removed as a barrier to access and for 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 frequently intersect 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 HIQA considers important for this sector. These key areas are described in Table 1.0 and set out in full in Chapter 6:

Table 1: 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

Since the early 2000s, Ireland's population has increased by 1.3 million people. 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) a decline in fertility; (2) a change in the pattern of mortality, and (3) net inward migration.[15] One consequence of this increase in Ireland's population is the demand for more health and social care services. This demand is well acknowledged by the Government of Ireland and the 2017 Sláintecare programme committed to reforming health and social care services in Ireland. Sláintecare is the 10-year programme to transform Ireland's health and social care services, presenting a roadmap for building a world-class health and social care service for the Irish people. A fundamental objective of Sláintecare is to ensure that care is provided in the right place, at the right time, by the right person. A core component of this transformation is the development of a homecare system that meets the needs of people who require such services, and in 2020 the Programme for Government committed to introducing a statutory scheme for the financing and regulation of homecare.

This commitment comes at a timely juncture as the current homecare system has evolved from a 'home help' scheme enacted in the 1970 Health Act (as amended)[**][24] (hereafter referred to as the '1970 Act'). It has been well acknowledged that current homecare provision needs to be reformed,[25,26,27,28,29] as it is a discretionary service where demand often outstrips supply.[28] The absence of a statutory footing in Ireland has significant implications for those developing, procuring, delivering and most importantly, receiving homecare services. For example, if people who want to continue to live at home need additional supports, these supports may not be available and they may need to enter a nursing home as a result. While this may seem a reasonable approach, nursing home care is often not the preferred choice of care for people.

In addition, a recent publication by the Office of the Ombudsman highlighted that younger people with disabilities are living 'wasted lives' in nursing homes.[30] Due to the lack of choice and a bias in favour of institutional settings, people had little choice but to live in a nursing home. The move away from institutional care to more focused community-led systems is well highlighted in the literature.[6,8] COVID-19 has also served to highlight the weaknesses in traditional forms of residential care for older people[31] (for example, the incidence of mortality and difficult living conditions experienced during the COVID-19 pandemic, along with the move towards more medical type settings).[31,32] It is therefore a matter of critical

[**] All the functions and 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.

importance that the statutory scheme for homecare is progressed in an urgent yet comprehensive manner.

It is through this lens that the following a 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.

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

What is formal homecare?

It is important to firstly set out this report means by the term 'formal homecare'.[††] In broad terms, formal homecare provides a range of services for those who need support due to deficits in functioning. There are varying definitions of homecare across the literature. For example, Kiersey and Coleman (2017)[(33)] has previously been guided by the definition proposed by Boerma and Genet (2012)[(34)] 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)[(33)] 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),[(35)] 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.

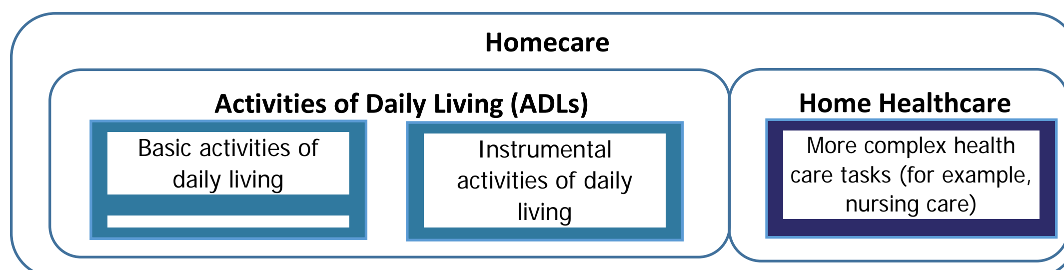
Despite these differences, the term used by the Health Service Executive (HSE) to define the foremost type of homecare services it provides is 'home support services' for older people. The HSE Home Support Service — formerly called the Home Help (until 2006) Service or Home Care Package Scheme (until 2018) — aims to support people to remain in their own homes for as long as possible and to support informal carers. The HSE 'home support service' is narrower than the previous

[††] 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.

definitions[19,34] as it does not consider the professional services of nurses or various therapies, as this role generally falls under the scope of primary care. There is also another form of homecare that is also provided by the HSE referred to as the 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 where they may require high levels of personal care and potentially some form of nursing care.[36]‡‡ Other areas of homecare that exist relate to homecare services provided to people with a disability under various guises and to children who have complex needs.

While it is acknowledged that homecare mainly focuses on activities of daily living§§ or instrumental activities of daily living,*** some forms of homecare may include services that go beyond these supports. Essentially, some aspects of homecare in Ireland are placed within an intersection, because the range of activities provided in a person's home overlaps and therefore may include both health and social care services. This intersection has been discussed from a European context and is best illustrated by Guericke[37] in Figure 1.1 based on the work of Genet et al. (2012).[38]

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



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. Essentially, homecare serves to maintain the independence, autonomy, health and wellbeing of people, enabling them to remain in their own home. As

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

such, it should be integrated and needs led. Therefore, it is through this lens and for the purpose of this report that HIQA considers formal homecare to be:

> 'A term that represents paid care that is provided in a person's home'.

Furthermore, 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 draft 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 has become even more complicated and for that reason HIQA engaged with the HSE and service providers in an attempt to fully understand the homecare landscape.

Engagement with the HSE

Considering complexities outlined within the sphere of homecare, HIQA consulted with the HSE to set out the scope and reach of homecare services being provided to people over the age of 65, people with a disability and to children under the age of 18 years in Ireland. 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 services and disability services relating to 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 out a synthesis of the responses received from the HSE highlighting the types of homecare provision, delineated into disability services, children's services and 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	Disability services are generally delivered on a person centred basis often on a social model of care sometimes into the community. **Home support** provides personal and or essential domestic care and support to facilitate participation in social/leisure activities. It can include: - 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	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. 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.	Home support services is defined as **personal care and where appropriate, essential household duties relating to assessed needs of the individual client.** The overall objective of the home support service is to: • **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**

	Home Care Assistant is not available, the Home Help may also provide support of a personal nature. - Home support: is assistance provided to the family in terms of assisting with care and facilitating attendance at social activities. **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.		**hospital settings** when admission does occur on a home first basis.
Formal homecare eligibility	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	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	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.**

	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'.**

	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.	(CCHN) in the home is the foundation on which the delivery of healthcare for CCHN both in the present and into the future.	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**.
Funding of formal homecare	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**	The service is funded by Government each year as approved in the HSE annual National Service Plan.	**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

	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.**		assessment of the person's needs and subject to the limit of funding available.
Process of care	**People apply for services, are assessed and allocated hours either directly or through a Provider.** 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. Where children receive services there is a requirement to have an adult family member present or	The process can be summarised as follows: ▪ Identification of need ▪ Assessment of nursing needs ▪ Submission of business case and assessment ▪ Procurement of managed nursing service	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: ▪ Application/referral ▪ Care needs assessment ▪ Draft care plan/schedule of service ▪ Decision on HSS application

	to have two staff present at all time		▪ Notification of outcome of application ▪ Service delivery
Assessment of need	**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.	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.	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.
Communication of assessment outcome	The outcome(s) of assessment are **communicated in a variety of ways according to the person** receiving supports or to their primary carer where		**The outcome of the application for home support is notified to the applicant either verbally (if urgent) or issued in writing, usually**

	capacity is an issue. Communication with providers formally may be through the service arrangement process, incident reporting or ongoing informally.		**within 10-days** of the decision being made.
Delivery of formal homecare	There are a range of providers including; • **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** Some national providers operating across all CHOs should deliver very similar services but there may be some differences between service providers.	Providers include: • **Lead agencies provide home support. (Also potentially for adults although this is sometimes returned as day or evening respite.)** • **Primary care (mostly nursing interventions)**	Home support services may be delivered in a number of ways: • **Directly by the HSE** • **Voluntary not-for-profit services** • **Private for-profit services** • **Through a combination of the above**

Monitoring of HSE homecare services	**The HSE monitor disability homecare/PA 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. **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.**	The **procured service providers provide governance of PHCP and the HSE at CHO level monitors the delivery of service. Each 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.** **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. 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.	HSE directly provided home support services are **managed by Home Support Co-ordinators who have line responsibility for Healthcare 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. **Clients in receipt are reviewed on request or by regular review that is undertaken primarily public health nursing**. The HSE operates a complaints policy that enables service uses

			and or their carers raise issues of concern.
Monitoring of HSE-commissioned homecare services	**HSE defines the requirement for safeguarding and protection in the service arrangement.** Delivery on this 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.**		**Each approved home support provider has a service arrangement (SA) with the HSE and management and 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 **Procedures for non-compliance are detailed in the service arrangements.** The HSE also regularly engages at national level with representative groups for both the voluntary private groups of providers.

Through engagement with the HSE, it is apparent from Table 1.1. that there is a wide range of variation with the types of homecare that exist across the three sectors. This fits in with a previous review by Timoney in 2018[39] 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 of 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 is key to note 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 that this provision of homecare will also expand, a situation seen in other areas of health and social care over the last decade.[40]

Funding of homecare

Older people's services

There is no statutory scheme for the funding of homecare in Ireland. Currently, 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.[41] 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 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.

Disability

There is no tender specification regarding the funding of homecare for disability services, and the HSE has informed HIQA that funding for homecare is provided to CHOs in their annual budget and allocated to service provision accordingly. This is

the case for disability services which will then enter into arrangements with homecare providers. For example, 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 the HSE may provide assistance to them for that purpose.

Children

For children's homecare services, funding is made available through the HSE for children 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 the competing demands for services.

Assessment of need

Older people's 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. 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. Nonetheless, its implementation is slow as it was initially adopted in 2010 and piloted during 2016 and 2017, but it is yet to be fully implemented across Ireland.[‡‡‡][(42)] In the context of privately commissioned or procured homecare (for example, those not funded by the HSE), it is not fully known how needs are assessed.

Disability

For people with a disability the assessment of need 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

The National Health Service (NHS) in Northern Ireland used an assessment tool and the Paediatric Community Assessment Tool (P-CAT) was rolled out to the CHOs in

[†††] 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.

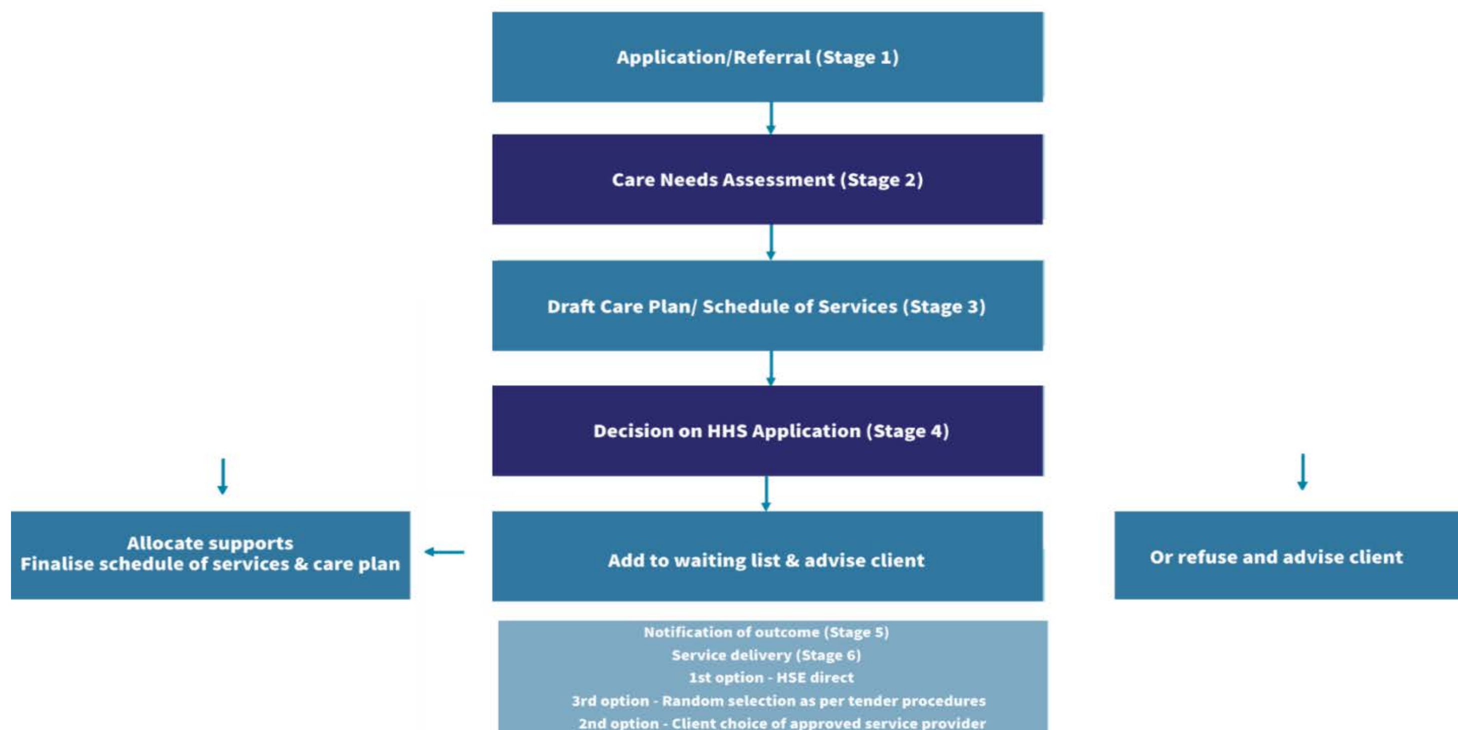
Ireland following an education programme in 2019. This tool is an essential component of assessment of nursing need for homecare recipients.

Delivery of formal homecare

Older people's services

Home support services for older people can be provided by, or on behalf of, the HSE in a number of ways as outlined in Figure 1.2. Of importance, while the first option is that the HSE provide the homecare service, this is often not available due to a lack of 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. Home and Community Care Ireland (HCCI) has highlighted some negative aspects to this process in older people services, citing the 'random selection of homecare providers' where a 'fastest responder first' model is used as particularly inadequate.[28] In this scenario, services are allocated on the basis of which service provider responds first after services are emailed out a tender detailing the needs of a person requiring homecare.[28] In addition to the HSE 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 as such, 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 1.2: HSE-funded Home Support Services Process



Disability

There is no national process for disability services like for older people 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. Furthermore, the approach may vary across each CHO.

Children

There is a process in place where a procurement exercise was undertaken to put in place a framework of providers for 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

Older people's services

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 change. 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. These service specifications are referred to as standards[41] and are founded on the *National Standards for Safer Better Healthcare* that HIQA developed in 2012.[43] Successful tenders, referred to as 'approved providers', are then monitored by the HSE through a 'Management and Monitoring of Service Arrangement'.[44]

Disability

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; and safeguarding policies. However, the HSE informed HIQA that it does not have capacity to monitor services intensively due to finite resources.

Children's

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.

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

Chapter 2 presents HIQA's research to better understand the scope and breadth of homecare services in Ireland, and to determine the difficulties and challenges service providers face. This took the form of an online survey which was then followed up with focus group interviews with service providers and relevant stakeholders who advocate on behalf of people who may require homecare services. Full methodological details are detailed in the main report, while this chapter presents the principal findings.

Online 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. 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. The majority of respondents, 86% (n=42), identified that they provide Intensive Home Support Packages (IHSP), while 49% of respondents 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 seven days a week, but not at night time.

Variation in homecare

Given the variation identified 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 2.1. As seen from the data, there is significant variation in what 'homecare' service providers provide, or what they consider homecare services to be.

Figure 2.1: Word cloud outlining services provided by homecare providers

Out of 42 (86%) responses, only seven respondents (14%) did not employ any clinical staff and the remainder of respondents did.[§§§] Overall, the majority of staff employed were non-clinical. If employed staff were clinical, they only made up a small percentage of the provider's workforce (range of >1% to 20%). This was evident insofar as 38 (78%) respondents reported that they did not undertake any clinical tasks that can only be undertaken by registered health and social care professionals. Eleven 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 people's home support services (in 5 out of 11 responses) or in private care arrangements which are determined by the client and provider (in 4 out of 11 responses).

Challenges associated with providing homecare services

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. 27% 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%).

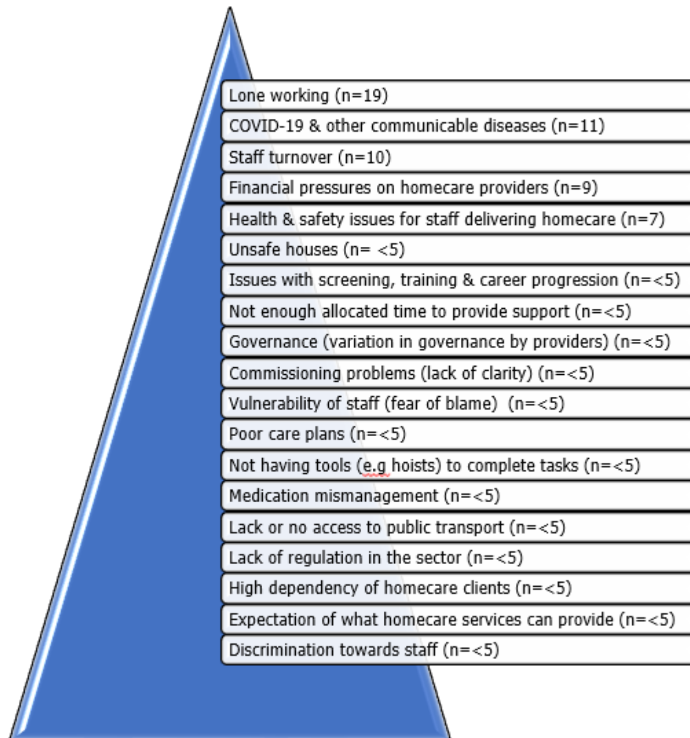
[§§§] In the most recent tender for older people it outlines that The Service Provider must ensure that there is a management structure and clinical governance oversight in place, including clear lines of accountability, which enables the Service Provider to deliver services effectively on a 24/7 basis.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

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?

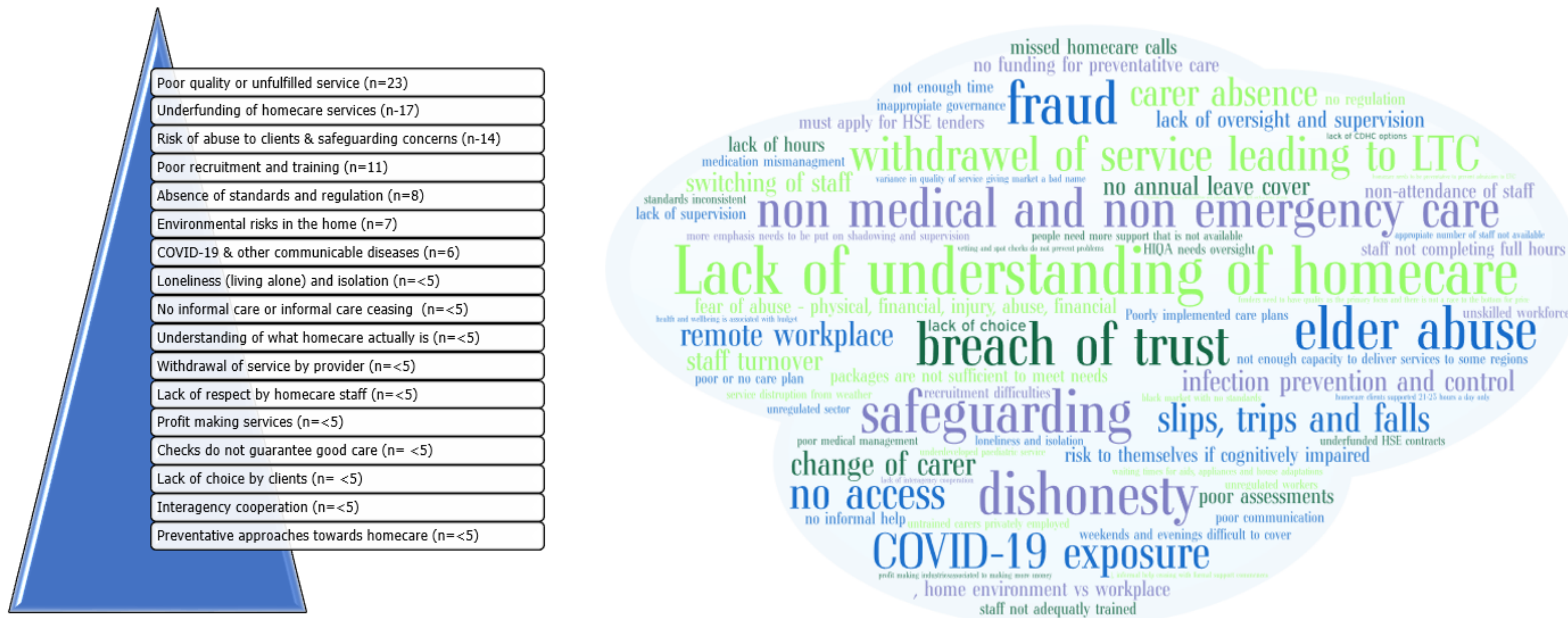
The findings from these are outlined in Figures 2.2 and 2.3. However, providers cited lone working as being the greatest risk to people delivering homecare services, with 19 respondents identifying this as a concern. The greatest reported risk reported in relation to people receiving homecare services was described as being a poor quality or unfulfilled service (n=23).

Figure 2.2: Categories identified as being the greatest risk to people providing homecare services (response n=48)



* 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 2.3: 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 2.1. The responses are organised across three themes:

1. Quality and safety,
2. Capacity and capability,
3. 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 2.1: Respondents view of what regulation and standards should focus on

Quality and safety	Capacity and capability	Government, HSE and regulator considerations
▪ Advocacy is available	▪ Appropriate infrastructural links. For example, there are links in with local HSE governance structure, such as Community Healthcare Network	▪ Align to current HIQA National Standards for Safer Better Healthcare[43]
▪ Apprenticeship model of staff development – for example, learning on the job and attaining a QQI qualification in a certain timescale	▪ Carers should be supported and provided with supervision and guidance	▪ Ensure privately commissioned care does not negatively impact (for example, reduce) HSE homecare hours
▪ Care needs to be compassionate	▪ The service provider undertakes routine inspections of service provision	▪ Ensure there is regulatory balance
▪ Care needs to be effective	▪ Roles of people involved should be clarified	▪ Regulation should avoid unnecessary operational bureaucracy that may inflate costs that are not funded
▪ Carers need to be competent to deliver services	▪ Service provider ensures that there is an appropriate delivery of homecare services	▪ Be explicit on what the scope of homecare involves

▪ Ensure that there are proper processes for risk assessment and risk management	▪ Ensure that there are appropriate governance structures (includes clinical) and good systems in place	▪ Consider the registration of healthcare workers
▪ Clients and carers needs to be protected	▪ Relevant to service provision, policies and procedures are in place and accessible	▪ Define what homecare is – this needs to be broad
▪ Clients need to be treated as an equal and having dignity upheld	▪ There are processes in place to learn from errors and from when things go wrong	▪ Ensure regulation and standards are achievable
▪ Clients should have choice	▪ Processes are in place for how information is used and shared	▪ Ensure regulated entry into system
▪ Flexibility needs to be built in to services	▪ Hold appropriate insurance to provide services	▪ Ensure appropriate funding systems exist for providers
▪ Homecarers should be paid a wage that is in line with HSE staff and receive travel time	▪ There are appropriate controls and processes in place if technology is used	▪ 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
▪ Homecare should be person centred	▪ There are appropriate use of resources	▪ The role of the public health nurse is defined
▪ Staff undertake a bespoke 'homecare qualification' – set educational requirements	▪ There needs to be a contract between the client and service provider for services provided	▪ Uphold carer rights and provide protection for carers
▪ There is an overall focus on quality & safety	▪ Have processes and contingency plans in place to manage staff turnover	
▪ The should be a focus on improving quality of life	▪ Staffing levels are appropriate and safe for the levels of services provided	
▪ The should be a focus on medication management	▪ The service provider has a register of all carers	
▪ Ensure that there are appropriate safeguarding processes in place	▪ Have leadership and management systems and processes in place that are fit for purpose and effective	
▪ There needs to be a transparent complaints process	▪ There is safe accident and incident reporting systems and processes	
▪ Provide training, education and continuous education (development) for staff -	▪ Service provider conducts internal auditing	

clinical professionals such as nurses or allied healthcare professionals are employed to provide clinical oversight of training		
▪ There needs to be consistency and continuity – for example, being provided care (client) and providing care (staff)	▪ Undertake vetting and reference checks and have appropriate recruitment and human resource processes in place	
▪ There should be a focus on carer wellbeing	▪ The provider has a process in place for maintaining the quality of scheduling and matching homecare clients and staff	
▪ There should be a focus on customer experience	▪ There needs to be care plans that are properly implemented, reviewed and evaluated – this should include advance care planning	
▪ There should be a focus on dementia	▪ There should be multidisciplinary involvement	
	▪ Ensure that services are only responsible for the quality and safety of care provided whilst visiting and providing that service	
	▪ Ensure provider has a regional presence to provide local oversight	
▪ 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. The 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; and (3) what needs improvement. These thematic analyses are outlined in Tables 2.2, 2.3 and 2.4.

Results

Theme 1: Positives of the homecare landscape

As can be seen from the findings from these focus groups, there are some positives to the homecare landscape. In broad terms, it was identified that there was a very strong sense of self-regulation that already exists in this sector which included robust processes, policies and procedures. 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. The HSE tender arrangements were also considered as very positive for the homecare sector. Respondents also had 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. Informal carers were also seen as assisting the homecare environment positively, while being spontaneous and meeting a person's needs at the point in time were also seen as helpful. The impact COVID-19 was also identified as having had 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 whom. Finally, it was reported by participants that providers were aware the HSE has 'no choice' but to use the systems that were available to them. They identified 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 2.2: Positives of the homecare landscape

Theme	Subtheme(s)	Categories
Positives of the homecare landscape	Self-governance and management	▪ 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	▪ 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

The ability to retain staff was reported to have a detrimental impact on homecare providers. 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 participants 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 to retain their staff. It was also highlighted by participants that working in homecare is a difficult job which made it difficult to recruit and retain staff. This was further complicated as it was reported that a two-tier system exists where the HSE are in competition with homecare providers for staff. Issues regarding continuity were cited as problematic, whereby the transient nature of staffing impacted the delivery of homecare. 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 often negatively influenced social welfare payments and therefore working in homecare for some people was seen as not being financially beneficial.

The majority of participants stated that the funding process for homecare was problematic. The concept of 'pots of money', which refers to funding streams that are diverse and irregular was cited as being difficult to navigate, particularly so for disability services. 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. The issue of 'zero hour' tenders was also raised by providers. This refers to service providers' funding being cut when a person in receipt of homecare goes into hospital. An additional pressure to the inconsistency and uncertainty of funding was the increase in service provision costs that 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' financial viability. Some providers reported that this was amplified by insurance companies refusing to cover certain activities in light of COVID-19.

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

[****] 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 people.

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 was voiced as a concern by providers. This is where many different homecare providers deliver a service to the same person. 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.

The timing of homecare was also identified as a sub-theme which negatively impacts on 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 also explained that these time constraints meant that visits were task based, rather than person centred. As such, these were potentially undignified or disrespectful for the person in receipt of care. The timing of homecare visits also impacted on the ability of providers to be able to meet the needs of homecare clients. 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.

Assessments are equally complicated. While providers acknowledged that the Single Assessment Tool (SAT) 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. Furthermore, different CHOs supplied various amounts of information on an assessment that was sent out to tender. Some providers received comprehensive information regarding the service or services needed, while others said they received limited information. Data protection and General Data Protection Regulations (GDPR) were cited as one reason for limited information. However, providers stated that as a result of this, at times risks were not being communicated to them. For example, one provider 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.

Table 2.3: what is not currently working well in homecare provision

Theme	subtheme(s)	Categories
What is not currently working well in homecare provision?	Ability to retain staff	▪ Travel time/mileage and TYCO case ▪ Undocumented workers ▪ Limited career opportunities ▪ Social welfare payments restrictive ▪ Low level support/supervision ▪ Hourly employment ▪ Competition ▪ Continuity ▪ Availability
	Funding and tenders	▪ 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
	Time constraints of homecare	▪ Loneliness ▪ Split packages ▪ Geography

		▪ 30 minute visits ▪ Respect and dignity ▪ Same appointment times ▪ Task based
	Inconsistencies in assessment	▪ 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

There was 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. Moreover, while it was also acknowledged that informal care and the involvement of clients' families in their care is of paramount importance, there is a need to ensure that the clients' rights and choices are at the forefront of all decisions. 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 to advocate for the improvement of clients' 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, focus group participants said that it is absolutely critical that these issues are consistently advocated for.

Across the six focus groups different terminology was used by providers to describe the services they provide. A common theme identified by providers was the increasing complexity and diversity in the services they offer. It was reported that the parameters of homecare needed to be delineated. This was explained by a large provider who identified that they now have a clinical care department due to the increasing complexities of healthcare services they provide within the homecare sphere.

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 and this was worrying for participants. 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.

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

A consistent issue raised by participants was where homecare providers are required to respond to a tender in the fastest fashion possible in order to secure it once it has been sent out via email. This was referred to as 'fastest finger first' (a hybrid of the term referred to by HCCI as 'fastest respondent first').[28] This creates multiple issues, particularly when providers accept clients with limited assessments or limited information available regarding the clients' needs. Some providers explained that they were unable to participate in this 'fastest finger first' process due to IT data protection measures in place, such as firewalls. One provider identified 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 concerns in relation to data protection practices amongst providers.

Table 2.4: What needs improvement?

Main theme	Subtheme(s)	Categories
What needs improvement?	Improving person-centred care	▪ 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
	Defining homecare parameters	▪ 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
	Balancing regulation with reducing bureaucracy	▪ Funding to allow same conditions as HSE ▪ Allocation of funding e.g. hospital vs homecare ▪ HSE don't 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	▪ Equality for tenders ▪ Providers treated differently ▪ Assessment and allocation ▪ Equally applied rules for all providers

Summary of findings

This research identified that participants in this research reported wide variation in the provision of homecare. The primary challenges associated with delivering homecare come in the form of lone working from a service provider perspective and from a poor quality or unfulfilled service from a service user perspective. The facilitators and barriers to homecare service provision were explored, with areas for improvement highlighted. Service providers discussed their strengths in provision, outlining that there are high standards of 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 client groups.

In contrast, providers described many barriers to providing homecare services to the best of their ability. These barriers included an inability to retain staff, difficulties with funding and tenders, time constraints in homecare and inconsistencies in assessment. Providers of homecare services informed us 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 services. These were the need to define homecare parameters, improve person-centred care, balance the implementation of regulations with increasing bureaucracy, and eliminating the 'faster 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 has been undertaken using the Donabedian Model to categorise the structure, processes and outcomes of homecare as shown in Table 2.5.[45]

Table 2.5: 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 residential nursing home care	Residential nursing home care 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.

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

Background

HIQA conducted an international scoping review to determine what constitutes quality in terms of the delivery of formal homecare. The aim of this review was to map existing evidence concerning the regulation of homecare. This will 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.(46) Acknowledging that there is a severe absence of empirical literature concerning the impact and effects of regulation in homecare more broadly,(10,33) this review conceives regulation as a quality improvement and assurance mechanism.(47) 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; that is, through regulation, monitoring, quality improvement to include recipients of, and carers providing formal homecare services'.

Methods

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.(48) 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 collaboration with colleagues in 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. 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 through regulation, monitoring, quality improvement, assurance to include 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) in this area which reviewed research until 2010.[8] 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.

Given the size and coverage of this review, a Donabedian[45,49] lens is applied (structure, processes and outcomes) to assist synthesis when charting the data.

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.

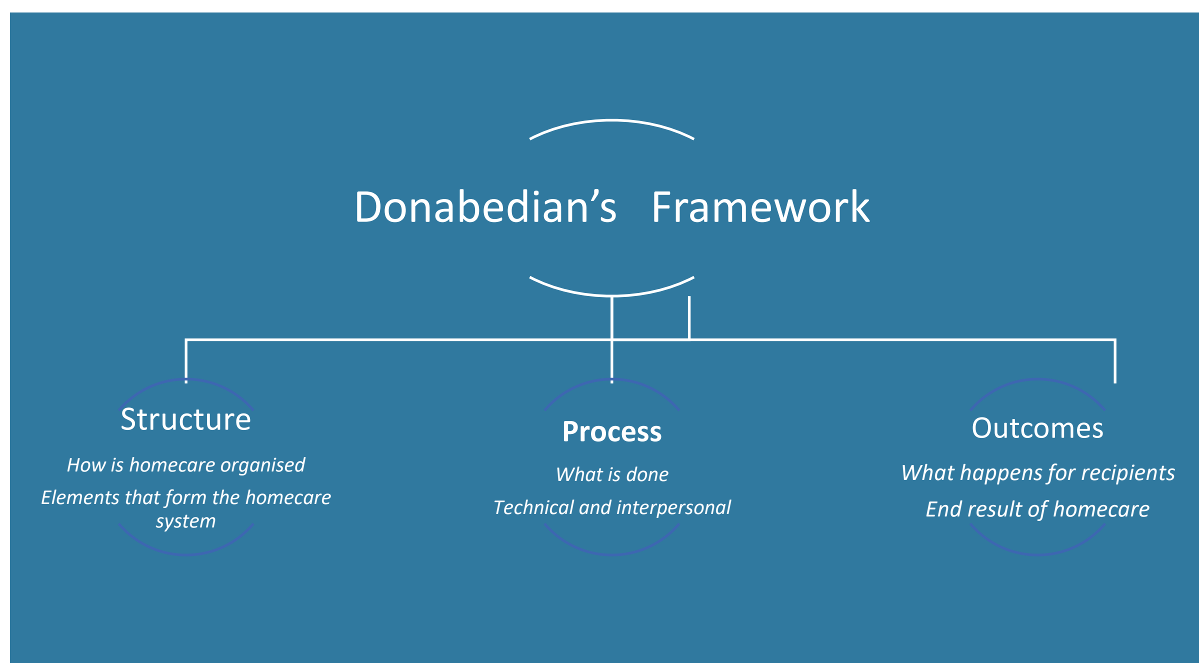
Table 3.1: Articles were included if the met the following criteria	
Inclusion criteria	**Exclusion criteria**
▪ Must be in English ▪ Must relate to formal homecare or domiciliary services ▪ Must be in Europe, Canada, Australia, New Zealand ▪ Must focus on quality of service and protection of people 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	▪ Not related to formal homecare - i.e. paper specifically relates to a medical procedures or medical maintenance carried out in the person's 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 were 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 Donabedian's framework for contextualising quality.[21] This included structures, processes and outcomes. Under 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).[††††]

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.

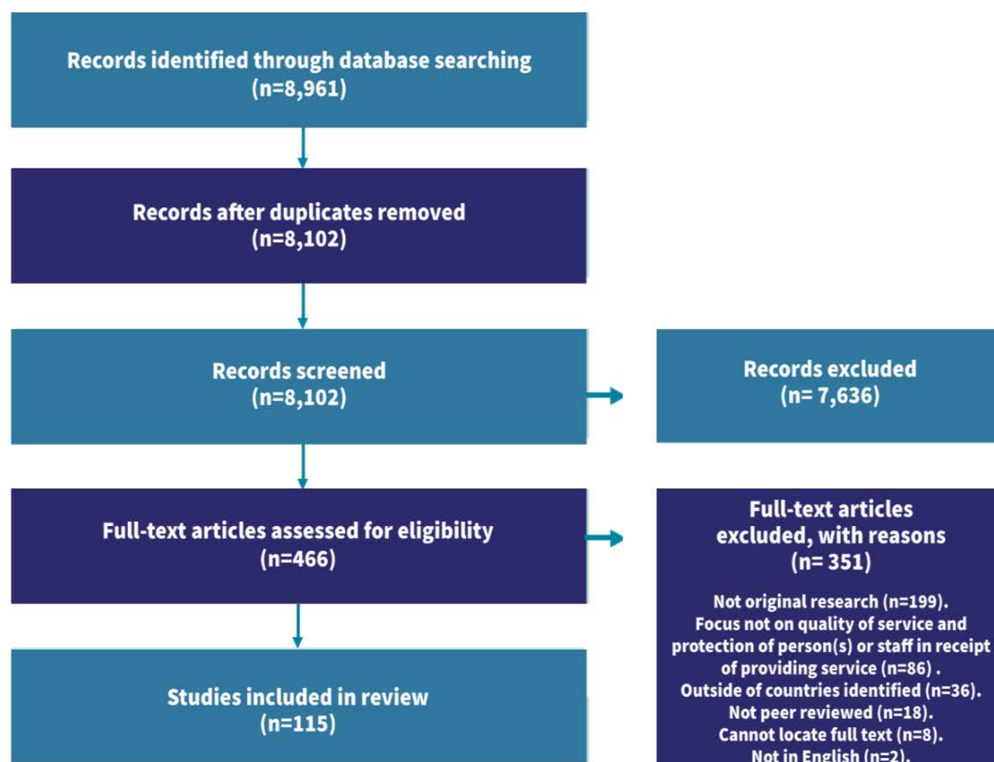
Results

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). The review examined 466 full text articles for inclusion and,

[††††] A supplementary Excel file that further details the characteristics of included studies is available upon reasonable request.

from this, 115 articles were deemed to be eligible for inclusion. Figure 3.2 summarises the flow chart of study identification.

Figure 3.2: Flow chart of study identification



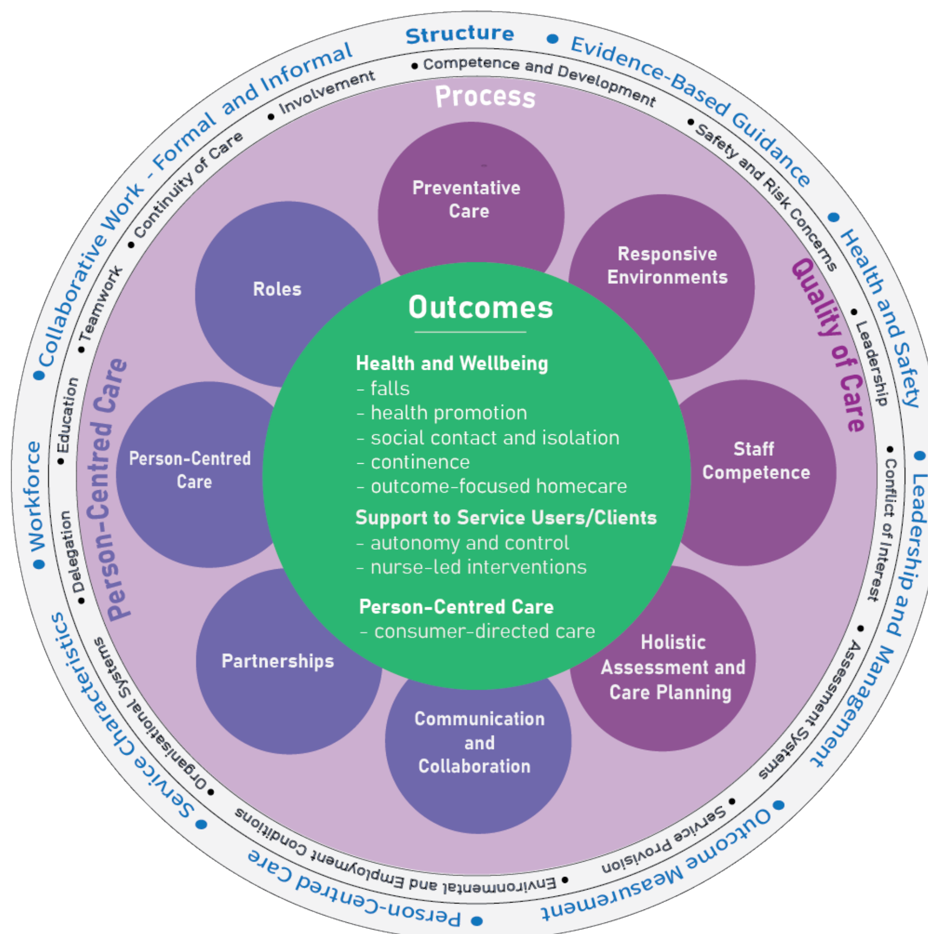
Geographical spread

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. Where data originated from multiple countries (n=7), this is referred to a as a multi-country study.

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 3.4) details the themes and subthemes generated from the thematic analysis.

Figure 3.4: Infographic reflecting the themes and subthemes generated from the thematic analysis



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)[50] 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)[51] 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[52] 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 Genet et al. (2012)[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)[53] (child study) outlines 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)[54] identified that protocols used in pressure ulcer care in homecare do not ensure that practice is in accordance with current scientific knowledge. This 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. It calls for a consistent, standardised approach with a systematic implementation of regulations. Another concept of evidence-based practice is the 'phrases of spread' model discussed by Ploeg et al. (2014).[55] 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.[56] Twelve studies identified a multitude of risks that are broadly multi-dimensional and intersectional.[57] The delivery of care in the 'home' amplifies risks. Sears et al. (2013)[58] identified in their study (using a stratified randomised sample) that 13.2 of every 100 homecare cases were exposed to adverse events, of which one in three (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'.[56] These increased risks in health and safety were corroborated by a further cohort study[59] 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[60,61] were cited as highly prevalent and Tariq et al. (2015)[61] report that the use of incident data (for example, falls and medication incidents) may improve client safety. This is aligned with Ross et al.

(2014)[62] who 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)[57] had similar findings to Craven et al. (2012).[63] Both studies were conducted in Canada in which Tong et al. (2016)[57] conducted qualitative interviews with clients and family care givers, while Craven et al. (2012)[63] conducted qualitative interviews with homecare workers only. Despite this difference in samples, both studies identified physical (musculoskeletal, injuries falls, communicable disease), 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. In addition to these, Craven et al. (2012)[63] also highlighted temporal (timing of service, rushing with travelling and travelling to clients homes) risks.

A reoccurring theme in the literature was the 'transient', 'lone' or 'remote' nature of homecare. According to Jackson et al. (2019)[64] these 'invisible journeys' are associated with safety risks, and health and economic costs. Safety was also viewed through the lens of the potential exposure to violence and harassment that homecare staff may also experience[65] when lone working, and their inability to undertake appropriate risk assessment due to lack of time, equipment and resources.[66] Sun, Doran[67] identified that higher levels of therapeutic self-care ability can be a protective factor against the occurrence of adverse events, which signals this as 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)[68] identified that a lack of functional leadership in homecare compromised patient safety. It also detailed specific management responsibilities that are co-dependent, such as lack of routines and failure to update procedures. This study emphasised that management need to listen to nurses and be more aware of the dilemmas they experience.

Lundgren et al. (2016) investigated leadership factors in homecare settings and reported that leaders have less opportunity to organise, structure and immediately address problems which may negatively impact homecare services due to 'direct vs distant' roles.[69] 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).[69] In this vein, Westerberg and Tafvelin (2014)[70] identified that a transformational leadership style is associated with more positive job satisfaction and 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[71] 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 that they work within certain parameters, but they also need to be conscious of the rights and choices of homecare recipients. Breitholtz et al. (2013)[71] 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. Elliott et al. (2020),[72] Foebel et al. (2015),[73] Mofina and Guthrie (2014),[74] Morris et al. (2013),[75] Morris et al. (2016),[76] Stolle et al. (2015)[77] and van der Roest (2019)[78] reported on a suite of interRAI tools. 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, implementation can be burdensome and homecare providers find using assessment tools difficult.[79] Firbank (2010)[80] and Firbank (2012)[79] 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[81] 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)[82] 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)[83] outlined in their study. They described how nursing staff 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)[84] described the lack of recognition that food provision (resulting in malnutrition) receives in homecare and cited organisational barriers and budget cuts as a causative factor.

In terms of regulation, a qualitative Dutch study [85] 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)[86] highlighted issues with the inappropriate use of homecare and Holm et al. (2015)[87] identified that allocation systems need to be fair and subject to review. Kitchen et al. (2011),[88] Riedel et al. (2016)[7] and Vecchio (2013)[89] 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.[90] Three studies of homecare workers in Canada[91,92,93] 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). 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.(94) 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 (95,96) and where 'dirty workplaces' pose risks.(97) Larsson et al. (2018)(98) 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.

<u>Workforce</u>

Continuity of care (for example, an individual recipient of homecare has few consistent carers) is a prerequisite for quality in homecare.(99,100) However, 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 their professional standards in which they must balance the patient's wellbeing with the wellbeing of their staff. The concepts of 'delegation'[‡‡‡‡] or 'task shifting'[§§§§] may increase continuity, but come with caveats. While delegation in homecare has been associated with increased autonomy and reinforcing the intrinsic rewards of care work,(102) it is also associated with blurred responsibilities(103) due to accepting delegation (unquestioned or involuntary delegation) that may be outside of a care worker's scope of competence.(104,105,106) This is particularly true where there is no defined scope of practice.(106)

Hasson and Arnetz (2011)(107) 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)(108) 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,(109) training and oversight(110) with a particular focus on dementia(110,111,112) and mental health issues.(113) Morgan et al. (2016)(111) outlined that educational programmes should be aligned with perceived needs and warned that basing education solely on typical

[‡‡‡‡] 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.
[§§§§] 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. Organization WH. Task shifting: Global recommendations and guidelines. Geneva: World Health Organization. 2008.

activities in homecare may be ineffective. The workforce theme is perhaps embodied by a single study[114] on children's homecare that identified that in order for provide a person-centred service, there is a need for close collaboration and good team work.

Process themes

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[116] and focusing on preventative measures as opposed to treatment (for example the cause of falls as opposed to their management)[117] and age-related health issues.[118] In terms of improving the quality of responsive environments, Bagchus et al. (2015)[119] 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,[120] identified how care workers struggle to improve these responsive environments due to time constraints. However, staff compensate for this by employing certain tactics, such as 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 Bijnsdrop et al. (2019)[121] who refer to caregiver burden and outline that in order to uphold quality, it is important healthcare professionals ensure partner caregivers receive adequate and timely support.[122]

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';[123] while also being culturally competent and responsive to sexuality,[124] have a good level of emotional intelligence and social skills,[125] and be able to detect early deterioration in frail older patients.[126]

Swedberg et al. (2013)[122] 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)[127] 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 to their professional roles. Two other studies have addressed competence evaluation [Nursing Older People-Competence Evaluation Tool (NOP-CET)][128] and rehabilitative competence development ('Stay Active at Home' training programme).[129] 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)[130] developed evidence-based standardised care plans (EB-SCP) for use internationally to improve homecare practice. The care plans are intended 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,[131] pain assessment [in dementia],[132] oral care[133] and medication management[134] in homecare.

Personal-centred planning

Johnasson et al. (2017)[135] and Kazemi and Kajonius (2015)[136] 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)[137] reported that person-centred responses from care workers were associated with the way distress was expressed by older people. 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)[138] regarding nutritional care identified that poor collaboration and communication obstructed optimal clinical decision-making. Additionally, Kristensen et al. (2017)[139] 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. In their qualitative study, Gregory et al. (2018)[140] deconstructed partnership 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)[141] also reference user involvement as being an integral part of 'support in daily living', but suggest that having less detailed plans (including rules and restrictions) may facilitate better partnerships. In a quasi-experimental study, McWilliam et al. (2014)[142] 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)[(143)] refers to formal homecare as supplementary, with family being primary providers, and 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[(144)] 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 themes

Health and wellbeing

From a health and wellbeing perspective, homecare should have a health promotion philosophy.[(145)] Burton et al. (2015)[(145)] 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 exercise. Another study[(146)] 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.[(147)]

Poorer outcomes for people in receipt of homecare were also associated with urinary incontinence.[(148)] A Swiss study identified that where urinary incontinence was present in homecare recipients, if they were admitted to hospital, they are more likely to have longer lengths of stay and a higher mortality rate.[(148)] The mortality rate increased in line with the incidence of urinary incontinence; for example, the hazard ratio (HR) range: 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[(149)] identified 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. (2010)[(150)] found that perceived social provisions were high

in a Norwegian study of 242 persons 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 that where homecare was outcome focused, or consumer directed (that is, more person centred), more favourable outcomes were reported. In a longitudinal UK study, Gethin-Jones (2010) identified a greater improvement in subjective wellbeing in a comparison group receiving outcome-focused care versus traditional task-focused homecare.(151) This subjective wellbeing was also found to remain even with physical decline. A randomised control trial that focused on restorative homecare (a person-centred approach towards the restoration and maintenance of older peoples 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.(152) Additionally, Parsons et al. (2012)(153) and Parsons and Parsons (2012)(154) explored the concept of goal setting in homecare. They found that where a goal facilitation tool was used in the assessment of older people'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)(155) have explored the experiences of persons 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 persons in receipt of homecare. Faeø et al. (2020)(156) detailed that maintaining control and autonomy over one's own life was fundamental for persons 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. Evidence from Glasdam et al. (2013)(157) advance this further and highlight 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 process impact on a person's own way of living. It is also important that a person is viewed as a 'human' and not a 'case'.(158) Liveng (2011) 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.[158] In terms of overseeing homecare support,[159] supporting the concept of health promotion and disease prevention interventions with multiple home visits using a holistic suite of approaches facilitated this.

Discussion

In summary, there is a severe lack of empirical research about regulation in homecare. While some studies have made reference to regulation or called for regulation in varying degrees[6,64,66,82,105,113,141,155,158] (or varying aspects) only Verver et al. (2018)[85] reported on how the Dutch Health and Youth Care Inspectorate tested a regulatory framework focusing on care networks around older people living independently. They do, however, caution against its implementation given the substantial time and resource investment.

This review signals 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.[50] The evidence 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 by 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 impact on all identified structural themes.[56,57,58,59,60,61,62,63,64,65,66,67]

Overall, homecare should be about quality, and it should consider the following elements as fundamentally important from a Donabedian's framework perspective for contextualising quality:

> **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.

A principal 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. It therefore needs to be noted that this review cannot fully occupy the absence of such evidence, despite highlighting the necessary areas that homecare regulation should address. Secondly, due to the volume of evidence found, this review has excluded the role of technology, palliative care and medical procedures or medical maintenance carried out in the 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.

The use of health technology in homecare is vast and used 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 services must be recognised. 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.

The use of health technology within homecare in Ireland has received increased attention over the past two decades as the feasibility of its implementation has grown.[160,161,162] Health technology can reduce complications associated with chronic conditions,[163] reduce hospital readmissions and length of admissions, reduce visits to outpatient services and reduce costs associated with home-based services for chronic disease patients.[164] However, the evidence supporting these benefits is mixed.[160,165]

Facilitators for the successful implementation of health technology are evident in several systematic and scoping reviews. These include collaboration between all 'actor' in the process of care,[162] the use of a participatory approach when designing health technology, and facilitating access to supports for informal carers.[166] Barriers to the implementation of health technology have been cited as; the low level of 'smart home readiness' in older people's homes,[160] costs associated with implementation,[164,167] perceptions of health technology[162] and a lack of solid evidence base needed to inform practice.[162,165,166]

Conclusion

This review suggests that the structures, processes and outcomes of homecare are reliant on each other. Without good structures, processes are compromised and as a result, outcomes are poorer for people in receipt of homecare services. The concept

of person-centred care is very important and this needs to be considered at all stages of the homecare process. Homecare should be about quality, and in this regard it should consider the following elements as fundamentally important:

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

This chapter details the international approach towards the regulation of homecare in 13 jurisdictions. Research identified in Chapter 3 signalled which jurisdictions would be included in this review. The substantial bulk of evidence was retrieved from online sources through a desktop review. Additionally, international experts from a number of countries participated in an online survey. The findings presented set out how homecare is regulated, and the tasks regulated homecare providers provide across jurisdictions.

Findings

Seven out of an original 23 jurisdictions contacted responded to the survey with information regarding homecare. These were Denmark, Finland, France, Germany, Greece,[*****] the Netherlands and Sweden. To mitigate the non-response from English speaking countries, Australia, Canada, England, New Zealand, Northern Ireland, Scotland and Wales were targeted for inclusion in the desktop review.

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.[(168)] CQC regulates treatment, care and support services in people's own homes (both personal and nursing care).[†††††] Homecare agencies are the most common services providing care in a person's home.[(169)]

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out a broad range of regulated activities.[(170)] A 'service provider'[‡‡‡‡‡] must register with CQC for each of the regulated activities they carry out, that is 'personal care' and or 'nursing care'.

Type of work carried out by the regulator

[*****] Greece was excluded as its homecare system Greece was excluded from the review as the response was not aligned to needs or objectives of this review.
[†††††] 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.
[‡‡‡‡‡] A service provider can be an individual, a partnership or an organisation. Examples of organisations are companies, charities, NHS trusts and local authorities.

The CQC register care providers and monitor, inspect and rate services. Inspection findings are published online, which can help people choose care. There are specific Care Quality Commission (Registration) Regulations 2009 that relate to registrating and monitoring providers of regulated activities.[171] Additionally, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, sets out requirements relating to people managing a regulated activity, that is service providers, registered managers and so on.[170]

A care provider must register with the CQC before providing care and demonstrate that they meet legal requirements, such as fundamental standards of quality and safety. There is no registration requirement for homecare workers, nor is there any requirement for staff to be fully qualified before they begin working.

Up until the COVID-19 pandemic, CQC broadly carried out three types of inspections; announced, themed or responsive. Homecare providers are assessed against the fundamental standards of care[172] as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). Where care does fall below these standards, CQC takes appropriate enforcement action; such as, issuing a fine or formal warning and, in some cases, taking action to close the agency.[173] In March 2020, routine inspections was paused due to COVID-19 and activities focused on regulating where there was a risk to people's safety.[174] The CQC has published *Our Strategy* 2021 setting out how CQC will be 'smarter' in how it regulates.[175] This includes a digital-first approach with virtual inspections, which is being piloted among homecare providers.

Type of homecare tasks provided by services

Regulated homecare services are those registered with CQC to provide the regulated activity of 'personal care'. This includes assisting or supervising with: eating and drinking; toileting; washing; dressing; oral care; and care of skin, hair and nails. It is also possible that providers can be registered to provide both personal and nursing care and or other regulated activities.[170,176]

Northern Ireland

Is homecare regulated?

The Regulation and Quality Improvement Authority (RQIA) is the independent body that regulates and inspects Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.[177,178]

RQIA's registers and inspects statutory and independent domiciliary care providers using:

- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007[179]
- The Domiciliary Care Agencies Minimum Standards (2011).[180]

Since 2015, there is compulsory registration for all homecare workers with the regulatory body for the social care workforce, the Northern Ireland Social Care Council (NISCC). Registered social care workers are required to comply with the NISCC Standards of Conduct and Practice for social care workers.

Type of work carried out by the regulator

RQIA carries out the following functions:

- **Registration:** RQIA must take into account the extent to which the minimum standards have been met in determining if a service maintains its registration, or whether to take action for breach of regulations.
- **Inspection**: RQIA inspections take place on site at the agency's office. RQIA currently uses a remote and blended approach to inspections due to COVID-19. RQIA reviews previous inspection outcomes and information received about the service, records including policies, care records, incidents, complaints, and so on. RQIA provides a report of inspection findings to outline failings in compliance with regulations and or standards.[177] 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.[181]

Type of homecare tasks provided by services

Under the 2007 Regulations, prescribed services that homecare agencies may undertake are:

(a) personal care

(b) assessment of the need for such care.

Personal care includes the provision of appropriate assistance to promote rehabilitation, and assist with physical or social needs, and counselling; it does not include any prescribed activity.[§§§§§] Nursing care services do not come under the remit of homecare. If nursing care is provided in the home, it is a distinct service regulated under the Nursing Agencies Regulations (Northern Ireland) 2005.[182]

[§§§§§] No description of prescribed activity given in the order.

Scotland

Is homecare regulated?

Homecare services are available without charge to all adults assessed as requiring these services. The Regulation of Care (Scotland) Act 2001 established regulatory mechanisms and a legal framework for the care sector, including homecare. The Care Inspectorate, established under the Public Services Reform (Scotland) Act 2010 regulates the care sector.[183] This excludes personal and private arrangements or where the care is provided by a hospital as part of its continued healthcare service.[184] The Care Inspectorate regulates providers of homecare using the Health and Social Care (HSC) Standards (2017).[185]

The Scottish Social Services Council (SSSC) regulates the social care workforce; all social service workers must register with the Council. Homecare workers must have relevant qualification or be working towards gaining them.[33] The SSSC 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: Services providing homecare must register with the Care Inspectorate. Applicants must provide how they plan to evaluate their homecare services in the future, and how they involve staff and service users in this process.[33]

Inspection and monitoring: Prior to COVID-19, random inspections were carried out on homecare providers annually, and specific complaints were investigated separately.[33] Inspections involved visiting people receiving care (once permission was received), sending questionnaires, and speaking to staff. Services are monitored against quality frameworks. The same frameworks are incorporated into self-assessment forms. In recent years, the Care Inspectorate has shifted inspections from a focus on compliance to supporting services to improve.

Since COVID-19, the Care Inspectorate places particular focus on infection prevention and control, wellbeing, and staffing in care settings. This means carrying out short, focused inspections with colleagues from Health Improvement Scotland and Health Protection Scotland.[186]

Enforcement action: The Care Inspectorate rates the service and sets out areas for improvement if the standards are not met. Where the Care Inspectorate finds that a care service is not operating according to the standards it expects, tit has the powers to:

- make recommendations
- make requirements
- take enforcement action
- apply to the sheriff for emergency cancellation of registration
- attach a condition to the registration of the service.(187)

Type of homecare tasks provided by services

People over the age of 65 are eligible for homecare.(33) Tasks include supporting with dressing, washing, using the toilet, shaving, assistance with daily tasks, housework, meal preparation, administering medication, and supporting the person out for trips, shopping or to local amenities.

Wales

Is homecare regulated?

Homecare is mostly funded by local authorities in Wales and is delivered by the independent or voluntary sector. The Care Inspectorate Wales (CIW) is the independent regulator of social care and childcare including homecare services.(188) The CIW has the power to register and inspect services under the:

- Social Services and Well-being (Wales) Act 2014
- Regulation and Inspection of Social Care (Wales) Act 2016.(189)

The CIW inspects against the following regulations:

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

The Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) Regulations 2017,(190) sets out that domiciliary support services have:

- a 'schedule of visits' which delineates the time allowed for, and to travel between each visit
- non-guaranteed hours contracts and the choice of alternative contractual arrangements for homecare workers.

Statutory guidance issued under the Regulation and Inspection of Social Care (Wales) Act 2016 is intended to help providers understand how they can meet the applicable requirements within the regulations. CIW uses this guidance to inform decisions on inspections and enforcement action.(190)

Type of work carried out by the regulator

Registration: CIW registers and inspects homecare services. All homecare workers must register with Social Care Wales.[191]

Inspection: CIW has two types of inspections: full (as part of inspection schedule) and focused (for when concerns are raised or to follow-up on areas of improvement).[192] Routine inspections are carried out every 18 months, and priority inspections every six months. Inspectors may visit people receiving services.[193]

Enforcement action: CIW generally employs a graduated approach towards service improvement. Where it has identified serious or persistent non-compliance, it may restrict the care a provider can deliver, or prevent operation. Where there is a risk of harm, the CIW will take immediate enforcement action.[193,194]

Type of homecare tasks provided by services

Homecare services in Wales are considered within three categories:

- **Maintenance** – supporting mobility, physical health, hygiene and continuing social contacts.
- **Change** – helping increase physical ability, higher morale and confidence, more social contact, and so on.
- **End of life** – ensuring health, social, emotional, and spiritual needs are respected and advance care plans are followed at end of life.

The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 sets out that homecare is not:

- services provided without involvement of an employment agency
- services wholly under the direction of the person receiving the care
- services provided in a care home or other accommodation
- services providing nursing care by a registered nurse or Local Health Board.[******]

[******] 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 or care provision
- how they intend to provide the service information on the numbers and qualifications of staff.

Australia

Is homecare regulated?

The Aged Care Quality and Safety Commission (the Commission) regulate homecare for older people. The Commission independently accredits, assesses and monitors aged care services subsidised by the Australian Government. The Aged Care Legislation Amendment (Single Quality Framework Consequential Amendments and Transitional Provisions) Act 2019 gives legal footing to the 2019 *Aged Care Quality Standards.*[195]

The Commission defines homecare as care consisting of a package of care and services provided in a non-residential care setting. Homecare for people with disabilities is funded by the National Disability Insurance Scheme (NDIS). This includes personal care, and supports for independent living.

Type of work carried out by the Commission

The Commission assesses and approves applicants to provide homecare services.[194] Providers delivering government-subsidised 'Homecare Package Services' must meet the *Aged Care Quality Standards.*[195] Providers must also be transparent about the fees they charge, and use funds in a consumer-directed care approach. The Commission applies a risk-based regulatory approach. Compliance is checked through a mix of quality assessments, reviews and consumer feedback. If a provider does not meet the quality standards, the Commission will give them a direction to make improvements. If there is continued non-compliance, a sanction may be imposed.

The quality of NDIS care and supports is monitored by the NDIS Quality and Safeguards Commission against the NDIS Practice Standards. Providers under the NDIS must be registered with the Commission, and staff must comply with the NDIS code of conduct.

Types of homecare tasks provided by services

Various homecare provisions are legally permitted as long as the approved provider and recipients agree, and the approved provider is able to provide the care and services. Tasks include:

- Care services: personal services, activities of daily living, nutrition, hydration, meal preparation, continence management, and mobility
- Support services: leisure, interests and activities
- Clinical services: clinical care and access to health services
- Exclusions: purchase of food, accommodation, gambling costs, entertainment activities.[196,197]

Canada

In Canada, federal government provides funding to provincial, territorial and some municipal governments who then deliver homecare 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.(198) This Act ensures a wide range of community services are available to people in their own homes so that alternatives to institutional care exist. Since 2021, Home and Community Care Support Services (HCCSS) control publicly-funded homecare. There are 14 HCCSSs in Ontario and their role is to plan, integrate and fund local healthcare, as well as deliver and coordinate homecare. A HCCSSs-funded health service provider is an agency that has a service accountability agreement with the HCCSSs. This holds the agency accountable for delivering healthcare services to patients.(199)

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 they fund through the service accountability agreement. This includes authority to issue policy or operational directives, engage in or permit an audit, and appoint investigators to report on the quality of care provided.

The Resident Assessment Instrument-homecare(200) is a standardised homecare indicator tool created by Health Quality Ontario (HQO) to measure 'long-stay' patients' health status. It recommends service providers use the tool every six months as a performance measure.

Despite the authority placed on HCCSSs and the implementation of the Resident Assessment Instrument, a 2015 audit highlighted that monitoring of contracted service providers' performance needs improvement. It stated that HCCSSs 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.(201)

Types of homecare tasks provided by services

HCCSSs oversee the following activities:

- Healthcare professionals providing nursing care and therapy
- Personal care including washing, hair care, eating, toileting and so on.
- Homemaking tasks

- Family-managed homecare where a person can receive funding directly to pay for homecare services
- End-of-life care at home.[202,203]

New Zealand

Homecare services in New Zealand are publicly funded, and are delivered by service providers under contracts with government agencies including:

- District Health Boards (DHBs) fund homecare services for people with health needs, including older people
- The Ministry for Health Disability Support Services funds homecare services for people with physical, intellectual or sensory disabilities
- The Accident Compensation Cooperation (ACC) funds homecare services for people recovering from, or living with an injury.

Individuals must meet eligibility criteria for homecare by having their needs assessed by a Needs Assessment and Service Coordination organisation (NASC). The NASC makes contact yearly or whenever needed if a person's needs change.

Is homecare regulated?

There is no legislative regulatory framework or requirements that govern the homecare 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 places a duty on health and disability service providers to take responsibility to provide safe services and to continuously improve quality.[204] This legislation describes the setting of standards and the certification of listed services against these standards.

Contracted providers must be certified against the the *Home and Community Sector Standards* (2012).[205] These standards set out the minimum requirements to be attained by organisations. In 2015, a Director General's Reference Group highlighted a number of issues homecare services faced. These included increased demand and lack of funding; inconsistent and fragmented services; lack of person-centred care; lack of training of the workforce, and inconsistent quality improvement processes.[206] Currently, the National Framework for Home and Community Support Services[206] is being implemented and this provides guidance for DHBs for future commissioning, developing, delivering and evaluating homecare services.

Type of work carried out by the authority

Conformity assessment bodies audit and certify homecare providers contracted by the Ministry of Health. Homecare providers must demonstrate that they are

complying with the *Home and Community Support Sector Standard* in order to obtain certification.[207,208]

Types of homecare tasks provided by services

The Ministry of Health outlines that the following tasks delivered as part of homecare services:

- Household management including preparing meals, laundry and house cleaning
- Personal care including help with eating and drinking, dressing, getting in and out of bed, showering and going to the toilet and getting around a home.

Denmark

Is homecare regulated?

Homecare in Denmark is regulated by primary legislation.[209] At local level, there are 98 municipalities fully responsible for public governance, provision, delivery and financing of elderly care, including homecare.[210] Each municipality sets quality standards and inspects homecare services. Homecare agencies are also subject to quality risk inspections by the Danish Patient Safety Authority, with a biannual survey conducted among people receiving homecare.

What tasks are provided for within homecare?

The homecare sector is publicly funded and delivered to adults over 66 years, and people with a disability. Homecare falls in two categories: practical help and personal care. Primary tasks undertaken include:

- Household chores
- Dressing, bathing or showering
- Help with eating
- Help getting in or out of bed
- Help using the toilet
- Nursing care
- May also include food services.

Finland

Is homecare regulated?

Homecare in Finland is regulated by primary legislation.[211] The Ministry of Social Affairs and Health 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 based on age, but rather according to need.[212] This need is assessed using the interRAI assessment instruments.[212] Both public and private homecare is available, with public homecare being most common. The government also directs the policy on social and healthcare client fees through legislation, ensuring fees are kept at a reasonable level.

How is homecare regulated?

Valvira is Finland's national supervising authority on social welfare. Accreditation is mandatory and a condition for public reimbursement.[213] Valvira handles welfare-related supervisory cases when they are of nationwide importance. Agencies are also required to analyse their own service to help drive improvement.

What tasks are provided for within homecare?

The following tasks are undertaken by homecare services in Finland:

- Providing meals
- Doing household chores
- Support taking medication
- Help with dressing, mobility, washing
- Help with eating
- Help getting in or out of bed
- Help using the toilet
- Nursing care[214][††††††]
- Escorting outdoors.

France

Is homecare regulated?

Homecare in France involves several levels of governance: 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 sectors.[215] Homecare is partly regulated for two primary reasons. Firstly, three types of service providers exist – public social services, non-profit organisations, and private companies. Each 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 markers' that are out of reach of regulation. The absence of a unique regulatory

[††††††] Homecare services and home nursing care are combined in many municipalities as homecare and this is supplemented by additional support services.

framework is seen as an obstacle to structuring both service provision and employment.

How is homecare regulated?

Formal homecare is delivered by public and private providers who have received an agreement from the French local authority called the Département. The government develops national legislation and regulation for access and quality of homecare and at the regional level: France's regional health agencies are responsible for regulating homecare. Homecare providers are accredited 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.

What tasks are provided for within homecare?

The following tasks are undertaken by homecare services in France:

- Providing meals
- Household chores
- Shopping for groceries
- Managing money
- Making phone calls
- Support taking medication
- Help with dressing, walking, washing, eating, getting in or out of bed and using the toilet.

It should be distinguished that nursing services or personal care delivered by nursing services is not subject to the same regulation as homecare delivered by homecare workers.

Germany

Is homecare regulated?

In Germany, homecare is regulated by Social Code SGB XI.[216] 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 are made available. A fixed amount of benefit is paid by the Long Term Care insurances. In long-term care, people can choose between care-in-kind or cash benefits or a combination of both.

How is homecare regulated?

The MDK (Medical Board of the Health Insurances) oversees the quality assurance procedure and agencies have to meet certain structural standards in an accreditation process to operate.[33] Homecare agencies are assessed by the regional medical

review boards for care deficits. There is a regulatory framework which defines specific performance indicators. Annual inspections are carried out alongside inspections to follow up on complaints.

Types of homecare tasks provided by services

Typically, in homecare services, qualified nurses provide nursing care; qualified nurses for the aged provide personal care, and home helps provide domestic care. Home helps receive training for a period between three months to one year. Accreditation at provider level necessitates that homecare staff are suitably qualified and adequately paid. Tasks undertaken by homecare services include:

- Providing meals
- Household chores
- Grocery shopping
- Making phone calls
- Support taking medication
- Managing money
- Help with dressing, mobility, washing, eating
- Nursing care.

Netherlands

Is homecare regulated?

The regulation of homecare in the Netherlands is complex, borne in part from the multiple stakeholders who are involved in its provision.

How is homecare regulated?

Under the Care Providers (Accreditation) Act (WTZI),(217) 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 must satisfy several legal requirements including meeting quality standards, ensuring employees are registered, ensure patient involvement and have a complaints procedure in place.(217)

The Dutch Health and Youth Care Inspectorate (IGJ) guards the quality and safety of care, enforcing laws, guidelines and standards in the Netherlands.
In addition to normal supervision, the homecare institution may also be inspected on:(217)

- Supervision of incidents
- Supervision of new homecare providers
- Supervision of care networks.(85)

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

What tasks are provided for within homecare?

The Social Support Act encompasses activities such as house cleaning, buying groceries, and cooking. Medical, nursing and personal care do not fall under the term 'homecare', with these activities covered under the Healthcare Insurance Act. Therefore, it is becoming common for clients to be provided services in the home by multiple providers.[217]

Sweden

Is homecare regulated?

In Sweden, services are governed at national, regional and local level. At national level, the government governs through legislation, policy, state subsidies and supervision through the Health and Social Care Inspectorate (IVO). Homecare is granted by social services under the Social Services Act 2001.[218] Sweden is unusual insofar as the legislation governing elderly care is based on a 'goal orientated framework' law that sets out a right to services; however, it does not set out specific regulations.[219]

How is homecare regulated?

There is little regulation and control in homecare services in Sweden[220] with some commenters arguing that stricter regulation may be a threat to the quality of care.[221] Monitoring services is the responsibility of the State and Local Authorities, with the government responsible for ensuring services are adequate and in line with regulatory criteria set out in the Social Services Act.[218] The IVO is responsible for supervising healthcare, social services and activities since 2013. The IVO grants permits to providers to deliver services and considers:

1. Whether the service is safe and of good quality
2. Whether staff and management are competent
3. The service's quality and management system, premises and other features.

The IVO also investigates complaints about the quality of services and use this information for ongoing monitoring.

Types of homecare tasks provided by services

Homecare tasks include:

- non-personal services, such as cleaning or shopping

- personal care, such as hygiene, help at mealtimes, and emotional and social support
- non-contact homecare services for example social care alarms, delivery of meals, collecting laundry, and so on.

Additionally, basic medical tasks can also be included in homecare services for example insulin injections and treatment of wounds.(219) However, this is delivered through a separate assessment process.

Discussion

The review has identified many similarities and differences regarding how homecare is regulated. Where decentralisation of services exists, regulation is more fragmented and difficult to identify. Homecare however is generally embedded within legislation across jurisdictions. In Wales, homecare is regulated against a framework under the Regulation and Inspection of Social Care (Wales) Act 2016; and in Scotland free personal and nursing care is a statutory entitlement outlined and defined in legislation, and monitored against national standards. Embedding similar legislation in Ireland will strengthen the regulation of homecare 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. In countries such as New Zealand, Finland, France, Germany and the Netherlands, there is an accreditation approach towards homecare. An additional safeguard used in Wales is where services are registered at a regional level; this means concerns, sanctions or restrictions do not need to be applied on a national basis.

When considering the registration and requirements of homecare workforce, in Wales, Northern Ireland and New Zealand, the workforce falls under the regulatory framework. Legislation places emphasis on improving working conditions, wages and professional development. In Wales, the Regulation and Inspection of Social Care (Wales) Act 2016 introduced 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. In contrast, there is no registration or qualification requirement for homecare workers in England. With homecare being largely unsupervised work, workforce registration and regulation can enhance competency and quality of care.

We can learn from jurisdictions insofar as how the scope of homecare is set out. In England, the concept of regulated activities is set out under the Health and Social Care Act 2008 Regulations 2014. There are a number regulated activities including nursing care and personal care.(222,223) Homecare providers need to register which

activities are relevant to the service they provide for example personal care and or nursing care.[170] From a regulation perspective, this would mean that the regulator would maintain a register that would identify who was legally entitled to provide regulated services and they would be inspected accordingly.

Alternatively, in Wales and Australia, the distinction is not fully made between homecare tasks. The Care Inspectorate Wales 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. In Australia, regulations provide legal footing for homecare services; however, they do not specifically outline the scope of tasks involved in these services. These examples could be viewed as a pragmatic approach towards personalisation of care. A stepped approach towards regulation where some providers could provide more advanced levels of care in the home would provide a way forward.

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 homecare. This may be restrictive and introduce challenges. In England, household tasks are excluded. This is an important issue to consider from an Irish perspective.

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, with a holistic view of the person receiving care and support. Such a focus may ensure that inspections of homecare services are not restricted to a compliance versus non-compliance approach. If this is to be the case in Ireland, there needs to be significant consideration and consultation on how this should be developed.

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

This chapter outlines the objectives of regulation in broad terms and aligns this to the sphere of homecare. It broadly considers the impact that regulation may have on the homecare sector and sets out what HIQA considers to be an appropriate regulatory approach toward the regularisation of homecare services in Ireland. This is underpinned by HIQA's experience of being a statutory regulator of social care services since 2009.

Objectives of regulation

From a social care perspective there 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. For some providers, there is also a complete absence of any oversight if they 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.(224,225)

The introduction of regulation is nearly always the result of previous failures.(46) However, it is often necessary when voluntary arrangements are not enough to guarantee compliance with expected levels of performance. This is where regulation is used by governments as a key policy instrument to achieve policy objectives.(226) Regulation generally comprises of three key characteristics:(227)

1) providing direction for the regulated
2) determining the level of performance or compliance of the regulated
3) using regulatory powers to bring about a positive change in performance of the regulated.

Achieving good regulatory outcomes is not only dependent on having regulations; rather, it is a cooperative effort between the government, the regulators, the regulated and other concerned parties.(228) This means that through cooperative effort, regulation sets out to deliver on three priorities:

‡‡‡‡‡‡ HCCI (undated) cited in Timoney (2017):(39) "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."

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. (adapted from Sutherland and Leatherman [2006][227])

Deconstructing these three priorities would suggest that the introduction of regulation stems from the perspective that homecare is 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 needs). Nonetheless, despite being positioned within a social policy context and accepting that it is the right thing to do, advancing the objectives of regulating homecare may have both intended and unintended consequences. Subsequently, its impact needs careful and detailed consideration and engagement with concerned stakeholders.

Impact of regulation

Introducing regulation into homecare services in Ireland may bring with it a number of intended and unintended consequences. Therefore, it is essential 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 RIA) must be undertaken in line with the Department of An Taoiseach's Cabinet guidance.[229]

Some potential impacts include reducing 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:[46]

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 trying to demonstrate compliance, rather than on delivering high-quality person-centred care.

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 call on governments to:[226]

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

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 its impact is regularly reviewed once implemented, identifying that its:

- original objectives are still valid and or being achieved,
- regulation remains effective,
- and objectives to be improved or removed in light of legal, economic or social changes are undertaken.(230)

These principles are outlined in a 2004 Government report entitled *Regulating Better, A Government White Paper Setting out Six Principles of Better Regulation*.(230) Although this report is 17 years old, these principles remain 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.(231) There are different processes that could potentially be used to regulate the homecare sector in Ireland, such as directive approaches and external oversight approaches (adapted from Sutherland and Leatherman [2006]).(227) 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:** This would mean that 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:** This would mean that 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:** This would mean that homecare providers need to ensure the provided homecare services 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:** This would mean that homecare providers would need to ensure they provide homecare services to a required level of best practice 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 organisations 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".[(232)] 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:** This would mean that the homecare provider is 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 Organization 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".[(233)] In the context of homecare, this would be seen as a mandatory credentialing process and, once approved, the service provider could provide homecare services to varying degrees that are set out.
- **Registration:** This would mean that the homecare provider would need to register with the regulator to be deemed as an organisation that can provide homecare services. They would need to provide evidence that the can meet a basic set of standards in order to be registered.

- **Inspection, reviews and audits:** This would mean that the homecare provider would be subject to external oversight by inspection, review or auditing. This would be either on-site or off-site (or both) and be dependent on the mechanism for which a provider was registered to provide services and on which directive approach it is being assessed against.
- **Enforced self-regulation:** This would mean that homecare provides 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, it is important to reflect on the work of Kiersey and Coleman (2017)[33] — based on the work of Genet et al. (2012)[38] — which categorises Ireland's current governance of homecare as laissez-faire, with weak involvement and no vision for homecare regulations, and where eligibility criteria is often set by voluntary and private providers. However, it is reasonable to also conclude that before the regulation of older people's services in 2009, similar inferences could be made about that sector. Nonetheless, the transformation of this sector over the last decade has been immense, and now all designated centres for older people, along with designated centres for people with a disability, are subject to regulation by HIQA.[*******][234,235]

HIQA is a mature regulatory body that has adapted an approach to regulation that is transparent, proportionate, targeted and responsive to the needs of service users.

[*******] HIQA also regulates Special Care Units for Children and Medical Ionizing 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

Therefore, it would be reasonable to build upon this approach if HIQA is going to regulate homecare in the future. Under HIQA's current programme of regulation it has adopted a responsive approach. 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 regulated services that persistently breach regulations or place people in receipt of services at risk of harm are identified quickly and face proportionate and meaningful sanctions. HIQA calls this responsive regulation a risk-based approach. HIQA's 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 gathers. 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.

It is through this lens that HIQA would advocate to use a similar mechanism for the regulation of homecare in Ireland. That is to say, it would be a responsive approach[236] using a risk-based strategy 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).[237]

There also needs to be adequate powers for the regulator of homecare. HIQA and the Chief Inspector are of the firm view that the regulatory powers in the legislation must be agile and responsive for the regulator to be effective. HIQA has commented on this concern in detail in its 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;[238,239] the overarching legislation needs to be agile to ensure that the regulator can respond in a proportionate manner to varying non-compliances with regulations. In the absence of this flexibility, the legal framework does not support the regulator to make certain decisions at particular times, or the decision becomes entangled in a lengthy legal case that dilutes the regulator's response irrespective of legal outcome.

[†††††††] See Silvergrove Nursing Home Limited v. Chief Inspector of Social Services and HIQA [2019] IEHC 774.

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?

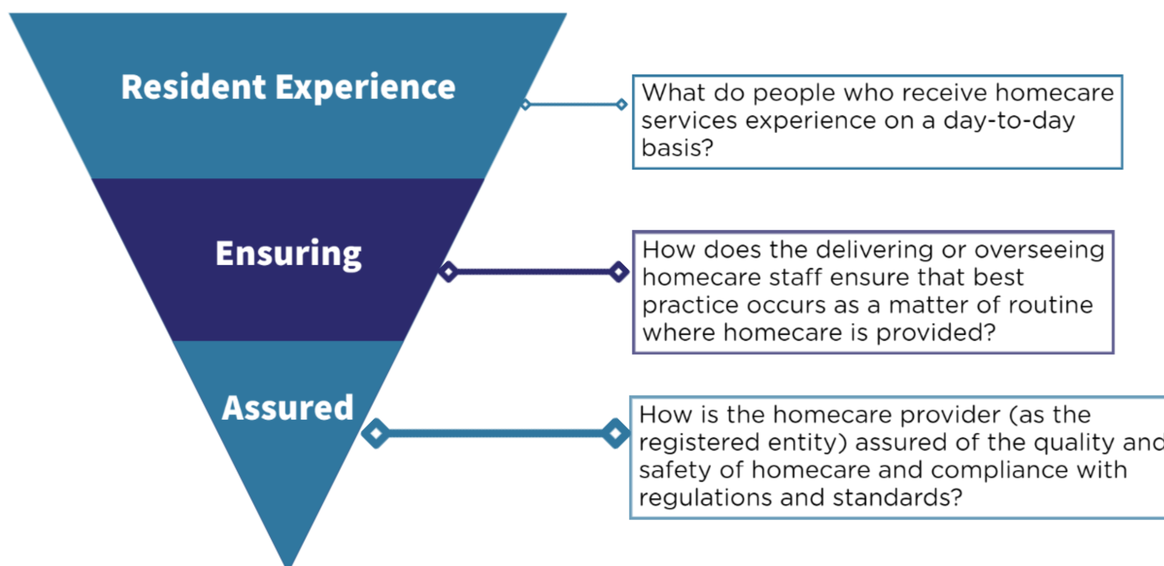
2. What is the purpose of regulating homecare in Ireland?

    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 it should not be understated that there cannot be the 'carte blanche' attitude that regulation is the 'cure' to all the problems highlighted in this sector. Rather, regulation will be one cog in the broader transformation and quality improvement that serves to strengthen this sector. In essence, regulation is the third line of defence that comes after the people delivering the service, and the provider's governance and management arrangements to ensure 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, they have a voice 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 services are protected by assessing against regulations and or standards (or any other mechanism that is instituted). Figure 5.1 outlines how this interrelates.

Figure 5.1: Relationship between regulation and resident experience



Secondly, it is important that a full Regulatory Impact Assessment (RIA) is undertaken by the Government before any potential legislation 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 regulation of this sector will have.

Thirdly, directive and external oversight approaches should be associated with the specific approach towards regulation; that is to say, homecare must be carefully defined and the objective of regulation clearly set out.

Fourthly, it is imperative that the regulators have enforcement powers that are agile and responsive, while proportionate to the breaches of regulations they may face, for regulation to function properly and to be effective. If the regulator's powers are either too weak or to blunt, this makes it difficult for the role of 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 would be fundamentally important that there was not a 'regulatory shock' to services. There would need to an interim period for providers 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 working to achieve minimum standards.

Chapter 6: Discussion and key recommendations

This research report has provided a broad overview of homecare 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.

It is important to highlight that homecare operates in a complex environment, which creates challenges for everyone involved in the process. The HSE has made significant strides towards improving the delivery and oversight of homecare services over the last decade; however, it is well acknowledged that significant challenges still remain. The successful provision of homecare depends on the funder of homecare, the provider of services, homecare workers, informal carers, employers, and the homecare recipient working together. Given that each of these stakeholders has 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.

This discussion chapter will draw on some of the conclusions that can to be extracted from this report, and sets out some key areas of consideration below.

Concerning the parameters of homecare delineated in Table 1.1, it is clear that homecare is diverse and issues regarding the scope of homecare, the terminology used and the intersection of health and social care exist. HIQA is firmly of the belief that homecare should be needs led and integrated. HIQA calls on the Government to legislate for what tasks can and cannot be provided in the sphere of homecare regulation. For example, it needs to be clearly outlined if the regulation will only include the current provision of what is performed within the current 'home support service' sphere. If this is the case, there needs to be a degree of caution expressed as this may lead to an increased burden on providers. It is reasonable to conclude that while the current 'home support service' scheme 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 suggests that there needs to be clear delineation of what homecare is and what it is not. If any future homecare scheme is going to have a narrow focus, then there will be a responsibility on policy-makers to ensure there is a national clinical governance and monitoring framework that protects people who have complex needs and who receive complex care in their own home.

The report also outlines a scoping review of the literature to determine what constitutes quality in terms of formal homecare in Chapter 3. Acknowledging there is a severe absence of empirical literature concerning the impact and effects of regulation in homecare, this review operationalised 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. 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, showing how there needs to be a person-centred ethos incorporated in all components of the homecare sector.

In Chapter 4, this review identified many similarities and differences regarding how homecare is regulated internationally. This review highlighted the need to embed homecare legislation in Ireland to afford a level of protection to people who require homecare services. An interesting additional safeguard used in Wales is where services are registered at a regional level; this means concerns, sanctions or restrictions do not need to be applied on a national basis. In some countries included in this review, legislation placed an emphasis on improving working conditions, wages and professional development. Ireland can learn from these jurisdictions insofar as how the scope of homecare is set out.

In England, the concept of regulated activities is set out under the Health and Social Care Act 2008 Regulations 2014, and includes nursing and personal care.[222,223] Homecare providers need to register which of these activities are relevant to the service they provide.[170] From a regulation perspective, this would mean that the regulator would maintain a register that would identify who was legally entitled to provide regulated services and they would be inspected accordingly.

Additionally, some regulators use varying mechanisms to inspect homecare providers. Across jurisdictions, an outcomes-focused approach is adopted when monitoring and inspecting services, with a holistic view of the person receiving care and support. Such a focus may ensure that inspections of homecare services are not restricted to a compliance versus non-compliance approach. If this is to be the case in Ireland, there needs to be significant consideration and consultation on how this should be developed.

In Chapter 5, this review considered the objectives of regulation and set out what regulation is trying 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. (adapted from Sutherland and Leatherman)[227]

However, the evidence warns that it is important to consider the impact of regulation and the unintended impacts may have on the homecare sector. This highlights the need to undertake a detailed Regulatory Impact Assessment in line with the Department of An Taoiseach's Cabinet guidance.

This chapter also details directive and external oversight approaches towards regulation, as well as using HIQA's current approach towards regulation as an appropriate methodology for homecare services. This approach, referred to as a responsive or risk-based approach, is where the type, frequency and intensity of regulatory intervention is informed by an assessment of risk. In practical terms, over the course of HIQA's work, this has meant regulated services that persistently breach regulations or place people in receipt of services at risk of harm are identified quickly and face proportionate and meaningful sanctions. This risk-based approach is undertaken by building a composite picture of service providers through assessing different pieces of information. This information takes the form of routine monitoring notifications, service user questionnaires, unsolicited information and inspection findings. Finally, this chapter identifies that there cannot be a 'carte blanche' attitude that regulation is the 'cure' to all the problems highlighted in this sector. Essentially, regulation needs to be seen as one cog in the wheel of broader transformation and quality improvement that serves to strengthen this sector.

It is from this perspective that 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 key areas 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[(25)] welcomed the proposed adoption by the Health Service Executive (HSE) in 2010 of the interRAI suite of tools — and this needs to 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 in 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 be 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 7: Limitations of this research

The findings from this report need to be considered in the context of the following limitations:

1. Only a small sample of homecare providers engaged in 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 homecare provision practices, the voice of care recipients were not heard and not all homecare providers in Ireland took part. Despite the coherence and consensus identified across the research, it is not possible to generalise the findings to all providers across the country. These findings are from the participant's perspective, rather than an assessment of this sector by HIQA. As acknowledged throughout this report, it is also imperative that the voices of care recipients are included in further research in order to adhere to a person-centred across the reform of the homecare sector.

2. Due to the sheer breadth of literature available in relation to homecare provision, the international scoping review (Chapter 3) of what constitutes quality in homecare provision implemented exclusion criteria. This may have introduced bias to the review.

3. The international approaches towards the regulation of homecare 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 8: 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 current homecare provision in Ireland by 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 from this research that homecare services operate 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 or self-governance, there are also many challenges. These challenges are becoming more acute, and this is expected to continue moving forward as the Sláintecare plan works to to deliver health and social care in line with the philosophy of "right care, right place, right time". 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.[160,161,162]

There is a general consensus amongst 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 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 people in receipt of homecare services. Ireland can learn from other English speaking jurisdictions in relation to how homecare is clearly defined, such as 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 reforming homecare services. Rather, regulation is one component for improving services, together with collaboration between people delivering services and those in receipt of services, and providers' ability to ensure that the care they provide 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 listened to and their day-to-day experience is at the centre of service provision.

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