

# Health Service Executive – Services for Older People

Activity & Resource Review: Home Care Services

May 2016



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## 1. INTRODUCTION

The Health Service Executive (HSE) commissioned Mazars to perform a review of Home Care Services (HCS), which comprises Home Help services (HH) and Home Care Packages (HCP), under three staged headings:

- Phase 1: Activity and Resource Review (Data Validation)
- Phase 2: Service Improvement Initiatives
- Phase 3: Models of Service Delivery Review (both Irish and International)

This report sets out our findings and recommendations.

### 1.1 TERMS OF REFERENCE

The terms of reference for each of the three phases were:

#### **Phase 1: Activity & Resource Review (Data Validation)**

To ensure that the HSE had full oversight of the budget /expenditure of the Home Help Services and Home Care Package resources. Phase 1 considered:

- The feasibility of centralisation of funding;
- The workability of the introduction of a funding resource allocation model designed to ensure that funding allocations evolve to reflect the distribution of population in each CHO area;
- Whether the HSE could be confident in its governance structures (both clinically and managerially) across the nine Community Health Organisations (CHO);
- If the HSE had available to it a range of relevant and reliable data to account for its resources and upon which to base its management decisions in relation to allocation (and use of resources, taking account of equity of access); and
- The evaluation of the change management impact and the potential costs or savings accruing from the recommendations.

#### **Phase 2: Service Improvement Initiatives**

To propose a range of service initiatives arising directly from the Phase 1 recommendations for improvement.

#### **Phase 3: Models of Service Delivery Review**

Document the current service delivery model(s) in operation for the HSE-funded HH/HCP and identify / propose a range of feasible options in relation to alternative models of service delivery that would enhance the current service delivery, taking account of the current operational constraints. The report was to outline feasible service delivery models, recognising international best practice and setting out the benefits and weaknesses of each option considered.

### 1.2 APPROACH TAKEN

The project work underpinning our report involved:

- Interaction with the senior management in Services for Older People;
- Presentation to and subsequent interaction with service staff in CHOs;
- A comprehensive national survey of key Home Care Services staff within each CHO was undertaken and responses were received from all 9 CHOs;
- A national survey of Voluntary Service Providers funded under the auspices of Section 39;

- Desk-based research into the practices pertaining to Home Care Services in 14 countries.

The three phases of the project are addressed in the following sections:

- Section 3: Service Providers
- Section 4: Service Funding
- Section 5: Governance
- Section 6: Systems and Management Information
- Section 7: Resource Allocation
- Section 8: Findings from the review of International Models of Service Delivery

## 1.3 CONCLUSIONS

Mazars in recognition of the limited financial, staffing and time resources of the Home Care Services has prioritised the following recommendations for immediate action:

### 1) **Creation of a common national client database**

Create a single information technology platform as soon as possible. A basic Access template or alternative mechanism could be used as a starting point while phasing in a comprehensive IT support over a defined period, in order to allow all CHOs to capture essential data about their clients. This project should incorporate a unique client identification number to be linked to the national project led by the Chief Information Officer.

### 2) **Design of a single management structure for HCS, applicable to all nine CHOs**

This new management structure should be developed, initially, without reference to the format of the existing services. The structure should be developed with a single Manager for HCS overseeing the full provision of services, along with sub-CHO management, across the network of services.

### 3) **Single clinical governance responsibility to be assigned within each CHO**

Overall clinical responsibility should be assigned to a member of the Public Health Nursing team in each CHO and at National level. This action will need to be congruent with other CHO management arrangements. Such measures must extend to the Voluntary and For-profit services provision also – such that every client has an identifiable member of the HSE nursing staff who has oversight of their care.

### 4) **Introduction of a National Standard Assessment/Single Assessment Tool (SAT) and client review processes**

It is recognised that a SAT process has been developed (which is based on the internationally accepted Inter RAI System) and the national roll-out of this process is in progress at this point in time. It is essential that the processes around the Assessment and Appraisal stages of client care are standardised, thereby ensuring equality of access and service provision. Therefore, the roll out of a SAT across the CHOs and networks is an essential component of provision of HCS into the future.

### 5) **Redesign of reporting processes, with new financial and performance indicators**

The existing reporting processes focus on inputs whereas the current requirement is to deliver more information about the efficiency and effectiveness of the operation of the service. The information required includes:

- Conversion of staff time to client care;
- Relative performance of the different channels of care provision;
- Age profile of client cohort;
- Geographical differences in resource consumption.

It is essential that future reporting happens in a much shorter timeframe, enabling national management to react to changes or developments on the ground.

## **6) Rebalancing of HCS finances, in line with population, with a centralisation of budgetary control as the CHOs become delivery organisations**

The new management structure of the HSE places the responsibility for service planning and finance allocation on the Social Care Division. A resource allocation tool has been developed to enable the Social Care Division to allocate funds on the basis of defined population needs. Historically there were disparities across the former LHOs as regards the amount of funding received and where new resources were allocated. This resource allocation tool identifies the population of people aged over 65 and what the demographic of that population is in a particular CHO versus the total population and demographic nationally. The tool can then allocate a proportionate amount of funding based on need from the national budget to each CHO based on these statistics. This process will provide a fully transparent basis for funding distribution going forward. The Social Care Division must decide how it will implement these changes in the short-to-medium term period.

## **7) Consolidation and Unification of Care Services**

Currently Home Help services and Home Care Packages are funded and managed separately within the HSE. It is recommended that both the funding and management of these services be merged going forward. The objectives of this merger are to:

- Simplify the process for clients in applying for services;
- Implement a standard waiting list procedure across each CHO which can be consolidated periodically into a national waiting list;
- Introduce a patient specific and outcome focussed assessment process;
- Remove any duplication in services delivered;
- Maximise the utilisation of available resources in each CHO;
- Streamline the management of HCS;
- Standardise operational processes nationally;
- Increase accountability for the delivery of services nationally;
- Focus on the delivery of those services that are the responsibility of the Social Care Division whilst fostering an integrated approach with the Primary Care Division of the HSE in order to ensure that an optimal service continues to be provided to clients.

It is envisaged that the outcome of this initiative will be to improve clinical and management governance and lead to an improved service to clients.

## **8) International review considerations**

As part of this project a review was undertaken of the Home Care Services provided in 14 countries worldwide. This review provided a commentary on:

1. Initiatives being undertaken internationally
2. A movement towards increased freedom & flexibility in service provision
3. Increased adoption of an outcome based approach to services
4. Levels of quality regulation and assurance internationally

Further to this review 14 options were presented for consideration. In line with the above analysis we believe that the following 5 options should be prioritised for consideration:

- Embed home care within the full continuum of care approach
- Combine reablement with step-down accommodation
- Incentivise service providers to adapt their service provision behaviour to ensure retention of their level of service provision to the HSE
- Agree a pathway to home care licensing or regulation

- Enhance the use of information and communication technology

## 2. BACKGROUND

National oversight and management of Home Care Services for older people falls within the remit of the Social Care Division of the Health Service Executive. The services exist to ensure that older people can remain living in their own homes with the support of family, neighbours, friends and carers for as long as is practically possible rather than be admitted to residential care nursing homes.

In this section we firstly determine the position of these services within the HSE and then set out what the provision of these services entails.

### 2.1 HEALTH SERVICE EXECUTIVE

The HSE is responsible for providing Health and Personal Social Services to the population of Ireland. It provides an extensive range of different services, in hospitals and communities, across the country. These services include the provision of care to older people in the community. Delivery of care in the community is now organised across 9 Community Healthcare Organisations (CHOs) and delivered at local level to a population of between 35,000 to 50,000 people. Prior to 2014 the services were organised across 32 Local Health Offices. The service delivery model will change as the new Community Healthcare Organisations network is fully established.

### 2.2 COMMUNITY HEALTH ORGANISATIONS (CHO)

As part of its on-going review of HSE wide service delivery, the HSE published “Community Healthcare Organisations (CHO) – Report and Recommendations of the Integrated Service Area Review Group” Healy Report in October 2014. The report set out the way in which health services (other than those delivered by acute hospitals) would be organised and managed in the future. Community healthcare services – primary care, social care (services for older people and for persons with a disability), mental health and health & wellbeing – would be delivered under a new governance and organisational structure.

The main proposal was that the regional / Integrated Service Area (ISA) structure would be replaced by nine CHOs. The fundamental reorganisation aimed to:

- Improve services by delivering care closer to where people live, with better access and more local decision-making involving GPs and other clinical staff;
- Simplify the process for people who need services from both community healthcare and acute hospitals to receive that care in an integrated manner;
- Appoint a senior manager, working with an identified GP, who will be responsible for ensuring that integrated care is delivered to a population of approximately 50,000 people;
- Achieve a reduction in management structures at a senior level, with new roles and responsibilities achieved by reassigning existing staff.

Each CHO would have a Head of Social Care reporting directly to the Chief Officer of the CHO for service delivery purposes. Each Chief Officer would also have a direct line relationship to the National Director of Social Care’s team for the purposes of activity, resource and finance allocations and reporting purposes.

This organisational change represents an important opportunity for HCS to ensure accountability and responsibility for the delivery of such services at CHO level. The organisational change is vested in a named individual for each of the nine CHOs reporting directly to the Chief Officers to ensure that service delivery processes become standardised nationally.

The revised structure is currently in its early stages of implementation, within the HSE, as are the defined geographical network of services at which the Home Care services will be delivered.



## 2.3 HOME CARE SERVICES

Home Care services incorporates personal and necessary domestic services provided to older people in their homes. The services provided are:

- Home Help Services (HH) (also known as Mainstream services);
- Home Care Packages (HCP).

These services are the responsibility of the Head of Operations and Service Improvement for Services for Older People (SOP) within the Social Care Division of the HSE acting on behalf of the Director of Social Care. The delivery of these services is the responsibility of the 9 Chief Officers of the CHOs.

The service providers are from three areas:

- The HSE;
- Voluntary Service Providers;
- For Profit private companies operating in this sector.

The provision of these services has a basis in law but there is no statutory entitlement to these services. Services are not means tested or 'limited' in any other way, e.g. services are not restricted to medical card holders and there are no arrangements in place to charge for these services.

### 2.3.1 Home Help Services

Home Help services are provided to assist people to:

- Maximise their independence;
- Remain in their own home;
- Support their informal carers;
- Avoid where possible going into long-term care.

In some cases, CHOs are also able to provide a limited Home Help respite care service for carers.

The service provides a number of hours' assistance each week to successful applicants to deliver:

- Personal care (washing, changing, oral hygiene, help at mealtimes);
- Essential domestic duties related only to the individual client (lighting a fire / bringing in fuel, essential cleaning of the person's personal space).

This service does not include nursing or medical care. It is not an emergency service. Persons can apply for the service subject to undergoing a needs assessment. The service is primarily reserved for older people but is also provided, in a limited way, to other people with disabilities and other identified care needs as assessed. The service is fully funded through the Services for Older People budget irrespective of the age of the care recipient. Following favourable assessment, the individual will be provided with the service subject to supply constraints within HSE resources. As per national guidelines the service provided to individual clients should be reviewed on a 6 monthly basis or more regularly if indicated based on assessed needs of the individual.

### 2.3.2 Home Care Package Scheme

The Home Care Packages scheme aims to help people with medium-to-high support needs to continue to live at home independently.

There are two types of Home Care Packages provided by the HSE:

- Standard HCP - inclusive of the Delayed Discharge Initiative (DDI);
- Intensive packages – prioritises delayed discharges and acute hospital pressures providing higher levels of resources than standard HCPs.

The services are provided to clients in their own homes and support is primarily aimed at older people who are:

- I. Living in the community or
- II. Who are in-patients in acute hospitals and are at risk of admission to long-term care, or
- III. Who are in long-term care, but who, with support, could return to limited independent living.

Some younger patients, or those with a disability or mental health issue, may also receive packages where it is deemed appropriate to their needs.

Each CHO has responsibility for the operation of HCPs in their area in line with national guidelines and within their allocated resources. Packages are tailored locally to each individual's needs depending on local demand and supply constraints. Service levels provided can differ across the CHOs as allocated resources to Home Care Services vary. The services provided may include nursing, home helps and therapies (physiotherapy, speech and language therapy, occupational therapy etc.), respite care and aids or appliances. The services delivered will be based upon the assessed client needs and the level of other supports already provided such as Home Help services or informal care by family / friends / neighbours to the client. On that basis there may be an overlap with Home Help services.

The duration of service provision may vary too, depending on an individual client's assessed needs and circumstances e.g. an individual client may be recovering following a hospital admission, recuperating following illness or require a longer-term support for daily living.

The level of service provided to an individual client should be reviewed on at least a 3 monthly basis (or more regularly) after approval for the service as per the national guidelines.

The care needs assessment is not currently standardised nationally. An interim national approach exists whereby (upon client application) a Public Health Nurse or other health care professional (e.g. Community Nurse or Physiotherapist) will evaluate the client's needs using the national guidelines. Following assessment, a Home Care Package may be provided.

Access to the scheme is limited to those who meet the definition of need and applicants are assessed against national guidelines. The scheme is not means tested and there is no requirement for the successful applicants to contribute towards the cost of services.

## 2.4 FINANCING THE SERVICE

Home Help Services and Home Care Packages are funded separately by the Department of Health. Accordingly, the two schemes report their numbers of clients served and costs of provision as separate entities.

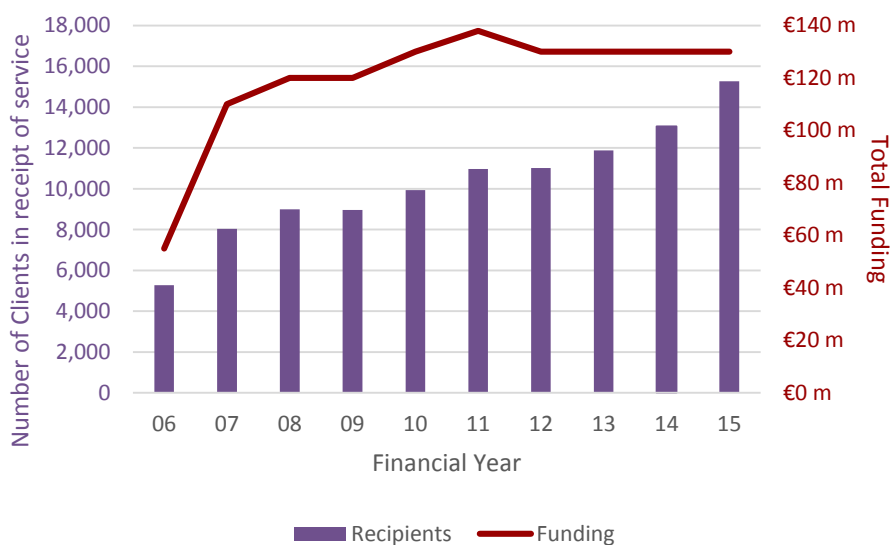
Graph 1 overleaf illustrates the funding provided to and the number of clients using the Home Help Services over the period 2006-2015. The funding provided increased from circa €160m in 2006 to circa €211 million in 2009 and remained at this level for 2010 and 2011. Funding decreased to €185 million in 2012 and remained relatively constant at this level from 2013 to 2015. The allocation for 2016 is €192 million.

The total number of clients quoted are those in receipt of a service at the end of the year. It should be noted that a higher total number may have benefitted from the service at some point during the year.



*Graph 1*  
 Home Care Services “Home Help” funding and numbers served: 2006-2015 – source HCS

Graph 2 shows the relationship between funding received and the total number of clients in receipt of services under the Home Care Packages at 31 December each year. The total number of clients using the service has increased in line with funding increases.

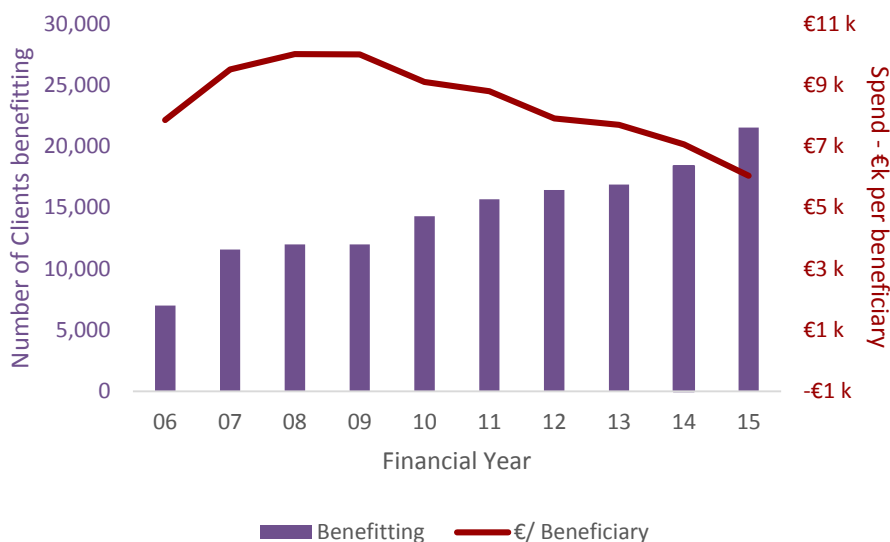


*Graph 2*  
 Home Care Package funding and numbers in receipt: 2006-2015 – source HCS

The total funding of €130m on this graph is made up of Home Care Package funding of €105m and funding for services provided within primary care of €25m. For clarity please note that only €105m of this funding is dedicated HCP funding – with the remainder held in the Primary Care Division allocation.

In graph 3 below the total number of clients benefitting from the Home Care Package scheme was compared with the total available funding to estimate the “spend per beneficiary” for the service. The total number of clients benefitting from the service is defined for the purpose of this graph as “clients

who use or have used the service at any point during the year”. Given that not all clients will still be in receipt of these services at year end, the “number of clients benefitting” from this service figures quoted on Graph 3 are higher than those quoted in Graph 2. This analysis shows that spend per beneficiary has fallen continuously over the period 2009-2015.



*Graph 3  
 Home Care Package funding and numbers benefitting: 2006-2015 – source Home Care Services*

The reduction in spend per beneficiary could be seen as greater efficiency in the deployment of HCP resources (i.e. fewer resources provided to more clients) – however, anecdotal evidence suggests that funding has failed to keep pace with demand.

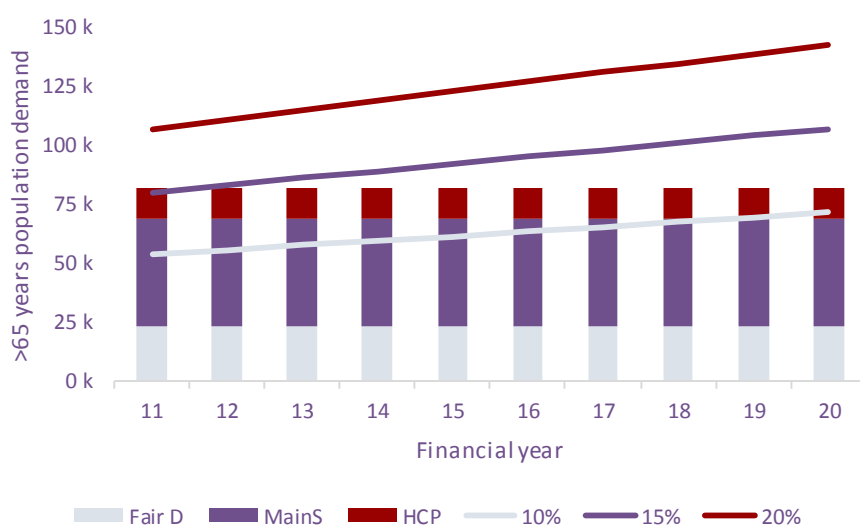
## 2.5 POTENTIAL DEMAND

The Organisation for Economic Co-Operation & Development (OECD), quoted in the Economist Intelligence Unit’s study “Healthcare strategies for an ageing society” (2009) indicates that, in Western Europe, long-term care (including home and residential care) is required for between 10% and 20% of the population aged over 65 years.

At 31 December 2015, HSE figures for individuals in receipt of long-term care were:

- Fair Deal – 23,073;
- Home Help – 47,915;
- Home Care Packages – 15,272 – many of whom are also in receipt of HH services.

When the over-65 years’ population of 535,000 in 2011 (2011 Census) is extrapolated to 2015, by adding a net estimated increase of 20,000 people aged over-65 per year, the approximate population is 615,000 in 2015. The provision of long term care services to approximately 86,000 clients in 2015 equates to approximately 14% of the over 65 population in 2015. The pattern of demand and supply can be graphed 2011-2020 as:



*Graph 4  
 Total number of Older People requiring care over between 2011 and 2020*

This analysis implies that at a 15% population requirement (mid-point assumption – illustrated by the purple trend line on graph 4) a current shortfall in capacity of 6,250 clients (2015) could grow to circa 35,000 by 2020 if no additional resources are provided. If the true demand was 20% of the elderly population, this would imply that 40,000 over-65s in need of a service are not receiving HSE funded long-term care of some description (home-based or institutional) in 2015, and that this gap will widen considerably by 2020 as depicted by the red trend line on Graph 4 above.

It is important to note that the above figures may underestimate the number of people in receipt of Home Care as they do not factor in the private purchase of Home Care and Residential Care or take account of home care provided by carers who have received support through the Department of Social Protection. The emergence of the private own Home Care market in Ireland has been a relatively recent development with particular growth having been experienced since circa 2006 when the Home Care Package Scheme was introduced. Tax reliefs may be available for the purchase of private care in certain circumstances which may encourage those with the capacity to do so to pay for services.

No firm figures are immediately available in regard to the number of people self-funding their home care without reference to the HSE but it is likely to be a significant and growing factor as HSE resources are limited and supply becomes more constrained.

### 3. SERVICE PROVIDERS

#### 3.1 EXISTING SERVICE PROVIDERS

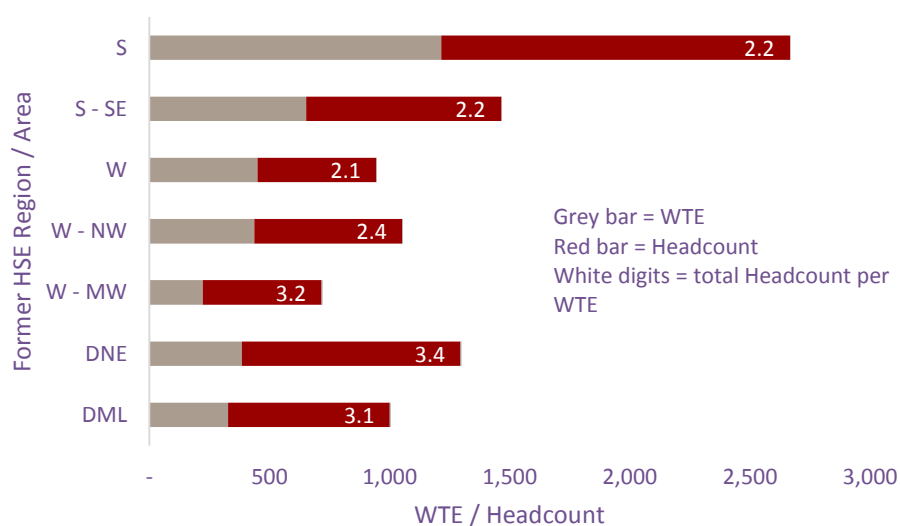
Home Care Services are currently delivered directly by the HSE, by Voluntary Service Providers and by For Profit Service Providers.

All 32 LHOs (now 9 CHOs) and twenty six Section 39 Service Providers were engaged with during the information gathering process undertaken by Mazars.

#### 3.2 OBSERVATIONS ON SERVICE PROVIDERS

##### 3.2.1 HSE Resourcing

There were circa 9,100 home help staff which equals circa 700 whole time equivalents employed in the HSE direct services in December 2014. The geographical spread of these resources is detailed in the table below as per the former HSE Regions/Areas:

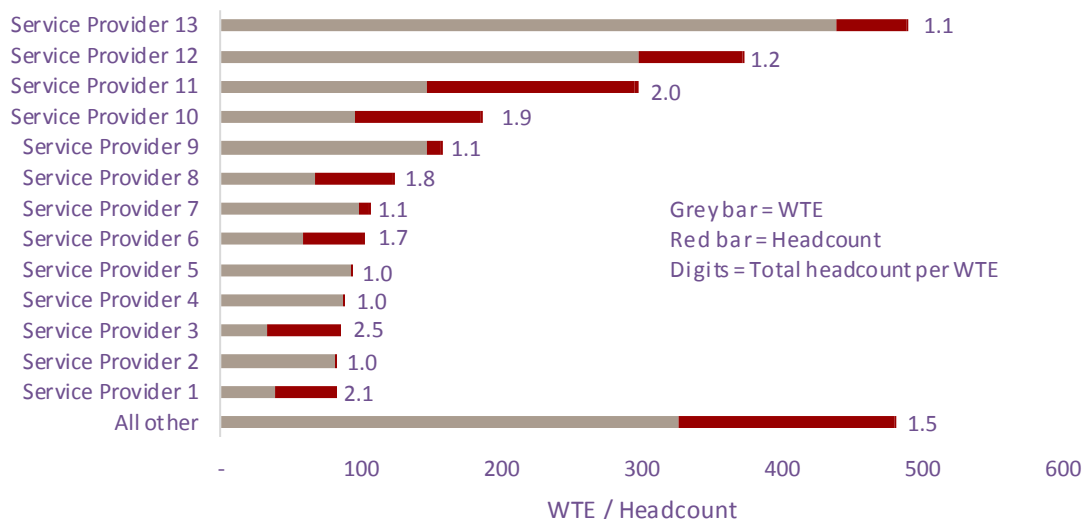


Graph 5: Home Help headcount & WTE: December 2014 – source HSE Corporate Finance

This analysis shows that there is a significant difference in the number of hours worked per head across the country. In the former West Region each Home Help WTE is working approximately 17 hours per week whilst in the DNE Region the comparable figure is circa 11 hours per week.

### 3.2.2 Voluntary Service Providers Resourcing

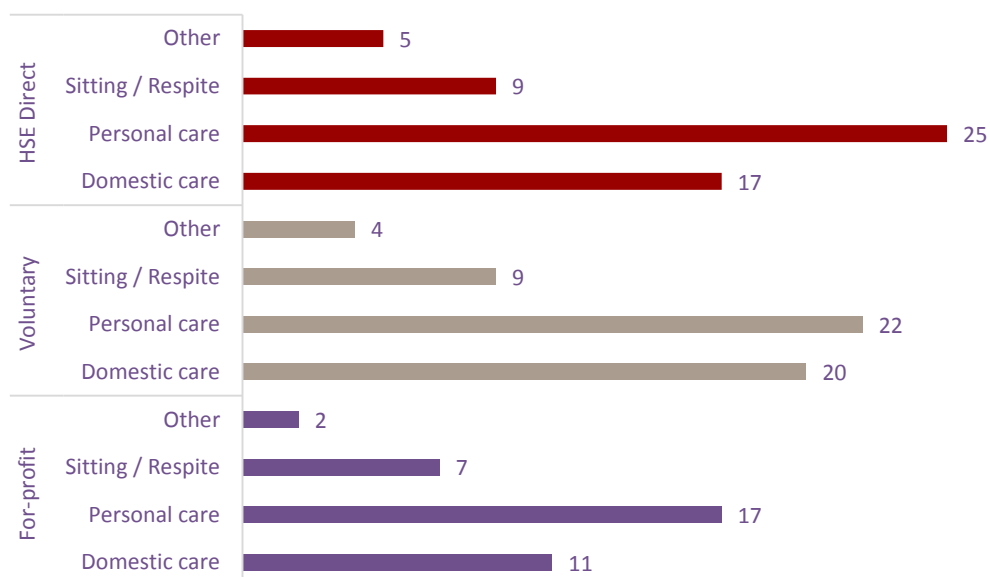
The Voluntary Service Providers return, which was not independently verified by Mazars, indicates that there are more staff working close to standard full time hours within these providers:



Graph 6: Analysis of the number of WTE to Headcount in the Voluntary Service Providers

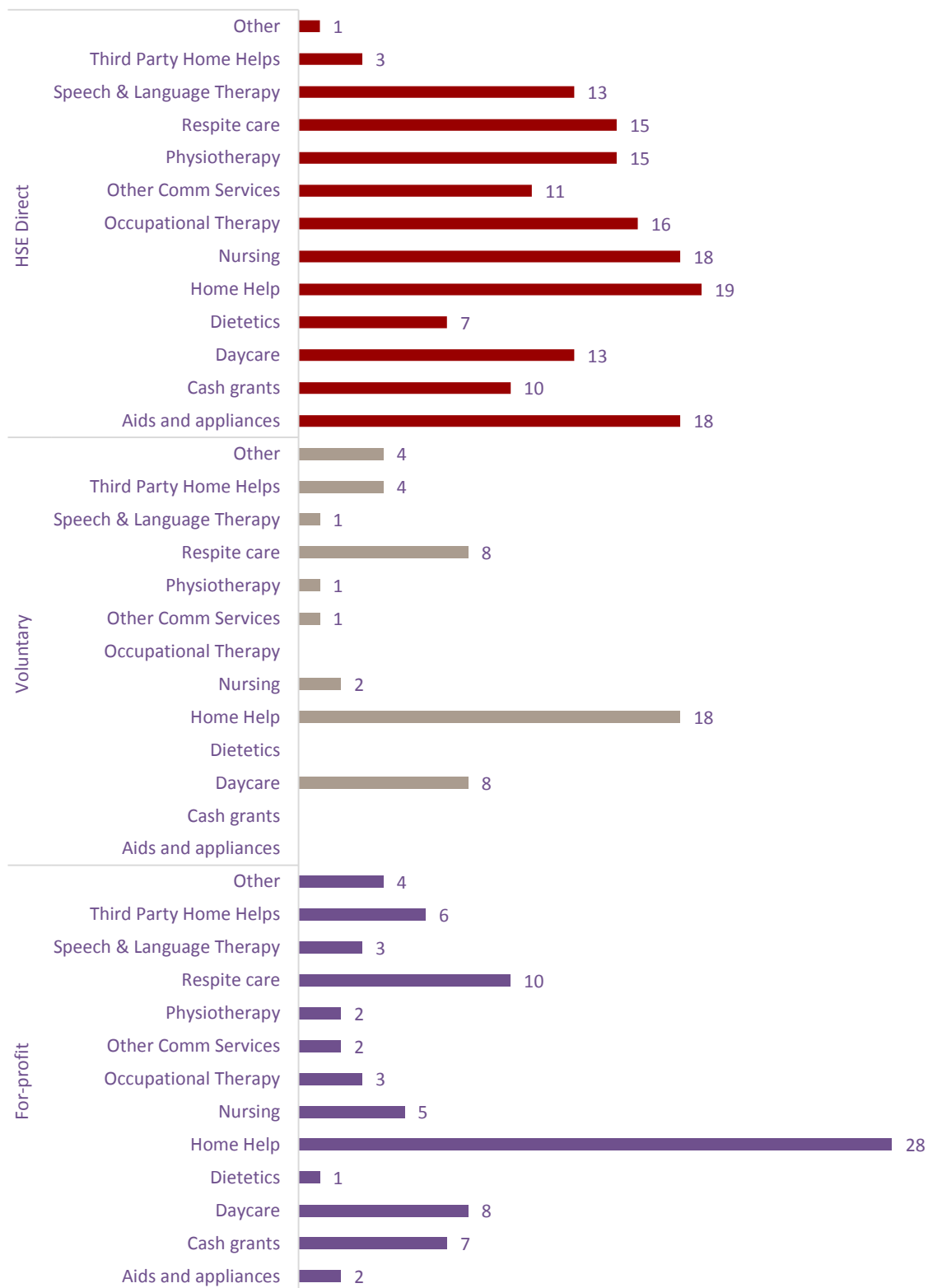
### 3.2.3 Range of Services Provided

The range of services provided in Home Help services was similar for all providers. This analysis highlights that there is a limited provision of Sitting/Respite services reported.



Graph 7: Analysis of the range of services provided by Service Provider Category in HH

For Home Care Packages the differences in the array of services delivered was much broader. The range of HSE direct services was more varied when compared to the other providers. It should be noted that there is a greater focus on respite and therapy in the HSE direct services than in the Voluntaries/For Profit providers which is to be expected:



Graph 8: Analysis of the range of services provided by Service Provider Category in HCP



In the Voluntary sector, the survey identified the provision of other services in addition to the standard Home Care Services. The survey did not identify if these additional services are HSE funded. These services include social centres, meals on wheels, alzheimer’s/dementia care, palliative care, day care, rehabilitation, transitional care, respite care, short term residential care and long term residential care.

The extent of service offerings is determined by staff availability, which is influenced by:

- Reported shortages, in some CHOs of therapy staff (i.e. Physiotherapists, OTs, Speech Therapists)
- For-profits organisations -reporting difficulty in attracting and retaining staff
- Voluntary organisations -reporting difficulty in retaining staff
- Particular services being time-of-day specific (e.g. personal service, such as helping a client to wash and dress) requiring more individual carers as opposed to hours of care from the existing establishment

### 3.2.4 Limits on Service Provision

The results of our consultations indicate that limits on service provision are not consistent nationally.

In the Home Help service one third of respondents indicated that there were no limits on service provision within their CHO. Although the service guidelines include a notional limit of five hours of HH services Mazars noted that upper limits of 10 hours and above were reported in 6 CHOs.

In the Home Care Packages scheme circa 66% of CHOs have upper limits on service provision in place. National guidelines suggest €525/week as a financial limit which equates to approximately 21 hours. However, this is not consistently applied and it is noted that limits are dictated locally by existing resource constraints and growing demand rather than being applied consistently on a national level.

### 3.2.5 Availability of Out of Hours Services

Mazars sought to identify which of the service providers provided out of hours services. The trends that emerged were:

- Weekend cover is much more prevalent than night cover
- Night cover is not provided by HSE direct
- Night cover is only provided in a small number of areas

CHO	Weekend			Night Cover		
	HSE	Voluntary	For-Profit	HSE	Voluntary	For-Profit
1	✓	✓	✓	X	✓	✓
2	✓	✓	✓	X	X	X
3	X	✓		X	X	
4	✓			X		✓
5	✓	✓	✓	X	X	X
6	✓	✓	✓	X	X	X
7		✓			X	
8	✓	✓	✓	X	X	X
9		✓			X	

Table 1: Summary of out of hours services being provided by CHO

### 3.2.6 Improving Services

A number of suggested improvements to service provision, some of which are already operational in individual areas, that could be rolled out nationally include:

- The use of uniforms and name-badges for Home Help staff
- Deployment of a formal complaints register, with codified follow-up procedures
- On-line or app-based sign-off facility for staff to obtain confirmation of service delivery from clients in their homes
- IT based recording of attendance to support the subsequent generation of payments

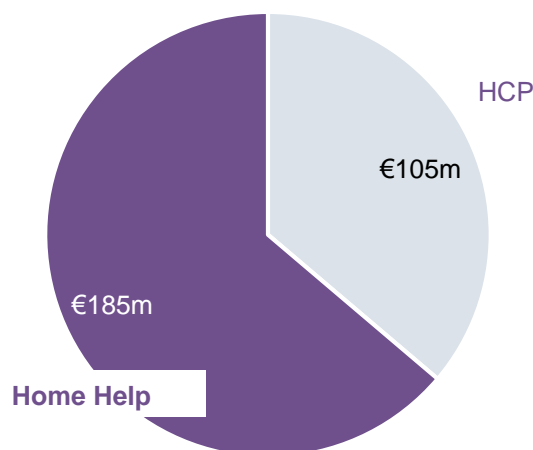
## 3.3 RECOMMENDATIONS

1. Consolidate the multiple means of capturing HSE staff actual hours' data – some are captured direct from payroll and others from independent lists. Introduce a standard system that interfaces with the different payroll systems of the HSE.
2. Review the data capture systems relating to mobile staff and consider the introduction of a time recording system to capture actual time spent with clients.
3. Implement a standard rostering system to support compliance with recent EU Directive on working time.
4. Implement a system that will capture staff time as a resource input for reporting purposes. Time recorded should be categorised as client facing, travel, administration, leave, sickness, training and other.
5. Introduce a conversion ratio for performance reporting, comparing staff hours' inputs with the resultant client-facing hours.
6. Create a standard staff database recording contracted and actual hours of staff inputs, capable of national consolidation.
7. Remove the anomalies between the provision of Home Help Services across individual CHOs (and networks within CHOs). Services for Older People needs to decide upon a balance between national guidelines / standardisation and local delegation / autonomy. In Mazars' opinion, there should be national minimum standards where the CHO's are accountable on provision, delivery and cost where additional services are provided.
8. Address-cost effective service improvement issues that can be introduced in the short term to improve the quality and perception of the service.
9. Establish whether the limits on hours of service designated as Home Help are appropriate and seek to standardise services across all CHOs.
10. Seek to remove the inconsistency in the availability of night and weekend services nationally – this will require guidelines on the minimum standard of service available.
11. Re-evaluate the Department of Health's requirement to differentiate between Home Help and Home Care Packages when reporting, given the apparent overlap that exists between the services, in order to address the administrative and financial reporting issues that are arising. An amalgamated home care service would have benefits for clients too as it would provide a home care service that is easier to access and navigate.

## 4. SERVICE FUNDING

### 4.1 EXISTING FUNDING ARRANGEMENTS

The funding for Home Care Services in the HSE 2015 budget was circa €290m. The funding split between Home Help Services and Home Care Packages is illustrated by the graph below (excludes HCP funding within Primary Care Division):



Graph 9: All HCS services: HSE 2015 budget

The Social Care Division of the HSE distributes these funds to the CHOs.

There are two additional sources of service available for Home Care Services clients within the HSE:

#### 1. Primary Care

Nursing and therapy services provided to clients either as part of a community service or specifically allocated as part of a HCP are resourced and funded predominantly via the Primary Care budget. In the case of HCPs, any allocation of nursing and therapy time (normally on a specific intervention basis) is subdivided between that deemed to be provided for within existing “mainstream” Primary Care services (the first two hours of such services) and additional amounts over-and-above mainstream, which may lead to an indirect charge between Primary Care and HCS.

#### 2. Transferred funding

In financial years 2007/08, a number of positions were identified as Services for Older People Development Posts and funding was allocated to Primary Care within the LHOs for provision of services. These services included:

- Posts relating to the delivery of HCPs – circa 170 WTE
- Posts relating to the delivery of HH services – circa 40 WTE

These positions are still required to deliver services to Older People through Primary Care. The funding is made available through the Director of Primary Care.

## 4.2 OBSERVATIONS ON SERVICE FUNDING

### 4.2.1 Reporting

Financial performance by channel of delivery (i.e. HSE, Voluntary and For-profit) and category of care (Home Help /Home Care Packages) is not currently reported in a consistent manner.

In the table below we have set out a suggested reporting format that could be used to show the national picture by service and by CHO against budget at a given time and which could be adjusted to reflect an overall home care funding approach:

CHO #	Mainstream		HCP			Total	
	HSE	Vol	HSE	Vol	FP	BUD	OT
	Var €m	Var €m	Var €m	Var €m	Var €m	Var €m	Var €m
CHO 1	0.3	0.3	0.6	0.1	-0.8	10.0	0.5
CHO2	0.7	0.0	-0.1	0.0	0.0	10.0	0.6
CHO3	0.7	0.0	-0.1	0.0	0.0	10.0	0.6
CHO4	-0.9	0.0	-0.8	0.0	0.0	10.0	-1.7
CHO5	-1.3	0.0	-0.7	0.0	0.0	10.0	-2.0
CHO6	0.3	-0.2	0.0	0.0	0.8	10.0	0.9
CHO7	-3.3	-0.3	0.0	0.0	1.1	10.0	-2.5
CHO8	-1.5	0.7	1.1	1.6		10.0	1.9
CHO9	-2.2	1.2	-0.6	-0.3	1.8	10.0	-0.1
<b>Total</b>	<b>-7.2</b>	<b>1.7</b>	<b>-0.6</b>	<b>1.4</b>	<b>2.9</b>	<b>90.0</b>	<b>-1.8</b>

Table 2: Estimated financial performance by new CHO

This approach has the advantage of bringing together into a single report:

- Delivery organisation
- Channel of provision
- Category of spend
- Budget
- Actual performance and variance against plan

### 4.2.2 Financial Processes

The surveys carried out indicated that the costs in relation to the HH & HCP funded services are identified through direct coding in the HSE and through invoices for HCP in the Voluntaries and For Profit Service Providers. This suggests that the Services for Older People rely on their own coding or that of colleagues elsewhere in the HSE to ensure that the correct staff hours are charged to these services. The HSE must ensure that the costs for the Voluntary Service providers and For-Profit Service Providers are adequately verified prior to being approved and posted within the finance system. This verification will ensure their legitimacy and facilitate a full understanding as to the nature of the costs incurred. These costs can then be recorded in a fashion that allows comparability across service providers including the HSE. The risk is that at present the costs incurred are not being correctly coded given the complexity of the processes involved across Home Help services and the Home Care Packages scheme.

Controls on overspending tend to centre around after the event month end reporting rather than pre-allocation controls which may reduce the prevalence of overspends.

### 4.2.3 Separation of charging

Although the provision of HCS is broadly integrated, the process of accounting for HH and HCP is separate owing to the distinct funding lines for each service in the HSE. A uniform accounting approach would allow both services to compare the services being provided to each individual client. This would enable both services to work together to remove duplication of effort and identify potential economies and savings with a view to providing a more efficient service with fair access levels for all service users.

Discussions held throughout this process indicate that significant difficulties arise as regards allocation of costs when the accounting for both services is separate. Mazars are of the view that the home care service should be amalgamated and funded as a single home care service for older people.

### 4.2.4 Financial Contribution from Clients

At present there is no mechanism to seek a financial contribution from clients towards the services being made available to them in cases where a client is deemed to be able to afford such a contribution. Mazars note that currently there is no basis in law to introduce charges of this nature.

### 4.2.5 Voluntary Service Providers

At present 80% of the Home Help voluntary sector funding is provided to 14 Voluntary Service Providers. There is an expectation that economies of scale will occur in the larger service providers on the assumption that the unit cost of providing the service will decrease when the number of clients serviced increases. In practice the analysis showed that when hours of provision were measured against unit costs that the unit cost did not decrease when the total level of services provided increased.

## 4.3 RECOMMENDATIONS

1. Unify the Home Help and Home Care Package budgets and processes into a single home care funding arrangement with appropriate governance and accountability, agreed KPIs and standard processes. This would greatly simplify the current complex arrangements both for the HSE and more importantly for clients of the home care service.
2. Ensure that the financial reporting process allows for the differentiation between the various service providers (i.e. HSE direct, Voluntary and For-profit), rather than focus upon CHOs (currently) and category of care (HH / HCP). The structure of the financial reporting should be updated to include an agreed number of variables such as patient category, channel of provision, geography, variances against budget.
3. Utilise available live data in helping to understand performance. Much of the control process around financial reporting is currently after-the-event, usually monthly in arrears.
4. Finalise the position re Home Care Package resources allocated to Primary Care and the use of such funding within Primary Care.

## 5. GOVERNANCE

### 5.1 EXISTING POSITION

Mazars reviewed the processes underpinning the Home Help and Home Care Package services and noted that the processes are broadly similar in nature. During the course of their work with the CHOs, Mazars sought to understand how the governance of these processes works on a practical level and the level of consistency in governance on a national level.

### 5.2 OBSERVATIONS ON GOVERNANCE

#### 5.2.1 Clinical Governance

In reviewing the clinical structure, Mazars sought to establish whether each individual employee providing care to clients receiving either HH, HCP or both services reports into a senior health professional. The survey illustrated differing results between HH and HCP, with more clinical oversight in the latter.

Nine different categories of personnel were named as being the responsible staff member across both services:

Designation	Mainstream	HCP
General Manager	6%	3%
HCP Manager		3%
HHCs and PHNs	3%	
Home Help Manager	3%	
Manager of Community Services for Older People	6%	
MSOP		9%
Operations manager		3%
Professional line manager		3%
Public Health Nursing	38%	50%
Report clinical issues to PHN then HHC	6%	
Reporting obligation to Public Health Nurse		3%
SLA / Review meetings	6%	16%
<b>Subtotal - assigned governance</b>	<b>69%</b>	<b>91%</b>
No HSE Manager with clinical governance responsibility	16%	9%
None - ad hoc basis with PHNs	16%	
<b>Subtotal - no assigned governance</b>	<b>31%</b>	<b>9%</b>

Table 3: Reporting channels for clinical governance in HH and HCP

A member of Public Health Nursing was the most often cited responsible staff member.

## 5.2.2 Reporting lines – Non-Clinical governance

Non-clinical services report more nominated staff in positions of authority, but again, there are multiple categories of personnel.

Designation	Mainstream	HCP
General Manager	6%	6%
HCP Manager	0%	3%
HHC	22%	16%
Home Help Manager	6%	0%
Home Support Manager	13%	16%
Line Manager	0%	3%
Manager of Community Services for Older People	6%	0%
MSOP	31%	31%
Operations manager	0%	3%
Public Health Nursing	3%	3%
SLA / Review meetings	6%	19%
<b>Subtotal - assigned governance</b>	<b>94%</b>	<b>100%</b>
None	6%	0%

Table 4: Reporting channels for non-clinical governance in Home Help and HCP

The Manager of Services for Older People (MSOP) was the most-often cited responsible staff member.

## 5.2.3 Support Structure

Mazars sought to understand how the front line staff are supported on a day-to-day basis to deliver services. The individual CHOs were requested to advise the total number of client facing/clinical staff in the service and the total number of support staff that they had dedicated to supporting the client facing/clinical staff.

The results show that there are an average of 19 client facing/clinical staff to every support staff member, although these results vary widely across CHOs. Mazars noted that there are opportunities for economies of scale, in the area of support staff, in locations where there are larger numbers of client facing/clinical staff as the number of resource staff should not increase incrementally.

## 5.2.4 Accountability

Mazars sought to establish who in each CHO was responsible for managing client numbers, financial results, staff deployment and staff numbers and performance reporting.

The results demonstrated that:

- Staff within Services for Older People had most responsibility for Client Numbers, Staff Deployment and Performance Reporting oversight;
- Responsibility for Finance was more evenly spread across Finance, Operations, SOP and Administration;
- Over 20 different job descriptions nationally were cited as having these responsibilities;
- Only one of the job descriptions reported by service providers, that of the Manager for Services for Older People, covers each of the responsibilities listed above;
- The responses were not consistent across the CHOs.

### 5.2.5 Audit / Inspection

Further to the analysis undertaken it is clear that there is a lack of consistency as regards the frequency of audits and/or inspections being conducted on services nationally. There are further inconsistencies between HH Services and HCPs and within those service lines, between those services being provided by the Voluntaries and For -Profit Service Providers.

### 5.2.6 Performance of Client Reviews

In the Home Help services it is anticipated that six month reviews are undertaken and in the Home Care Packages scheme reviews are intended to be undertaken within three months of the services being provided to each client. The responses received from the CHOs in this regard were incomplete and varied significantly by region.

Mazars further noted that the review processes are not consistent across the system.

### 5.2.7 Staff Training and Appraisal

Training appears to be more prevalent for HSE staff however an annual assessment of staff and their performance is more common for the staff in the For-Profit and Voluntary Service Providers.

### 5.2.8 Governance of Voluntary Provision

The devolved nature of the governance relating to provision of services under Section 39 (i.e. annual service level agreement (SLA); contracted hours of service provision and number of clients) places emphasis not only on the regular liaison between HCS, Primary Care and the individual Voluntary organisation, but also on the formal governance arrangements (e.g. review meetings) as part of the SLA. Responses to queries posed by Mazars indicate that 46% of the Voluntary Services Providers only meet with the HSE on a six monthly or annual basis.

## 5.3 RECOMMENDATIONS

The existing guidelines for Home Help Services and Home Care Packages do not provide sufficient clarity on the governance structure: they have either a single line manager, or managers, responsible for HH and HCP separately (for HCP, it is not clear if the manager responsible should report to the same person, as for HH services, or not). The process of service provision is now assessed, using a combination of the responses to the survey and answers provided to the clinical governance survey performed in autumn 2014. Based upon the guidance available and the issues noted at each service provision process stage our recommendations are to:

1. Introduce a standard application form for home care and a set of nationally set timelines for process completion. These timelines should be monitored for compliance. Implement standard procedures in terms of operational processes, quality guidelines, monitoring and consumer feedback to support a centrally funded home care service.
2. Introduce a standardised assessment tool nationally (SAT). Mazars note that a standardised test/standard assessment tool (SAT) is currently being trialled and rolled out. Consideration should also be given to who should be carrying out the assessment. It is understood that assessments are currently carried out by nursing staff and there is a suggestion that assessment waiting periods could be addressed if therapists could also undertake assessments.
3. Designate overall responsibility for approvals to individual managers in each CHO. Multiple manager approvals are causing delays in the system. Funding budgets should be equally distributed throughout the financial year to ensure that there is no bias towards applications being made at different times during the financial year.
4. Monitor the level of resources that are provided to a client. Where the client cannot be provided with their assessed level of resources, establish a process to ensure that the client is provided with their assessed level of resources over time as further resources become available. This requires careful and active management of the waiting lists.



5. Reach a national consensus on the use of waiting lists. Mandatory introduction and reporting of waiting list numbers aged in terms of waiting time, for Home Care services should be introduced as a key performance indicator for the service.
6. Consistently monitor on-going supervision of service provision for all CHOs on a national basis. This will involve standardising responsibility for governance, quality control, client care and the process for the day-to-day administration of the service. HSE should insist that, as part of funding arrangements for external providers that specific staff positions are provided to ensure governance and control of service provision.
7. Roll out a mandatory standardised national review process for Home Care recipients. All reviews should be appropriately recorded, such that any CHO should be capable of passing a snap audit of such records.
8. Focus on implementing a demonstrably objective review process which is undertaken for all patients on a regular basis and which can address resistance displayed by client's relatives where services are reduced because a client has a reduced need.
9. Engage early with the external providers, in order to help them understand the impact of any service improvements being implemented giving them an opportunity to be proactive and to commit to working with the HSE to achieve an improved HCS.

## 6. SYSTEMS AND MANAGEMENT INFORMATION

The common foundation of all the phases of this project is the data that is currently available to the HSE. This information is stored on local systems within the HSE and within the Voluntary Service Organisations and is reported centrally on a periodic basis and consolidated to provide data on the service nationally.

### 6.1 EXISTING POSITION

The recording and monitoring of client data is an essential element of the management and control of the Home Care Services. The existing approach to reporting requires the completion of a Performance Report Dataset Template – one for Home Help, one for Home Care Packages – each month by each CHO. The template is then emailed to the Services for Older People Divisional office.

The data collected includes:

- Numbers in receipt of services;
- Channel of provision (HSE direct or indirect for Home Help; HSE direct or indirect for Home Care Packages);
- Identification of new Home Care Package cases;
- Waiting lists for Home Care Packages;
- Care Group (other than Older People) for Home Help;
- Financial data: Budget / Actual by Pay / Non-Pay.

The data collected feeds into the national performance indicator system for the HSE, and is also reported through the Corporate Information Facility (CIF) system.

Measurement of client activity (i.e. the number of clients in receipt of either the HH or HCP service during a period) is achieved through a seven-step process.

1. Original paper or system recording of various client assessments, consent and personal details;
2. Transposition / recording of client data in a primary data system, and subsequent updating of the record;
3. Period-end analysis of population data;
4. Transposition of data to Excel-based data collection templates;
5. Communication of results to the National Office – Services for Older People;
6. Collation and consolidation of results;
7. Reporting of activity.

The reporting system is:

- Dependent upon a number of systems which are not interlinked;
- Work-generating, in that data obtained through a primary system is subsequently re-keyed;
- Prone to error – due to data being re-keyed;
- Not conducive to drill-down for further analysis, with data being provided only in summary format.

## 6.2 OBSERVATIONS ON THE DATA CURRENTLY BEING GATHERED

Further to its research, data collation and its consultations with the HSE, For-Profit and the Voluntary Service Providers, Mazars make the following observations in relation to the quality and the consistency of the data that is being provided to the HSE:

- 1) There is no consistency across the service providers on where the data reported to the HSE is sourced from. This data is mostly sourced from the individual service providers' proprietary databases. Each of these proprietary databases are different and are not integrated.
- 2) There is no common analysis tool in place across the service providers. Microsoft Excel is the most commonly used tool but this is used for different purposes across different organisations.
- 3) The local data recorded by the CHOs contains many common items which are useful for the creation of a national data set.
- 4) National guidelines state that the basis of counting the number of active users of the service should be the "persons in receipt of the service on the last day of the month". This approach has not been adopted consistently across the former LHOs now CHOs.
- 5) The frequency of returns being provided nationally is inconsistent as certain service providers are returning four weekly rather than monthly returns. On that basis the returns are not co-terminus.
- 6) There is considerable variation as to who is responsible for reporting across the service providers.
- 7) Across the 9 CHO s, 21 out of the 32 former LHOs indicated that they would be willing to remit their databases directly to the divisional SOP office to facilitate national consolidation of information

## 6.3 RECOMMENDATIONS

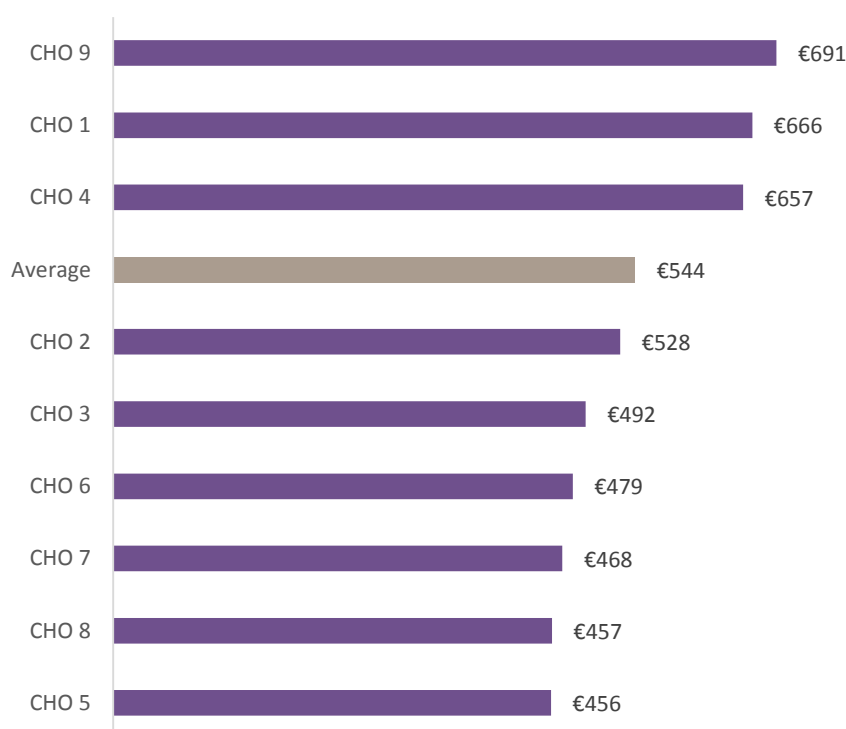
1. Create an integrated database which will form a single information technology platform. It is intended that this database would bring together the rostering of staff, client details, the assigned resources and allow for the association of staff time worked with time spent with individual clients.
2. Introduce a unique identification number for all HCS clients.
3. Design an excel or database system for each CHO as an interim measure whilst the integrated national database is being developed as a variety of databases, spreadsheets and documents are currently used to collate and analyse client data.
4. Ensure that the new integrated database is designed to capture the requisite data to enable the identification of all service users at any point in time at national and local level.
5. Specify that the integrated database identifies the joiners and leavers for any period and will be in a position to distinguish the individual joiners and leavers at any given time.
6. Ensure that the integrated database collates the quantum of service consumed by clients, expressed as allocated resources. This measure is important as a performance indicator to understand the conversion of inputs (staff time) to client outputs (services provided) and to detail how long an individual client has been using the service
7. Define a standard data structure for the capture of primary client data as currently the CHOs capture a variety of data items for clients in their databases, but not on a consistent basis.
8. Standardise the reporting periods used for submissions to a monthly reporting cycle across all CHOs.
9. Allocate responsibility for the collection, collation and reporting of numbers to a management position across all CHOs going forward.
10. Source financial data from the Corporate Finance System going forward and ensure that it is reviewed for accuracy by the individual CHOs.
11. The assessed needs of clients "not provided for" should be formally monitored and reported on a regular basis.

## 7. RESOURCE ALLOCATION

### 7.1 EXISTING ALLOCATION

When taking the 2015 HCS budget as a starting-point, and comparing it to the over-65 years' age population (using the 2011 Census data) in each CHO, it can be seen that there are significant variations in the annual funding received by the CHOs on a funding/per head of population basis.

As a result, the existing allocation of funds to each CHO does not necessarily mirror the size and level of dependency of its constituent population. When graphed, the disparity between highest and lowest funding per head of the over-65 years population is quite pronounced:



*Graph 10: Funding of CHOs per head of population aged over 65 years*

The existing allocation is a consequence of historical funding. As additional funding is provided it's allocation is being targeted to bring equity to the CHO split of resources over time.

Other things being equal, the intention of any Resource Allocation Model (RAM)-based approach to funding should be to bring all funding in line with an agreed parameter (in this case, population) – or modified version thereof. Total funding should, therefore, be the same per head of population served in each CHO.

### 7.2 RESULTS OF RAM

Graph 11 summarises the impact of the RAM, based upon population which would give rise to a shift in funding to CHOs 5-8 from CHOs 1, 4 & 9. However, this reallocation of funds needs to be carefully considered as it does not take account of other factors that may impact on demand and the requirement for home care such as availability of long stay beds, short stay community support beds, and other community supports for older people such as day care.



Graph 11: RAM re-allocation by CHO: Green bar = funding gain; red= funding loss

### 7.3 IMPLEMENTATION OF NEW APPROACH

There are at least five approaches that HCS could take in implementing RAM in its budget process - each being, progressively, more prescriptive:

1. **Do nothing** – simply ignore the outcome from the RAM process. This is only an option where no alternatives exist (probably due to restrictions on funding): in reality, any piece of analysis that reveals significant imbalances in resource allocation cannot be ignored. This is not a viable option for HCS, other than if it is imposed upon it.
2. **Macro-geographical** – on the basis of calculations, reallocate funds at CHO level (inter-CHO differences are smaller than those at former individual LHO level) immediately – leaving the working through of specific former LHO differences to the individual CHOs to remedy. The risk with this approach is that individual CHOs may not deliver reductions to plan as it is unlikely that any CHO would fail to spend additional sums if they are made available to them.
3. **Gradual** – accept that the RAM allocations to CHOs are a future target, and make all financial allocation decisions in line with such an approach. This would mean no future allocation of additional funds to CHOs which are deemed “over-allocated” by reference to other CHOs in 2015 as any additional resources would be targeted at notionally “under-funded” CHOs only. This approach has the disadvantage of being both slow and contingent upon other processes (e.g. availability of additional funding).

4. **Phased** – a planned approach to moving funds from the over-funded to under-funded CHOs over a period of three to five years. Although this option provides more certainty of outcome, results will still be “eventual” and subject to short-term distortion of priorities which would add to the eventual timeframe
5. **Radical** – enforce as much change as possible in the shortest feasible time through an internal market approach. An internal market approach where the budget set is provided using RAM, runs the risk of double-spend if the additional spend in one CHO is not offset by reductions in other CHOs.

## 7.4 AREAS TO BE ADDRESSED

1. Agree on the approach to introduce a resource allocation model on a phased basis and having taken into account the other support services outlined allocate any additional resources secured based on the greatest need and population demographics.
2. Communicate progress in rebalancing resourcing of services along need/population lines with staff.

## 8. FINDINGS FROM THE REVIEW OF INTERNATIONAL MODELS OF SERVICE DELIVERY

### 8.1 INTRODUCTION

As part of the broader review of Home Care Services, Mazars undertook a review in early 2015 of the delivery models for these services in Ireland and across 14 countries internationally.

The developments in and characteristics of each of the following countries were reviewed:

1. England
2. Northern Ireland
3. Scotland
4. Austria
5. Denmark
6. Finland
7. Germany
8. Italy
9. Norway
10. Sweden
11. Canada
12. USA
13. Australia
14. New Zealand

These countries were selected for inclusion in this report on the basis of a number of criteria:

- a) Relevance to / similarities with the Irish healthcare system;
- b) Availability of accurate / comprehensive information;
- c) The inclusion of innovative approaches to deliver cost effective and high quality, accessible care.

### 8.2 REVIEW METHODOLOGY

For each of the countries reviewed we sought to understand:

1. Their definition of Home Care;
2. The Home Care services provided;
3. Specific initiatives being undertaken on Home Care services;
4. The strengths of their service;
5. The weaknesses of their service.

The following table sets out the key findings of this review:

CHARACTERISTIC	EUROPE									REST OF WORLD		
	IRELAND	AUSTRIA	DENMARK	ENGLAND	FINLAND	GERMANY	ITALY	NORWAY	SWEDEN	AUSTRALIA	CANADA	NEW ZEALAND
<b>Provider Mix</b>												
- Public Provision	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Private Provision	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
- NfP Provision	Yes	Yes	N/A	No	Yes	N/A	Yes	No	No	N/A	Yes	Yes
<b>Provision Dominated by Public Providers</b>	Yes	No	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	No
<b>Direct Payment / Home Care Vouchers Approach Available</b>	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	N/A
<b>Standardised Assessment</b>	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
<b>Quality Management</b>												
- National Regulation Criteria	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No
- Regular Inspections	No	No	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	No
<b>Means Tested</b>	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
<b>Eligibility Criteria</b>	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Governance divided over more than 1 Ministry</b>	No	Yes	No	No	No	No	Yes	No	No	No	No	No
<b>Public Funding Mechanism</b>												
- Taxation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Social Insurance	No	No	No	No	Yes	Yes	No	No	Yes	No	No	No
- Health Insurance	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes



## 8.3 SUMMARY FINDINGS

### 8.3.1 Initiatives Being Undertaken

Reform programmes are ongoing within most of the countries considered. Typically, these reforms stretch beyond the traditional provision of home care services and incorporate all/most facets of the model of care for older people. For example, Australia is in the process of redesigning services using the *Living Longer Living Better* aged care reform package.

The Australian Government is expanding home care significantly to assist older people to remain living at home, and to introduce more choice and flexibility for people receiving care at home. The Government has committed to increasing the total number of Home Care Packages from around 66,000 to around 100,000 by 2017. A further 40,000 additional packages are expected to be available over the following five year period, from 2017-18 to 2021-22. Since 2013, all new Home Care Packages are delivered on a Consumer Directed Care (CDC) basis.

CDC is a way of delivering services that provides consumers with greater control over their own lives by allowing them to make choices about the types of care and services they access and the delivery of those services, including who will deliver the services and when. Under a CDC approach, consumers identify goals, which could typically revolve around independence, wellness and reablement. These in turn then form the basis of the care plan.

The consumer also decides the level of involvement they wish to have in managing their package, which could range from involvement in all aspects of the package (including co-ordination of care and services) to a less active role in decision-making and management of the package. Care plans and care arrangements are subject to ongoing monitoring and a formal re-assessment by the provider, at least every 12 months to ensure that the package continues to be appropriate for the consumer.

The Australian system has also prioritised the establishment of a more consolidated approach to service delivery. A new Commonwealth Home Support Programme (CHSP) is being established and will bring together a number of related service lines including home care, respite care and day care services. The ambition is to offer one consolidated point of entry for all service users to the Australian aged care system.

The COSE project in New Zealand takes a similar approach to the coordination and case management of services. It involves placing a dedicated key worker with responsibility to liaise with a broad mix of healthcare professionals on behalf of each service user as a means to provide a coordinated approach to service based delivery.

Equally, the PACE programme in the US has successfully provided a continuum of care approach for older people with chronic care needs. With a footprint in 31 US states, PACE has had a strong role in influencing the US approach to home care provision since the 1980s.

While the Canadian approach tends to vary by province / territory, it too applies a core focus on integrating home care with other related components of the healthcare system. A number of strong examples exist such as the CHOICE<sup>1</sup> Programme in Alberta. Established and operational since 1996, CHOICE provides a variety of supports for citizens with multiple health problems with the objective to avoid / delay hospitalisation or admission to long term care. PRISMA and Ontario's Home at Last Programme offer further examples of integrated care and collaboration across traditional service boundaries. PRISMA has been adopted in a number of regions across Quebec and is highly regarded throughout Canada, given its successes associated with reductions in Emergency Department admissions and reductions in the preference of participants to move to long-term residential care. Like the CHSP in Australia (above), PRISMA too offers a single point of entry and a collaborative approach to case management / care planning.

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<sup>1</sup> Comprehensive Home Option of Integrated Care for the Elderly

### 8.3.2 Movement Towards Increased Freedom and Flexibility

Ensuring that the service user has more freedom and flexibility to choose how and when they receive support is a key objective of the Scottish Social Care Act 2013. The Act places the individual firmly in the centre of the decision-making approach as regards the range and timing of services assigned within a care plan. The 2011-2021 Programme for Change commits to double the total spend on care in the home for older people over the lifetime of the plan. The Programme includes a number of other interesting commitments including: (1) assigning an enhanced role to long term residential care units for the delivery of rehabilitation, intermediate and short-term care, (2) ensuring that older people are not admitted directly to long-term institutional care from an acute hospital, and (3) offering all people over 75 years of age a telecare package.

The Danish approach is guided by an '*as long as possible in own home philosophy*' and is widely recognised as a leader in making the shift from institutional care to community-based care. A proactive approach has been taken to early preventative measures, including an annual prevention home visit to all citizens aged 75+ years. Danish research confirms that this has offered a cost-efficient approach to reduce admissions to hospital / long term residential care. A further interesting characteristic of the Danish approach is the use of a 'provision contract' as part of the needs assessment. The care approach / mix of services is outlined against target goals or outcomes for the service user. In addition, the contract in some cases affords the home care worker the flexibility to vary care provision according to daily / weekly needs rather than adhering strictly to a set number of hours at prescribed times each week.

This increased level of flexibility is also a feature of the service delivery model in New Zealand. A large proportion of the contracts in place between the District Health Boards and third-party providers have already moved away from fixed tasks and hours to a more flexible approach where the core focus is on supporting the service user to maintain or improve independence (although this has an impact on planning the delivery of services). Most District Health Boards now endorse a restorative service approach.

### 8.3.3 Movement to an Outcome Based Approach

'Restorative care' and 'reablement' are often used on an interchangeable basis. The association between home care and reablement is particularly prominent in England. Typically, it involves the provision of intensive, short-term interventions where the core objective is to restore confidence and self-care skills over a defined period – generally the time period ranges between 3 and 12 weeks. Research undertaken in England supports the view that effective reablement programmes (1) lead to immediate and longer-term reductions in assessed needs for home care and (2) are cost effective.

The shift to an outcomes-based commissioning approach remains an ambition more so than a reality in countries considered as part of this review process. The Burstow Commission on Home Care (England) recently highlighted an outcomes-based commissioning approach as their preference due to its focus on planning service delivery around agreed measurable outcomes. The Burstow Commission found that a significant proportion of providers are frustrated by the existing system of time-and-task commissioning, as it provides little security of revenue and offers little or no discretion for change. Despite commitment from local authorities and an appetite amongst service providers to reform the commissioning approach, progress to date in this regard across the UK has been limited.

### 8.3.4 Quality Regulation and Assurance

The approach to quality regulation and quality assurance varies considerably between international borders. The Care Quality Commission (CQC) is responsible for quality control in England with the necessity that all providers register with the Commission in order to secure authorisation to deliver services through public frameworks or service level agreements. The CQC also inspects service delivery on an ongoing basis.

The Nordic countries have all introduced quality regulation requirements to varying degrees. The level of regulation has not stretched to national guidelines or standards as of yet but this is the overall

direction of travel being adopted. All public health and social care services in Norway, for example, are subject to a quality regulation approach. All municipalities are required to have specific plans and procedures in place to successfully deliver care against agreed standards. Norway introduced a *National Strategy for Quality Improvement in Health & Social Care Services* in 2005. Service quality is defined and measured around a number of principles such as: the provision of safe and secure services, appropriate resource utilisation, effective coordination and integration, service user involvement, and equitable access to services.

A number of initiatives have been progressed in Sweden over recent years to address known service deficits. For example, annual grants from central government to municipalities are linked to the achievement of specific targets such as reductions in avoidable hospitalisation of older people. In addition, bonus schemes are available for municipalities that successfully raise the competence level of home care workers over a defined period of time. In addition, reforms to the Swedish taxation system have encouraged older people to avail of tax concessions when topping-up their home care package through the use of private providers.

Since 2010 a proportion of the funding to Swedish municipalities is indexed to performance-based incentives. For example, funding is linked to metrics such as: readmissions to hospital within a 30-day period, unnecessary hospital admissions, etc. A further reform progressed within Sweden now requires municipalities to cover the costs of hospital stays for patients that are judged by a physician as being 'ready for discharge' but remain within an acute setting. This has challenged municipalities to ensure appropriate step-down and home care services are in place and accessible to those who need them.

Some parallels exist between the rationale behind these Swedish reforms and that of the recently established Better Care Fund in England. The Better Care Fund now requires that local authorities and clinical commissioning groups (CCGs) provide seven-day services to support hospital discharge and prevent unnecessary hospital admissions. The Fund is based on the accepted principle that as the needs of the population have changed, then the model of care must evolve also. It is accepted that it will be necessary in many cases to decommission and close existing acute capacity but appropriate incentives for Trusts must be provided in order to implement such reforms.

## 8.4 OPTIONS FOR CONSIDERATION IN IRELAND ARISING FROM THE REVIEW OF INTERNATIONAL MODELS OF SERVICE DELIVERY

The following outlines a range of options for consideration by the HSE to enhance the current approach to the delivery of home care in Ireland. While it is considered that all of the options outlined have direct relevance to the service delivery model used in Ireland, a number of these also look beyond service delivery and into specific related areas such as commissioning, quality assurance and research.

The Options outlined are:

1. Embed home care within the full continuum of care approach.
2. Incorporate a prevention-focussed component to the service delivery model.
3. Reassign more involvement in decision-making to the service user.
4. Align home care with a discharge-to-assess model.
5. Incorporate a reablement approach to home care.
6. Combine reablement with step-down accommodation.
7. Introduce housing models (with home care supports in place) to preserve independence for older people.
8. Position long term residential care units as care hubs.
9. Introduce a direct payments approach.
10. Incentivise providers to adapt service provision behaviour to retain their level of service provision to the HSE.
11. Move to an outcomes based approach.
12. Agree a pathway to home care licensing or regulation.
13. Enhance the use of information and communication technology.
14. Adopt a structures approach to research and evaluation.

### Option1: Embed Home Care within the Full Care Continuum

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Australia</li> <li>- New Zealand</li> <li>- Denmark</li> <li>- Norway</li> <li>- Sweden</li> <li>- Canada</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Provision of seamless and service user-centric care</li> <li>- More appropriate application of existing health and social care resources</li> <li>- Optimisation of the flexibility offered by home care</li> </ul>

Offering services on the basis of a full continuum of care approach allows a healthcare system to deliver integrated care and facilitate smooth transitions between care providers and care settings. It represents the most service-user centric approach. While alignments between some services on the continuum are relatively advanced and stable in Ireland, other service components continue to operate within their own particular spheres and according to their own specific procurement and commissioning frameworks. One such example is the Nursing Homes Support Scheme (Fair Deal). Any future evolution of the scheme requires careful consideration. Equally though, it is imperative that the lessons learnt from the operation of the scheme since 2009 are taken on board when considering how best to provide an accessible, high-quality and value-for-money continuum of care.

A wealth of evidence exists from across modern healthcare systems to support the diagnostic that older people do not always transfer between health and social care services in a timely and efficient way. Where pathways are developed and financed, these can act as funnels and in turn draw service users in a particular direction that may not align with their precise service needs at that point in time.

Often home care is viewed as the first step on a continuum of care for older people. The experience of other jurisdictions however suggests that an individual can and should weave in and out of home care supports depending (1) on their needs at any given time and (2) the service partnerships that are in place between home care and other service components (e.g. short-term respite care, rehabilitative care, etc.) featuring on the care continuum.

It is recommended that the emerging model within Australia be considered by the HSE, particularly the establishment and consolidation of the Commonwealth Home Support Programme. The experience of the key worker approach, as within the COSE Project (New Zealand) should also be considered when reviewing potential service inputs to successfully implement and embed home care within the full care continuum.

### Option 2: Incorporate a Prevention-Focussed Component to the Service Delivery Model

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Denmark</li> <li>- USA</li> <li>- Canada</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Shifting from a reactive to a proactive service delivery approach</li> <li>- Cost effective hospital admission avoidance measure</li> </ul>

While it could be argued that the existing home care service delivery model is in many respects a preventative measure (e.g. avoidance of hospital / long term residential care admissions), adopting a more proactive approach such as that applied in Denmark merits consideration. The annual prevention home visit for all individuals over the age of 75 years is accompanied by evidence to support its overall cost-effectiveness and impact in preventing admissions to long term residential care / hospital.

Incorporating a telehealth component to the service delivery model may also support the achievement of prevention-related objectives. The application of modern telehealth technology, particularly in North America, is being effectively and efficiently used as an early intervention to prevent the health status of an individual from deteriorating to the point where admission to hospital / residential care is necessary. As indicated in this report, telehealth is emerging as a regular component of many innovative care models used by home care agencies in New York State. Provided the technology is accompanied by appropriately trained / skilled professionals and clinical protocols, it has much to offer in terms of delivering a high quality and cost effective service for older people.

### Option 3: Reassign More Involvement in Decision-Making to the Service User

Summary Overview	
<b>International Reference Locations</b>	- Australia - Scotland
<b>Potential Benefit(s) of Implementing in Ireland</b>	- Enhance the level of flexibility and control possessed by the service user to align services (type / timing / delivery agent) with assessed need

The service user should be placed in a more central position when aligning service need and provision. This is accepted by most of the countries reviewed and is viewed as an ongoing priority. This will not always be appropriate, nor is it advisable that all decision-making authority simply transition to the service user.

It is recommended that the continued Australian roll-out of Consumer Directed Care be actively considered. The related implications of the Scottish Social Care Act 2013 should also be factored into any future consideration of the decision-making flexibility between the commissioner, the provider and the end user.

### Option 4: Align Home Care with a Discharge-to-Assess Model

Summary Overview	
<b>International Reference Locations</b>	- England
<b>Potential Benefit(s) of Implementing in Ireland</b>	- Integration of community and acute care - Effective and efficient transitioning of service users between settings

This model of discharge has now become embedded within a number of elderly medicine wards within NHS England. The 2014 NHS England Guide for Commissioners refers to it as 'best practice'<sup>2</sup>. The approach has in some respects overhauled the emergency care pathway for frail older patients and involves the introduction of an innovative discharge process, where patients leave hospital as soon as they are medically fit to have their support needs assessed at home. The acute team ensures that the person's needs are assessed and that any acute illness is stabilised and treated. Instead of conducting

<sup>2</sup> NHS England (2014) Planning and delivering service changes for patients: A good practice guide for commissioners on the development of proposals for major service changes and reconfigurations

a more detailed assessment within the confines of the hospital regarding the person’s ongoing care and support needs, they refer the patient back out to a community team who then complete all other associated assessments and organise the necessary supports from the person’s own home. Effective discharge-to-assess models require timely expert assessment on initial acute presentation to hospital and adequate capacity for providing ongoing assessment and support at home.

Research emanating from the Sheffield Teaching Hospitals NHS Foundation Trust highlights a 34% increase in patients being discharged on the day of their admission or the following day, with no increase in the proportion of patients readmitted to hospital<sup>3</sup>. A key requirement of this model is the existence and appropriate resourcing of care in the community such as home care. It also satisfies key policy considerations such as the delivery of cost-effective care and the provision of a patient-centred approach.

Reviewing options to progress the above in collaboration with the HSE Clinical Care Programme is recommended. Of equal relevance is potentially the provision of seven-day services to support hospital discharge and the prevention of unnecessary hospital admissions. It is recommended that developments associated with the Better Care Fund initiative in England in this regard are monitored and considered.

### Option 5: Incorporate a Reablement Approach to Home Care

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- England</li> <li>- Australia</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Redevelopment of confidence and self-care skills amongst a cohort of service users</li> <li>- Cost effective means of preventing or delaying admission to long term residential care</li> </ul>

The concentration of home care services on service users with the highest levels of need is an obvious service delivery philosophy if/when demand exceeds available supply of services. International research suggests that the absence of low level support is likely to increase the risk of needing more costly, intensive services in the long-term<sup>4</sup>. As a result, those charged with delivering accessible and high quality services for older people have sought to introduce a range of rehabilitative and preventive-type service. Reablement home care services are one such approach used in England. The English approach typically involves intensive, short term home care interventions for a period usually up to approximately six weeks. The service is used to improve clients’ psychological and physical functioning in the expectation that needs for long-term care support will be reduced. Research suggests that reablement programmes have led to immediate and longer-term reductions in assessed needs for home care and represent a cost-effective service delivery approach<sup>5</sup>.

Variations of the general concept behind a reablement programme have been applied across all modern healthcare systems, including Ireland<sup>6</sup>. Although it is often defined differently, essentially reablement focuses on helping an individual to do things for themselves rather than the traditional home care approach of doing things on behalf of the service user.

<sup>3</sup> <http://www.health.org.uk/news-and-events/newsletter/discharge-to-assess-at-sheffield-frailty-unit/> - accessed 06/02/2015

<sup>4</sup> Danish National Centre for Social Research (2011) LIVINDHOME: Living Independently at Home. Reforms in Home Care in 9 European Countries

<sup>5</sup> Glendinning, C., et al (2010) Home Care Reablement Services: Investigating the Longer-term impacts. Social Policy Research Unit, University of York.

<sup>6</sup> The establishment of Intensive Home Care Packages could reasonably be considered a variant of a reablement programmes provided in other jurisdictions. In addition, a reablement pilot programme was run and reviewed in HSE Dublin North Central over the period 2013 – 2014.

Key to the successful application of a reablement programme is the early identification of the at-risk candidates from within either acute or community care settings. This requires a clear and consistent understanding amongst healthcare professionals regarding the alignment of reablement with present needs. It also requires the effective use of established lines of communication between relevant healthcare professionals.

It is advised that evidence-based best practice, such as the Social Care Institute for Excellence (SCIE) guide, *maximising the Potential of Reablement*<sup>7</sup>, is considered as a first step. Emerging Irish evidence such as the Retrospective Review of Service User Outcomes from the HSE Dublin North Central Pilot should also be factored into any assessment of the role and remit of a future reablement service. It is recommended also that a reablement approach be used to assist further integration of hospital and community services as per the mandate of the HSE Clinical Care Programme.

### Option 6: Combine Reablement with Step-down Accommodation

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Sweden</li> <li>- Denmark</li> <li>- Norway</li> <li>- Finland</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Facilitate the introduction of an enhanced continuum of care</li> <li>- Provide a cost-effective solution to support timely discharges from acute settings</li> </ul>

International models of care involve the provision of reablement programmes across a variety of settings, including for example; the home of the service user, residential care settings, community hospitals, and supported-living accommodation. In addition, reablement programmes have been incorporated with other innovative service delivery approaches such as the patient hotel approach.

The concept of a patient hotel first originated in Scandinavia but has since been used by a diverse mix of healthcare systems across the world<sup>8</sup>. In some jurisdictions patient hotels now represent a core component of intermediate care models. Service delivery models have been designed for patient cohorts that are typically recovering from illness or recuperating after a medical procedure and need ongoing support, but not the level of medical care provided in a hospital. Home help, both domestic and personal care variations, are offered and available through the patient hotel concept as a further means to extend the applicability of the model to service users that might otherwise potentially find themselves in 'grey areas' between acute care and long term residential care.

The Lund Patient Hotel in Sweden offers a prime example in this regard. In this instance, hotel accommodation relatively adjacent to Skåne University Hospital (previously Lund University Hospital) is used to facilitate an on-time discharge approach. Accommodation is provided by an established hotel chain that has full financial and administrative responsibility for the service level agreement. The referring doctor maintains clinical responsibility for the patient through-out their stay.

Odense University Hospital (Denmark) opened a patient hotel in 1997 in the grounds of the hospital. Norlandia Care is the largest patient hotel company in Scandinavia and now operates patient hotels in Norway, Sweden and Finland. Norlandia Care's hotels are available to hospital patients needing minimal nursing care. Estimates from Norway and Denmark suggest that the average cost reduction per patient hotel bed compared with a hospital bed is approximately 60%<sup>9</sup>.

<sup>7</sup> Social Care Institute for Excellence (2013) Maximising the Potential of Reablement

<sup>8</sup> OECD (2011) Health Reform: Meeting the Challenge of Ageing and Multiple Morbidities. OECD Publishing

<sup>9</sup> Innovation Unit (2010) Radical Efficiency: Different, Better, Lower Cost Public Services

On the basis of (1) the above international models, (2) the growing evidence-base to support a coordinated roll-out of the reablement concept, and (3) the existing deficit in terms of step-down accommodation in Ireland, it is recommended that consideration be given to the alignment of a reablement approach with that of various accommodation settings.

**Option 7: Introduce Housing Models (with home care supports in place) to Preserve Independence of Older People**

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Germany</li> <li>- Denmark</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Prevent and/or delay admissions to long-term residential care</li> <li>- Provide a cost-effective solution to support timely discharges from acute settings</li> </ul>

Most modernised healthcare systems, particularly those with larger or growing older populations, have prioritised the development of individualised services as the core means to prevent or delay admissions to long term residential care. Countries that have been more successful in this regard are generally those that (a) have put greater emphasis on home or community-based services and (b) have reformed the associated budgeting mechanisms to allow money to flow to the most appropriate type of care for each individual.

The Netherlands has introduced mixed forms of housing for older people since the 1970s. These developments normally comprise of a minimum of 10 apartments within a 250-metre radius of a care and support unit. The housing units have a maximum size of two to three rooms. The vast majority of the costs (~85%) for household help and out-patient nursing care are borne by the social insurance system with the remainder being paid by the resident. Services such as caretakers and on-call security are provided to further enhance the independence and quality of life of residents.

Germany has also taken a proactive approach to the development of new models of community-based care provision, including the increasingly popular *senior flat share*. This service model involves residential apartment living with a kitchen and bathroom, but also communal facilities such as living rooms and kitchens for group preparation of meals. Denmark has equally long promoted a *shared housing community* approach that represents an established form of independent living in later life. These consist of living space in single-family homes for persons aged 50 and above. Communities can range from as little as five units right up to 100 housing units. The Danes now have 200+ shared housing communities which are financed either by housing associations, private owners or cooperative organisations.

It is recommended that consideration be given to the feasibility of housing models, such as those described above, delivered in combination with and supported by a home care service delivery model.

**Option 8: Position Long Term Residential Care Units as Care Hubs**

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Scotland</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Optimise the availability of existing infrastructure to deliver a cost-effective 'local' supplementary service to the traditional home care service delivery model</li> </ul>



With over 400 nursing homes located across Ireland, this sector of the overall care continuum for older people provides an established reach and footprint. Optimising the availability of existing infrastructure and resources merits further exploration and consideration. As outlined earlier in this document, NHS Scotland is currently exploring opportunities to enable residential care units to have a greater role in the provision of rehabilitation, intermediate care and short term care services. The development of care hubs around existing nursing homes infrastructure potentially provides a means to fast-track the provision of services designed to foster the independence of older people. This type of model could provide a cost-effective means to supplement existing home care services and enhance the ‘package of care’ approach for older people.

The Scottish Programme for Change (2011 – 2021) outlines a commitment to realign the role of traditional residential care units with that of a future ‘care hub’. The roll-out of this is potentially worth exploring further by the HSE.

### Option 9: Introduce a Direct Payments Approach

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Canada</li> <li>- England</li> <li>- Germany</li> <li>- Northern Ireland</li> <li>- Finland</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Promote the maintenance and/or enhancement of independence levels amongst older people</li> <li>- Provides additional flexibility to the service user</li> <li>- Has a positive impact on the quality of overall service provision</li> </ul>

Most healthcare systems within developed nations offer some options to service users regarding direct payments (or individualised budgeting / funding) for the purposes of procuring care directly. Germany allows home care clients to receive either services or a cash payment worth about half the monetary value of the services option.

In England, direct payments were initially introduced in 1997 and shortly extended to those aged 65 and over. Since April 2003, local councils have been obliged to make, not just offer, direct payments where individuals consent to and are able to manage them, with or without assistance. Clients control their own budget and are free to choose their caregiver, pay for their own care and manage the desired services. It also allows them to choose a personal caregiver. The amount of money they receive is determined through a means test and consideration of their health and personal needs. The number of “adults and older people receiving direct payments per 100,000 of the population” is now a measure of performance and included within the relevant KPI suite.

Canada also has experience of individualised funding with British Columbia, Saskatchewan, Nova Scotia and Ontario all providing examples of implemented versions of the allocation approach.

A Direct Payments approach shifts the responsibility to administer home care funds from the healthcare system to the service user or his/her family. It theoretically offers greater flexibility and choice to the service user in terms of aligning need with available supply of services. Ultimately it should then have a positive impact on the quality of service delivered as providers are required to compete against one another for contracts with individual service users.

### Option 10: Incentivise Providers to Adapt Service Provision Behaviour

Summary Overview	
<b>International Reference Locations</b>	- Sweden
<b>Potential Benefit(s) of Implementing in Ireland</b>	- Influence the shift to a 'right care, right setting, right time' philosophy - Provide a financial-based mechanism to encourage / reward innovations to existing models of care

While capacity and funding deficits in terms of appropriate step-down and home care provision are potentially a contributing factor towards delayed discharges, it is likely also that continuing financial disincentives associated with admission and discharge policies influence the behaviour of acute hospitals. The Swedish approach to reward the achievement of specific targets while penalising inefficient practice is a potentially more applicable option now to the Irish healthcare system given recent reforms (e.g. the introduction of money-follows-the-patient, and the establishment of hospital groups). Indexing the performance of service providers to performance-based incentives is likely to become a more viable option as the healthcare reform programme continues. It is recommended that the HSE considers medium-term and longer term options in this regard, with particular emphasis on the Hospital Groups.

### Option 11: Move to an Outcomes-Based Approach

Summary Overview	
<b>International Reference Locations</b>	- England
<b>Potential Benefit(s) of Implementing in Ireland</b>	- Incentivise service providers to increase their focus on rehabilitation / restorative care approaches as a means to enhance service user independence - Facilitate the shift from the measurement of outputs to outcomes

Contracts for services that the HSE currently commission from the private and voluntary sector are predominantly time or task based rather than outcomes based.

Home care providers are usually paid to deliver specific tasks for an individual, within a specific allocation of time. Tasks for completion are generally decided on the basis of a needs assessment. Ultimately the service provider is paid according to whether or not the tasks are delivered, rather than whether or not the outcomes are achieved. If the outcomes have not been achieved, not only is the provider still paid, but there is every likelihood that they will receive another care package to continue the additional support that is necessitated by their failure. This is a cycle that could arise in social care services in particular.

It is widely accepted that time / task based agreements do not incentivise providers sufficiently to rehabilitate or improve user independence. Outcomes-based commissioning removes or dilutes the association between an output (e.g. hour of service) with an agreed rate of payment. Instead the provider is reimbursed based on their success in achieving an agreed outcome for a particular service user. Moving to an outcomes-based approach is not without challenges and it requires an additional suite of commissioning skills not always developed and readily available within healthcare systems.

The “Help to Live at Home’ Project successfully progressed by Wiltshire Council in the west of England is recognised as a best practice example in terms of the design and introduction of an outcomes-based approach for the commissioning of home care<sup>10</sup>. While the transition from time/task based contracts to outcomes-based commissioning is at a relatively early and immature stage, it is recommended that the HSE considers developments on an ongoing basis and tests the applicability of this procurement approach using experience from other emerging areas both within the HSE (e.g. supply and reimbursement of medicines) and beyond (e.g. Wiltshire).

### Option 12: Agree a Pathway to Home Care Licensing

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Australia</li> <li>- England</li> <li>- Scotland</li> <li>- Norway</li> <li>- Denmark</li> <li>- Germany</li> <li>- Finland</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Introduce a nationally consistent approach to the quality assurance of service provision</li> </ul>

The Law Reform Commission (LRC), when tasked with recommending the enactment of legislation to clarify and modernise the law, recommended that the Health Information and Quality Authority (HIQA) be given additional regulatory and inspection powers to ensure that appropriate legal standards are in place in the home care sector. Under the Health Act 2007, HIQA is the regulatory and standard-setting body for the residential nursing home setting. This Act could, as recommended by the LRC, be extended to broaden HIQA’s powers over the provision of professional home care.

The out-going Programme for Government includes a commitment to the introduction of a national licensing system and work remains ongoing by the Department of Health in this regard. The future licencing framework could provide for a mandatory system of licensing for public and private home care providers. As with all health and social care service components included within the remit of the licensing approach, it will be designed to improve service user safety by ensuring that home care is only provided by licensed providers and that these provider are subject to on-going review to ensure that they do not operate below agreed standards at any point.

While a licensing approach is the long term objective, it may be beneficial to first develop and pilot draft standards as has been the approach in other care areas. This will enable providers to make the necessary preparations for a licensing system and will facilitate continuity of care objectives in the short to medium term. It is recommended that the HSE designs a pathway to home care licensing that may incorporate interim milestones informed by the experience of other jurisdictions such as England, Norway, Denmark and Australia.

<sup>10</sup> Institute of Public Care (2012) Wiltshire Council Help to Live at Home Service – An Outcome-Based Approach to Social Care. Case Study Report

### Option 13: Enhance the Use of Information & Communications Technology

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Canada</li> <li>- USA</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Apply technology-based solutions to enhance the service delivery model for home care</li> <li>- Enhance partnerships with industry for the ultimate benefit of service users</li> <li>- Earlier introduction of innovative technology</li> <li>- Provision of safer, cost effective care</li> </ul>

On an international basis, the effective use of information technology to facilitate safe / high quality home care remains largely under-utilised. Technology such as sensors to detect falls, machines to monitor blood pressure and respiration, and medication dispensers are widely available but infrequently incorporated into home care service provision. Although the willingness of service users in Ireland to use such technology has not been tested on a widespread basis, familiarity with such devices and sensors could be achieved with relative ease through effective planning and implementation. Irish and European initiatives, such as *Smart Ageing, Healthy Ageing*, etc., should be taken full advantage of to explore the technological opportunities that might support cost effective and high quality home care provision.

Partnerships with industry could provide the foundation to incorporate a more progressive approach to the use of technology in supporting older people to maintain their independence for longer periods on a safer basis. For example, a pan-European commitment by Abbvie in 2014 resulted in the development of a white paper involving 19 countries (including Ireland) that documented practical solutions to support the achievement of sustainable healthcare. In addition, The 2014 Life Sciences International Summit focussed specifically on 'smart ageing'. Given that Ireland is now home to many of the more innovative and creative technology-based companies from across the globe, the potential to forge partnerships between the healthcare system and industry is possibly stronger than ever.

### Option 14: Adopt a Structured Approach to Research & Evaluation

Summary Overview	
<b>International Reference Locations</b>	<ul style="list-style-type: none"> <li>- Denmark</li> <li>- England</li> </ul>
<b>Potential Benefit(s) of Implementing in Ireland</b>	<ul style="list-style-type: none"> <li>- Enhance our understanding of (1) service user preferences, (2) the impact and effectiveness of service models / components, and (3) quality drivers</li> <li>- Exploit the opportunity to apply outcomes-based findings for service planning purposes</li> <li>- Achieve an increased return on investment (associated with staff, infrastructure, service delivery models)</li> </ul>

Effective service delivery models are largely dependent on robust evidence bases to guide their continued evolution and alignment with the needs / preference of service users. International research regarding the delivery of high quality, accessible and cost effective home care remains under-developed. We continue to allocate funding to services on an annual and recurring basis in the absence of solid outcomes and impact data. Continuing along these lines is not in the interests of the service user, the service provider, or the tax-payer.

Mazars propose a range of more immediate actions for progression regarding the management information, datasets and information systems that the HSE should advance. In the medium-to-longer term specific investment in the area of impact and evaluation would prove beneficial for future service design and resource allocation purposes.

Areas for initial prioritisation could include:

- The reasons for, and trends in, unmet need;
- An assessment of private expenditure (including top-up care);
- An assessment of the existing and future supply of home care workers (building on the workforce audit conducted as part of this review process);
- The impact of technology;
- The link between training received and the quality of outcomes;
- The relationship between home care models (e.g. with/without option for short-term respite care, reablement programmes, etc.) and the outcomes for different service users;
- The cost-effectiveness of prevention-focused home care services.