Care Alliance Ireland

Guiding support for family carers

Briefing Paper 2

Public Provision of Home Care in Ireland – Update

October 2018

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Care Alliance Ireland

Introduction

This Care Alliance Ireland briefing paper aims to describe the current level of provision of publicly funded home care in Ireland. We revisit the data presented in our 2016 report *Analysis of Home Care Supports Funded by the HSE 2008–2016*,[1] and present an update on the recommendations made in that report.

We describe the recent and ongoing national policy developments in home care provision.

We have made use of the Freedom of Information Act 2014 to secure from the Health Services Executive (HSE) countrywide details of the average waiting time for accessing home care and the gap between assessed need and actual home care delivered.

We look at the drivers of demand for home care and highlight the potential of the Single Assessment Tool (SAT) in delivering better home care.

We make a number of observations and recommendations that we hope will inform the future development and delivery of home care supports in Ireland.

[1] Care Alliance Ireland, *Analysis of Home Care Supports Funded by the HSE 2008–2016* http://bit.ly/2cZhd9y

Background

In June 2016 we published *Analysis of Home Care Supports Funded by the HSE 2008–2016*, the first comprehensive longitudinal and quantitative report to be published on the topic, detailing the then state of the public provision of home care.

In the report we highlighted the difficulties experienced in accurately capturing the level of actual home care provision, due to the absence of robust publicly available data. We made various estimates about provision from 2008 to 2016, which will be discussed in more detail below.

In summary, we found the following:

- Accurately measuring the overall quantum of publicly funded home care was complicated by opaque reporting methods, variable use of terminology and lack of readily available data.
- A material and ongoing shift away from 'home help' towards 'home care packages',[2] although both seemed to be providing similar home care.
- An increase in the use of 30-minute home visits; a reduction in the intensity of home care per client (i.e. weekly hours provided); and a shift towards personal care and away from help with household chores.
- An overall marked increase in the absolute level of home care provision over the past 15 years. 2008 appears to have marked peak provision in both the number of hours of home care and the percentage of those aged 65 and over in receipt of such care. There was a noticeable reduction in services between 2009 and 2012, and most acutely between 2011 and 2012, when there was a reduction of over 10%, or 1.5m hours of home care.
- From a utilisation and accessibility perspective, increases in services since 2013 had by 2016 only partially reversed the significant reduction in the actual percentage of the 65+ group in receipt of home care support. This means that a lower percentage of people aged 65+ were in receipt of publicly funded home care in 2016 than was the case in 2008.

The 2016 report made ten recommendations in respect of home care. Table 1 examines the recommendations and their current status.

[2] Making clear distinctions between these services has proven difficult if not impossible. Our 2016 report states the official distinctions: http://bit.ly/2cZhd9y (Appendix I, p. 19), but in practice both terms have come to mean the same thing – namely the provision of care and support to an individual in their own home. There is some evidence that home help was traditionally focussed more on general household chores (shopping, housework, etc.), whereas the more recently introduced Home Care Packages explicitly include intimate personal care (washing, toileting etc.).

Table 1: 2016 Home care report recommendations

1	Short term: additional 1.55m home care hours to reach 2011 accessibility levels	Not met	Additional 1,540,000 hours delivered between 2016 and 2018. Ongoing demographic pressures however mean accessibility target is not met
2	Collection of data re number of home care hours delivered	Delivered	Reported in HSE Performance Data from Q1 2018
3	Medium term: additional 3.58m home care hours to reach 2008 accessibility levels	Not delivered	
4	HSE publications to use consistent terminology when describing home care provision	Progressing well	
5	Attempts to be made to assess the current volume of privately provided home care	No evidence of this being done	
6	Move towards the regulation of home care to be progressed during 2016	Progressing slowly	Minimum standards required to be approved provider. Home care review underway with a view towards regulation
7	Home care provision to be set up on a statutory basis	Progressing slowly	Home care review underway with a view towards statutory provision
8	Further analysis to be undertaken to explore the apparent material reduction in home help hours delivered per client	No evidence of this being done	
9	Department of Health to liaise with the HSE and other interested parties in developing more sophisticated models of assessing appropriate levels of home care provision based on international norms and agreed levels of dependency	No evidence of this being done	
10	Roll-out of the InterRAI Assessment Tool	Limited progress	Referenced again in *2018 HSE Service Plan*

Why a New Briefing Paper?

Recent major developments in home care have prompted the publication of this new briefing paper. In April 2017 the government published the Health Research Board's review[3] of the regulation and financing of home care in Germany, the Netherlands, Sweden and Scotland.

In July 2017 the government announced a public consultation regarding home care provision. More than 2,600 individuals responded, mostly family carers. This significant response rate highlights the importance of access to home care for many families.

Care Alliance Ireland understands that phase two of this public consultation process will progress in autumn 2018, following a final decision on the scope of the review as well as a further analysis of the funding and delivery of home care in ten other countries. We also understand that the Sláintecare Implementation Strategy suggests that it will take three years for a statutory home care system to be put in place.

Since early 2017, a number of non-governmental organisations (NGOs) with an interest in home care provision (including Care Alliance Ireland) have been meeting to discuss how best to positively influence both the consultation process and the outcome of this review.[4] There is a level of consensus in the group that more and better home care provision is critical to the wellbeing of our community, for a number of reasons: to mitigate the impact of an ageing population; to minimise unnecessary long-term care admissions; and to give expression to the National Dementia Strategy, the Positive Ageing Strategy, the National Carers Strategy, the National Disability Inclusion Strategy and other relevant policies.

We understand that the departmental review will not focus exclusively on home care supports for those aged 65 and over. This is to be welcomed. Currently, under a number of schemes, the HSE also provides funding to support thousands of people under the age of 65 who have care support needs to live at home. In 2018 in the region of 2,350 people will benefit from approximately 1.5m hours support through a Personal Assistant scheme, and over 7,400 people will benefit from close to 3m home support hours. We welcome the fact that the review extends to people within the ambit of these schemes.

[3] Kiersey, RA, & Coleman, A (2017) 'Approaches to the regulation and financing of home care services in four European countries'. Dublin: Health Research Board, https://health.gov.ie/wp-content/uploads/2017/04/FINAL-HRB-Evidence-Review-7-4-17.pdf

[4] As of October 2018 this group included the following organisations; SAGE Advocacy, Third Age, Age Action, Alone, The Alzheimer Society of Ireland, Family Carers Ireland, MS Ireland, MRCI, Age and Opportunity, Irish Heart Foundation, Irish Hospice Foundation, IASW, IMDNA, NAI, DFI, NWCI, CF Ireland, ABI Ireland, Cheshire Ireland and Care Alliance Ireland.

Assessing Waiting Periods for Home Care and the Assessed Need/Care Provision Gap

We have made use of the Freedom of Information Act 2014 to secure from the Health Services Executive (HSE) countrywide details of the average waiting time for accessing home care and the gap between assessed need and actual home care delivered.

Rationale for Seeking Information Under the Freedom of Information Act

Care Alliance Ireland believes in the value of high transparency in respect of the provision of publicly funded services. We believe transparency can positively influence trust in a system, support higher quality provision of health and social care, and be a tool in encouraging public confidence and in delivering genuine stakeholder collaboration.

Accessing reliable and comprehensive data on home care has proven difficult to date. Care Alliance Ireland therefore made the following Freedom of Information (FOI) request in early July 2018:

> *I would like to apply under the FOI Act 2014 for the following information.*
>
> *Note this request relates to the provision of home support services operated by the HSE older persons' services.*
>
> *1) What is the average duration on the waiting list both nationally and within each CHO [Community Healthcare Organisations] area – from when a client/ their representative/family submits an application for home care support, until they are approved by the HSE and then until they are provided with the full approved allocation. (For example application received 1/7/18. Home care approved 16/7/18. Home care delivered in full 25/7/18. – Waiting time 24 days)*
>
> *2) What is the difference between the number of hours of assessed need in each individual situation and the actual allocation of home care hours. (For example – a client may have been assessed by the public health nurse to need 14 hours home care per week, but be subsequently provided with 10.5 hours per week by the allocation committee. In this case the, difference is 3.5 hours per week. I wish to be provided with the average figure nationally and in each CHO for this difference.*

The deliberate focus of the FOI request was to look past the nominal waiting list length, as this figure in isolation is of limited value. We were keen to establish the average time spent waiting for a home care service and the gap between assessed need and actual provision. A significant recent report looking at future health and social care demands[5] acknowledged the absence of data around unmet needs in home care and the importance of having this data to inform future projections.

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Following feedback and further consideration we agreed to time extensions in respect of the original FOI and sought to modify our FOI request, per below:

> *In respect of the period of time on such waiting lists, I agree to a small sample of either 20 waiting list clients or not less than 5% of the numbers on the waiting list, whichever is the lesser, being used in estimating the length of time prospective clients are on the waiting list. I also agree to the use of such sampling in respect of the difference between assessed clinical need and actual provision.*

Immediately following the submission of our initial FOI, we were advised by the national Health Services Executive (HSE) FOI office that as the information we requested was not held centrally, each of the nine regions in the HSE would respond separately. At the date of publication of this briefing paper (October 2018) eight of the nine regions have responded to our FOI. We acknowledge the time they have spent in processing this request.

We now detail the various responses and reflect on the nature and level of detail in the responses, as well as the significant variations between them and the possible reasons for this.

[5] *Health Service Capacity Review 2018*. Review of Health Demand and Capacity Requirements in Ireland to 2031. See https://health.gov.ie/wp-content/uploads/2018/02/71580-DoH-Dublin-Report-v6.pdf

Responses to Freedom of Information Requests

Only three of the nine HSE regions provided the full data requested, and in one case full data was provided only after our initial FOI was refused on the grounds that the records requested did not exist.

The fact that so few of the regions provided the full data requested is of concern. The law is clear about the right of the public and civic bodies to access to such public information.

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Our view is that the FOI request was not given the full consideration it was entitled to in respect of the majority of the HSE regions from whom information was requested. We are also of the view that the responses provided by a number of HSE representatives were not in keeping with the spirit and purport of the Freedom of Information Act. For us this raises questions about public accountability, transparency and lack of willingness to engage with civic not-for-profit organisations in areas of legitimate public interest.

We appreciate that Freedom of Information requests place a level of administrative burden on a system endeavouring to meet immediate and pressing health and social care needs, and that excessive and reckless use would negatively affect the public health and social care system. However, it is our view that the request made was reasonable, at worst placing a once-off, moderate, time-limited administrative burden on a particular section of the home care service in each region, but ultimately serving to create an impetus for a more transparent, accountable, professional and fairer home care support system.

Eight of the HSE regions did provide some of the data requested, although in two HSE regions, the response provided related to only one of several areas within that region.

One of the nine regions failed to respond beyond acknowledging the request. This failure to respond is currently being followed up through an internal review process.

Another two of the HSE regions refused the request on the basis of their view that the information requested was not readily available. One of these regions provided a narrative around home care provision, as well as the absolute figure for those awaiting home care in that region. One region said that the information requested could not be measured.

Other regions simply failed to answer the questions asked, providing narratives that were not directly relevant to the questions posed.

Six of the regions provided what we would describe as partial responses. Representatives from two of the HSE regions actively engaged with us early in the process by phone and email in pursuit of the provision of a fuller response to our requests. Care Alliance commends the relevant officials in these two regions.

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If it is the case that the information requested was not available in a number of HSE regions, which seems unlikely due to the nature of the information sought, this raises serious questions about record keeping and organisational processes within a number of HSE regions.

Duration of Waiting Period

Data for each HSE region has been anonymised.

In one region, a number of clients assessed as low priority have been on a waiting list in excess of two years, although this is likely to be the exception rather than the rule.

One region advised the following:

> *It is not possible to calculate the time between when each application is received to when it is approved.*

We believe this response to lack credibility.

The average time individuals spend on a waiting list in each region is detailed below.

HSE Region (Anonymised)	Response
A	6–9 months
B	Average of 24 days, immediate for end-of-life care (Note: Only one of four areas within the region responded)
C	FOI refused, modified request submitted, modified FOI refused. Appealed to internal reviewer, awaiting response
D	Priority cases 2–3 days, others circa 30 days
E	Request acknowledged but no response provided. FOI appealed to internal reviewer, awaiting response
F	FOI refused, narrative provided
G	FOI initially refused, modified request submitted, data provided in full. Time spent is 53 days average (median 35 days, max 340 days)
H	No waiting list for high priority, 6 months for lower priority
I	Max 2 weeks for palliative care and high-risk/urgent situations. Average waiting list for others 3 months (Note: Only one of three areas within the region responded)

Amongst the six HSE regions that provided data, the average waiting time for non-priority clients is estimated to be approximately 3.3 months.

Assessed Need Versus Actual Provision

Only four of the nine HSE regions provided an estimate of the gap between assessed need and actual provision, as detailed below.

HSE Region (Anonymised)	Response
A	85% of assessed need met
B	61% of hours requested met. (Note: Only one of four areas within the region responded)
C	FOI refused, modified request submitted, modified FOI refused. Appealed to internal reviewer, awaiting response
D	87–90% of assessed need met (hours not provided)
E	Request acknowledged but no response provided. Appealed to internal reviewer, awaiting response
F	Data not provided. Detailed narrative provided referring to prioritisation and move towards standardised assessment processes nationally
G	Original FOI refused, modified request submitted, data provided. 104% of assessed need reported to be provided
H	Data not provided. We were advised that the Public Health Nurse has discretion to increase to pre-approved maximum
I	Data not provided

Of the four HSE regions that provided an estimate, there was an average 15% gap between assessed need and actual provision. As not all HSE regions provided data, we should treat this figure with caution. This figure does not take account of the approximately 6,100 clients deemed in need of home care who are waiting for an initial service.

The 2017 Sláintecare report[6] suggests a 10% level of unmet need, based on a crude calculation using the figure for those on the waiting list divided by the figure for those in receipt of a home care service. This is a poor estimate of unmet need, as it takes no account of the difference between assessed need and actual provision. The report does, however, acknowledge that this 10% figure is likely to be an underestimate of unmet need.

The 2010 TILDA Wave 1 report, based on then current data, reported a 26% level of unmet need amongst those aged 50 and over.[7]

[6] *Committee on the Future of Healthcare Sláintecare Report* May 2017, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

[7] Murphy, C, Kamiya, Y, Savva, G, Timonen, V, (2012) *Profile of Community-Dwelling Older People with Disability and their Caregivers in Ireland*. Dublin: Trinity College Dublin, TILDA (The Irish Longitudinal Study on Ageing), https://tilda.tcd.ie/assets/pdf/Carer%20Report.pdf

International Comparisons

Whilst outside of the scope of this paper, we believe there to be merit in a separate analysis looking at international comparisons. This might usefully include comparison of the following:

- nominal numbers waiting for home care
- average duration on the waiting list
- assessed need versus actual provision
- intensity of provision (i.e. hours of home care received each week)
- percentage of those aged 65 and over in receipt of home care.

We know for example that waiting lists are not unique to Ireland, even amongst developed welfare states. In Australia there are reported to be in excess of 120,000 people aged 65 and over on home care waiting lists, although 75% of those waiting are reported to be in receipt of some level of home care support from the state.[8]

In Ireland, whilst the nominal number of people aged 65 and over waiting for a home care service currently stands at over 6,000,[9] it is not clear if this figure includes both those waiting to receive an initial home care service as well as those waiting for additional home care to fully match the assessed need.

[8] Martin, L, 'Number of older Australians waiting for home care packages climbs to 121,000', *Guardian*, 30 September 2018, https://www.theguardian.com/australia-news/2018/sep/30/waiting-list-for-home-care-blows-out-to-more-than-121000-older-people. Department of Health, *Home Care Packages Program Data Report 4th Quarter 2017–18*. Australian Government, Department of Health, https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCP-Data-Report-2017%E2%80%9318-4th-Qtr.pdf (p. 3).

[9] O'Regan, Eilish, 'West suffering in HSE homecare "postcode lottery"', 28 September 2018, https://www.independent.ie/irish-news/health/west-suffering-in-hse-homecare-postcode-lottery-37362772.html

Benefits of the Single Assessment Tool for Capturing Home Care Data

The development by the HSE and relevant stakeholders of a Single Assessment Tool (SAT) for the assessment of care needs has been ongoing since 2009. The process of choosing an assessment tool was robust and inclusive of all stakeholders, and the tool chosen (InterRAI) has been modified to ensure local and national suitability. The project resulted in the development of a separate Family Carer Needs Assessment for assessing the support needs of family carers. Care Alliance Ireland is delighted to have been instrumental, with others, in ensuring that such a tool is available to practitioners where there is considerable family carer involvement in the care of a dependent person.

Whilst the main Single Assessment Tool has been piloted, the slow national roll-out of the tool is a cause for concern

Whilst the main Single Assessment Tool has been piloted, the slow national roll-out of the tool is a cause for concern. The tool would provide the following major benefits for the consistent and adequate provision of home care:

- The tool has the capacity to **capture quantitative data**, including the waiting period for home care and the gap between assessed need and actual provision.
- It supports **the management of fair and efficient allocation of resources** by health and social care professionals, taking account of the varying complexities of care needs.
- It supports **regional consistency** in the provision of care, and allocation of resources based on a **more objective assessment of need**.

This proposed practice development has been referenced in a number of HSE Service Plans since 2010, and is again referred to in the *2018 Service Plan*.

Table 2: Selected references to the Single Assessment Tool in HSE Service Plans

Year	Reference to SAT in *HSE Service Plan*
2010	Single Assessment Working Group (*HSE Service Plan 2009*, p. 38)
2014	'Service Priority – Implement a Single Assessment Tool (SAT). The first phase implementation will commence in 2014 with a minimum of 50% of all new entries to NHSS [Nursing Home Support Scheme], home care packages and home help schemes assessed by the SAT in the last quarter of 2014, with full implementation in 2015.' (*HSE Service Plan 2014*, p. 45)
2018	'Continue to progress the implementation of the Single Assessment Tool (SAT) across all CHOs.' (*HSE Service Plan 2018*, p. 47)

We strongly recommend that the roll-out of the SAT be made a high priority in order to avoid the current discrepancies and different emphases in home care needs assessments across the HSE areas, as clearly illustrated by the data gathered.

Observations on the Data Gathered

Our attempts at capturing the average length of time clients are waiting for home care have been partially successful. We found the average waiting time for home care to be in the region of 3.3 months, with the range going from no wait time to over two years. Other recent research[10] on clients' experiences of waiting for provision of home care indicates a similar wait, ranging from little or none to over two years.

> Overall, based on the responses to the FOI request, it would seem that each HSE region has a different approach to assessment, management and provision of home care

Differences in approach: Overall, based on the responses to the FOI request, it would seem that each HSE region has a different approach to assessment, management and provision of home care.

Failure to capture data on unmet need: It is also clear that the extent to which data on unmet need is captured varies, and indeed it seems that little or no formal attempt is made to capture such data in some regions. This is of major concern.

Move towards a more flexible response: There appears to be a move towards a more flexible response to provision to allow the level of care to be varied as the needs of clients or their families change, without recourse to a full review by the local home care allocations team. This is welcome.

Discrepancies in prioritisation: Whilst we know that at least some regions operate a prioritisation system, this process remains unclear in the majority of regions. It appears that some regions use a 1, 2, 3 prioritisation system, others a 1, 2, 3, 4 system, whilst some also appear to offer immediate home care for those at end of life.

Challenge of accessing home care from providers: It appears that accessing home care providers who can respond to demand is an increasing challenge, due to a recent marked improvement in the labour market. Specifically, it appears that in some cases where provision is approved there are considerable delays in actual provision of care. Our FOI request did not illuminate the extent to which this is an issue in the various regions.

[10] D'Alton, M et al. (2018) 'The patient experience of home care services'. Paper presented at 66th Annual & Scienti¬fic Meeting of the Irish Gerontological Society: Transforming Ageing Across Borders, September 2018.

Differences in emphases for home care provision: Although the available data is limited, it is of note that the relationship between waiting lists and gaps between assessed need and actual provision differed across the regions. In one area within a region we were advised that only two clients were on the waiting list, but the same area reported a very significant gap (39%) between assessed need and actual provision. Meanwhile, whilst there were in excess of 600 clients on a waiting list in one region, it was estimated that 85% of assessed need was provided for. This may reflect variation in focus between regions, with some seeking to provide a more limited service to a greater number of clients, and others to provide a more intensive service to fewer clients. These trade-offs are arguably inevitable in a resource-based rather than needs/demand-led service. However, this likely level of variation in assessment of need outcomes is of concern.

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Possible assessment of need in the light of resources available rather than independently: One region responded to the question around assessed need and home support provided in the following way:

> *their (health care professionals') assessment (of need) will correlate directly with the actual provision.*

This may be read in two ways – it may indicate either that the individual's identified needs are met in full (which appears unlikely, based on the response of other regions), or that the resources available will directly influence the assessment of need.

We are strongly of the view that assessed need should be independent of actual public resources available. If this is not the case, either in this or any other region, we would have concerns about health and social care operational practices in these regions.

Assessment of needs without regard to the resources available would also help to ensure that gaps between identified need and actual provision are documented. This is the basis on which the Disability Act 2005 and the related Assessments of Need under the Act operate. Documenting unmet health and social care need is a fundamental aspect of a mature welfare state.

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The Drivers of Demand for Home Care

Although we now know that the overall number of hours of home care delivered is likely to rise by about 10% over the three-year period between 2016 and 2018, this will improve access to home care only moderately, due largely to our ageing population. On the basis of a number of data sources and reports,[11] it is estimated that demand for home care support will increase by approximately 3.25% per year. This is driven by a number of factors, most significantly the increase in the age profile of our population. This is most pronounced in the cohort aged 85 and over, a large percentage of which requires home care support. These pressures are mitigated somewhat by a modest reduction in the rates of morbidity and ill-health amongst the population aged 65 and over and the associated improvement in people's capacity to live well and independently as they age. The extent to which people opt for private home care, general expectations of care levels, and the extent to which family members can/will provide care are also factors that influence demand. Public policy regarding residential care is also an influencer. The recent ongoing levelling off and indeed modest reduction in the relative take up of the state-subsidised Fair Deal/ Nursing Home Support Scheme may point to a shift towards a preference for and actual delivery of care at home and away from institutional delivery. This shift in itself could put further pressure on the demand for home care.

It may also be that increasing asset prices in recent years make the Fair Deal scheme relatively less attractive as the contribution made by the client towards the cost of residential care under the scheme is directly related to the total value of the client's assets.

[11] i) 2015 HSE report *Planning for Health Trends and Priorities to Inform Health Service Planning 2016*, ii) *Health Service Capacity Review 2018. Review of Health Demand and Capacity Requirements in Ireland to 2031*. See https://health.gov.ie/wp-content/uploads/2018/02/71580-DoH-Dublin-Report-v6.pdf, iii) *Review of the Nursing Homes Support Scheme, A Fair Deal*, https://health.gov.ie/wp-content/uploads/2015/07/Review-of-Nursing-Homes-Support-Scheme.pdf

Current Provision of Home Care: Updating the Figures

The *2018 HSE Service Plan* has, for the first time, stated the number of hours of home care that the HSE is seeking to deliver.[12] This development is both welcome and long overdue, and enables more accurate measurement of trends in provision and estimation of deficits in provision.

A number of previous data sources for home care have been merged into one in the *2018 HSE Service Plan*. The HSE hopes to provide just over 17.25m hours to approximately 50,500 individuals in 2018. Latest HSE performance data suggests that it will be a challenge to deliver on this figure

A number of previous data sources for home care have been merged into one in the *2018 HSE Service Plan*. The HSE hopes to provide just over 17.25m hours to approximately 50,500 individuals in 2018.[13] Latest HSE performance data suggests that it will be a challenge to deliver on this figure.[14]

Revisiting the 2016 Data

Access to this new data from the HSE also enables us to revisit the 2016 *Analysis of Home Care Supports Funded by the HSE 2008–2016* report, and to update and clarify some aspects of that report. Our review of the 2016 report suggests that the report overestimated home care provision by several million hours each year, or approximately 17% in the case of 2015. We assumed at the time of writing that a home care package equated to 10 hours per week; it now seems that the actual amount provided was approximately 6 hours per week.[15] For the purposes of estimation, we assume that this figure of 6 hours has remained largely consistent

[12] https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf p. 115.
[13] This is a combination of the 2018 *HSE Service Plan* target of 17,094,000 hours and the additional 156,000 hours allocated under the Adverse Weather Initiative in early 2018. It is not entirely clear if this figure relates exclusively to those aged 65 and over. In previous communications with the HSE (2016) we have been advised that approximately 15% of home care is delivered to those under 65. We assume this 15% figure is now reported on within disability services.
[14] *HSE Performance Report Q1 2018*, p. 4. See https://www.hse.ie/eng/services/publications/performancereports/january-to-march-quarterly-report.pdf
[15] 'This is the equivalent of 10.57m hours of home help combined with 20,175 HCPs and a total of 235 IHCPs of 360,000 hours.' Source: *HSE Service Plan 2018*, pp. 46, 115, 116, https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf

in more recent years and that a somewhat lower number of hours is provided weekly for home help clients,[16] with intensive home care package recipients (< 300 clients) currently receiving in the region of 29 hours per week. On average then we estimate that each client received approximately 6.5 hours of home care per week in each year over the period 2008 to 2016.

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2008 and 2011 Baselines

In the 2016 report we attempted to calculate the home care provision deficit using two baselines: 2008 and 2011.

2011 was the year when funding for home care experienced a squeeze, with a 10% cumulative reduction in number of hours of home care delivered during 2011 and 2012.

Furthermore, using 2011 as a baseline is significant in light of the HSE's own 2016[17] report which stated:

> *if the proportion of older people receiving the service (home help) was extended to 10.1% (the level of service provision in 2011, and more reflective of the actual need as estimated by OECD) there would be an increase in clients to 65,040 in 2017 and 76,280 in 2022/27.*

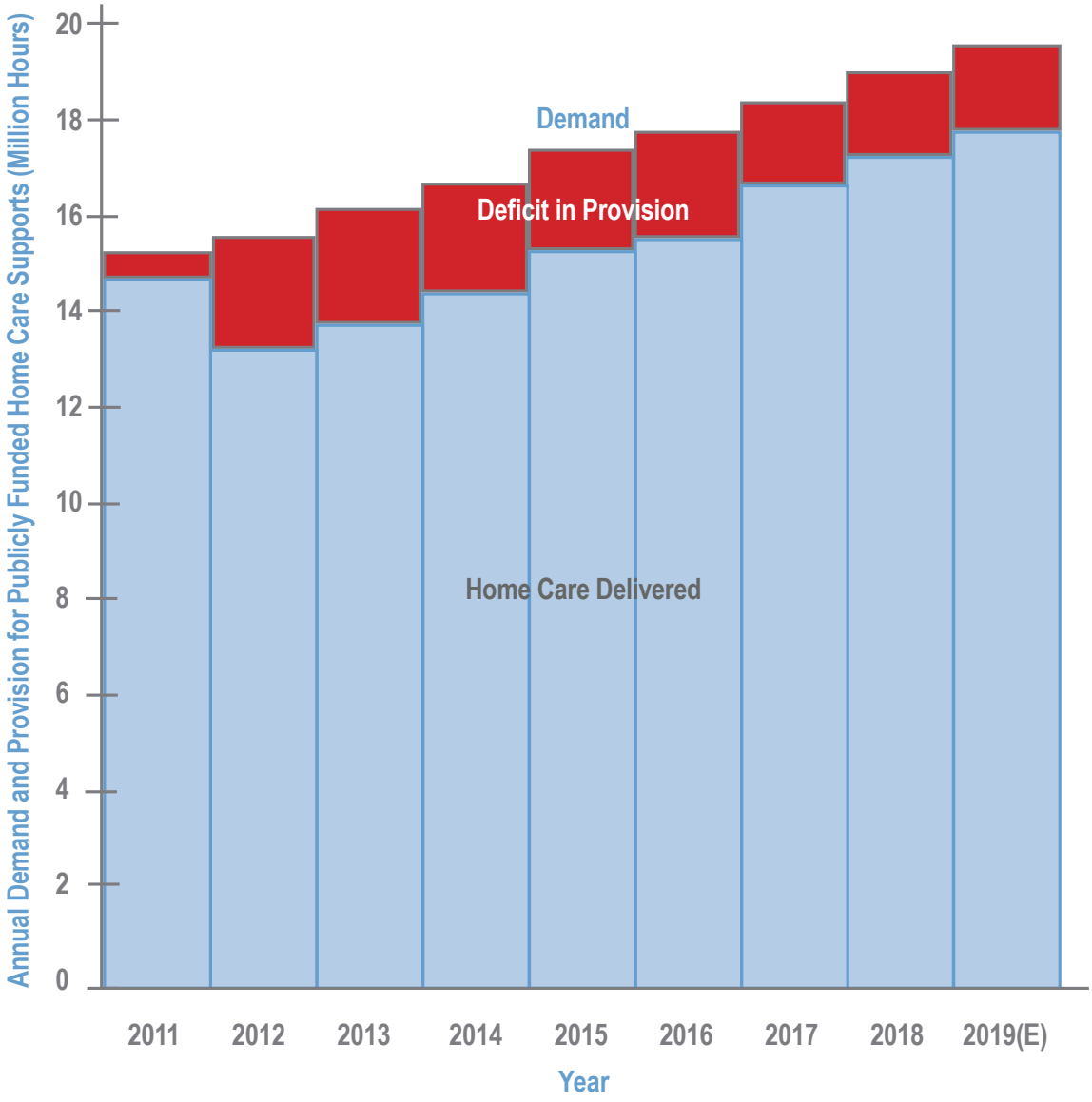
In 2018, the HSE plans to deliver home care to 50,500 people aged 65 and over. Clearly, the estimated client numbers cited in this extract – 65,040 and 76,280 – demonstrate how far there is to go to meet reasonable levels of provision and accessibility.

[16] The Sláintecare Report of 2017 (p. 56) refers to an average of 4.3 hours per client per week under the home help scheme and 6.5 hours under the home care package scheme. The schemes were merged into one service in 2018, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

[17] Smyth, B et al. (2016) 'Planning for health: Trends and priorities to inform health service planning 2017'.

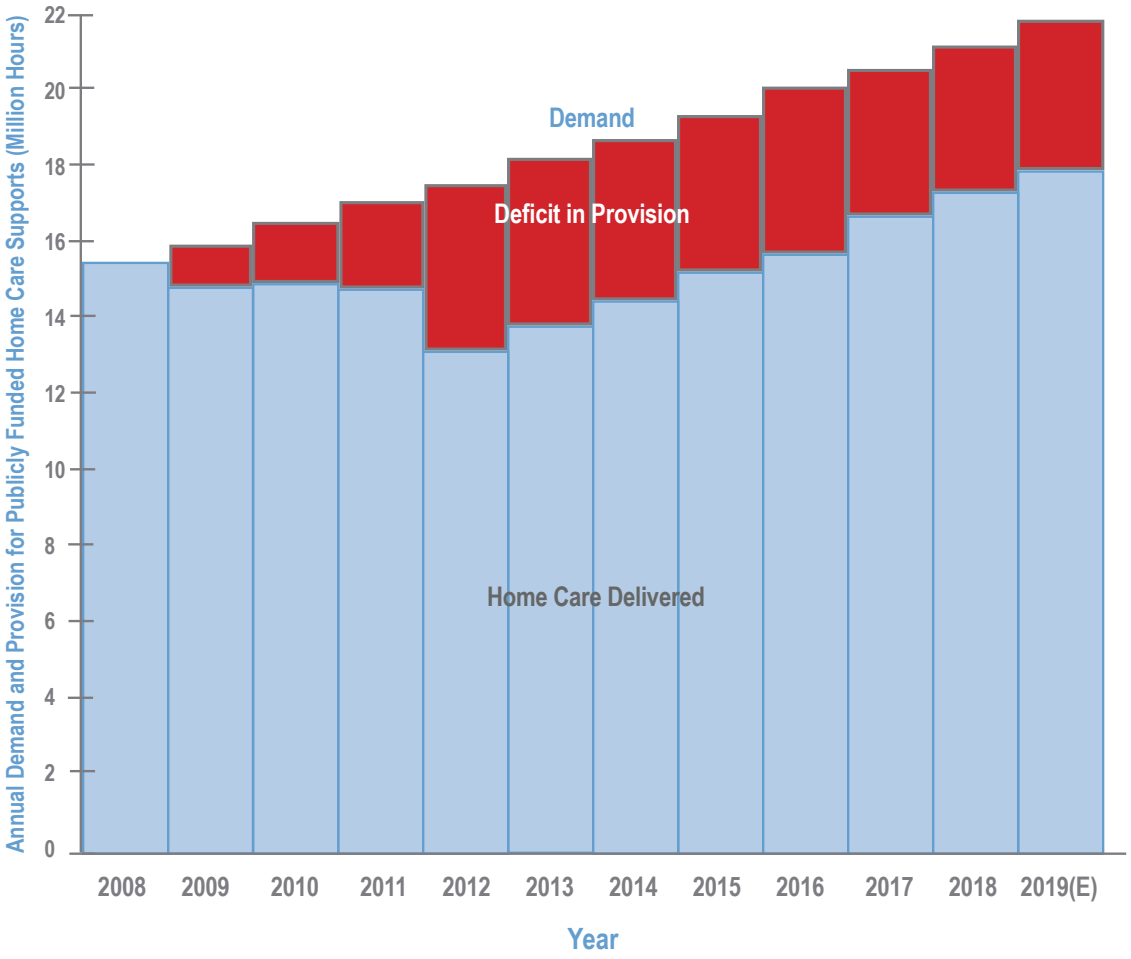
Using the original 2011 HSE service goals as a baseline, we found a deficit in provision in 2016 of 1.64m hours. As alluded to earlier in this paper, whilst provision has since increased, the rate of increase has merely kept pace with demand. As such we estimate a deficit in provision in both 2018 and 2019 of a similar amount, in both cases well over 1.5m hours. See Figure 1 below and Appendix 1.

Figure 1: Home care deficit – 2011 Baseline



We also looked at the more challenging 2008 baseline. 2008 was the year when provision peaked before the economic downturn adversely affected resourcing of home care. Using the more robust data we now have access to, we estimate a home care provision deficit for 2019 as shown in Figure 2, using the 2008 baseline of 4m hours (18% of the need). See Figure 2 and Appendix II.

Figure 2: Home care deficit – 2008 baseline



Analysis of Home Care Provision in 2018

Care Alliance Ireland does acknowledge that the level of resourcing of home care has increased significantly since 2013. This is to be welcomed. The challenge is that to stand still, as it were, there needs to be a 3% or more increase in provision annually. The harsh reductions in provision and associated accessibility in the 2009–2012 period have yet to be fully reversed.

Increases in funding are only keeping up with demographic pressures: The allocation of €412m in 2018 will provide for approximately 17.25m home care hours. This represents an increase of approximately 4.1 million hours (32%) since the low of 2012. However, as the demographic pressures of an ageing population are relentless, such an increase in nominal levels of provision has not restored the level of access to publicly funded home care that was present in 2008. It is of note that the *2018 HSE Service Plan* (p. 71), when looking at demographic and inflationary pressures, appears to provide for only a 1% increase in funding in the older persons' budget. This is considerably less than the population increase in this cohort, which is in excess of 3% annually. This means that Budget Day announcements around increases in home care tend to be merely playing catch-up with the relentless demographic pressures. As such, Budget announcements of increased funding may exaggerate the extent to which there will be actual increases in services.

Increased hourly cost of home care: In addition, due to a tighter labour market, collective agreements, increased levels of monitoring and higher qualification requirements for care staff, the hourly cost of home care has increased and now stands at approximately €25. This is likely to increase annually. It is clear that ongoing and significant annual increases in public resourcing of home care will be needed well into the future to meet the growing home care needs of our community.

Due to a tighter labour market, collective agreements, increased levels of monitoring and higher qualification requirements for care staff, the hourly cost of home care has also increased and now stands at approximately €25

Home care deficit is estimated at 18% for 2018: On the basis of the Freedom of Information request referred to above, and using data supplied by a number of HSE regions, the gap between clinically assessed need and actual home care provision is estimated at 15%. This figure, combined with the figures for the significant numbers on waiting lists (in excess of 6,100 currently), is relatively close to Care Alliance's own 2018 and 2019 home care deficit estimates of 18%, based on the 2008 baseline. It is significant that recently published Irish research[18] suggests that a high percentage (42%) of clients felt that they needed more intensive home care than they were currently in receipt of.

Restoring provision to the accessibility levels of a decade ago is only right for those in need of care, and for the families that continue to provide the overwhelming majority of care.

Recommendations

- **System-wide roll-out of the Single Assessment Tool (SAT):** In light of the data that our FOI has unearthed, we have concerns about the possible significant variation in approaches being taken by HSE practitioners at a local level with respect to assessment of home care support needs. We believe that the use of a Single Assessment Tool will to some extent address this issue. A number of HSE primary care practitioners we have spoken with are unaware of the new Single Assessment Tool. This suggests that the tool's roll-out continues to be slow and patchy rather than system-wide. The *2018 HSE Service Plan* is vague in its aspirations in regard to the roll-out of the Single Assessment Tool, stating that the HSE will seek to 'Continue to progress the implementation of the Single Assessment Tool across all CHOs.' An important metric in measuring progress would be the percentage of Assessments of Need undertaken in 2018 that use the approved InterRAI SAT. This was a metric included in the *2014 Service Plan*, but never reported on publicly or included in subsequent service plans.

An important metric in measuring progress would be the percentage of Assessments of Need undertaken in 2018 that use the approved InterRAI SAT

[18] D'Alton, M et al. (2018) 'The patient experience of home care services'. Paper presented at 66th Annual & Scienti¬fic Meeting of the Irish Gerontological Society: *Transforming Ageing Across Borders*, September 2018.

- **Increase in provision:** In spite of recent increases in home care resourcing, the deficit in home care provision continues. On a very conservative level, using 2011 as a baseline, we estimate a deficit in provision of in excess of 1.5m home care hours for 2018 and 2019. Using the more challenging baseline of 2008, we estimate a deficit in provision of 4m hours in 2018. This could be addressed by an injection in 2019 of approximately €110m, allowing for inevitable demographic pressures and for increases in hourly costs. Some of these resources could arguably be secured from the existing Fair Deal/residential care budget, the demand for which appears to have moderated or indeed reduced in recent years.

- **Annual increase in funding:** Such an increase in home care provision is unlikely to be practicable over a one-year time frame. A more realistic objective would be for a 10% nominal increase in home care resourcing annually for three to four years. This could result in annual high-single-figure increases in actual provision, allowing for the increasing cost of hourly provision. By then, there should be a legislative framework in place for home care that addresses the not insignificant challenges of sustainability of funding, labour availability and regulation.

A more realistic objective would be for a 10% nominal increase in home care resourcing annually for three to four years

- **Changes to process of tendering for home care provision:** Not-for-profit home care providers have been shown in recent years to be well placed to deliver high-quality home care, dementia care and home-based respite care. After some difficulties, there now seems to be a fuller appreciation by those commissioning care within the system that the race to the bottom in terms of hourly rates through the tendering process has had negative unintended consequences in the areas of consistency of care, complaints and zero-hour contracts, and has negatively impacted the availability of care during evenings and weekends.

- **System-wide roll-out of the Family Carer Needs Assessment tool alongside the Single Assessment Tool (SAT):** We welcome the modest once-off allocation of €180,000 under Dormant Funds to resource one HSE region to begin using the bespoke Family Carer Needs Assessment tool, in parallel with the use of the main Single Assessment Tool (SAT) for the dependent person. This new tool, however, needs to be rolled out throughout the HSE alongside the primary SAT.

- **Comprehensive dissemination plan for client home care guidelines:** There is work to be done in providing a clearer picture to clients and their families about the process of applying for and obtaining home care. We welcome the updated web-based guidelines, information booklet and application form. However, we are disappointed that there appears to have been no consultation with either not-for-profit providers or NGO advocates in the redesign of the booklet and application form. The apparent lack of user experience testing of the updated guidelines prior to publishing is also disappointing, and the fact that the updated guidelines appear to be currently accessible only online is potentially problematic. We recommend that the HSE create and operationalise a comprehensive dissemination plan for the new guidelines, using the existing infrastructure of Citizens Information Centres, health centres, post offices and the wide range of NGOs that successfully reach a large number of likely clients and their families.

- **Department of Health to prioritise the review of the home care scheme:** We do not get a sense that the statutory home care scheme is a departmental priority. Although identified as a priority by the Department of Health in a number of recent policy documents, we feel that progress has been very slow.[19] Whilst we acknowledge that policy and legislative reform can take time, it is now nearly two years since plans for a formal consultation about a statutory scheme were announced, yet the Department has yet to finally approve the scope of the planned reform. This may be in part due to the political challenges of raising the possibility of client financial contributions to the cost of home care. However, in light of the ongoing demographic and other pressures discussed above, the Department must make the statutory scheme a real priority for 2019. Whilst we in Care Alliance Ireland welcome the ongoing opportunity to influence this process, the process itself must move up a gear or risk losing momentum. The experience of the lengthy (circa 5 years) development of the Single Assessment Tool, followed by minimal implementation to date, must not be repeated in this instance.

- **As part of the current review of home care, there should be an assessment of the current volume of privately provided home care.**

- **As part of the current review of home care, there should be an independent exploration of the apparent material reduction over time in the home care support hours delivered per client.**

- **Create improved models for optimum home care levels:** The Department of Health should liaise with the HSE and other interested parties in developing more sophisticated models for assessing appropriate levels of home care provision based on international norms and agreed levels of dependency.

[19] Department of Health Business Priorities, 2017, 2018, and Department of Health Statement of Strategy 2016–2019, https://health.gov.ie/wp-content/uploads/2016/12/DoH-SoS-2016-2019-Final-En.pdf

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Appendix 1

Table 3: Estimated home care deficit using 2011 HSE service plan targets

Year	Home Help (mhrs) Notional Demand	Home Care Package (equivalent hours, assuming 6 hrs per week, mhrs) Notional Demand	Increase for Demographic Pressures	Total Hours Needed Based on 2011 Target Service Delivery per HSE Service Plan (mhrs)	Total Hours Delivered (mhrs)	Estimated Deficit (mhrs)
2011	11.98	3.19	1.00%	15.17	14.62	0.55
2012	12.37	3.29	1.0325%	15.66	13.1	2.56
2013	12.77	3.40	1.07%	16.17	13.86	2.131
2014	13.19	3.51	1.10%	16.70	14.31	2.39
2015	13.61	3.62	1.14%	17.24	15.21	2.03
2016	14.06	3.74	1.17%	17.80	15.71	2.09
2017	14.51	3.86	1.21%	18.38	16.67	1.71
2018e	14.98	3.99	1.25%	18.98	17.25	1.73
2019e1	15.47	4.12	1.29%	19.59	17.85	1.75

Notes

1. Assuming a 3.5% increase in hours provided in 2019.

2. mhrs = million hours.

3. Column 4 (Increase for Demographic Pressures) reflects the annual percentage increase in hours of home care needed to sustain the level of access (i.e. utilisation ratios). Demographic and other pressures are estimated at 3.25% annually.

4. e and e1 are estimates.

Appendix 2

Table 4: Estimated home care deficit using 2008 HSE provision

Year	Home Help (mhrs) Notional Demand	Home Care Package (equivalent hours, assuming 6 hrs per week, mhrs) Notional Demand	Increase for Demographic Pressures	Total Hours Needed Based on 2008 Target Service Delivery per HSE Service Plan (mhrs)	Total Hours Delivered (mhrs)	Estimated Deficit (mhrs)
2008	12.60	2.81	1.00	15.41	15.41	0
2009	13.00	2.90	1.03	15.90	14.69	1.21
2010	13.43	2.99	1.07	16.42	14.78	1.74
2011	13.87	3.09	1.10	16.96	14.62	2.34
2012	14.32	3.19	1.14	17.51	13.1	4.41
2013	14.78	3.30	1.17	18.08	13.86	4.22
2014	15.27	3.40	1.21	18.67	14.31	4.36
2015	15.76	3.52	1.25	19.28	15.21	4.07
2016	16.27	3.63	1.29	19.99	15.71	4.28
2017	16.80	3.75	1.33	20.55	16.67	3.88
2018e	17.34	3.87	1.37	21.21	17.25	3.96
2019e1	17.91	3.99	1.42	21.90	17.85	4.05

Notes

1. Assuming a 3.5% increase in hours provided in 2019.

2. mhrs = million hours.

3. Column 4 (Increase for Demographic Pressures) reflects the annual percentage increase in hours of home care needed to sustain the level of access (i.e. utilisation ratios). Demographic and other pressures are estimated at 3.25% annually.

4. e and e1 are estimates (2018 & 2019).

Care Alliance Ireland

Guiding support for family carers

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