The Future Organisation of the Home Help Service in Ireland

National Council on Ageing and Older People
THE FUTURE ORGANISATION OF THE HOME HELP SERVICE IN IRELAND
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Policy Research Centre, National College of Ireland

Research Team/Authors
Dr Deirdre Haslett
Dr Helen Ruddle
Ms Geraldine Hennessy

NATIONAL COUNCIL ON AGEING AND OLDER PEOPLE
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Foreword

The National Council on Ageing and Older People is pleased to have been involved with this project examining the future organisation of the home help service in Ireland. At the request of the Minister for Health and Children, the Council established a Consultative Committee to oversee the preparation of the report, which was commissioned by the Department of Health and Children and undertaken by the Policy Research Centre of the National College of Industrial Relations, now the National College of Ireland.

The report builds on earlier work completed by the Council which examined home help service provision for older people in Ireland. This work recommended a fundamental redefinition and reorganisation of the service to ensure availability to all older people in the country who need it on the grounds of dependency and social circumstances.

The research literature states conclusively that the vast majority of older people wish to remain living in their own homes for as long as possible. The home help service is a vital part of the continuum of care necessary to facilitate older people in achieving this wish.

The Council’s recent publication *The Years Ahead Report: A Review of the Implementation of its Recommendations* identified a number of key problems with the home help service. One of the main issues identified includes the discretionary nature of access to home help services which has resulted in differences in a number of areas including, eligibility for the service, the level of provision of the service, and the costs associated with use of the service. In addition the absence of out-of-hours and weekend provision was identified.

The Council has argued that the home help service should be designated as a ‘core’ community service underpinned by legislation and appropriate funding. It agrees with the authors of this study that, after a decade of discussion, what is now required is the provision of a service with designated funding and agreed national quality standards. The Council also believes *inter alia* that there is a need for the immediate extension of a weekend and twilight home help service to all areas of the country.

The Council wishes to thank Dr Deirdre Haslett, Dr Helen Ruddle and Ms Geraldine Hennessy from the Policy Research Centre of the National College
of Ireland for preparing the report in accordance with the Department of Health and Children's brief for the study.

It would also like to thank the members of the Consultative Committee for their comments and advice at a number of meetings. In particular it would like to thank Mr Martin Duffy, Director of Corporate Strategy, Mid-Western Health Board, for chairing the committee. The other committee members were Mr Alan Aylward, Mr John Brady, Mr Michael White, Dr Davida de la Harpe, Ms Ann Harris, Ms Una Doherty, Ms Dervilla Doyle, Mrs Kathleen Callaghan, Ms Marie Mates, Ms Margaret Geary, Ms Dolores O'Neill, Mr J Lee, Mr Adrian Charles, Mr Frank Goodwin and Mr Niall Walsh.

The Council would also like to thank its Director, Mr Bob Carroll, its Research Officer, Mr Frank Houghton and its former Research Officer, Mr John Browne for assisting the Consultative Committee in its work and facilitating liaison between the Committee and the authors of the report. It also thanks Ms Catherine Mulvenna for organising publication of the report and Ms Ann Ward for secretarial support throughout the course of the project.
Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td></td>
<td>v</td>
</tr>
<tr>
<td>Executive Summary</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Chapter 1</td>
<td>Background to the Study</td>
<td>15</td>
</tr>
<tr>
<td>1.1</td>
<td>Introduction</td>
<td>15</td>
</tr>
<tr>
<td>1.2</td>
<td>Focus of the Study</td>
<td>16</td>
</tr>
<tr>
<td>1.3</td>
<td>Problems Identified in the Service</td>
<td>16</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Policy Issues</td>
<td>17</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Practice Issues</td>
<td>21</td>
</tr>
<tr>
<td>1.3.3</td>
<td>Organisation and Administration of the Service</td>
<td>25</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>The Consultation Process</td>
<td>33</td>
</tr>
<tr>
<td>2.1</td>
<td>Introduction</td>
<td>33</td>
</tr>
<tr>
<td>2.2</td>
<td>The Consultation Process</td>
<td>33</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Service Providers</td>
<td>34</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Managers of Voluntary Organisations</td>
<td>36</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Older People</td>
<td>36</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Carers</td>
<td>37</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Programme Managers for Community Care</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>(representing Chief Executive Officers of health boards)</td>
<td></td>
</tr>
<tr>
<td>Chapter 3</td>
<td>Summary of Key Findings from the Consultation Process</td>
<td>39</td>
</tr>
<tr>
<td>3.1</td>
<td>Introduction</td>
<td>39</td>
</tr>
<tr>
<td>3.2</td>
<td>Policy Issues</td>
<td>39</td>
</tr>
<tr>
<td>3.2.1</td>
<td>The Legal Basis of the Service</td>
<td>39</td>
</tr>
<tr>
<td>3.2.2</td>
<td>The Role and Purpose of the Home Help Service</td>
<td>42</td>
</tr>
<tr>
<td>3.3</td>
<td>Practice Issues</td>
<td>43</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Nature of Service Provided</td>
<td>43</td>
</tr>
<tr>
<td>3.3.2</td>
<td>Assessment of Need</td>
<td>44</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Standards of Service Provision</td>
<td>45</td>
</tr>
<tr>
<td>3.4</td>
<td>Issues of Organisation and Administration</td>
<td>47</td>
</tr>
<tr>
<td>3.4.1</td>
<td>Models of Service Provision</td>
<td>47</td>
</tr>
<tr>
<td>3.4.2</td>
<td>Organisational Structure of the Home Help Service</td>
<td>47</td>
</tr>
<tr>
<td>3.4.3</td>
<td>The Role of Voluntary Organisations</td>
<td>48</td>
</tr>
<tr>
<td>3.4.4</td>
<td>Criteria for Eligibility</td>
<td>49</td>
</tr>
</tbody>
</table>
This report was commissioned by the Department of Health and Children and was undertaken by the Policy Research Centre at the National College of Ireland. It has been published as submitted by the Policy Research Centre to the National Council on Ageing and Older People.

Appendices to accompany the report are available from the National Council on Ageing and Older People. These are (i) Geographical Distribution of Groups of Respondents (ii) Schedules used in the Consultation Process (iii) Results of Consultation Process.
Executive Summary

INTRODUCTION
It is widely acknowledged, not only in Ireland but internationally, that home help is one of the key services in the community care of older people. Since its introduction in 1972 the service has changed and developed across and within the different health boards.

Following several reports in recent years a great deal is known about the home help service in Ireland – its scale and intensity, entitlement to the service, modes of delivery, its voluntary sector aspects, its comparisons with several European regions and so on.

It is not the purpose of this study to reiterate the findings of these reports, but rather to explore the many recommendations that have emanated from these various reviews with a focus on finding solutions, which would be acceptable and agreed to all the parties involved, to the numerous problems previously and repeatedly identified. The present study is designed to build upon these reviews in order to radically reform the home help service and, *inter alia*, achieve the targets referred to in the 1994 Department of Health National Strategy document *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s*.

The home help service is also available to client groups other than older people, including people with physical and mental disabilities, at-risk families and people suffering from psychiatric illness. This study is centred on home help for older people. This particular focus has been chosen because older people comprise over 80 per cent of the clients of home help and because a research base already exists on the needs and problems of this group in relation to the service.

PROBLEMS IDENTIFIED IN THE SERVICE
As a result of the studies and reviews referred to above, problems have been identified in the home help service related to:

- policy issues
- practice on the ground
- organisation and administration of the service
In the area of **policy**, the main issues arising relate to:

- the legal basis of the service
- the role and purpose of the service

In the areas of **practice**, the main issues arising relate to:

- nature of the service provided
- assessment of need
- standards of provision

Finally in the area of **organisation and administration**, the primary issues arising relate to:

- diversity in models of organisation and delivery of service
- the role of voluntary organisations
- eligibility criteria for the service
- funding issues
- training of Service Providers

**Consultation Process**

In the summer of 1997, the Department of Health, commissioned a study designed to:

>'culminate in recommendations as to how a quality Home Help service might be made available to all who need it, on a statutory basis if necessary'.

With the focus on providing agreed solutions to the problems, a nationwide process of consultation was to be carried out which would involve all the partners concerned with the home help service.

With the co-operation of the health boards and several representative organisations throughout the country, the consultation process took place between November 1997 and April 1998. Consultations, through interviews and structured focus discussion groups, took place with Service Providers, clients (older people and carers) and Managers (both statutory and voluntary) of the home help services throughout all eight health board regions of the country.

**Conclusions and Recommendations**

(a) **Policy Issues**

*Legal basis of the service*

Discussion with the parties produced arguments both in favour of legislation and arguments against. The primary arguments in favour of legislation were:
EXECUTIVE SUMMARY

- it would give recognition to the service
- evolution of the service has been very slow, and legislation could speed it up
- it would copperfasten funding

The major arguments against legislation were:

- lack of flexibility thus preventing a health board from meeting a particular need from a particular client or client group
- inefficient use of the service
- further delay in reforming the service
- funding may get out of control
- legal challenges

However, whether groups were primarily in favour of legislation or not, consultation with all the parties in this study indicated numerous and repeatedly articulated anxieties and concerns about many aspects of the home help service. Some of the major concerns were:

- the service was perceived as lacking recognition
- it was not seen as a real priority and therefore suffered from a lack of funding
- it had suffered from slow development over the years
- there was a lack of standardisation at many levels which resulted in unevenness and inequity
- there was no right of redress
- from the point of view of the voluntary organisations there was a lack of parity

Recommendations

There is a real danger that, because of the complexities surrounding legislation in this area, calling, yet again, for the legalisation of the home help service with only have the effect of further delaying any attempts at reform.

What is vitally important, after a decade of discussion, analysis and synthesis, is the provision of a service with designated funding and agreed quality national standards. The future organisation of the home help service must address and implement these changes:

- clarification of the nature of the service provided by Home Helps
- explicit and agreed criteria for assessment of need
- standardised criteria for entitlement
• contractual service agreements with the voluntary organisations
• national guidelines for level of service provision based on assessed needs
• recognition of the home help service as a service in its own right, within the overall health services
• recognised training for Home Helps and Home Help Organisers
• uniform rates of pay

If these changes are implemented the issue of the legal basis may become secondary. If these changes are not implemented the demand for legislation may become irresistible.

The role and purpose of the service
There were very high levels of agreement between all partners on all aspects of the role and purpose of the home help service. The days of the 'good neighbour' basis of the home help service are disappearing – the majority view of all groups was that the home help service should be run as a professional service to which certain categories of people are clearly entitled rather than be regarded as a 'good neighbour' service. The older people, who by and large love their Home Helps and see them as caring friends, want them to receive fair treatment from the health boards. Many of them pointed out that Home Helps often do a great deal more than they are paid for, and the older people felt embarrassed and annoyed at this.

The majority view of all groups consulted in this study was that the home help service should be provided for older people whether they are supported by their families and neighbours or not. Many of the older people, in particular, felt very strongly that even where they had families, they should not have to rely on them for care. Many expressed the view that older people want to keep their independence. They do not want to have to rely on their families or neighbours. To this end Home Helps should be available to all older people, whether they have the help of family and neighbours or not.

Many of the recent policy shifts in Ireland have not been informed by deliberate consultation with older people themselves. There is no doubt from the findings of this study that independence from family and neighbours is emerging as a priority need among older people themselves. They want to stay in their homes but they do not expect or even want their adult children, and much less their neighbours, to have to care for them.

The majority view of all groups was that the home help service should take account of the needs of family carers as well as the older person. The majority of the carers consulted in this study, were of the opinion that what carers need
most from home help is respite from care-giving, as opposed, for example, to assistance with household care or with personal care of the older person. Some thought that regular breaks in daytime care-giving would be most welcome, whereas others felt that regular holiday relief would be better. Others chose regular breaks in weekend care-giving whereas relief in times of illness would be more valued by others.

The Health Strategy (Department of Health, 1994) explicitly includes carers as well as older people as the intended targets for strengthened support from home help (among other services).

**Implications for Implementation**

All of these aspects were agreed on by the Programme Managers in spite of the fact that their implementation would have substantial financial, administrative and staffing implications.

The financial implications of a professional service to which certain categories of people are clearly entitled are considerable. Professionalisation of the service implies increased costs for increased training, leading to increased standards and higher pay rates. The issue of entitlement has implications and so the criteria for eligibility will need to be very clear.

If the home help service is provided for older people, whether they are supported by their families and neighbours or not, the increased number of Home Helps required would lead to increased costs. This would result in administrative problems in managing the numbers of part-time staff for payroll and staff records.

If the home help service takes account of the needs of family carers as well as the older person, there would be a considerable cost through increased demand for service, but it could not be quantified. An assessment process would be required to take account of the needs of family carers, leading to a need for more Home Helps, and more Assistant Organisers/Supervisors.

**Recommendations**

The introduction of a service with agreed quality standards will transform the home help services into a quality service with standards, available to all older people in need. The call from the National Council on Ageing and Older People (Lundström and McKeown, 1994) that the home help service is redefined to take account of the needs of family and informal carers is reiterated.
(b) Practice Issues

Nature of the service provided

All of the older people interviewed, with one exception, said that if their needs changed and they required more personal care, they would want their Home Helps to give them this care. Most of the older people were clearly very attached to their Home Helps and were adamant that they did not want personal care from other people. Most would prefer just the one person to give whatever care they might need. There was also enormous support for this direction from the Service Providers, the voluntary organisations and the carers.

Although the Programme Managers were in favour of Home Helps providing personal care they saw considerable cost difficulties in formalising the level of care to be given by Home Helps. There would be the increased costs of training, supervision and assessing suitability of personnel.

Generally speaking the Programme Managers, in keeping with the recommendation of the National Council on Ageing and Older People, saw a need for the functions of both Home Helps and Care Assistants/Attendants to be more clearly defined. A revamped service should provide for both categories who might complement each other's skills. Whether all of these skills can reside in one person will depend on the circumstances of each case. Several of them felt that, with appropriate training, both of these functions could be carried out by some Home Helps. Training for all Home Helps in personal care of more dependent and disabled clients is costly and unnecessary in most cases.

Apart from help which can be regarded primarily as task-based (household tasks and personal care tasks) many of the older people emphasised, repeatedly, how lonely they would be without visits from their Home Helps. There is no doubt that to many older people living alone, the Home Help as listener, as friend, as confidant, as companion, was just as important as the Home Help who makes a meal, changes bedding or helps with personal hygiene.

This need was appreciated by the vast majority of Service Providers. That they recognise and have confidence in the listening, befriending and caring services provided by Home Helps - services that are provided despite the absence of a formal job description and recognised training - is indicative of the personal qualities of Home Helps in Ireland and of the qualities sought by those who recruit them.

Recommendations

All Home Helps will continue to provide the necessary level of household and domestic support which is essential to keeping an elderly person at home. This
aspect of the service is of vital importance and has to be recognised and respected as valuable and of consequence.

Hand in hand with household care all Home Helps must provide supportive and emotional care. Being able to provide care for the whole person is not simply a matter of being a ‘good woman’, or a ‘good man’ for that matter. The Home Helps and Home Help Organisers recognise this by requesting overwhelmingly that listening and communication skills be one of the core modules in any new training programme. It is essential that any standard training programme for Home Helps acknowledges this aspect of care as essential to the role of home help.

With regard to personal care, all home helps should receive core training in the personal care issues which commonly, if not always, affect older people. More specialised personal care training, such as severe incontinence management, should be delivered through training modules as needed.

Home Helps should not, as a rule, be involved in activities which would be regarded as nursing duties (there are common-sense exceptions to this where a Home Help has a nursing background).

In any consideration of the future organisation of the home help service, and its relationship with the Care Assistant/Attendant service, the wishes of older people, clearly and strongly expressed by them in this study, must be to the forefront.

Assessment of need

The majority view among Service Providers and the Programme Managers was that specific criteria for assessing need are necessary.

Recommendations

A number of the health boards have needs assessment forms and others are currently devising similar forms. It seems that with the clear unanimity coming from this study for agreed standards on assessment of needs and the essential characteristics of needs, it should not be a difficult exercise to devise a common, standard, national approach to the assessment of the needs of older people for home help. A template, when drawn up, can be discussed among the health boards and a standardised approach agreed upon.

Standards of service provision

Standardisation of number of hours of service in relation to defined criteria of needs and existing available services

The majority view of Service Providers and of the voluntary organisations was that the number of hours of home help given to older people should be left to the
discretion of the Home Help Organiser or equivalent person. The view of Programme Managers was that the number of hours given should be standardised according to defined criteria of needs. Many of the older people complained that a minimum of one hour at a time is of very little use. A visit should last two hours to make it worthwhile.

Several of the Programme Managers saw standardisation of the number of hours of service as part of the 'agreed quality standards' process, and suggested a detailed process of standardisation which could be presented to the health boards for discussion and agreement.

**Recommendations**

It is recognised that there are apparent difficulties here. It might be the case that the apparent physical needs of, and resources available to, two elderly people might be almost identical but their emotional needs might be so different that one needs more time from her Home Help than the other. Time is needed for this kind of caring.

While acknowledging these difficulties, equity, and the delivery of a quality service, requires that guidelines for the standardisation of hours, as related to needs and the availability of other services, be drawn up. It is recommended that a Working Group, representative of the health boards, the voluntary organisations, professionals and Service Providers, be established by the Chief Executive Officers of the health boards, in order to draw up these guidelines.

It is recommended that the Working Group, having agreed a common basis for weighting standardised assessment criteria for need and having agreed weights for the availability of other care services will then determine the hours required to implement a quality service. It is recommended that, in order to ensure that, along with equity there is a level of flexibility, that the hours be banded with lower and upper limits.

It is recommended that this Working Group report within two months of being established.

**Hours of service**

The majority view of all groups consulted in this study was that a 'normal' home help service as opposed to an 'emergency' service should operate after hours on weekdays and at weekends, as well as during office hours.

**Recommendations**

With the increasing emphasis on the location of care to the home, and bearing in mind the targets of the National Strategy (Department of Health, 1994), the
demand for a service which operates at the weekend and after hours on weekdays is becoming more evident. It makes sense that if an older person needs support for the everyday tasks of living during the week, this may also apply at the weekends.

(c) Issues of Organisation and Administration

Models of service provision and organisational structure
In this study, the Programme Managers were of the view that there should be one, standardised model for the delivery of the home help service throughout the country. The majority view of both the Home Help Organisers and the Home Helps was that Home Help should be recognised as a service within its own right. Many of the Home Help Organisers felt that the home help services should be recognised primarily as a social service with health care dimensions, rather than as a health service with social care dimensions. They want to see it develop parallel to, but independent of, other caring disciplines while at the same time, liaising closely with them.

Recommendations
The ability of the home help service to fulfil its purpose of maintaining older people at home depends on it having a specific place on a continuum of care options, with liaison and co-ordination between different stages on the continuum. In the context of the overall provision of a package of care for older people, it is recommended that the home help service should have its own identity and its own organisational structure within the health services, parallel to, but also with strong links to, the public health nursing and other services.

In order to develop as a core service, and to contribute to realising the targets set out in the National Strategy (Department of Health, 1994) the home help service must have parity of esteem with other community care services. It should have its own devolved budget as part of the new general manager structure with a reporting relationship similar to other parts of the health service. The Home Help Organiser would be responsible for recruitment and placement of staff, and for personnel matters such as payment of wages.

The role of voluntary organisations
The findings of this study report that, from the point of view of the voluntary organisations, there were considerable difficulties in their relationships with the health boards. Apart from the often mentioned funding difficulties, repeated references were made to the lack of consultation, the information gap, and the failure of the boards to appoint development officers. There was the need for full and regular consultation between the health board and the voluntary organisations before decisions are made in regard to service provision.
Recommendations
The participation of the voluntary organisations in providing home help services is not only a desirable objective of social policy, but, in some parts of the country, essential to the very existence of the service. Both the statutory and voluntary sectors need to be given the conditions to provide a seamless quality service:

- The voluntary organisations must be further developed
- The issues of service agreements and funding for the voluntary sector must be addressed, including the introduction of an appeals procedure
- The criteria for assessment of need and entitlement must be the same for both sectors
- Standards of provision must be broadly standardised
- Pay rates and training (as they apply to both Home Helps and Home Help Organisers) must be the same for both sectors
- Problems relating to the information gap must be addressed. All professionally managed Home Help organisations should be equipped with appropriate software with which to run the service.

These essential reforms will eliminate the contentious variations in service, promote equity, help meet the targets of the National Strategy and enhance the partnership between both sectors.

Determining financial eligibility including charges for non-medical card holders
In this study, the Programme Managers were of the view that the possession of a medical card should determine entitlement to the home help service. They saw it as an acceptable, measurable and agreed criteria of eligibility which is standardised across the country. They argued that it ensures equity in the disbursement of resources and eliminates the need for invasive income enquiries. As a result, services would be provided to those who can least afford it.

These arguments did not find favour with the Service Providers, many of whom were of the view that often the ‘wrong people’ ended up with medical cards (one oft-quoted example was that of EU residents who had retired here and were automatically entitled to a medical card regardless of their means) and others were denied one when they were more in need. The anecdotal observation, that often older people who just failed to qualify for a medical card had a burden of costs to carry, was a source of anxiety to many Service Providers.

For these and similar reasons, the majority view of the Home Help Organisers and the Public Health Nurses was that older people should be means tested to determine entitlement to the home help service and many of them would have
supported this on equity grounds. The older people themselves, however, made it very clear that they were very adverse to the idea of means testing, regarding it as a terrible invasion of privacy.

The Programme Managers were not enthusiastic about the idea of means testing on the grounds of convenience as well as equity. Means testing would add to the administration involved and would have to be reviewed regularly. More staff would be required for administration leading to greater costs.

The Home Helps, the other Service Providers, the carers and the voluntary organisations were of the view that the home help service should be available to all older people regardless of their means or whether or not they have a medical card.

Recommendations
It has been acknowledged over and over again, in this and other studies, that the home help service is critical to permitting older people stay in their own homes. Where need has been established, elderly medical card holders should be entitled to a home help service which is free of charges or contributions. Where voluntary organisations are providing home help services to elderly medical card holders, they must get the funding to do so at the same level of service as that provided by the health board, without having to levy charges or request contributions.

The practice of levying charges or asking for contributions from medical card holders, which still exists in some health boards, should be discontinued on both cost-effectiveness and equity grounds.

Although it is the case that, strictly speaking, health boards are entitled to charge medical card holders for services for which rules governing charges have not been set down in legislation (such as community paramedical services, day care centres and home help) it is, in the words of the National Strategy:

 inequitable that a person’s entitlement to a service should depend on the area in which he or she happens to live. (Department of Health, 1994).

There needs to be a very flexible approach in the granting of medical cards to elderly people.

In the case of elderly non-medical card holders many will wish to, and do, make their own private arrangements for help in the home. However, in the case of elderly non-medical card holders who do not wish to, or are unable, to make their own arrangements, and where need has been established, the health board or voluntary organisation must still supply the same quality service as will be given to medical card holders, with an appropriate charge. It is recommended
that the drawing up of guidelines for these charges be referred to the Working Group, established by the Chief Executive Officers of the health boards. As stated earlier, it is recommended that this Working Group report within two months of being established.

**Pay for Home Helps**

Although the issue of pay for Home Helps was not within the terms of reference of the study, it was felt that it had to be referred to, given the importance attached to the subject by all of the participants.

It has been acknowledged, both by the participants consulted in this study and by other studies, that the system of remuneration and the rates of pay for Home Helps are not satisfactory. There was a general agreement among all the groups consulted in this study that the question of pay for Home Helps needs to be addressed.

**Recommendation**

The question of remuneration for Home Helps needs to be addressed urgently. Regard must be given to the recommendations of the National Minimum Wage Commission. Rates of pay must be standardised across all health boards.

**Training of Home Helps**

The results from this study show that there was general agreement in all groups on the need for training for Home Helps and a requirement from Home Help Organisers for training for themselves.

**Recommendations**

It is strongly felt that procedures for the training of Home Helps must be implemented immediately. Not only will training improve the standard of care within the community and prevent institutionalisation, but it will also afford greater protection to provider agencies in the event of litigation.

Training for Home Helps would consist of two elements. The first would be a national standard induction course, which would be a basic requirement for all Home Helps, both part time and full time. The course would consist of a number of core modules, for example, communication skills and health and safety at work.

The second element would consist of appropriate modules which would be added on to allow specific groups of Home Helps to cope with specific situations (for example, modules on conditions such as Alzheimer’s Disease and incontinence). The combination of these elements would ensure that all Home Helps had training appropriate to the level of care they were giving.
All modules must be delivered both with sensitivity to the learning needs of adults and with sensitivity to the other responsibilities which part-time Home Helps, in particular, may have.

Access to bereavement counselling is important for Home Helps where an older person in their care has died.

The training of Home Help Organisers would consist of a national, standard course, which would be a requirement for all Organisers and Assistant Organisers. As with the induction course for Home Helps it would have standards, would be recognised as a training course, with national accreditation and would be paid for by the employer.

**SUMMARY: A SERVICE WITH AGREED QUALITY STANDARDS**
The primary recommendation of this study, in keeping with several previous studies, is that the home help service is regarded, presented and resourced as a core community service, fundamentally vital to the stated national policy which is to maintain older people in dignity and independence at home. In order to produce a core, quality service with agreed quality standards, the future organisation of the home help service must address these issues. It must:

- Clarify the nature of the service provided by Home Helps;
- Reflect this clarification in training programmes for Home Helps and Home Help Organisers;
- Further reflect the core nature of the service in the rates of remuneration and conditions of work for Home Helps;
- Draw up explicit and agreed criteria for assessment of need of client which will apply nationally;
- Standardise criteria for entitlement, including carefully considering obligations to all older people in need regardless of their means;
- Determine national guidelines for the level of service provision based on assessed needs;
- Implement an organisational structure for the home help service within the health services;
- Have regard for the inter-dependence of the voluntary organisations and the health boards, with mutual recognition of each other’s respective role and ethos.

None of these recommendations will be without cost. Between 1994 and 1997 the costs of the home help service increased from £14.18 million to £19.59 million. Implementing the recommendations in this study will cause them to increase a great deal more. Maintaining older people in dignity and
independence at home, in accordance with their wishes for a quality service, is not a cheap option. There will be a cost; there will be a price to pay; there is no doubt, however, that everyone involved in this study, managers, providers and beneficiaries strongly believe that our older people deserve nothing less.
CHAPTER ONE

Background to the Study

1.1  INTRODUCTION

It is widely acknowledged, not only in Ireland but internationally, that home help is one of the key services in the community care of older people. Since its introduction in 1972 the service has changed and developed across and within the different health boards. At present there are about 12,000 (mostly part-time) Home Helps and approximately 20,000 recipients of the service (Aylward, 1998). There are at present six different models of service delivery operating around the country, and the nature of the service provided and the criteria of need and eligibility vary considerably from health board to health board (Lundström and McKeown, 1994).

The Department of Health, in 1994, produced a seminal document – *Shaping a Healthier Future* – which detailed the national strategy for effective healthcare for Ireland for the 1990s (Department of Health, 1994). Based on the principles of equity, quality of service and accountability, and addressing the concepts of health gain and social gain, the document, in its reference to services for older people, states, *inter alia*:

*Priority in the next four years will be given to strengthening the role of the Home Help and other primary care professionals in supporting older people and their carers who live at home. The target will be to ensure that not less than 90% of those over 75 years of age continue to live at home.*

The rapid rise in the number of people in the oldest age groups currently poses, and will continue to pose into the next millennium, a special challenge to the home help and other community health services for older people. The National Council on Ageing and Older People (formerly the National Council for the Elderly) – an advisory body to the Minister for Health – in a recent review of the demography of ageing and older people in Ireland, indicated that the population aged 65 years or more will grow by approximately 108,000 persons in the period 1996-2011. Currently 22 per cent of older people are aged 80 years or more and this percentage is projected to increase to 25 per cent by the year 2011. (National Council on Ageing and Older People, 1997; Central Statistics Office, 1997).
1.2 Focus of the Study
Following on the 1994 National Council for the Elderly report (Lundström and McKeown, 1994), the Review of The Years Ahead Report (Ruddle et al., 1997) and several health board reports (e.g. Eastern Health Board, 1996; Midland Health Board, 1997; Southern Health Board, 1995) a great deal is known about the home help service in Ireland – its scale and intensity, entitlement to the service, modes of delivery, its voluntary sector aspects, its comparisons with several European regions and so on.

It is not the purpose of this study to reiterate the findings of these reports, but rather to explore the many recommendations that have emanated from these various reviews with a focus on finding solutions, which would be acceptable and agreed to by all the parties, to the numerous problems previously and repeatedly identified. The present study is designed to build upon these reviews in order to bring forward recommendations for appropriately developing the home help service and, inter alia, achieving the targets referred to in the 1994 Department of Health National Strategy document.

The home help service is also available to client groups other than older people, including people with physical and mental disabilities, at-risk families and people suffering from psychiatric illness. This study is centred on home help for older people. This particular focus has been chosen because older people comprise over 80 per cent of the clients of home help and because a research base already exists on the needs and problems of this group in relation to the service.

1.3 Problems Identified in the Service
As a result of the studies and reviews referred to above, problems have been identified in the home help service related to:

- policy issues
- practice on the ground
- organisation and administration of the service

In the area of policy, the main issues relate to:

- the legal basis of the service
- the role and purpose of the service

In the areas of practice the main issues arising relate to:

- nature of the service provided
- assessment of need
- standards of provision
Finally in the area of **organisation and administration**, the primary issues arising relate to:

- diversity in models of organisation and delivery of service
- the role of voluntary organisations
- eligibility criteria for the service
- funding issues
- training of Service Providers

### 1.3.1 Policy Issues

**The Legal Basis of the Service**

The home help service in this country was established under Section 61 of the *Health Act, 1970* and became operative in 1972 when Circular 11/72 with an attached memorandum was sent to the Chief Executive Officer of each health board (Department of Health, 1972). Section 61 of the *Health Act, 1970* states that a health board ‘may make arrangements to assist in the maintenance at home’ of certain categories of people — the word ‘may’ thereby empowering but not requiring the health boards to provide a home help service.

*The Years Ahead* report, which since 1988 constitutes official policy on the care of older people, recommended that:

> ‘Health boards should be legally obliged to provide or make arrangements to provide services to maintain persons at home who would otherwise require care in another setting’ (Department of Health, 1988).

The call for legislation to make home help a mandatory service has been repeated by the National Council for the Elderly in several reports since publication of *The Years Ahead* including Mulvihill (1993) and Lundström and McKeown (1994). In the latter study, the National Council for the Elderly argued that the absence of a legal obligation has constrained the evolution of the service and has left it:

> ‘vulnerable to underfunding, restricted allocation and lack of investment in training and the simple infrastructure needed to develop it further’ (Lundström and McKeown, 1994).

The National Council for the Elderly has also pointed out that within the Irish jurisdiction the legislative provision for home help is loosely framed compared with other services supplied by the health boards under the *Health Act, 1970* such as acute hospital services, home nursing and general practitioner services, all of which are regarded as obligatory rather than discretionary.

Lundström and McKeown (1994) show that the discretionary nature of the service in this country is very different from the three other jurisdictions...
examined in their study – Northern Ireland, Britain and Sweden – where there is a mandatory requirement on the agencies concerned to provide a home help service.

The Department of Health’s seminal document – *Shaping a Healthier Future* – which detailed the national strategy for effective healthcare for Ireland for the 1990s reaffirmed the role of home help, among other services, in supporting older people in living at home, and promised the development of national guidelines on eligibility for those services currently without such legislative provisions (Department of Health, 1994). However, the Review of The Years Ahead Report (Ruddle *et al.*, 1997) noted the continuing lack of a legislative underpinning in the service and included yet another call from the National Council on Ageing and Older People to have home help designated as a core service that would be provided as an entitlement rather than on a discretionary basis.

Mangan, in her discussion on the need for a legislative framework to govern the provision of essential services for older people, warns that too much reliance can be placed on the existence of a legal framework to provide the answer to complex problems and that legislation can sometimes restrict the development of a service (Mangan, 1998). The only piece of major legislation on services for older people which has been passed since 1988 is the *Health (Nursing Homes) Act 1990* and, in Mangan’s view, aspects of this legislation provide a good example of how not to provide for clear and enforceable rights.

There is a widespread feeling that lack of legislation is highly correlated with lack of resources and, thus, the presence of legislation will guarantee resources. Mangan argues that this does not necessarily follow. If obligations are clear (and she quotes examples of a number of social welfare ‘free’ services) and there is a clear right of redress for the older person (for example, access to the Ombudsman) then, in her view, resources must follow. She gives as examples national agreements such as the Programme for Economic and Social Progress (1991), the Programme for Competitiveness and Work (1994) and Partnership 2000 (1996) which have been significant in increasing service provision in recent years.

Mangan agrees with the National Council on Ageing and Older People that home help should be recognised as a core service with a legal obligation for its provision but argues that, as well as providing a legal underpinning for the service, the legal framework must also be enabling rather than restrictive and must allow Service Providers to develop new services and deliver them in imaginative and responsive ways.
Purpose of Home Help

When the home help service was established under the Health Act, 1970 (Section 61), its stated purpose was to enable people to be maintained at home who otherwise would require to be cared for in an institutional setting. It is not clear from the Health Act whether the desired benefit of maintaining people at home was enhanced quality of life, decreased pressure on hospital beds or lower costs. The Health Strategy (Department of Health, 1994) reaffirms the role of home help, among other services, in supporting older people at home, and sets the strengthening of the service as one of its priorities. Unlike the 1970 Health Act, Shaping a Healthier Future, in setting down this priority, does refer to quality of life as its intended outcome and speaks, for example, of wanting to:

'maintain older people in dignity and independence at home, in accordance with the wishes of older people as expressed in many research studies'.

The ability of the home help service to fulfil its purpose of maintaining older people at home, in dignity and independence, depends on it having a specific place on a continuum of care options, with liaison and co-ordination between different stages on the continuum. Issues that have to be faced in this context are the interrelationships between the home help service and preventative and anticipatory care, home nursing, hospital care, nursing home care and residential care. Findings from the Review of The Years Ahead (Ruddle et al., 1997) indicate, for example, that liaison and co-ordination between hospital care and community care Service Providers is often inadequate and that the focus can be more on freeing hospital beds than on identifying the most appropriate service for a given older person. Likewise, the findings reveal inadequacies in the provision of preventative and anticipatory care, home nursing and residential options.

A policy on health care that emphasises staying put in one's own home implies that there should be a shift in resources from institutional to community care. The Review of The Years Ahead shows, however, that such a shift in resources has not taken place. On the contrary, it was institutional care which was given a major boost in the 1990s through the enactment of the 1990 Health (Nursing Homes) Act and the allocation of £65 million to implement the Act over the period 1990-1997.

Role of Home Help

Jamieson (1991) in her cross-national examination of home care, classified the countries studied into one of three points on a continuum where home help:

- replaced informal care (e.g. Denmark)
- supported/encouraged informal care (e.g. UK)
- provided a safety net for those with no formal care (e.g. Germany)
In this country, Circular 11/72 assigned a residual or safety net role to home help by advising that the service was to be allocated only in those circumstances where the support of families or neighbours could not be marshalled (Department of Health, 1972). In practice, older people without family support continue to be the main client group of home help. Since the mid-1980s a number of research reports have highlighted the key role that family carers play in community care, and findings on the stress and burden of caring have lent weight to the lobby for support of carers as well as those for whom they care (O'Connor and Ruddle, 1988; Blackwell et al., 1992; O'Shea and Hughes, 1994).

The Joint Committee on Women's Rights (1996) estimated that, based on current morbidity patterns, population growth and care provisions, between 100,000 and 110,000 older people will require home care by the year 2011, an increase of 30 per cent. This will increase if the Department of Health's target of 'at least 90% of persons aged 75 years or more living in their own homes' is achieved (Department of Health, 1994). Accordingly, in recent years, policy on the service has shifted towards the centre point of Jamieson's continuum and its role is now seen as being complementary to the role of family carers rather than filling a gap where such carers are not available.

*The Years Ahead*, for example, recommended that:

> 'the Home Help service should be expanded in scope to provide an evening and weekend relief service for persons caring for elderly relatives at home' (Department of Health, 1988).

In its 1994 study of home help, the National Council for the Elderly recommended a fundamental redefinition of the service to take account of the needs of family carers (Lundström and McKeown, 1994). The Health Strategy explicitly includes carers as well as older people as the intended targets for strengthened support from home help (Department of Health, 1994). The importance of building upon family care is still very much emphasised and health board reviews such as that of the Southern Health Board stress that the provision of formal home help should not replace family or informal care (Southern Health Board, 1995).

These policy shifts have not, however, been informed by deliberate consultation with older people themselves. The importance of consultation is highlighted by evidence from Denmark and Belgium that older people may wish for some independence from their relatives and may see formal services as a way to achieve this (Jamieson, 1991). If independence from family and neighbours were to emerge as a priority need among older people themselves then a further shift towards a replacement role might be required. This is the case in Denmark.
where it is assumed that offspring will not and should not take on any major role in providing care for elderly parents. Historically in this country, the family has been very important in supporting older people but continuation of this role cannot be taken for granted nor can its desirability for older people themselves be always assumed.

1.3.2 Practice Issues

Nature of the service provided

Jamieson’s cross-national study of home care indicates a gradual shift from the original conception of the service as a non-technical, non-professional service concerned mainly with household tasks to a service that typically now also incorporates personal care and general social support (Jamieson, 1991).

In this country, Circular 11/72 envisages the tasks of the Home Help as:

‘normal household duties (e.g. making a light meal, cleaning the house, making beds, getting messages) for a sick or infirm person living at home who cannot do some or all of these things’ (Department of Health, 1972).

However, The Years Ahead report recommended that:

‘the Home Help service should be comprehensive enough to assist elderly people with all the tasks of daily living’ (Department of Health, 1988).

This implies that Home Helps should be able to provide an element of personal care as well as carrying out practical home care tasks. The National Council for the Elderly in 1994 also recommended that the home help service should be:

‘developed and extended to incorporate a significant personal care dimension’ (Lundström and McKeown, 1994).

In the view of the Council this personal care dimension should be provided not only for dependent older people living alone but also as a support to co-resident family carers.

In a study of home help in the European Union, Hutten and Kerkstra (1996) show that France is the only country in which Home Helps are not allowed to provide personal care. Ireland is one of six countries where apart from home care and personal care, Home Helps also provide general and family support, and moral support with psychosocial problems.

Sweden is the only country in which Home Helps also perform routine technical nursing procedures. In all countries Home Helps spend most of their time on housework.
Jamieson (1991) points out that pressure from competing needs – to professionalise home help on the one hand, and the need to be cost effective on the other – has resulted in more specialisation and subdivision of home help tasks. In Belgium, the Netherlands and Israel, for example, personal care is separated from home care tasks. The Review of The Years Ahead reveals that in this country not all the health boards are agreed that personal care should be part of the home help service. The employment of care assistants in four of the boards – as part of the public health nursing service – whose remit is personal care, suggests a movement towards redefining the home help service.

There is lack of clarity about the respective roles of Home Helps and Care Assistants and the kind of linkages between them that are needed. The National Council for the Elderly recommended that personal care should be integral to the role of the Home Help and that by providing such care over the long term it would complement the role of Care Attendant who would provide intensive care in the short term following discharge from hospital.

In Britain, where home help is one service only, home help is moving towards a higher degree of professionalism with the emphasis on personal care and the focus on those with the highest levels of dependency. In Denmark, home help is again one service only but the aim is to provide a variety of tasks ranging from light household care for less frail clients to personal care for more dependent clients (Jamieson, 1991). In Denmark it is considered that, rather than specialisation, the best solution is to be aware of the different needs in the population, some which may be emotional and general and some specific and task oriented, and to match the different qualities of the Home Helps employed in the service to those needs.

Apart from the tasks provided directly to the elderly clients themselves, Home Helps in several European countries are increasingly seen to have an important role in supporting family carers (Jamieson, 1991). The Years Ahead report recommended that the home help service should be expanded in scope to provide a relief service for family carers in the home (Department of Health, 1988). In the view of the National Council for the Elderly the home help service:

‘has potential not just for providing temporary relief to carers, but also in assisting with many of the tasks of home care such as the instrumental and personal care tasks of daily living’ (Lundström and McKeown, 1994).

Assessment of need
Unlike many other countries in the European Union (e.g. Italy, Spain, Sweden), where over 70 per cent of first contact with the home help service is initiated by
the client, first contact in Ireland is usually through referral by professional care providers (Hutten and Kerkstra, 1996).

In most European Union countries, the assessment of need for the service is made by a professional who is not involved in direct home help care. In nearly all countries, this professional is a social worker, whereas in Ireland, the assessment of need is usually made by the Public Health Nurse or the Home Help Organiser in conjunction with the Public Health Nurse.

Circular 11/72 advised that ‘the infirm and housebound’ should be given priority in the service. These criteria are very broad and are wide open to interpretation by local decision-makers. At local levels, health boards have little in the way of formal guidelines for those who actually carry out the day-to-day decisions about service allocation. The review of the service in the Eastern Health Board, for example, notes that:

‘... the assessment of need takes into account a range of factors, however, there is no common approach to determining need in general use’ (Eastern Health Board, 1996).

This health board recommends holistic assessment of need and suggests that, in this regard, the perspective of the Public Health Nurse is of particular importance. It is further recommended that the assessment should be multidimensional, rather than a mere checklist of material needs and physical disabilities, and should cover areas such as level of dependency, mobility, nutrition and degree of isolation. The Midland Health Board has recently developed a common application form which is to be used throughout the board’s area (Midland Health Board, 1998).

Standards of provision
The main problem areas include:

- The coverage of the service
- The number of Home Helps
- The intensity of the service
- Respite home help service for carers

Coverage
The Lundström and McKeown (1994) study indicated that home help coverage is quite limited in this country, at three per cent of those aged 65 or more, compared with fourteen per cent in Northern Ireland and nineteen per cent in Sweden. Comparison of the Irish figure with those supplied by Jamieson (1991) for other European Union countries again reveals relatively low coverage in this
country compared with, for example, nine per cent in the UK and twelve per cent in the Netherlands.

**Number of Home Helps**

*The Years Ahead* report recommended that:

> 'the immediate aim should be to develop the service to the extent of the whole time equivalent of 4.5 Home Helps per thousand elderly people' (Department of Health, 1988).

Lundström and McKeown (1994) noted that even in 1988, all but one of the health boards had exceeded the norm recommended in *The Years Ahead*, but the scale of provision was still inadequate. By 1995, the number of whole time equivalent Home Helps per 1,000 older persons in each health board ranged from a maximum of 13.1 to a minimum of 4.9 (Ruddle *et al.* 1997). Despite this expansion in recent years, the Review of *The Years Ahead* revealed widespread concern about the level of provision of the service. In this study, District Liaison Nurses (or those fulfilling this function) in all health boards, with one exception, typically rate the service provided as ‘inadequate’ or ‘fairly adequate’. The main reason for this, in their view, is that the service is greatly underfunded — more Home Helps are needed and better payment has to be provided for those in the service (Ruddle *et al.* 1997).

**Intensity of the service**

With regard to the number of hours of home help given to older people each week the figures provided by Lundström and McKeown (1994) were somewhat conflicting. Depending on the source of the information, clients were receiving between 6.4 and 9.7 hours of home help per week on average. Despite this considerable variation, comparison of these figures with those supplied by Jamieson (1991) for other European countries, suggests that Ireland may be categorised as a ‘high provision’ country in terms of numbers of hours of service.

Regardless of this apparent favourable comparison with other countries, Lundström and McKeown report that the commonest complaint among home help clients in the study was that they required longer hours of care.

With regard to home help outside the normal working day, *The Years Ahead* report recommended that:

> 'a service should also be available outside of normal working hours and at weekends.' (Department of Health, 1988).

The Review of *The Years Ahead* reveals that four of the health boards have implemented this recommendation, lack of resources being the main reason given for non-implementation among the other boards (Ruddle *et al.* 1997).
Respite home help for carers
The Years Ahead report recommended that:

'the Home Help service should be expanded in scope to provide an evening and weekend relief service for persons caring for elderly relatives at home.'
(Department of Health, 1988).

The Review of The Years Ahead indicates that five of the boards provide a limited home help service for carers (Ruddle et al. 1997).

1.3.3 Organisation and Administration of the Service

Diversity in models of organisation and delivery of service

Lundström and McKeown (1994), in their analysis of the organisation and delivery of home help services in Ireland, described the six basic models (four in the statutory sector and two in the voluntary sector) which exist throughout the country. At least two health boards have three different models operating within the board region. Only three health boards have one uniform model for the entire region.

These wide ranging variations in the organisation and delivery of home help services considerably affect the organisational links between these services and the public health nursing services both between and within boards. This ranges from very close monitoring of the service by Public Health Nurses at one extreme to a model in which the public health nursing service has very little, if any, monitoring role.

The Department of Health, in its response to the Lundström and McKeown analysis, argued that, in principle, organising home help services in a variety of different ways need not necessarily pose difficulties (Brady, 1994). There is an argument which suggests that flexibility of organisation allows for adaptation to local needs. The Department felt that the involvement of voluntary organisations, the varying needs of different parts of the country and the demands of geography and density of population mean that there may be no one model of organisation which is the best for the whole service.

This is very much is keeping with The Years Ahead report which recommended that:

'the flexibility and voluntary commitment, which form such an important part of the Home Help service, be safeguarded and built upon in future'.

On the other hand, the National Council for the Elderly found that these wide ranging approaches, along with:

'the lack of inter- and intra-regional consistency in the way assessments of need and eligibility are made, the varied levels of client contributions and the bewildering range of methods that currently exist for collecting contributions'.

25
were all signs that the evolution of the home help service has been constrained by the absence of an adequate legal basis (Lundström and McKeown, 1994).

**The role of voluntary organisations**

In most member states of the European Union, home help services are part of the social services and are organised by, and are the responsibility of, the local authorities. Ireland is one of only three countries in the European Union (the other two being Germany [partly] and the Netherlands) in which home help services are part of the health care system, rather than social services (Hutton and Kerkstra, 1996). In this country, home help services are provided either directly by the health boards or by voluntary organisations funded by the boards.

In Circular 11/72 there was an explicit reliance on the principle of subsidiarity. The direction given to the health boards was that the home help service was to be directly organised by the boards only if voluntary organisations failed to succeed in organising the service independently (Department of Health, 1972). Although only about one third of home help is now organised by voluntary organisations, the involvement of the voluntary sector is regarded by the Department of Health as an important contribution to the strength and vitality of the service. Great importance is attached to maintaining and fostering the current level of voluntary input to the service (Department of Health, 1994).

Several health boards endorse the maintenance of the 'voluntary' character of the service. The North Western Health Board, in its Service Plans for 1998, acknowledged the very important role that voluntary organisations play in the provision of home help. Approximately 20 per cent of the entire service is provided by these organisations with board funding, under conditions where procedures for identification of need, approval, and managing the operational service are exactly the same as when service is provided by the board (North Western Health Board, 1998).

However, the National Council for the Elderly has pointed out that the promotion of a voluntary ethos makes no clear distinction between voluntary (or optional) work and the concept of voluntary organisations organising a service (Lundström and McKeown, 1994). Given its role as a core service, the focus must be on how to ensure an effective and efficient service. Several recent studies (e.g. Mulvihill, 1993; O’Sullivan, 1994; National Economic and Social Forum, 1995; Haslett, 1998) have identified difficulties for voluntary organisations in attempting to deliver services, stemming mainly from the absence of clear contractual arrangements for funding by the health boards, and unequal organisational support and resources compared with statutory providers.
The National Council for the Elderly advised that:

*the participation of the voluntary sector in providing the Home Help services is a desirable objective of social policy; (but) to be successful it requires active development by policy makers and statutory personnel in the Health Boards in a spirit of genuine partnership. For its part the voluntary sector must be able to provide services to the same standard as the statutory sector* (Lundström and McKeown, 1994).

The Council believes that if this core service is to be provided by voluntary organisations, there must be:

- clearly defined levels and methods of grant payment;
- standardised grant application procedures;
- an elimination of the practice of deficit funding;
- clients receiving home help from a voluntary body should not be at a disadvantage compared with their counterparts served by a statutory service;
- staff employed by a voluntary body should be subject to the same pay and conditions as their counterparts in statutory home help services.

**Eligibility criteria**

Although home help in this country is delivered through the health service, there are distinct differences between the criteria of eligibility which are applied to home help and, for example, home nursing. In the latter instance allocation of the service is not subject to criteria of eligibility other than medical/health criteria, whereas in the case of home help, a number of criteria other than capacity to manage alone are used to determine eligibility. These eligibility criteria, however, are not clear-cut.

The Lundström and McKeown study (1994) reveals three different methods of assessing eligibility across the country. In some health boards, possession of a medical card is taken as determining eligibility, where the need for the service has been established; persons without a medical card are means tested by the Community Welfare Officer. In other health boards, family means as well as possession of a medical card determine eligibility. A third system applies in some boards whereby eligibility is determined by the Community Welfare Officer or Community Care Administrator who completes an overall means test.

In this country, as in most European Union countries, charges for home help services may be required, mostly related to means. Denmark is the only country in which those in need of home help are entitled to receive it free of charge. In most other countries the co-payments contribute between 10 and 20 per cent of
the home help services budget. This can rise to as much as 30 per cent in Luxembourg and as high as 50 per cent in Italy (Hutton and Kerkstra, 1996).

In this country, there are four different arrangements for charging clients. In some boards, clients are encouraged but not obliged to make a contribution. In two boards, the contribution by clients is used to reduce pro rata the health board payment to the Home Help. In some areas, the client is obliged to make a contribution directly to the Home Help; the amount being determined by the Community Welfare Officer. A fourth system exists in one board, where contributions are collected for the board through Home Helps employed by voluntary organisations, and the amount of grant aid paid to the voluntary organisations is abated by the amount of contributions collected.

The Health Strategy (1994) contains a commitment to introduce uniform rules for eligibility and charges across the country in relation to all health and social services including home help. The National Council for the Elderly has highlighted the urgent need for consistency and clarity in relation to eligibility and has made a number of recommendations to this effect (Lundström and McKeown, 1994).

One of the Council’s recommendations is that:

... the practice of asking for contributions from Home Help clients is only justified if it is applied fairly and consistently across and within Health Boards, and not such as to deter elderly people from seeking the service.

It argues that the method of assessment should be as simple as possible, and should be made widely known and understood by members of the public. It recommends that:

... the most equitable and transparent method for assessing eligibility for free Home Help Service is the existing medical card. Only those not entitled to a medical card should be asked to make a contribution.

The Council called for the abolition of means testing of families and advised that where a contribution is to be made, it should be paid to the health board or voluntary organisation contracted to provide the service, and not directly to the Home Help.

Funding of the service
Within the EU, home help services in Belgium, Italy, the Netherlands, Portugal and Ireland are funded by the central government, with co-payments from the clients (see above). Other forms of funding include local authorities and public insurance, and in many countries (e.g. Denmark, France, Luxembourg, Germany) more than one form of funding applies (Hutton and Kerkstra, 1996).
The Years Ahead report significantly underestimated the future costs involved in running the home help service. Between 1994 and 1997 the cost of the service increased from £14.18 million to £19.59 million (see Table 1).

Table 1: Cost of the home help service (£ million) by health board, 1994 to 1997

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</table>

Source: Department of Health (1998)

Lundström and McKeown (1994) in comparing the home help service with similar services in Northern Ireland, Britain and Sweden, found that the Irish service is 'considerably more cost-effective', but that this is achieved by 'less expenditure on staff salaries, inferior conditions of employment and a lack of investment in training.'

Blackwell et al (1992) argued that the case for community care cannot be made on the basis that it costs less. They argue that when all aspects of community care are quantified and given a value – cost of informal care hours, cost of acute care usage, cost of service usage – the cost of care in the community may be higher than in institutions at various levels of dependency. Even if this is the case, the compelling argument for community care is not cost but it is what older people want. It enables them in the words of Ruddle et al (1997) to 'take up their preferred care option which is to stay put.'

Training of Service Providers
In most European Union countries, Home Helps currently do not have formal training, but they do get some kind of training, mainly in the form of short induction courses and 'training on the job'. Specific training, varying in
duration from six months to three years is provided for all Home Helps in
Belgium, Germany, Italy, Sweden, for some Home Helps in Finland (65%) and
the Netherlands (20%). Denmark has a one-year special education programme
for Home Helps (Hutten and Kerkstra, 1996).

The question of training for Home Helps cannot be considered in isolation from
the question of the role and purpose of the service. Lundström and McKeown
(1994) showed that, in Ireland, training within the home help service is minimal.
Such minimal training is consonant with the original conception of home help as
a non-technical, non-professional job concerned with general household duties.
However, since its introduction the home help service has developed into more
than household help and now also typically incorporates personal care and
general social support. The National Council for the Elderly in 1994 pointed out
that training is a very important issue because home help is now a multi-faceted,
responsible and demanding job, and has recommended that:

\[\text{in order to address the emerging needs of dependent older people at home,}\]
\[\text{we need to provide Home Helps with practical caring skills, relevant listening}\]
\[\text{and communication skills, and basic knowledge about ageing and needs of}\]
\[\text{clients and their families.} \] (Lundström and McKeown, 1994).

The Council acknowledged that formal training may not be as important for
some Home Helps as it is for others, or as would be necessary for Home Help
Organisers, but advised that some formal process of induction, preparation and
training is necessary.

However, not all health boards have given adequate attention to the need for
training, and the Lundström and McKeown study revealed their apprehension
that training could lead to the undesirable consequences of increased wages and
'overqualified' Service Providers.

A 1997 report on training of carers of older people found a very high level of
support for the provision of some form of training for formal social care
workers, including Home Helps, with 88 per cent of older people themselves
endorsing this view (O'Donovan et al. 1997). Furthermore, this study found
that, apart from health board and voluntary organisation representatives, the
majority of those consulted, including the majority of older people, were in
favour of mandatory training for formal social care workers. The main
perceived advantages of training were that it would improve competence levels,
increase confidence and motivation, and broaden the scope of the work.

Some negative implications were also identified in the study, particularly by
those who were opposed to the introduction of mandatory training. The main
concern was that if training were to become a requirement, the supply of carers
could be affected negatively leading to reduced support for older people. A further argument raised against formal training is that it could undermine the 'good neighbour' dimension of much social care and could lead to over professionalisation. The authors of the study warned that:

'the introduction of any kind of training initiative would need to take particular care to avoid alienating existing social care workers from the care services.' (O'Donovan et al, 1997).

The Home Help Council (an umbrella organisation for some of the voluntary organisations) and National Association of Home Help Organisers recently conducted a survey (1997) of the members of both organisations. This study reported a high level of support for a national training programme for Home Help Organisers which all would have to undergo within a specified time frame.
CHAPTER TWO

The Consultation Process

2.1 INTRODUCTION

In the summer of 1997, the Department of Health, commissioned this study designed to:

'culminate in recommendations as to how a quality Home Help service might be made available to all who need it, on a statutory basis if necessary.'

The study, which was facilitated by a Consultative Committee established under the good offices of the National Council on Ageing and Older People, was required to address, and make recommendations on, the following matters:

- the legal aspect i.e. recognition as a core service;
- redefinition of the role and purpose of the home help service;
- designated and adequate funding;
- standards of provision, definitions of need and eligibility/consistency in relation to such matters as entitlement, fees and amount of service provided;
- training.

With the focus on providing agreed solutions to the problems, a nationwide process of consultation was carried out which involved all the parties concerned with the home help service. This included representatives of Service Providers (such as Home Helps, Home Help Organisers, Public Health Nurses, Community Welfare Officers), the participating voluntary organisations, older people and carers, and health board management.

2.2 THE CONSULTATION PROCESS

With the co-operation of the health boards and several representative organisations throughout the country, the consultation process took place between November 1997 and April 1998. Consultations, through interviews and structured focus discussion groups, took place with Service Providers, clients (older people and carers) and Managers (both statutory and voluntary) of the home help services throughout all eight health board regions of the country. The views of Geriatricians were canvassed by postal questionnaire.
As the consultation process differed with different groups, this section will describe the procedures used with each group – i.e. Service Providers, managers of voluntary organisations, older people, carers, and the eight health board Programme Managers for Community Care.

2.2.1 Service Providers
Throughout the country, the views of 398 Service Providers were canvassed. These included 100 Home Helps, 40 Home Help Organisers, 114 Public Health Nurses (all grades) and 144 Other Service Providers (i.e. Community Welfare Officers, Community Psychiatric Nurses, Social Workers, Occupational Therapists, Co-ordinators of Services for the Elderly and others).

Most of the Service Providers were consulted in health board offices. In so far as was possible the structured focus discussion groups were organised along occupational groups lines i.e. the Home Helps were together in one group, the Public Health Nurses in another, and so on.

Other groups were consulted within different locations. Groups of social workers were met in Dublin Civic Offices and at St Mary’s Hospital, Phoenix Park; Occupational Therapists were met at Beaumont Hospital, some Home Help Organisers were met at their monthly meeting in Dublin and so on. Geriatricians, at the request of their professional organisation, were consulted through the post; seven responses were received from the original 22 sent out. Documents were sent out again and from this one further response was received.

The average time spent with each group consulted was about 80 minutes

Key areas of consultation
All four groups of Service Providers, i.e. Home Helps, Home Help Organisers, Public Health Nurses and Other Service Providers, were asked to reflect on a number of aspects of key areas of policy, practice, and administration within the home help service which were the focus of this study and which were discussed in Chapter One.

The key areas of policy were:

• the legal basis of the service
• the role and purpose of the service.

The key areas of practice were:

• nature of the service provided
• assessment of need
• standards of provision.
Finally in the area of organisation and administration, the key areas were:

- diversity in models of organisation and delivery of service
- the role of voluntary organisations
- eligibility criteria for the service
- funding issues
- training of Service Providers
- pay rates for Home Helps.

After fully briefing the various groups of Service Providers with regard to the background and purpose of the study, the researchers presented a number of propositions relating to the key areas. The propositions provided a range of solutions to problem issues in the key areas.

The respondents were asked to consider these propositions and to discuss them with their colleagues if they wished. The dynamics of the groups varied considerably depending primarily on the size of the group. Small groups tended to discuss as a group. With larger groups there was either ‘local’ discussion (i.e. three or four respondents together), or ‘one-to-one’ discussion with the next person. With most groups, the researchers read through the schedule with the participants, but with one or two groups of Public Health Nurses these respondents preferred to go through the schedule alone or with a ‘local’ group. At all times, the researchers were present to facilitate discussion, answer questions and interpret ambiguities.

The respondents were asked to indicate the proposition with which they agreed most. They were invited to include their own proposition if it was not included amongst those given. In most, but not all cases, the Service Providers were able to select one or other of the given propositions. In many cases they availed of the invitation to elaborate on, or modify, their chosen proposition or (less frequently) to add a new proposition.

Extra modules for Home Helps and Home Help Organisers

The Home Helps and the Home Help Organisers were asked to consider extra modules using the format described above. In the case of the Home Helps this dealt with aspects of training for them; in the case of the Home Help Organisers their extra module covered:

- training of Home Helps
- training of Home Help Organisers
- service needs
2.2.2 Managers of Voluntary Organisations
Consultation was carried out with Managers of fourteen voluntary organisations - eight in the Eastern Health Board area, five in the North Western Health Board area and ClareCare in the Mid-Western Health Board area. The consultation procedures were similar to those described above for Service Providers.

The voluntary organisations were asked to complete two schedules:
- the core schedules for Service Providers
- an extra module for voluntary organisations only

The areas covered in the Extra Module were:
- criteria for funding
- contractual arrangements between health board and voluntary organisations
- integration into service planning and provision
- implications of mandatory service
- role and function of the home help service

2.2.3 Older People
The views of older people were obtained in two ways: (a) the researchers met with 64 older people from eight health board areas (b) the Irish Senior Citizens’ National Parliament submitted its views, including a copy of its recent policy statement A Quality Health Service for Older People (ISCNP, 1998).

The older people were assembled through the good offices of the health boards. They were met in groups ranging from one to nine, some in health board offices and some in Day Care Centres. The surroundings were made as comfortable and as informal as possible.

The consultation process with older people was different from the somewhat more structured approaches used with other groups. The researchers were very aware from the outset that, although all groups would have individuals within them who would have ‘their stories to tell’, in the case of older people it would be very important to build allowances for this into the consultation process.

Instead of using a structured approach the researchers drew up a number of topics which it was hoped to cover in gentle discussions with the older people. These areas were:
- The role and purpose of the home help service
- Legal Issue
• Need Issue
• Eligibility
• Contributions
• Information
• Training for Home Helps
• Complaints
• Critical Dimensions

2.2.4 Carers
Throughout the country (from seven of the eight health board areas) 68 carers were consulted. The good offices of the health boards, the Carers Association and the Soroptimists Society were used to bring together groups of carers.

The carers were asked to reflect on eight areas of concern to them which might impinge on the future development of the home help Service. These areas were:

• The role and purpose of the home help service
• Legal Situation
• Need
• Entitlement
• Information on home help service
• Contact person
• Amount of service provided
• Training for Home Helps
• Complaints procedure
• Respite service

After fully briefing the groups of carers with regard to the background and purpose of the study, the researchers presented a number of propositions relating to the key areas. As with the Service Providers, within each of these areas the carers were presented with a number of propositions and they were asked to indicate the proposition with which they agreed most. They were invited to include their own proposition if it was not included amongst those given. In most, but not all cases, the carers were able to select one or other of the given propositions. In many cases they availed of the invitation to elaborate on, or modify, their chosen proposition.

With all the carers’ groups, the researchers went through the schedule with the group and encouraged group discussion.
2.2.5 Programme Managers for Community Care (representing Chief Executive Officers of health boards)

Initial briefing
Towards the end of the consultation process with Service Providers, the research team had its first meeting with the Programme Managers for Community Care who were representing their respective CEOs.

The Programme Managers were fully briefed on the background and purpose of the study. They were then presented with the findings of the study as they affected the various groups of Service Providers i.e. the Home Helps, the Home Help Organisers, the Public Health Nurses and the mixed group of other Service Providers.

These findings were discussed informally and at some length and as a result of this process, the Programme Managers participated in a more structured consultation.

Structured Consultation
Following the initial briefing, the Programme Managers were asked to:

- Consider the various propositions which had been presented to the Service Providers in each of the key areas as outlined above;
- Give their considered opinion as to which of the propositions they would choose (or a different proposition if not included);
- Outline in as much detail as possible the financial, organisation/administrative and staffing implications of their chosen proposition.

In areas where there was discrepancy between the majority views of the Services Providers as a whole and the Programme Managers as a whole, as discussed at the initial meeting, the Programme Managers were asked to indicate the major implications if the majority view of the Services Providers was to be implemented.

The second meeting took place in mid-late April and focused on resolving major areas of disagreement between the Service Providers, the voluntary organisations, the clients (older people and carers) and the Programme Managers.
CHAPTER THREE

Summary of Key Findings from the Consultation Process

3.1 INTRODUCTION
This chapter presents a summary of the main findings for all the groups consulted i.e. Service Providers, voluntary organisations, older people, carers and Programme Managers for Community Care. In the case of some of the more 'technical' issues, such as the organisational structure of the services, the older people and the carers were not always consulted.

The findings below are presented under the headings of policy, practice and organisational issues.

3.2 POLICY ISSUES

- The legal basis of the service
- The role and purpose of the home help service

3.2.1 The Legal Basis of the Service
The study found a major difference between the views of the majority of Programme Managers on the one hand and all other groups on the other.

The majority view in all four groups of Service Providers (i.e. Home Helps, Home Help Organisers, Public Health Nurses and other Service Providers), the voluntary organisations, the carers and the older people (where the issue was understood), was that the law should be changed so that there is a legal obligation on the health boards to provide home help.

The majority view amongst the Programme Managers was that the present situation where the health boards are empowered, but not obliged, to provide home help, should continue. The Programme Managers presented a number of arguments against placing a legal obligation on the health boards to provide home help. The major arguments were those of cost, legal challenge and problems regarding lack of flexibility and responsiveness to needs.
Arguments against legal obligation

Cost
There was a very strong feeling that if a mandatory service was introduced, costs would be extremely difficult to control unless the service is mandatory only for people with high dependency and very strict financial criteria. There was the anxiety that there could be unlimited cost implications as happened with the Nursing Homes legislation.

Legal challenge
There are always difficulties with statutory schemes because interpretations are open to challenges through the courts. The legal liability implications could be very considerable.

Lack of flexibility and responsiveness
There was a fear that a statutory scheme could lead to major logistical problems if, for instance, the health board was obliged to provide a service to someone in a very isolated area. In such cases there would be little hope of recruiting a ‘good neighbour’ to work on a part-time basis. No discretion would be allowed to Programme Managers to switch resources between services and different element of service provision. The ability of the Boards to determine priority areas for expenditure under the present system would be removed – the service would no longer be flexible and responsive to needs.

Arguments in favour of legal obligation
The Programme Managers were also asked to outline arguments in favour of legal obligation. These included:

- Home help would be placed on same footing as other health services;
- Reduction in family obligations/pressure;
- Eligibility is ‘clean cut’ and certain;
- Persons as specified by legislation will have to get the service;
- It will respond to the perceived needs of the current majority viewpoint.

Home Help as a quality service in the absence of legal obligation
Finally the Programme Managers were asked for arguments which they would feel could be used to persuade Service Providers and clients that the home help service can be a quality service in the absence of legal obligation. The major arguments which they presented were related to agreed quality standards and monitoring/advocacy/outcome measurements.
Agreed quality standards
Several Programme Managers felt that legal obligation is not a prerequisite to quality service — for example voluntary organisations provide high standards of care although they are not legally obliged to provide services. What are needed, in their view, are agreed quality standards of provision — agreed nationally with the Department of Health, the health boards, voluntary organisations (through contractual service agreements) and older people’s and carers’ representatives. These agreed quality standards would include standardised criteria for assessment of need, standardised procedures for determining entitlement, standardised service provision and standardised training. All of these issues are discussed in greater detail below.

Monitoring/advocacy/outcome measurement
In the view of several Programme Managers, the Ombudsman, elected representatives, health board members and Freedom of Information legislation, all have a monitoring or advocacy or inspectorial role. They felt that quality can be measured by stating service expectations and measuring client satisfaction with the service that was agreed to be offered. If the Government was to make some of the additional funding available, under the existing system, which would be necessary under legal obligation, there could be a significant improvement.

The perspective from the voluntary organisations
Although the voluntary organisations as a group favoured legal obligation, all agreed that if the home help service becomes mandatory, huge demands will be made of the service and therefore of them. There would be major implications for funding, staffing and client referrals.

The demand on the service will lead to a requirement for additional funding. Greater resources will be required in the area of assessing cases. There will be major increases in cost of provision of evening, weekend and night care, especially if provided seven days per week. There will be an increase in numbers of Home Helps employed and an inevitable increase in rate of pay to meet the increased demand. There will be additional costs of reporting, explaining and administration. Training costs will increase. If respite is provided to all carers huge costs will be involved.

Lack of available personnel would present problems in delivery and there would be pressure on Home Help Organisers to recruit, train and supervise extra staff. There would be difficulty in recruiting staff due to inadequate rates.

There is the possibility that clients will feel they have entitlement regardless of Organisers’ assessment. There will be a high expectation that service will automatically be provided. Time will be wasted with inappropriate referrals —
e.g. domestic cleaning. There will be an increase in political pressure such as client referrals from public representatives and others.

3.2.2 The Role and Purpose of the Home Help Service

Families and neighbours
The majority view of all groups consulted was that the home help service should be provided for older people whether they are supported by their families and neighbours or not.

In spite of their considered and substantial support for this view, several Programme Managers saw significant financial, administrative and staffing implications. There would be increased costs because of increased number of Home Helps. This would lead to logistical problems in managing the numbers of part-time staff for payroll and staff records. Recent decisions by the Department of Social, Community and Family Affairs, Revenue Commissioners and legislation regarding part-time employment have imposed huge difficulties from an organisational perspective.

Needs of informal carers
The majority view of all groups and the unanimous view of the Programme Managers, was that the home help service should be redefined to take account of the needs of family carers as well as the older person rather than dedicating the service solely to the needs of the older person.

From the Programme Managers point of view there was a general feeling that there would be a considerable cost here, through increased demand for service, but it could not be quantified. An assessment process would be required to take account of the needs of family carers, leading to a need for more Home Helps, and more Assistant Organisers/Supervisors.

A ‘Good Neighbour’ service or a professional service
The majority view of all groups was that the home help service should be run as a professional service to which certain categories of people are clearly entitled rather than be run as a ‘good neighbour’ service.

Again, the Programme Managers perceived financial, administrative and staffing costs here. The financial implications of a professional service to which certain categories of people are clearly entitled are considerable. Professionalisation of the service implies increased costs for increased training leading to increased standards and higher pay rates. The issue of entitlement has implications and so the criteria for eligibility will need to be very clear.
Targeting or spreading
All eight Programme Managers and all four groups of Service Providers felt strongly that home help should range from a little help for less dependent clients to a lot of help for more disabled clients, as opposed to targeting it specifically at the most dependent clients.

3.3 Practice Issues
- Nature of service provided
- Assessment of need
- Standards of provision

3.3.1 Nature of Service Provided
The question of the level of care to be provided by Home Helps generated a great deal of discussion. The majority view among Home Helps, Home Help Organisers, other Service Providers, voluntary organisations and Programme Managers was that Home Helps should provide emotional care (such as being a confidant, a comforter, an advisor) as well as household care and personal care. All of the 64 older people consulted, with one exception, said that if their health deteriorated and they needed more personal and emotional care, they wanted this care from their Home Help and not from anyone else.

The majority of Public Health Nurses felt that Home Helps should provide household care and personal care only. The majority view among carers was that Home Helps should provide basic nursing care as well as household, personal and emotional care.

Difficulties in formalising the level of care
Although the majority of the Programme Managers were in favour of Home Helps providing emotional care (and some pointed out that the role of emotional carer is often automatically undertaken while carrying out household and personal care) they saw considerable cost difficulties in formalising the level of care to be given by Home Helps. Consideration would have to be given as to how the rate of payment to Home Helps is calculated. The hourly rate could be different depending on the time needed for household/personal care versus emotional care. A proper care planning process would have to be in place. There would be the increased costs of training, supervision and assessing suitability of personnel. The issues of ‘professionalism’ in the area of confidant or advisor would have to be addressed, especially where Public Health Nurses feel that the nursing role in general would be more appropriate to this type of care.
**Home Helps and Care Assistants/Attendants**

Generally speaking, the Programme Managers saw a need for the functions of both Home Helps and Care Assistants/Attendants. In keeping with the recommendation of the National Council for the Elderly, they saw the role of Care Attendant as providing intensive care in the short term following discharge from hospital, or providing more focused care for more dependent clients.

A revamped service should provide for both categories who might complement each other’s skills. Whether all of these skills can reside in one person will depend on the circumstances of each case e.g. both client and helper. Several of them felt that, with appropriate training, both of these functions could be carried out by some Home Helps. Training for all Home Helps in personal care of more dependent and disabled clients is costly and unnecessary in most cases.

### 3.3.2 Assessment of Need

**Specific criteria in assessing need**

The majority view of the voluntary organisations was that specific criteria for assessing an older person’s need for home help are not necessary as this would be regarded as part of the competence of those undertaking the assessment.

The majority view amongst Public Health Nurses, other Service Providers, Home Helps and the view of all the Programme Managers was that specific criteria are necessary (it is important to note here that several health boards have formalised this step to take into account, for example, dependency, state of health, financial status, family support level, voluntary sector input, degree of availability of extended care services and so on). Within this, however, there were differences of opinion.

The majority of Public Health Nurses and many of the other Service Providers felt that nationally agreed assessment criteria should be used, whereas most of the Programme Managers, a majority of Home Helps and many of the other Service Providers felt if would be better to agree criteria at health board level in order to take regional differences into account. The views of the Home Help Organisers were divided.

**Characteristics in defining need**

The majority view of all groups of Service Providers, carers, voluntary organisations and Programme Managers was that the two most important characteristics in defining need for home help were (i) the health, both mental and physical, of the older person and (ii) where the older person cannot manage the everyday tasks of living.
With all groups the next two most important characteristics were either 'living alone' or 'living in isolated conditions'.

As far as the older people were concerned not being able to manage everyday tasks, living alone, loneliness and poor general health were repeatedly mentioned as criteria for need. Loneliness is a major issue for many of the older people, and there seems to be an over-riding need for human contact. For many of these older people the only person they talk to during the day is their Home Help. They report that they look forward to her visits with great pleasure, and for many of them it is apparent that she illuminates the entire day.

**Who assesses need**
The majority view of Home Help Organisers and voluntary organisations was that the Home Help Organiser was the best person to assess the older person's need for home help. Both Public Health Nurses and other Service Providers felt that the Public Health Nurse was the best person.

The views of the Programme Managers were varied with the greatest number viewing the Public Health Nurse as best. These felt that more training would be needed for Home Help Organisers, there would be the (travel) cost of the Home Help Organiser attending homes where the Public Health Nurse had already been, there would be a separation of service from the Public Health Nursing service, the Public Health Nurse would be more aware of changing needs of older people, and so on.

The majority of carers thought that the GP was the best person to assess the older person's need for home help. In the opinion of the older people, the best persons to decide who needs the service are the older people themselves and 'health board officials' in a general sense. By and large they did not identify any one professional group within the health board for this purpose.

**3.3.3 Standards of Service Provision**

**Standardisation of number of hours of service**
The majority view of three groups of Service Providers (Home Help Organisers, Home Helps, other Service Providers) and of the voluntary organisations was that the number of hours of home help given to older people should be left to the discretion of the Home Help Organiser or equivalent person.

The Programme Managers agreed that the number of hours given should be standardised according to defined criteria of needs.
These were some of the many reasons given by Programme Managers for opposing the majority view of the Service Providers.

- 'Lack of equity and accountability'
- 'Most demanding and vocal are more likely to obtain service'
- 'Difficulty in monitoring and projecting budget and care requirements and outcome measurement'
- 'Discretion is difficult to manage'
- 'Absence of agreed criteria when investigating appeals or challenges'

The Public Health Nurses were almost equally divided between these two views.

Many of the older people complained that one hour at a time is of very little use. A visit should last two hours to make it worth while. Many would love to see their Home Helps again in the afternoon or evening. Home Helps often did extra, unpaid work. The older people expressed great gratitude here but thought this was not fair on their Home Help.

**Standardisation according to defined criteria of needs**

The Programme Managers were asked how should the process of standardisation of number of hours according to defined criteria of needs be undertaken. Several of them suggested processes along the following lines:

- Agree assessment criteria (as reported above, several Boards have formalised this step to take into account, for example, dependency, financial status, family support level, voluntary sector input, degree of availability of extended care services and so on).
- Formulate a care plan.
- Establish all stakeholders who have an involvement in the care of the older person.
- Establish the level of commitment of all stakeholders.
- Establish the key times and tasks which are relevant and deemed essential.
- Select hours required to implement plan.
- Key worker appointed and monitors service delivery.
- A template, when drawn up, can be discussed among the health boards and a standardised approach agreed upon.

**Out-of-hours service provision**

The majority view of all groups of Service Providers, the voluntary organisations, the carers, the older people and the view of all the Programme Managers was that a 'normal' home help service as opposed to an 'emergency' service should operate after hours on weekdays and at weekends, as well as during office hours.
In the opinion of the Programme Managers the financial implications involved would be very considerable: for example, weekend rates, premium payments for unsociable hours. Additional staff would be needed to service increased hours.

3.4. **ISSUES OF ORGANISATION AND ADMINISTRATION**

- Models of Service Provision
- Organisational structure of the service
- The role of voluntary organisations
- Criteria for eligibility
- Funding issues
- Training for Home Helps

3.4.1 **Models of Service Provision**

At present there are six different models of home help service provision in operation (McKeown and Lundström, 1994). Although the majority of Home Helps, Public Health Nurses, other Service Providers and Programme Managers were of the view that there should be one, standardised model for the delivery of the home help service throughout the country, it has to be pointed out that many of the Service Provider respondents were not familiar with these six models or only had a most cursory knowledge of them.

The majority of voluntary organisations favoured the view that there be two models of service provision, one for areas where voluntary bodies take responsibility for delivering the service and one for all other areas. The Home Help Organisers were divided in their support for both these views.

3.4.2. **Organisational Structure of the Home Help Service**

The respondents were asked for their views on the organisational structure of the service. The majority view of both the Home Help Organisers and the Home Helps was that home help should be recognised as a service within its own right. The Public Health Nurses and other Service Providers on the other hand both felt that home help is best seen as a support service to other services such as public health nursing.

Just as there was lack of a high level of agreement between the various groups of Service Providers, so too with the voluntary organisations. From their point of view, regardless of how services are structured, there is a need for the statutory partners to acknowledge the full involvement of the voluntary sector, to recognise the management role the Organisers undertake and to improve communication between the partners (see below for a fuller discussion on these issues).
Some of the Programme Managers felt that home help is best seen as a support service e.g. to public health nursing. One advantage of this is that no separate administrative structure is required. Others felt that the service should be more closely integrated with the public health nursing service. It was also suggested that it should be a 'complementary' instead of an 'independent' service. Establishing an independent service would lead to further disintegration, rather than integration, of services from administrative and management structures needed for the service.

3.4.3. The Role of Voluntary Organisations

The majority of voluntary organisations, other Service Providers and Programme Managers felt that the participation of the voluntary sector, along with the health boards, in the provision of the home help service is desirable and should continue. The majority of Home Helps and Public Health Nurses were of the opinion that home help should be provided solely by the health boards.

Several Programme Managers argued that, without the voluntary organisations, home help would be a more costly service, a less flexible service with a loss of local community involvement. There would be no local 'ownership' of services. From their point of view as long as a quality service was provided it was immaterial whether this was given by the statutory or voluntary agencies.

A number of Programme Managers, who felt that home help should be provided solely by the health boards, argued that, although voluntary service is often cheaper, if one is going to standardise/professionalise the service then inconsistency in service provision is likely. Health boards would have more control over the cost of the scheme if the services are provided directly rather than through voluntary organisations.

The Home Help Organisers were equally divided between these views.

The perspective of the voluntary organisations

In attempting to play their role in the delivery of home helps services, which is undoubtedly much appreciated on the whole by the statutory sector, the voluntary organisations reported a number of issues which they found difficult. These issues were primarily funding, contractual arrangements and integration into service planning.

Funding issues

The provisions of the Health (Amendment) Act, (Department of Health, 1996) provides for the need for co-operation with voluntary bodies providing services, similar or ancillary to services which the health board may provide. Notwithstanding these provisions, there was a very strong feeling from almost
all of the voluntary organisations that there is a need for clearly defined levels and methods of grant payments, there is a need for standardised grant application procedures, the practice of deficit funding of voluntary bodies should be eliminated and grants to be paid in advance.

**Contractual arrangements**

There is very strong agreement among all the voluntary organisations that there should be clear contractual arrangements between the health board and the voluntary organisations. The question of partnership and mutual agreement was raised by a number of organisations. There were calls for agreement on accounting procedures and break-even funding. All agreements should be worked on by both the voluntary organisations and the health boards.

**Integration into service planning**

The integration of the voluntary organisations into service planning was proceeding slowly because of lack of consultation and an information gap. The overwhelming requirement was the need for full and regular consultation between the health board and the voluntary organisations before decisions are made in regard to service provision. This must apply in the case of service modification as well as service introduction. Several organisations argued that representatives from the Home Help Council (an umbrella organisation for some of the voluntary organisations) should be invited to participate at the outset and throughout all stages of service planning.

Many of the voluntary organisations had difficulties with obtaining relevant information on changes within health services which would be of central concern to them. They felt that voluntary organisations must be told about changes to other services being provided in the community in order to allow them manage their services.

Many of the organisations felt that a necessary resource to facilitate consultation and to bridge the information gap would be the appointment of a Development Officer, particularly in the Eastern Health Board region.

**3.4.4 Criteria for Eligibility**

**Determining financial entitlement**

The majority view of the Home Help Organisers and the Public Health Nurses was that older people should be means tested to determine entitlement to the home help service.

The Home Helps, the other Service Providers, the carers and the voluntary organisations were of the view that the home help service should be available to
all older people regardless of their means or whether or not they have a medical card.

The general agreement among the older people was that an older person who needs home help because of poor health, or disability, or any other need should be entitled to the service. Many of them were very strongly of the opinion that an older person living on an old age pension cannot afford to pay for home help. Several of them pointed out that they had worked hard all their lives and felt that they should be cared for in their later years. These people felt that they had contributed through taxation and social insurance in their younger days, and therefore should be getting something back in their later life. They were, by and large, very adverse to the idea of means testing, regarding it as a terrible invasion of privacy. They fear that all of their expenses would not be taken into account.

The Programme Managers were of the view that the possession of a medical card should determine entitlement to the home help service.

Arguments in favour of medical card.
The Programme Managers saw it as an acceptable, measurable and agreed criteria of eligibility which is standardised across the country. It ensures equity in the disbursement of resources. It eliminates the need for invasive income enquiries and services would be provided to those who can least afford it.

Means testing would add to paperwork involved and would have to be reviewed regularly. More staff would be required for administration.

Should medical card holders make a financial contribution to the Home Help service
In the opinion of some Programme Managers there are no good arguments for such a charge, but several were of the view that this would encourage a partnership approach between individual, family and health board. Payment of a small charge provides greater client satisfaction and addresses the notion of not receiving all services free.

Charges for non-medical card holders
Respondents were asked that, if they agreed that the home help service should be available to all non-medical card holders who need it, how should the recipients pay? Both Home Helps and Home Help Organisers preferred a standard charge which is the same nationwide, whereas the Public Health Nurses and the other Service Providers both preferred a means-tested fee.

Most Programme Managers were of the view that the service should be available to non-medical card holders. Other views were that they should pay the full cost.
of the service; that there should be a range of charges up to the full cost of the service; that there should be a standard charge which is the same nationwide and that there should be ‘discretionary charges’.

**Who assesses entitlement**
The majority view of the Home Helps, the Home Help Organisers and the other Service Providers was that the best person to assess the older person’s financial ability to contribute is the Home Help Organiser, whereas the Public Health Nurses felt it was the Community Welfare Officer followed very closely by the Public Health Nurse, the Home Help Organisers, or either of these groups in conjunction with the Community Welfare Officer.

The Programme Managers were fairly evenly divided between the Home Help Organisers and the Community Welfare Officer. It was also felt that a multi-disciplinary approach would be most appropriate. Training will be required for all Home Help Organisers in how to apply assessment criteria uniformly.

In the majority view of the carers, the best person to assess the older person’s financial eligibility to home help was the Public Health Nurse followed almost immediately by the General Practitioner.

### 3.4.5 Funding Issues

**Client contributions**
The majority view of Home Helps, Public Health Nurses, other Service Providers, and most of the Programme Managers was that for some clients, depending on certain criteria, the service should be free, but that all other clients should make a contribution.

The majority feeling within the voluntary organisations was that all clients should make a contribution which should vary according to the client’s means.

Almost half the carers believed that the service should be free for all older people. This was considerably at variance with all other groups.

Many of the older people were very strongly of the opinion that an older person living on an old age pension cannot afford to pay for home help. Many, but not all, agreed that older people with means should make a contribution. At the same time they were, by and large, very adverse to the idea of means testing, regarding it as a terrible invasion of privacy. They fear that all of their expenses would not be taken into account.
In the majority opinion of the Programme Managers, medical card holders who need the service should do so free of charge (see above). The arguments for charging non-medical card holders are:

- equity in resource distribution in health service provision
- the cost can not be borne by the health board
- it will provide a type of filter for users
- to enable the service to be funded

Several of the boards do not collect contributions from older people. Of the two boards that were able to state how much they collected in 1997, the amount totalled less than £110,000. These sums amounted to less than 4 per cent of the total home help expenditure in these two boards.

**Maximum contribution from clients**

The vast majority of Service Providers felt that the maximum that contributing clients should be asked to contribute was £1.50 per hour, with very many of them feeling that no more than 50p per hour should be expected.

The voluntary organisations had a range of views. About half believed the maximum contribution should be less than £2 per hour; others felt that the contributions should vary according to issues such as number of hours and means of client. The carers felt very strongly that older People simply cannot afford to contribute to the cost of home help.

Most of the Programme Managers favoured a discretionary scale, in several cases extending to the full cost of the service. It was also felt that a system for collection of charges only would be difficult to administer. Making a contribution has the benefit of valuing service yet it is hard to control from an audit perspective.

**Collection of contributions**

Three of the four groups of Service Providers (Home Helps, Home Help Organisers and Public Health Nurses) and the voluntary organisations felt that on the whole the best mechanism for collecting contributions is collection by the Home Help. The majority of other Service Providers favoured collection by the Home Help Organiser. In each group, significant minorities felt that invoicing the client would be the best approach.

Different views were expressed by Programme Managers. These varied from favouring collecting contributions either by the Home Helps themselves, by somebody not directly involved in the service, or by invoicing the client. Yet difficulties in the administration of the collection of contributions had been
experienced and several Programme Managers thought that guidelines on this area were needed.

A significant minority of carers simply refused to consider this issue as they felt very strongly that older people cannot afford to make any contribution to the cost of home help.

**Pay for Home Helps**
There was a general agreement among the older people that the Home Helps give above and beyond the very small payment that they receive. The majority view of Home Helps, Home Help Organisers and Other Service Providers was that a fair rate fell between £4.50 and £5 per hour. The Public Health Nurses were more varied as a group, with the majority of them falling between £3.50 and £5 per hour. The majority view of the voluntary organisations was that part-time Home Helps should be paid between £3.50 and £4.00 per hour.

There was general agreement among the Programme Managers that the rates were inadequate, need to be reviewed and a fair rate given, while bearing in mind that increased payments to Home Helps will have implications for costs and recruitment.

With regard to cost, the Programme Managers were very concerned that even a small increase in remuneration for Home Helps would lead to a significant increase in costs. One Programme Manager calculated that an increase of 10p per hour in his board would require an extra £50,000. A £1 increase would cost £500,000. Additional funding would be required from the Department of Health and Children.

With regard to recruitment they felt that there is no doubt that increasing rates of pay will not only make it easier to recruit Home Helps, but also to retain them in the service.

### 3.5 Training for Home Helps

#### 3.5.1 Level of Training
There was general agreement in all groups on the need for some level of training for Home Helps but disagreement as to what the level of training should be.

A majority view of each of the four groups of Service Providers and the carers was that all Home Helps should be fully trained to allow them to provide all the different levels of care where necessary. Almost 20 per cent of Home Helps felt that Home Helps needed no training to carry out their jobs but not a single Public Health Nurse or Home Help Organiser (and only two other Service Providers) was in agreement with this view.
The majority of Home Help Organisers felt (as with the other three groups) that all Home Helps should be fully trained to allow them to provide all the different levels of care where necessary, but a significant minority of them would prefer to see several levels of training provided to reflect the different levels of care that Home Helps provide.

The older people tended to fall into two different groups: the ‘younger’ of the older people, and those who were able to see beyond their own immediate situation, tended to be in favour of training, whereas the ‘older’ and somewhat more frail older people saw the service in terms of their particular Home Helps and so did not see any need for training. This group felt that a good Home Help (which they all have) would know what to do without any training.

The voluntary organisations were divided into two main groups – those who agreed with the Service Providers as a whole and those who felt that all Home Helps should receive a certain minimum standard of training.

The Programme Managers were not in sympathy with the notion of full training and put forward a number of arguments to support this viewpoint.

- The majority of Home Helps work on a part-time basis with one client. Full training would be wasteful of resources as some Home Helps would never get the opportunity to use their skills.
- Full training would result in a high skill mix with consequent increase in financial costs where lower level of skill mix might suffice.

If training were necessary it would restrict the number of persons available to provide a home help service and thus reduce the support available to older people. Local training to meet local needs would be more suitable.

- Rapid turnover of staff towards other attractive employments;
- Costly, over trained staff;
- Home Helps will not do work which they see as below their level of training – will then need to employ others who will.

The majority of Programme Managers were of the opinion that several different levels of training should be provided to reflect the different levels of care that Home Helps provide. They saw need for some levels of training in terms of improvement of the quality of care, improved skill mix to meet the different needs of clients and improvement in the Home Help’s knowledge of the needs of older people.

Other arguments in favour of some training were:

- A duty of care to employees and compliance with legislation, i.e. Health and Safety:
• Improvement of the quality of care:
• Improvement of the Home Help's knowledge of the needs of older people:
• Improvement of the Home Help's and older people's awareness of safety so reducing accidents in the home:
• Increases Home Help's confidence in performing his/her duties and improves personal skills.

3.5.2 Who Should Provide Training
All the Programme Managers agreed that if training is to be provided, there should be a national standard system of training for Home Helps. The cost could be contributed to by each health board and there may be economies of scale in having a national system. Some locally based training would still be required but basic training would be provided to a national standard. This could be provided by a core training group which would decrease costs to some extent.

The Public Health Nurses and other Service Providers were in favour of this, whereas the Home Helps and the Home Help Organisers felt that each health board should design the system of training to be provided in its area. The views of the voluntary organisations were divided here, with most of them agreeing that there should be a national standard system of training but many of them feeling that each health board should design the system of training to be provided in its area.

3.5.3 The Nature of Training
The Home Helps, Home Help Organisers and the other Service Providers all felt that if training is introduced, then it should be generic training in social care as opposed to training which is specific to the care of older people. The Public Health Nurses on the other hand were evenly divided between these two propositions. The voluntary organisations were largely in favour of the proposal that training should be generic training in social care as opposed to training specific to the care of older people.

Some of the Programme Managers were of the view that if training is introduced, then training should be generic training in social care as opposed to training which is specific to the care of older people. The other Programme Managers were more in favour of client-group specific training. They pointed out the danger of a theoretical approach – when key needs are practical skills. They were also anxious about the cost of unnecessary training.

3.5.4 Accreditation
All four groups of Service Providers agreed that, if training is introduced it is important that the training be given national accreditation. Agreement ranged
from 95 per cent for Home Help Organisers to 75 per cent for Public Health Nurses.

Although the Programme Managers agreed that if training is to be provided, there should be a national standard system of training for Home Helps, some Programme Managers supported the view that this training be given national accreditation.

Amongst the reasons given were:

'National accreditation would result in standard rates and therefore either increase in cost of service provision or decrease in level of service provision'

'Home Helps with accredited training would be lost to other services'
CHAPTER FOUR

Conclusions and Recommendations

4.1 INTRODUCTION
As reported in Chapter Two, following detailed consultation with all concerned sectors, the purpose of this study is to:

'culminate in recommendations as to how a quality Home Help service might be made available to all who need it, on a statutory basis if necessary.'
(Department of Health, 1996b).

A major priority in the design and approach of this study has been the emphasis on finding agreed solutions to the numerous problems currently associated with the home help service for older People. Without doubt every group involved in the management and delivery of home help services to older people, and all those beneficiaries of the service, want to provide and to receive a quality service. They want the service to have equity and accountability, and standards with flexibility. There is a very high level of awareness of both the health gain and the social gain of providing a properly structured home help service.

Chapter Three has indicated that in many essential areas there is very considerable agreement amongst all the partners on the solutions which need to be promoted in order to provide such a properly structured, quality, service. In other areas the level of agreement is perhaps not apparently so high, but on further analysis, as demonstrated below, the differences are often those which could be resolved by the allocation of appropriate and guaranteed funding rather than fundamental differences of approach.

In keeping with the format adopted throughout this paper, summaries and recommendations are presented under the headings of policy, practice and organisational issues.

4.2 POLICY ISSUES

4.2.1 Legal Basis of the Service

Summary
Since the end of the 1980s, as Chapter One reported, the question of the lack of a legal basis for the home help service has been repeatedly discussed and
debated (Department of Health, 1988; Mulvihill, 1993; Lundström and McKeown, 1994; Ruddle et al., 1997; Mangan, 1998). Lundström and McKeown (1994) show that the discretionary nature of the service in this country is very different from the three other jurisdictions examined in their study – Northern Ireland, Britain and Sweden – where there is a mandatory requirement on the agencies concerned to provide a home help service.

Of all the issues examined in this study, this was the most difficult on which to reach a consensus.

Many of the Service Providers, voluntary organisations, and carers regarded the lack of progress on this issue as indicative of the low status which they felt the statutory authorities had for the service, for Home Helps, for carers and for older people in general.

There was a widespread feeling among the Service Providers that a lack of legal obligation meant that the home help service got, in the words of several respondents 'whatever crumbs were left over'. They are supported in this view by the Lundström and McKeown (1994) study which concluded that:

'**the personnel in the Home Help service – and the clients they serve – are not assisted in any way by the absence of a clear legal mandate – they have to compete for a share of the health budget against Service Providers who are guaranteed funding because their service is mandated.'**

The older people who understood the issue were very surprised, and, indeed in some cases, shocked, to discover that home help was not a legal obligation on the Boards. To them, the service was so central in enabling older people to remain in their own homes, that they strongly argued in favour of legislation.

The majority view amongst the Programme Managers was that the present situation where the health boards are empowered, but not obliged, to provide Home Help, should continue. The Programme Managers presented a number of arguments – those of cost, legal challenge and problems regarding lack of flexibility and responsiveness to need – against placing a legal obligation on the health boards to provide home help. They argued that a legal obligation *per se* does not guarantee a quality service; obligation brings entitlement, entitlement brings very defined criteria and loss of flexibility; legal entitlement would discourage partnership in care and reduce family input.

The Programme Managers, on the whole, were very aware of the link in the minds of Service Providers between funding and legal mandate and some of them had a certain sympathy for this view, but they felt very strongly that home
help could be a quality service in the absence of legal obligation. With agreed quality standards of provision (which would include standardised criteria for assessment of need, standardised procedures and standardised training) and quality monitoring and outcome measurement procedures, a quality service could be provided.

**Recommendations**

Discussion with the parties produced both arguments in favour of legislation and arguments against. The primary arguments in favour of legislation were:

- it would give recognition to the service;
- evolution of the service has been at a snail’s pace, and legislation could speed it up;
- it would copperfasten funding.

The major arguments against legislation were:

- lack of flexibility thus preventing a health board from meeting a particular need from a particular client or client group;
- inefficient use of the service;
- further delay in reforming the service;
- funding may get out of control;
- legal challenges.

However, whether groups were primarily in favour of legislation or not, consultation with all the parties in this study indicated numerous and repeatedly articulated anxieties and concerns about many aspects of the home help service. Some of the major concerns were:

- the service was perceived as lacking recognition;
- it was not seen as a real priority and therefore suffered from a lack of funding;
- it had suffered from slow development over the years;
- there was a lack of standardisation at many levels which resulted in unevenness and inequity;
- there was no right of redress;
- from the point of view of the voluntary organisations there was a lack of parity.

There is a real danger that, because of the complexities surrounding legislation in this area (which have been referred to in Chapter One), calling, yet again, for the legalisation of the home help service with only have the effect of further delaying any attempts at reform.
What is vitally important, after a decade of discussion, analysis and synthesis, is the provision of a service with designated funding and agreed quality national standards: The future organisation of the home help service must address and implement these changes:

- clarification of the nature of the service provided by Home Helps;
- explicit and agreed criteria for assessment of need;
- standardised criteria for entitlement;
- contractual service agreements with the voluntary organisations;
- national guidelines for level of service provision based on assessed needs;
- recognition of the home help service as a service in its own right, within the overall health services;
- recognised training for Home Helps and Home Help Organisers;
- uniform rates of pay.

If these changes (which are discussed in more detail below) are implemented, the issue of the legal basis may become secondary. If these changes are not implemented the demand for legislation may become irresistible.

4.2.2 The Role and Purpose of the Service

Summary

There were very high levels of agreement between all partners on all aspects of the role and purpose of the home help service. The days of the ‘good neighbour’ basis of the home help service are disappearing – the majority view of all groups, and the vast majority (over 90%) in each of the four groups of Service Providers, felt that the home help service should be run as a professional service to which certain categories of people are clearly entitled rather than be regarded as a ‘good neighbour’ service. The older people, who, by and large, love their Home Helps and see them as caring friends, want them to receive fair treatment. Many of them pointed out that Home Helps often do a great deal more than they are paid for, and the older people felt embarrassed and annoyed at this.

The majority view of all groups consulted in this study was that the home help service should be provided for older people whether they are supported by their families and neighbours or not. Many of the older people, in particular, felt very strongly that even where they had families, they should not have to rely on them for care. Many expressed the view that older people want to keep their independence. They do not want to have to depend on their families or neighbours. To this end Home Helps should be available to all older people, whether they have the help of family and neighbours or not.
As discussed in Chapter One, many of the recent policy shifts in Ireland have not been informed by deliberate consultation with older people themselves. There is no doubt that independence from family and neighbours is emerging as a priority need among older people themselves. They want to stay in their homes but they do not expect or even want their adult children, and much less their neighbours, to have to care for them.

The majority view of all groups was that the home help service should take account of the needs of family carers as well as the older person and this is very much is keeping with the progression in several other European countries (Jamieson, 1991, Hutton and Kerkstra, 1996). The majority of the carers consulted in this study, were of the opinion that what carers need most from home help is respite from care-giving, as opposed, for example, to assistance with household care or with personal care of the older person. Some thought that regular breaks in daytime care-giving would be most welcome, whereas others felt that regular holiday relief would be better. Others chose regular breaks in weekend care-giving whereas relief in times of illness would be more valued by others.

The Health Strategy (Department of Health, 1994) explicitly includes carers as well as older people as the intended targets for strengthened support from home help (among other services).

Implications for implementation
All of these aspects were agreed on by the Programme Managers in spite of the fact that their implementation would have substantial financial, administrative and staffing implications.

The financial implications of a professional service to which certain categories of people are clearly entitled are considerable. Professionalisation of the service implies increased costs for increased training, leading to increased standards and higher pay rates. The issue of entitlement has implications and so the criteria for eligibility will need to be very clear.

If the home help service is provided for older people, whether they are supported by their families and neighbours or not, the increased number of Home Helps required would lead to increased costs. This would result in administrative problems in managing the numbers of part-time staff for payroll and staff records.

If the home help service takes account of the needs of family carers as well as the older person, there would be a considerable cost through increased demand for service, but it could not be quantified. An assessment process would be
required to take account of the needs of family carers, leading to a need for more Home Helps, and more Assistant Organisers/Supervisors.

Recommendations
The introduction of a service with agreed quality standards as outlined above, and discussed in more detail below, will transform the home help services into a quality service with standards, available to all older people in need. The call from the National Council on Ageing and older people (Lundström and McKeown, 1994) that the home help service is redefined to take account of the needs of family and informal carers is reiterated.

4.3 Practice Issues
4.3.1 Nature of the Service Provided

Summary
The National Council on Ageing and Older People, in its recent recommendations following the Review of The Years Ahead (Ruddle et al, 1997) reiterated its belief that the home help service is the most appropriate source of regular formal personal care at home for older people. While acknowledging that Care Attendants and Assistants have a role in the provision of intensive care at home (for example, for a period after a discharge from hospital) the Council believes that the recommendation of The Years Ahead report (1988) that the home help service should be comprehensive enough to assist older people with all the tasks of living, both domestic and personal, should be implemented throughout the country.

This is very much in keeping with the direction in other European countries. Jamieson’s cross-national study of home care indicates a gradual shift from the original conception of the service as a non-technical, non-professional service concerned mainly with household tasks to a service that typically now also incorporates personal and social care (Jamieson, 1991).

There is no doubt that this shift has enormous support among the older people consulted in this study. All of the older people interviewed, with one exception, said that if their needs changed and they required more personal care, they would want their Home Helps to give them this care. Most of the older people were clearly very attached to their Home Helps and were adamant that they did not want personal care from other people. Most would prefer just the one person to give whatever care they might need. There was also enormous support for this direction from the Service Providers, the voluntary organisations and the carers.

Although the majority of the Programme Managers were in favour of Home Helps providing personal care they saw considerable cost difficulties in
formalising the level of care to be given by Home Helps. There would be the increased costs of training, supervision and assessing suitability of personnel.

Generally speaking the Programme Managers, in keeping with the recommendation of the National Council on Ageing and Older People saw a need for the functions of both Home Helps and Care Assistants/Attendants to be more clearly defined. A revamped service should provide for both categories who might complement each other's skills. Whether all of these skills can reside in one person will depend on the circumstances of each case. Several of them felt that, with appropriate training, both of these functions could be carried out by some Home Helps. Training for all Home Helps in personal care of more dependent and disabled clients is costly and unnecessary in most cases.

Apart from help which can be regarded primarily as task-based (household tasks and personal care tasks) many of the older people emphasised, repeatedly, how lonely they would be without visits from their Home Helps. There is no doubt that to many older people living alone, the Home Help as listener, as friend, as confidant, as companion was just as important as the Home Help who makes a meal, changes bedding or helps with personal hygiene.

This need was appreciated by the vast majority of Service Providers. That they recognise and have confidence in the listening, befriending and caring services provided by Home Helps - services that are provided despite the absence of a formal job description and recognised training - is indicative of the personal qualities of Home Helps in Ireland and of the qualities sought by those who recruit them.

**Recommendations**

All Home Helps will continue to provide the necessary level of household and domestic support which is essential to keeping an elderly person at home. This aspect of the service is of vital importance and has to be recognised and respected as valuable and of consequence.

Hand in hand with household care, all Home Helps must provide supportive and emotional care. Being able to provide care for the whole person is not simply a matter of being a 'good woman' or a 'good man' for that matter. The Home Helps and Home Help Organisers recognise this by requesting overwhelmingly that listening and communication skills be one of the core modules in any new training programme. It is essential that any standard training programme for Home Helps acknowledges this aspect of care as essential to the role of home help.

With regard to personal care, all Home Helps should receive a core training in the personal care issues which commonly, if not always, affect older people.
More specialised personal care training, such as severe incontinence management, should be delivered through training modules as needed. Home Helps should not, as a rule, be involved in activities which would be regarded as nursing duties (there are common-sense exceptions to this where a Home Help has a nursing background).

In any consideration of the future organisation of the home help service, and its relationship with the Care Assistant/Attendant service, the wishes of older people, clearly and strongly expressed by them in this study, must be to the forefront.

4.3.2 Assessment of Need

Summary
The majority view amongst Service Providers and the view of the Programme Managers was that specific criteria for assessing need are necessary, but that regional differences must be taken into account.

The almost unanimous view of all groups was that the two most important characteristics in defining need for home help were (i) the health, both mental and physical, of the older person and (ii) when the older person cannot manage the everyday tasks of living. With all groups the next two most important characteristics were either ‘living alone’ or ‘living in isolated conditions’. As far as the older people were concerned, not being able to manage everyday tasks, living alone, loneliness and poor general health were repeatedly mentioned as criteria for need.

Recommendations
A number of the health boards have needs assessment forms and others are currently devising similar forms. It seems that with the clear unanimity coming from this study for agreed standards on assessment of needs and the essential characteristics of needs, it should not be a difficult exercise to devise a common, standard, national approach to the assessment of the needs of older people for home help. A template, when drawn up, can be discussed among the health boards and a standardised approach agreed upon. This could be one of the tasks of the Working Group recommended below.

4.3.3 Standards of Service Provision

Standardisation of number of hours of service in relation to defined criteria of needs and existing available services

Summary
Throughout the country there is very considerable inter-health board variation. The highest average number of home help hours per client is almost fifteen
hours per week whereas the lowest is almost six hours. It is difficult to understand why the average client in one health board should receive two and half times more hours than an average client in another board. The reality is that this variation is more likely to reflect variations in payments to Home Helps rather than the needs of the clients.

The majority view of three groups of Service Providers and of the voluntary organisations was that the number of hours of home help given to older people should be left to the discretion of the Home Help Organiser or equivalent person. The view of most Programme Managers was that the number of hours given should be standardised according to defined criteria of needs. Many of the older people complained that one hour at a time is of very little use. A visit should last two hours to make it worth while.

Several of the Programme Managers saw standardisation of the number of hours of service as part of the ‘agreed quality standards’ process, and suggested a detailed process of standardisation (see Chapter Three) which could be presented to the health boards for discussion and agreement.

Recommendations
It is recognised that there are apparent difficulties here. For example, a common home help task is to ensure that the older person is kept warm. This might mean adjusting the thermostat on the central heating system for one older person or going to the end of the lane for turf for another. It might be the case that the apparent physical needs of, and resources available to, two elderly people might be almost identical but their emotional needs might be so different that one needs more time from her Home Help than the other. Time is needed for this kind of caring.

While acknowledging these difficulties, equity, and the delivery of a quality service, requires that guidelines for the standardisation of hours, as related to needs and the availability of other services, be drawn up. It is recommended that a Working Group, representative of the health boards, the voluntary organisations, professionals and Service Providers, be established by the Chief Executive Officers of the boards, in order to draw up these guidelines.

It is recommended that the Working Group, having agreed a common basis for weighting standardised assessment criteria for need (such as levels of dependency, social isolation, physical isolation and family support level) and having agreed weights for the availability of other care services (such as meals-on-wheels, access to day care services) will then determine the hours required to implement a quality service. It is recommended that, in order to ensure that, along with equity there is a level of flexibility, that the hours be banded with
lower and upper limits. In other words, if this process indicated that part of the care plan for an older person with a given combination of circumstances would be ten hours of home help a week then this would become a band of 'nine to twelve hours per week'. Depending on resources available, this particular older person would be allocated somewhere between nine and twelve hours per week.

It is recommended that this Working Group report within two months of being established.

4.3.4 Hours of Service

Summary
The majority view of all groups consulted in this study was that a 'normal' home help service as opposed to an 'emergency' service should operate after hours on weekdays and at weekends, as well as during office hours.

With regard to Home Help outside the normal working day, The Years Ahead report recommended that a 'service should also be available outside of normal working hours and at weekends' (Department of Health, 1988). The Review of The Years Ahead reveals that four of the health boards have implemented this recommendation, lack of resources being the main reason given for non-implementation among the other boards (Ruddle et al, 1997).

In this study, although the Programme Managers were unanimous in their belief that a 'normal' home help service should operate after hours on weekdays and at weekends, as well as during office hours, they were very aware that the financial implications involved would be very considerable: for example, there would be the question of weekend rates or premium payments for unsociable hours. Additional staff would be needed to service increased hours.

Recommendations
With the increasing emphasis on the location of care in the home, and bearing in mind the targets of the National Strategy (Department of Health, 1994), the demand for a service which operates at the weekend and after hours on weekdays is becoming more evident. It makes sense that if an older person needs support for the everyday tasks of living during the week, this may also apply at the weekends.

4.4 Issues of Organisation and Administration

4.4.1 Models of Service Provision and Organisational Structure

Summary
Lundström and McKeown (1994), in their analysis of the organisation and delivery of home help services in Ireland, described the six basic models (four in
the statutory sector and two in the voluntary sector) which exist throughout the country. These wide ranging variations in the organisation and delivery of home help services considerably affect the organisational links between these services and the public health nursing services, both between and within Boards. This ranges from very close monitoring of the service by Public Health Nurses at one extreme to a model in which the public health nursing service has very little, if any, monitoring role.

As discussed in Chapter One, the Department of Health, in its response to the Lundström and McKeown analysis, argued that in principle organising home help services in a variety of different ways need not necessarily pose difficulties (Brady, 1994). There is an argument which suggests that flexibility of organisation allows for adaptation to local needs. The Department felt that the involvement of voluntary organisations, the varying needs of different parts of the country and the demands of geography and density of population mean that there may be no one model of organisation which is best for the whole service.

In this study, the majority of Programme Managers were of the view that there should be one, standardised model for the delivery of the home help service throughout the country. Four of the Programme Managers felt that this model would be best seen as a support service to public health nursing. One obvious advantage of this is that no separate administrative structure is required and no additional staff needed to assess the need and make recommendations for the service as this is presently done by the public health nursing service. Two Programme Managers felt that the service should be more closely integrated with the Public Health Nursing Service. There is no doubt that any moves in this direction would be unfavourably received by the vast majority of Service Providers.

The majority view of both the Home Help Organisers and the Home Helps, however, was that home help should be recognised as a service within its own right. Many of the Home Help Organisers felt that the home help services should be recognised primarily as a social service with health care dimensions, rather than as a health service with social care dimensions. They want to see it develop parallel to, but independent of, other caring disciplines while at the same time liaising closely with them. They were very strongly opposed to the idea that all assessments of clients should be carried out by a Public Health Nurse and to any attempt to confine their role to supervising and paying Home Helps.

**Recommendations**

It was reported in Chapter One that the ability of the home help service to fulfil its purpose of maintaining older people at home depends on it having a specific place on a continuum of care options, with liaison and co-ordination between different stages on the continuum. In the context of the overall provision of a
package of care for older people, it is recommended that the home help service should have its own identity and its own organisational structure within the health services. Parallel to, but also with strong links to, the public health nursing and other services.

In order to develop as a core service, and to contribute to realising the targets set out in the National Strategy (Department of Health, 1994) the home help service must have parity of esteem with other community care services. It should have its own budget under the control of the Home Help Organiser who would report directly to health board management. The Home Help Organiser would be responsible for recruitment and placement of staff as well as personnel matters such as payment of wages.

4.4.2 The Role of Voluntary Organisations

Summary
There are very good historical reasons for the involvement of the voluntary organisations in the delivery of the home help services (Department of Health, 1972) and the enormous contribution of the voluntary sector must be acknowledged. However, notwithstanding the provisions of the 1996 Health (Amendment) Act, (Department of Health, 1996a) the problems identified by Lundström and McKeown (1994), which focused on the absence of clear guidelines for contractual arrangements and funding, is as acute now as it was then.

The findings of this study report that, from the point of view of the voluntary organisations, there were considerable difficulties in their relationships with some health boards. Apart from the often mentioned funding difficulties, repeated references were made to the lack of consultation, the information gap, and the failure of the boards to appoint Development Officers. There was the need for full and regular consultation between the health board and the voluntary organisations before decisions are made in regard to service provision.

Many of the voluntary organisations had difficulties with obtaining relevant information on changes within health boards which would be of central concern to them. The role of the voluntary sector in the provision of health and social services in Ireland was strongly acknowledged in the national Healthcare Strategy document, *Shaping a Healthier Future* (Department of Health, 1994). It recognised that voluntary agencies have been to the forefront in identifying needs in the community and in developing responses to them. More importantly, it promised that for the first time a specific statutory framework would be created between the health authorities and the voluntary agencies which recognises the role and responsibilities of both parties. Under this new structure, the independent identity of voluntary agencies would be fully respected.
Within this commitment, and guided by the principles of equity, quality of service and accountability which underpin the Health Strategy, a Working Group was set up in late 1995 by the Minister for Health to report on the implementation of the health strategy in relation to those with a mental handicap.

The recommendations of the Working Group (Department of Health, 1997) which are of particular interest in the context of the present study are its very specific recommendations on service agreements and finance issues. It recommends a number of core principles which should underpin such service agreements. These include, for example, respect for the operational autonomy and ethos of the voluntary agency, recognition of the statutory role of the health board and arrangements for monitoring, review and resolution of difficulties. In the area of funding, it discusses in detail issues such as establishing the base funding level, the allocation process and structures supporting this process as well as accountability.

Apart from this study, social policy research in the past decade has been marked by papers concerned with the development of genuine voluntary-statutory partnerships (Mid-Western Health Board, 1991; Mulvihill, 1993; National Economic and Social Forum, 1995; Department of Social Welfare, 1997, Haslett, 1998). What is now required, in the words of Lundström and McKeown, are ‘active developments by policy makers and statutory personnel in the health boards in a spirit of genuine partnership’ to ensure that the nationwide standards of quality for the home help service are such, that it will not matter whether the service is provided by the health board or a voluntary agency acting on its behalf.

**Recommendations**

The participation of the voluntary organisations in providing home help services is not only a desirable objective of social policy, but, in some parts of the country, essential to the very existence of the service. Both the statutory and voluntary sectors need to be given the conditions to provide a seamless quality service:

- The voluntary organisations must be further developed;
- The issues of service agreements and funding for the voluntary sector must be fully addressed, including the introduction of an appeals procedure;
- The criteria for assessment of need and entitlement must be the same for both sectors;
- Standards of provision must be broadly standardised;
- Pay rates and training (as they apply to both Home Helps and Home Help Organisers) must be the same for both sectors;
- Problems relating to the information gap must be addressed. All professionally run Home Help organisations should be equipped with the appropriate software (e.g. the OPSIS software package) with which to run the service.

These essential reforms will eliminate the contentious variations in service, promote equity, help meet the targets of the National Strategy and enhance the partnership between both sectors.

4.4.3 Determining Financial Eligibility including Charges for Non-Medical Card Holders

Summary
The Lundström and McKeown study (1994) reveals three different methods of assessing eligibility across the country. In some health boards, possession of a medical card is taken as determining eligibility, where the need for the service has been established; persons without a medical card are means tested by the Community Welfare Officer. In other health boards, family means as well as possession of a medical card determine eligibility. A third system applies in some boards whereby eligibility is determined by the Community Welfare Officer or Community Care Administrator who completes an overall means test.

As discussed in Chapter One, the national strategy document Shaping a Healthier Future, (Department of Health, 1994) contains a commitment to consistency in determining entitlements and charging arrangements and the introduction of uniform rules for eligibility and charges across the country in relation to health and social services, including home help.

In this study, the majority of Programme Managers were of the view that the possession of a medical card should determine entitlement to the home help service. They saw it as an acceptable, measurable and agreed criteria of eligibility which is standardised across the country. They argued that it ensures equity in the disbursement of resources and eliminates the need for invasive income enquiries. As a result, services would be provided to those who can least afford it.

These arguments did not find favour with the Service Providers, many of whom were of the view that often the 'wrong people' ended up with medical cards (one oft-quoted example was that of EU residents who had retired here and were automatically entitled to a medical card regardless of their means) and others were denied one when they were more in need. The anecdotal observation, that often older people who just failed to qualify for a medical card had a burden of costs to carry, was a source of anxiety to many Service Providers.

For these and similar reasons, the majority view of the Home Help Organisers
and the Public Health Nurses was that older People should be means tested to
determine entitlement to the home help service and many of them would have
supported this on equity grounds. The older people themselves, however, made
it very clear that they were very adverse to the idea of means testing, regarding it
as terrible invasion of privacy.

The Programme Managers were not enthusiastic about the idea of means testing
on the grounds of convenience as well as equity. Means testing would add to the
paperwork involved and would have to be reviewed regularly. More staff would
be required for administration leading to greater costs.

The Home Helps, the other Service Providers, the carers and the voluntary
organisations were of the view that the home help service should be available to
all older people regardless of their means or whether or not they have a medical
card.

**Recommendations**

It has been acknowledged over and over again, in this and other studies, that the
home help service is critical to permitting older people to stay in their own
homes.

Where need has been established, elderly medical card holders should be entitled
to a home help service which is free of charges or contributions. Where
voluntary organisations are providing home help services to older people with
medical cards, they must get the funding to do so at the same level of service as
that provided by the health board, without having to levy charges or request
contributions.

The practice of levying charges or asking for contributions from medical card
holders, which still exists in some health boards, should be discontinued on both
cost-effectiveness and equity grounds. Although it is the case that, strictly
speaking, health boards are entitled to charge medical card holders for services
for which rules governing charges have not been set down in legislation (such as
community paramedical services, day care centres and home help) it is, in the
words of the National Strategy:

> 'inequitable that a person’s entitlement to a service should depend on the
area in which he or she happens to live.' (Department of Health, 1994).

There needs to be a very flexible approach in the granting of medical cards to
elderly people.

In the case of elderly non-medical card holders many will wish to, and do, make
their own private arrangements for help in the home. However, in the case of
elderly non-medical card holders who do not wish to, or are unable, to make their own arrangements, and where need has been established, the health board or voluntary organisation must still supply the same quality service as will be given to medical card holders, with an appropriate charge. It is recommended that the drawing up of guidelines for these charges be referred to the Working Group, established by the Chief Executive Officers of the health boards. It is recommended that this Working Group report within two months of being established.

4.4.4 Pay for Home Helps

Summary
Although the issue of pay rises for Home Helps was not within the terms of reference of the study, it was felt that it had to be referred to, given the importance attached to the subject by all of the participants.

It has been acknowledged, both by the participants consulted in this study and by other studies (e.g. Lundström and McKeown, 1994), that the system of remuneration and the rates of pay for Home Helps are not satisfactory. There was a general agreement among all the groups consulted in this study that the question of pay for Home Helps needs to be addressed.

At present, rates of pay for Home Helps vary not only from one health board to another, but even within boards. For example, in a recent study, the Midland Health Board (1997) found that, although the average rate per productive hour for part-time Home Helps was £3.22, the range varied from less than £2 to greater than £5. Apart from the question of esteem, a recurrent complaint of Home Help Organisers, as reported by Ruddle et al (1997) is the difficulty in recruiting high quality personnel, given the low rate of pay for the service.

Recommendations
The question of remuneration for Home Helps needs to be urgently addressed. Regard must be given to the recommendations of the National Minimum Wage Commission. Rates of pay must be standardised across all health boards.

4.4.5 Training of Home Helps

Summary
As discussed in Chapter One, the O’Donovan et al (1997) report on training of carers of older people, found a very high level of support for the provision of some form of training for formal social care workers, including Home Helps. A recent survey carried out jointly by the Home Help Council and the National Association of Home Help Organisers (1997), of the members of both organisations, reported a high level of support for a national training programme for Home Help Organisers.
CONCLUSIONS AND RECOMMENDATIONS

The results from this study accord with these and similar findings (e.g. Midland Health Board, 1997) and show that there was general agreement in all groups on the need for training for Home Helps and a requirement from Home Help Organisers for training for themselves.

Recommendations

It is strongly felt that procedures for the training of Home Helps must be implemented immediately. Not only will training improve the standard of care within the community and prevent institutionalisation, but it will also provide greater protection to provider agencies in the event of litigation.

Training for Home Helps would consist of two elements. The first would be a national, standard, induction course, which would be a basic requirement for all Home Helps, both part time and full time. The course would consist of a number of core modules. Examples here would be:

- first aid
- personal care
- an understanding of old age
- safety and health at work (including Health and Safety Legislation)
- listening skills and communication skills

The second element would consist of appropriate modules which would be added on to allow specific groups of Home Helps to cope with specific situations (for example, modules on conditions such as Alzheimer's Disease and incontinence). The combination of these elements would ensure that all Home Helps had appropriate training to the level of care they were giving.

All modules must be delivered both with sensitivity to the learning needs of adults and with sensitivity to the other responsibilities which part-time Home Helps, in particular, may have.

Access to bereavement counselling is important for Home Helps where an older person in their care has died.

The training of Home Help Organisers would consist of a national, standard, course, which would be a requirement for all Organisers and Assistant Organisers. As with the induction course for Home Helps it would have standards, would be recognised as a training course, with national accreditation and would be paid for by the employer. The course would consist of a number of core modules. Examples here would be:

- management skills
- communication skills

73
• information technology
• tax and social welfare systems
• an understanding of old age
• community care

4.5 Summary – A Service with Agreed Quality Standards

The primary recommendation of this study, in keeping with several previous studies, is that the home help service is regarded, presented and resourced as a core community service, fundamentally vital to the stated national policy which is to maintain older people in dignity and independence at home. In order to produce a core, quality service with agreed quality standards, the future organisation of the home help service must address these issues. It must:

- Clarify the nature of the service provided by Home Helps;
- Reflect this clarification in training programmes for Home Helps and Home Help Organisers;
- Further reflect the core nature of the service in the rates of remuneration and conditions of work for Home Helps;
- Draw up explicit and agreed criteria for assessment of client need which will apply nationally;
- Standardise criteria for entitlement including carefully considering obligations to all older people in need, regardless of their means;
- Determine national guidelines for level of service provision based on assessed needs;
- Implement an organisational structure for the home help service within the health services;
- Have regard for the independence of the voluntary organisations and the health boards.

None of these recommendations will be without cost. Between 1994 and 1997 the costs of the home help service increased from £14.18 million to £19.59 million. Implementing the recommendations in this study will cause them to increase a great deal more. Maintaining older people in dignity and independence at home, in accordance with their wishes for a quality service, is not a cheap option. There will be a cost; there will be a price to pay; there is no doubt, however, that everyone involved in this study—managers, providers and beneficiaries—strongly believe that our older People deserve nothing less.
References


Midland Health Board. 1998: *Service Plan.*


REFERENCES


North Eastern Health Board, 1998: *Service Plan*.


South Eastern Health Board, 1998: *Service Plan*.


Western Health Board, 1998: *Service Plan*. 

77
APPENDIX I

Authors’ Acknowledgements

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Our greatest debt of gratitude, however, goes to all the older people and the carers of older people, whom it was our privilege to meet and to talk with during the course of the study. It is to them, and their future well-being, that this study is dedicated.
APPENDIX 2

National Council on Ageing and Older People

The National Council on Ageing and Older People was established in March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:
1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:

(a) measures to promote the health of older people;
(b) measures to promote the social inclusion of older people;
(c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;
(d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;
(e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;
(f) meeting the needs of the most vulnerable older people;
(g) means of encouraging positive attitudes to life after 65 years and the process of ageing;
(h) means of encouraging greater participation by older people;
(i) whatever action, based on research, is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

(a) undertaking research on the lifestyle and the needs of older people in Ireland:
(b) identifying and promoting models of good practice in the care of older people and service delivery to them;
(c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;
(d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health, welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

MEMBERSHIP

Mr John Brady
Mr Christopher Domegan
Mr Michael Finnerty
Ms Margaret Geary
Mr Frank Goodwin
Dr Mary Hynes
Ms Betty Keith
Ms Sheila Kennedy
Mr Jack Killane
Cllr Tim Leddin P.C
Ms Marie Mates
Mr Brendan O’Leary
Ms Mary O’Sullivan
Ms Sarah Scott
Mr Bernard Thompson
DIRECTOR
Mr Bob Carroll

RESEARCH OFFICER
Mr Frank Houghton

RESOURCES OFFICER
Ms Catherine Mulvenna

PROJECTS OFFICER
Dr Terry Connors*

* Temporary replacement for Ms Trish Whelan who is taking a one-year career break.