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*Long Term Support and Care: Facilitating Independent Living*

*Current Practices in Ireland – How to Access the System*



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## Contents

<b>Introduction</b> .....	3
<b>1. What are Community Healthcare Services?</b> .....	3
<b>2. Continuum of Care</b> .....	4
<b>3. Integrated Care – What Does it Mean ?</b> .....	5
<b>4. Community Health Care Organisations – New Organisational Management Structures to deliver integrated Care</b> .....	6
<b>5. Accessing Services &amp; Supports for Our Citizens :</b> .....	7
<b>5.1 Core Community Services - Primary Care Teams and Networks</b> .....	8
<b>5.2 Home Care</b> .....	8
<b>5.3 Transitional care/ Respite &amp; Convalescent Care</b> .....	9
<b>5.4 Nursing Homes Support Scheme (NHSS – A Fair Deal)</b> .....	9
<b>6. Assisted Decision Making Legislation (Capacity) Act 2015</b> .....	10
<b>7. Challenges and Oppertunities</b> .....	11
<b>8.Improving access &amp; responsiveness – a model of integrated care for older people</b> .....	12
<b>Appendix 1</b> Key Information with regards to accessing the NHSS.....	15

# Long Term Support & Care – Facilitating Independent Living – Current Practices in Ireland – How to Access the System

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## Introduction

This paper has been prepared in the context of the work of the Citizen’s Assembly in looking at Long Term Care & support for citizens and how this might best be developed in way which facilitates independent living.. In particular the focus of the paper is on the current practices and systems in Ireland and how citizens can access the system through services provided by the Health Service Executive (HSE) or its funded agencies. There has been significant reorganisation of health service structures in recent years which often gives rise to confusion on how services are organised and delivered at local level. In this context the paper will in the first instance outline what exactly comprises community healthcare services, the importance of developing models of integrated care in delivery of these services to people at local level and the new organisation and management structures which commenced implementation in 2015 to improve and simplify access to these services .

The paper will then go on to summarise how services and supports are accessed with links as appropriate to HSE websites where further detailed information can be found. The paper concludes with a short summary of challenges and opportunities and work underway on the development of an integrated model of care for older people in Ireland.

In this context this paper will focus on :

1. What are Community Health Care Services ?
2. Continuum of Care
3. Integrated Care – What does it mean?
4. Community Health Care Organisations - New Organisation & Management Structures to deliver integrated Care
5. Accessing Services & supports for our citizens
  - 5.1 Core Community Services – Primary Care Teams & Networks
  - 5.2 Home Care
  - 5.3 Transitional care/ Respite & Convalescent Care
  - 5.4 Long Term care – Nursing Home Support Scheme (NHSS)
6. Challenges and Opportunities
7. Improving access & responsiveness – a model of integrated care for older people

## 1. What are Community Healthcare Services?

Community Healthcare Services are the broad range of services that are provided outside of the acute hospital system and includes Primary Care, Social Care, Mental Health and Health & Wellbeing Services. These services are delivered through the HSE and its funded agencies to people in local communities, as close as possible to people’s homes.

Community Healthcare services focus on keeping citizens well so that citizens can continue to live at home or close to home through our health promotion, disease screening, diagnosis, treatment and rehabilitation programmes. Citizens can refer themselves to most Community Healthcare services or through their GP, public health nurse, community mental health team, etc. Services are provided as follows:

**Primary Care** includes citizen general practitioner (GP), practice nurse, public health nurse, dietician, dentist, physiotherapist, occupational therapist, speech and language therapist, podiatrist, community pharmacist, psychologist and others.

**Social Care** includes a team of specialists working together to meet the needs of our older people such as home helps and home care teams and including day care services, meals on wheels, community hospitals and nursing

homes. There are also specialist teams working with people with a disability through specialist day, training, home support, respite and residential services.

**Mental Health** refers to a wide range of services which extend from enjoying positive mental health through to severe and disabling mental illness. It includes specialised secondary care services for children and adolescents, adults, older persons, those with an intellectual disability and mental illness as well as a range of mental health promotion initiatives provided by the National Office for Suicide Prevention (NOSP). Services are provided in a number of different settings including the service user's own home, day hospitals, hostels and in acute units which are located in general hospitals.

**Health & Wellbeing Healthcare** reforms place considerable emphasis on keeping people healthy and well. Community health care services already play a critical role in promoting health and wellbeing by making every healthcare contact count and by working across sectors to create the conditions which support good health, on equal terms, for the entire population.

Community Healthcare services place a strong emphasis on working with communities and individuals to maintain and improve citizens health and social well being. We do this by providing citizens with an integrated, interdisciplinary, high quality, team based and user friendly service.

The focus of the service is to:

**“Deliver the right service, at the right time,  
in the right place, by the right team.”**

## **2. Continuum of Care**

If Ireland is to create the conditions to support our citizens in a way which facilitates independent living, this will require a cross-sectoral, community based approach to support the predominant choice of older people to live their lives in their own homes and communities. It entails a planning requirement based on a population health approach and with services delivered across the 96 Primary Care Networks on a geographic basis and within the current structures of 9 Community Healthcare Organisations. It recognizes the need to provide a range of services to older people with different needs as they journey through life. This includes information on lifestyle choices, helping create 'connected' communities where older people's values and experience are welcomed and used from a voluntary perspective, providing options for assessment and preventative care, responsive menu for those with growing dependencies or with temporary needs while recovering from an acute episode. It also will require identifying those with the greatest level of complexity and ensuring access to specialist services, providing key workers and case management, as necessary, to help older people and their carers to navigate the system.

National as well as International evidence indicates that older people view long stay care as the 'last resort' and will seek and require a menu of other supports, as part of the continuum of care to stay at home. These include Home Care, Day Care, Respite, Rehabilitation, Voluntary and Community supports, including Meals on Wheels, Social activities etc. Also the input of paid and unpaid carers, family and neighbours are key elements of the necessary supports.

The Continuum ensures that at all stages, the older persons requirements are put at centre of the service provision. It also recognises the worth and value of lifetime experience and skill sets needed by society and communities and where older people are seen as an asset and contributors and leaders in society.

One of the challenges facing the Health Service is that while people today experience many parts of the service as being very good, however, they experience difficulties in 'navigating the system' due to both complexity and

scale of present arrangements. What must be improved is how these parts fit together so that the services are integrated and people can move smoothly through the system. Our services and staff must be organised in a way that enables joined-up teamwork, responsive to the assessed needs of the local people.

### 3. Integrated Care – What Does it Mean ?

Much of the focus of International evidence now points to the importance of integrated care in meeting the needs of citizens. Integrated Care simply means that all services work together in a well co-ordinated way around the assessed needs of the person. This working together deals with two key issues for any person, community or the population.

- The first is the ease, through which a person can go through the different healthcare services to meet their needs.
- The second is the quality of outcome they get at the end of that patient journey.

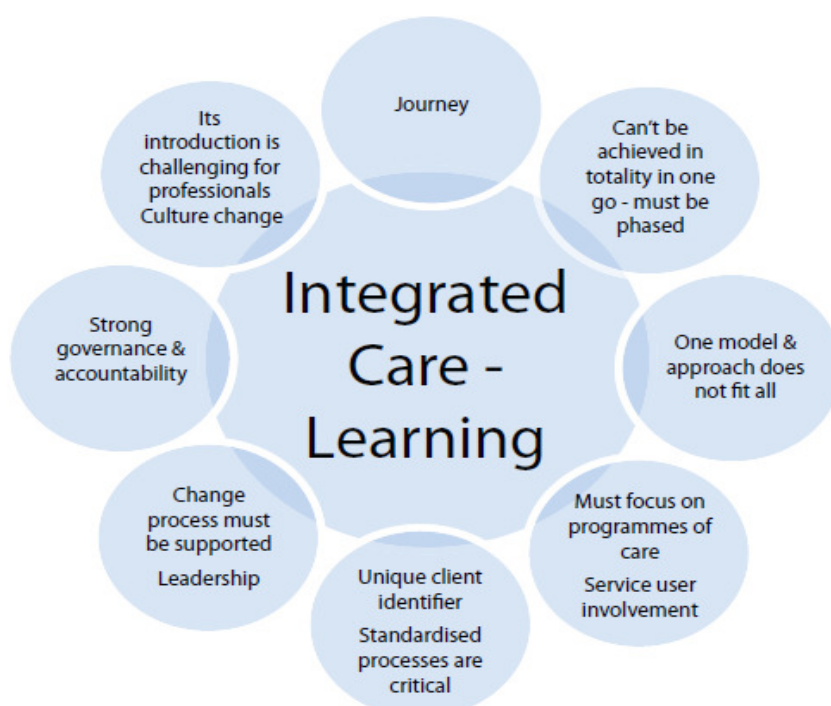
Many people need to access more than one service. People quite often need their Primary Care service. If however they need to go to hospital, have a mental health condition, an age-related illness or a disability then they may need the Primary Care and specialist service together at the same time.

To achieve this the way in which services are organised and delivered requires careful planning. Some key features of successful integration are:

- clarity of purpose and outcomes;
- strong leadership and
- a culture where the person receiving care and the staff delivering it are empowered.

**“Integrated Care - all services work together centred on the needs of the person.”**

Some of the key themes and learning from international experience of integrated care are captured in the illustration below.



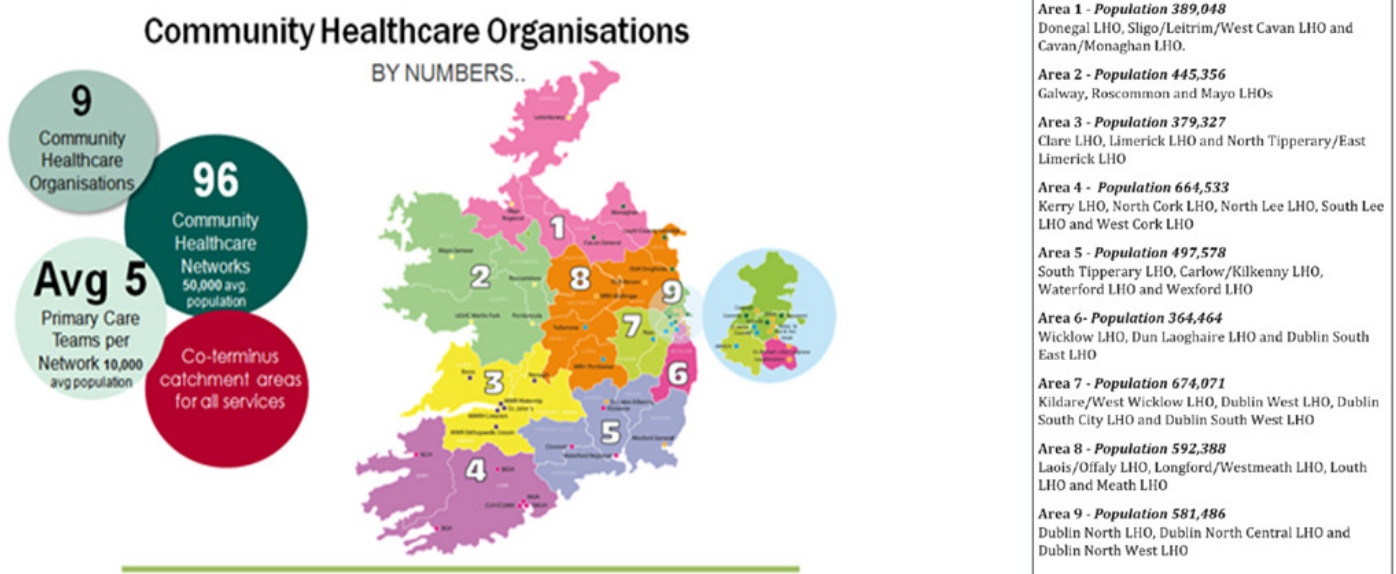
Work is underway by the HSE on the development of standardised models and care pathways nationally, which, will support effective integration between all aspects of community services across primary care, social care and mental health services and between these Community Healthcare services and the hospital system.

## 4. Community Health Care Organisations – New Organisational Management Structures to deliver integrated Care

To deliver national and government health policy, and ensure health delivery structures are appropriate to achieve national policy objectives, a review of organisational arrangements of community based health services was commissioned by the Director General in 2013. The recommendations of this review were set out in the Community Healthcare Organisations (CHO) Report, September 2014.

The report set out how health services, outside of acute hospitals, will be organised and managed. Known as community healthcare services, these services include primary care, social care (involving services for older persons and for persons with a disability), mental health and health & wellbeing.

Community Healthcare Organisations (CHO's) provide a framework for new governance and organisational structures in order to improve service delivery and ensure the public receive "the right service, at the right time, in the right place, by the right team". This new structure is now being implemented across the country.



### Benefits to Citizens and Service Users

#### CHO Level

- The CHO's will focus on delivering standard models and pathways of care developed nationally by service divisions and National Clinical Programmes, bringing consistency to how services are delivered across the country.
- Clinical staff and GP's will be appointed to CHO management teams bringing professional staff closer to patient decision-making.
- The CHO's will enable and support integrated care within community healthcare services, between community healthcare and acute hospital services, and better coordination with other bodies, such as the local authorities, the Gardaí, Child and Family Agency, Education, community organisations, etc.

#### Community Healthcare Network Level

- For the first time ever, an identified accountable person, a Community Healthcare Network Manager, working with a GP lead and a network team, will be responsible for driving integrated care in each primary care network.
- Focus on prevention and management of chronic disease at community level.

### **Primary Care Team Level**

- A team lead will be appointed to each primary care team, with protected time from the day job, to co-ordinate the daily working arrangements.
- Staff at local level will have more autonomy and decision-making ability to respond quicker, better and safer to patient and service user needs.
- A named key worker will be assigned to support people with complex needs so that all staff working with this patient will have a contact person to work through and the patient and carer will also know this key worker.

## **5. Accessing Services & Supports for Our Citizens**

Health and social care needs are changing. This requires the continued development of a model of care that is more integrated and continuous, person-centred, and delivered at the lowest level of complexity consistent with patient safety. This approach will provide a better service user experience and better health outcomes, but it is also vital if the health services are to deal effectively with the demographic pressures and rising burden of chronic disease.

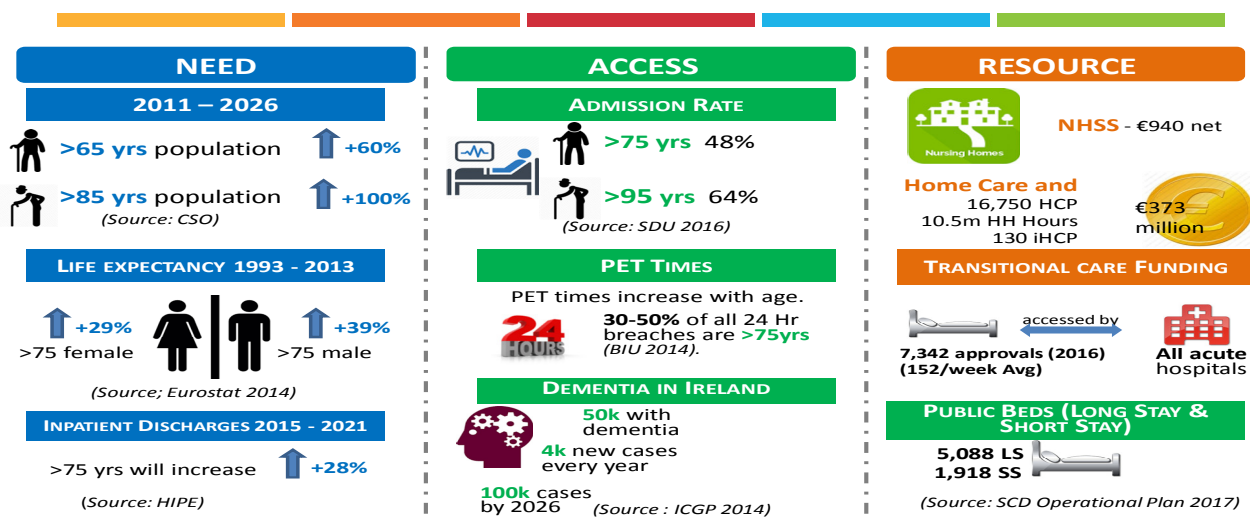
The Programme for Partnership Government confirmed the Government's commitment to a decisive shift towards primary care so that we can provide more comprehensive care for people within their own communities.

Complementary to general reforms in health care, social care services have evolved considerably to better meet individual needs with an emphasis on personalised approaches, maintaining independence, and community-based interventions. Substantial progress has been made in Ireland in recent times in moving the provision of social care towards a more community-based service and supporting independent living, and providing access to mainstream services supported by recourse to specialist services where required. The HSE and the Department of Health continue to work collaboratively on developing innovative and enhanced approaches to homecare, strengthened day care and short-term residential services, and new long-term residential models for older people.

The diagram below, captures some key statistics relating to the demand and access to services for older persons. The demographic pressures have and will call for additional demand in key service areas. The effect of not having sufficient levels of resources in community services, puts pressure on hospital services and in particular in terms of Emergency Department activity and the resultant higher level of admission of older people due to the level of complexity of their requirements.



# Older persons Some Key Statistics



## 5.1 Core Community Services – Primary Care Teams & Networks

As outlined above the Community Health & Social Care services are organised across the HSE through 9 Community Health Care Organisations (CHO's), on a geographic basis. Each of these 9 CHO's, manage their services across 'Primary Care Networks', which again, are geographically based and with populations in the region of 50,000 people. These Networks of services consist of a number of Primary Care Teams (PCT's) and supporting services, charged with the provision of service delivery to the community that they serve. These 96 networks will provide the majority of their services, accessed through Primary Care, within their local community.

There are decisions to be made with regards to eligibility to services, which are required to bring clarity to access to services but the basic unit of delivery will continue to be through the combined and integrated work of local PCT's, consisting of GP's, Community Nursing, Therapies, all working in a coordinated manner to meet the assessed needs of the population they serve.

### Planned Care

- Care needs of older people are determined in general by the GP and PHN, depending on the requirements, it may be possible to maintain the older person at home with minimal support from the GP and access to PHN services and possible some Home Care working with families and other carers. Other supports within the Primary Care Team can be called on for additional assessments and supports e.g
  - Occupational therapy – for aids and appliances, maximise function within home etc,
  - Physiotherapy- Mobility and functional activity
  - Day Care Centres – with nursing support
  - Community & Voluntary Supports
- If and when the above supports no longer suffice to maintain the older person at home and their care needs are increasing, the GP in conjunction with the Primary Care Team will refer to a Consultant Geriatrician team for assessment and review of the medical needs. This may require an Assessment in a Day Hospital or Acute Medical Assessment Unit, or General Outpatients Clinics.

## 5.2 Home Care

- Home Care - €373m
  - Home Help service to support 49,000 people with 10.5m hours.

- Home Care Packages to support 16,750 people at any one time.
- Intensive HCP's – 130 people at any one time to be maintained in their own home with high complex needs rather than in nursing home care.

Access to Home Care is a key element of support to maintain people in their own homes and communities. Almost 50,000 people avail of Homecare Supports, including Home Helps and Home Care Packages (HCP's). This service is hugely effective in providing an alternative to Long stay residential care. It is accessed through Public Health Nursing (PHN) in general, and a level of Homecare is provided to meet the persons assessed need, within the resources available. Some of the criticisms of Homecare provision relate to lack of access to sufficient levels of service and also the type of service the person experiences. The view is that access to the scheme varies and is more dependent on your postal address rather than your assessed need.

Many of these criticisms are justified and are a symptom of the fact that homecare is not provided on a legislative basis, nor are the services themselves regulated against a set of standards. The Department of Health have commenced a Public Consultation Process in relation to bringing forward legislation to develop a Homecare Scheme and to regulate the services appropriately. The HSE will welcome this supporting legislative basis which will allow for the development of the service and in order to enable an equitable process of provision across the country to be implemented. This is a significant challenge in the context of the complexity of this matter. Decisions will be required with regard to a sustainable funding model for Homecare and the recognition that people choose to purchase significant levels of private homecare, and the recognition of unpaid carers who provide a valuable service to support older people in their own homes.

[Information on Home Care Packages - HSE Website](#)

### 5.3 Transitional Care/ Respite & Convalescent Care

Many of the community Hospitals throughout the country provide short stay beds (in the region of 2000 beds) which provide for a range of services, including, Respite, Palliative, Rehabilitation and general convalescence.

Respite care is an essential component to ensuring older people with care needs in the home including those with Dementia can be cared for in their community and close to their carers. Respite beds offer additional assistance to families and carers thus helping to alleviate the ongoing stress associated with providing care. The provision of respite can often assist with avoidable acute hospital admissions. Respite care is provided in a number of different ways and settings across the health system. It is provided through designated respite beds in Public Residential centres and also 'contracted' by the HSE in private nursing homes – where it is used to boost the availability of such beds to meet demand – within the resources available in the local area. Respite can be provided on an emergency basis for unforeseen circumstances that occur due to bereavement/illness of carers or emergency environmental changes to the residence of the client. Planned Respite can be provided to clients, which allows carers a planned break throughout the year. This is planned in conjunction with the client and their carers and is seen as a part of the continuum of care for the client. Respite may also be provided via an enhanced 'Home Care Package' where the funding can be utilised to procure a period of respite. At 31st May 2017 there were a total of 628 beds available (522 Public and 106 privately contracted respite beds) .

Transitional Care funding is provided to ensure people classified as having completed their episodes of acute care, but may require some period of convalescence or who are waiting on completion of the (NHSS) application. Private nursing home beds are utilised for this purpose and are accessed by the acute hospital discharge team and are funded nationally through Social Care Division. The HSE supports approximately 152 approvals per week for discharges from acute hospitals.

### 5.4 Nursing Homes Support Scheme (NHSS – A Fair Deal)

- Nursing Homes Support Scheme (NHSS – Fair Deal) - €940m
  - To provide for a 2017 projected out turn of over 23,600 people.

The NHSS is a scheme of financial support for people who need long term residential care services. It replaced the various systems of support that existed prior to that i.e. Subvention for people in Private Nursing Homes or Long Stay charges for people in public nursing homes and contract beds. The old Subvention Scheme had been in existence since 1993 and was deemed unfair and unaffordable for people who needed long term care. People were being forced to sell their homes in order to pay for long term care in nursing homes. In addition, in some instances family members were making contributions from their own resources to fund long term care for their relatives.

The NHSS commenced on the 27<sup>th</sup> October, 2009 and it aims to ensure that Long Term Nursing Home Care is both accessible and affordable for everyone and that people are cared for in the most appropriate settings. The systems of support that existed prior to the introduction of the scheme were acknowledged as being inequitable with different levels of funding support available to residents in the public and private systems. The Nursing Homes Support Scheme was reviewed by the DOH in 2015, and the recommendations of the Review are currently being implemented. The review focused on a range of measures including improvements in the communication and information to members of the public who wish to avail of the Scheme. In addition the review called for a pricing re-evaluation to be undertaken, across public, voluntary and private providers. The funding available to the scheme is €940m net, and in December 2016, 23,142 people were in receipt of financial support through the scheme.

Under the NHSS, people who qualify following a care needs and means assessment, make a contribution towards the cost of their care and the State pays the balance. This applies whether the person is in a public, private or voluntary registered (with HIQA), residential care centre. **It is important to note that a person's assessed contribution will remain the same regardless of the choice of care provider and centre, and even if the costs of the service to the state in these centres vary.**

For the purposes of the scheme, long term residential care services are provided in approved private nursing homes and designated Public Community Hospitals/Community Nursing Units, as registered with HIQA.

[Information on the Nursing Home Support Scheme - HSE Website](#)

**Appendix 1** is a brief Summary of the Key information and processes regarding access to the NHSS.

## **6. Assisted Decision Making Legislation (Capacity) Act 2015.**

The Assisted Decision Making (Capacity) Act 2015 will strengthen the rights of all individuals but it will have particular relevance for people with intellectual disabilities, older people with diminished capacity or dementia and people whose capacity has been affected by traumatic injury. It will also ensure that people with capacity can register in advance their wish not to receive treatment which they perceive as futile in the event that they lose capacity to make decisions.

Central to the proposed legislation is the establishment of a Decision Support Service and the introduction of new roles:

1. Decision-Making Assistant
2. Co-Decision Maker
3. Decision Making Representative

The HSE is currently developing Guidance Documentation to support staff who work in this area and where significant decisions with regards to for example, choice of care including longstay, will need careful consideration to protect people's interests and rights.

## 7. Challenges and Opportunities

The HSE in April, 2017 made a submission to the Dáil Committee on the Future of Health Care “A planning for Health Discussion Paper 2017”.

The Director General in identifying some of the challenges and opportunities stated as follows “*the balance of health and social care services needs to shift away from an over-reliance on acute hospital services towards stronger primary and community services. Poor orientation to primary care and underdevelopment of eHealth infrastructure mean the starting point for our goal of building a sustainable service model capable of meeting unmet need together with increasing demand is weak.*” He went on to say that “*For decades we have been aware of the need for a shift in health service delivery in order to move from the more traditional focus of treatment and cure to that of prevention and treatment, when required, at the lowest level of complexity. The solutions are relatively well articulated nationally and internationally.*” I have outlined earlier in this paper some of the initiatives which have been taken to develop an organisational and management structure at community level which is better placed to deliver more responsive integrated care for our citizens. The HSE submission identified some of the key challenges faced to 2030 and an indication of the investment required to shift the balance of care towards primary and social care models, e.g. Social Care investment in the order of €400-€700m is required to shift the balance of care.

Focussing on older people, in the period 2009 to 2015, there was a 9.8% reduction in total HSE budget assigned to the need of older people (from €1.74 billion to €1.57 billion), while in the same period, the number of older people rose from 498,900 to 606,000 (21.5% increase); a 25.7% reduction in per capita budget for older people. In the same period, there was a reduction in home help services (Figure 3): the 20% reduction in Home Help coverage coincided with an 8% increase in admissions for people 65 years and older. To put this in context, avoiding one average hospital admission for older person could fund one year’s supply of 1 hour/day home help service for that person. As at July, 2016, there were 2,256 people waiting for Home Care Packages and 2,097 waiting for Home Help.

In order to address these challenges the HSE has developed and is implementing a multi-layered Reform Programme across Older Person’s Services, and is moving forward with a number of key initiatives in this regard.

- Home Care – Working with the DOH in identifying the key elements of a future Homecare Scheme, and the necessary regulatory requirements. In the interim, the HSE is developing Audit mechanisms to improve the quality of the service that it procures from Voluntary and Private Providers as well as through its own direct provision.
- Day Care Services – The scope and capacity of current Day Care provision is currently being examined to ensure that it is responsive to the needs of Older People, fulfilling its role as a valuable service provision, in supporting older people to stay at home.
- Short Stay Public Bed Capacity – Short stay beds include Rehabilitation and Convalescent services and are important part of the continuum of care for people who may have experienced a period of ill health or some loss of independence and where the input of nursing and therapy services can help a person to rehabilitate. A review of such services with a view to maximising their potential in the area of rehabilitation is being undertaken and also where a cost model of the Money Follows the Service recipient.
- Integrated Care Programme for Older Persons (ICPOP) – It is recognised that older people with the higher levels of dependency are most at risk of requiring unplanned hospital attendance and admission as well as premature admission to long stay care. The integrated Care Programme sets about identifying those most dependent who require on-going support by specialist services and the development of Care plans to meet their overall needs. The Programme has commenced in 12 locations across the country, as Pioneer Sites, and the early indications are that through careful identification of those most at risk, appropriate services can be coordinated across hospital and community, to provide a greater quality of life and extending peoples ability to stay at home for longer.
- Single Assessment Tool (SAT)- Inter Rai. An international evidenced based holistic assessment has been developed to suit the Irish context which allows professionals to undertake overall

assessments and provide both an analysis and an outcome of care planning on an IT based platform. Following testing and Pilot sites, the 9 CHO's are currently identifying roll-out plans for this assessment process to be implemented across the country. This will form the basis for Service Planning and indeed Resource Allocation into the future.

- Nursing Homes Support Scheme – as the Administrator of the Scheme and following the DOH Review of the NHSS, as published in 2015, the HSE is undertaking a set of reforms to improve the information and responsiveness of the administration of the Scheme, with a key development being the reduction of the Nursing Home Support Offices to 5 main centres.

Members of the assembly will be aware that the “10 Year Health Committee” recently launched their report which will be the subject of comprehensive debate both in the Oireachtas and in the wider public for the coming period and I am sure will inform the work of the assembly.

## **8. Improving access & responsiveness – a model of integrated care for older people**

### **Integrated Care Programme for Older Persons (ICPOP)**

As stated earlier, it is recognised that older people with higher levels of dependency are most at risk of requiring unplanned hospital attendance and admission as well as premature admission to Long stay care. The aim of the Integrated Care Programme for Older Persons (ICPOP) is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care. It follows a 10 step programme as outlined below. This approach addresses key barriers by;

1. Incentivise existing examples of good practice that gets clinical and managerial buy-in.
2. Facilitating buy in by combining national enablers of integration (Seed funding and ICT enablers). Harnessing local innovative service initiatives, including the voluntary sector.

# 10-Step Integrated Care Framework for Older Persons



## Key benefits of ICPOP

1. Older persons with long term complex care needs will have a single point of contact (case manager).
2. A case manager will help older people to access services when needed.
3. A multidisciplinary, community approach will be taken that provides a one stop shop for care coordination.
4. Beds in acute hospitals will be utilised for those who are in medical need.
5. Carers will be supported.
6. Technology will enhance care co-ordination through sharing of information.
7. There will be clearly defined pathways in hospitals with minimum lengths of stay.
8. More patients will stay at home or get back home more speedily.
9. Shift future model of care away from institutional care/long term care where possible.

A core component of the ICPOP approach is to leverage existing community resources in the local health ecosystem. These include acting as a conduit to and co-ordination of care in tandem with social care providers (public and private), community intervention teams, day hospital, day care, community intervention teams etc.

In 2016, development funding of €1.7m was allocated to ICPOP in order to commence the foundation steps towards integrated care for older persons. This allowed for the programme to commence in 12 locations across the country, as Pioneer Sites, and the early indications are that through careful identification of those most at risk, appropriate services can be coordinated across hospital and community, to provide a greater quality of life and extending people's ability to stay at home for longer.

## Funding Requirements

The HSE must be cognisant of the resources of the State and ensure that the current levels of resource are deployed to maximise their value and to do the 'most good' for the 'most people'. Through better lifestyle choices, and options that are inclusive of older persons wishes and requirements, there will be a lesser dependency on more expensive interventions of clinical care and better health outcomes. However, to develop the continuum of care and fund its various elements significant decisions are required around the funding model and sustainability.

A single example that brings home the scale of the requirement is as follows:-

- The provision of 1 additional hour of Home Help per week, to each of the current recipients (50,000), would require an additional resource of €52m/ annum.
- An additional 100 people requiring long stay care would require approximately €5m/annum.

## Appendix 1:

### Key Information regarding accessing the NHSS

#### 1.1 The Application Process

Applications are made to the Local Nursing Home Support Office (NHSO), who are also available to provide information and guidance in relation to the application process. There are 3 steps to the application process.

Step 1 is an application for a Care Needs Assessment. The Care Needs Assessment identifies whether or not the person needs long term nursing home care.

Step 2 is an application for state support. This will be used to complete the financial assessment which determines the person's contribution towards care, and the corresponding level of financial assistance that will be provided, (State Support).

Step 3 is an optional step which will need to be completed if the person wishes to apply for the Nursing Home Loan, (this is termed 'Ancillary State Support' in the legislation.)

The application form will need to be completed and signed by the person applying for nursing home care. Where a person may need care, and due to some condition of ill health, they are unable to make an application for a care needs assessment, a *specified person* may apply for the assessment on their behalf. A *specified person* can include the spouse or partner, relative, the Committee of a person who is a Ward of Court, a Care Representative appointed under the Nursing Home Support Scheme Act.

#### 1.2 Care Needs Assessment

The Care Needs Assessment identifies whether or not the person needs long term nursing home care. Its purpose is to ensure that long term nursing home care is necessary, and is the correct choice. The assessment will consider whether the person can be supported to continue living at home or whether long term nursing home care is more appropriate. The Care Needs Assessment will be carried out by appropriate Health care professionals, it includes consideration of the ability of the person to carry out the activities of daily living, their medical health and personal social services being provided to them, family and community support as well as the persons wishes and preferences. This information is currently captured in a report called a 'Common Summary Assessment Report' or CSAR. Currently the HSE is introducing an IT based internationally recognised Single Assessment Tool (SAT) to replace the CSAR.

The Needs Assessment is further enhanced by review of a multidisciplinary team called the Local Placement Forum (LPF) which brings additional oversight to the determination that long stay care is the correct options for the person who has applied for support under the scheme.

#### 1.3 Financial Assessment

In addition to the Needs Assessment, the financial assessment takes account of a person's income and assets in order to calculate his/her contribution to care. A person's contribution is based on 80% of his/her assessable income and 7.5% of the value of any assets. It should also be noted that the first €36,000 or €72,000, for a member of a couple, of the value of the person's cash and non-cash assets are disregarded as part of the financial assessment. In cases where the person is a member of a couple, the assessment must be based on half of the couple's combined assessable income and assets i.e. the aggregated net value of all assets – cash and non- cash assets (value of assets less allowable deductions) less the asset disregard x 7.5% divided by 2 divided by 52 for assessed weekly assets. The value of the person's principal private residence is only included in the financial assessment for the first three years that an individual receives care services in a nursing home.

All applications are assessed in accordance with the NHSS Act 2009 and in line with the 'National Guidelines for the Standardised Implementation of the Nursing Homes Support Scheme' (available on [www.hse.ie](http://www.hse.ie)). Each



applicant has a right to appeal the decision of the HSE in respect of the determination of weekly client contribution towards the cost of the nursing home.

#### 1.4 Ancillary State Support

When a person's assets include land or property, the contribution based on such assets may be deferred. This is an optional benefit of the scheme. It is effectively a loan advanced by the state, which can be repaid at any time but will ultimately fall due for repayment upon the person's death. This Nursing Home Loan - (Ancillary State Support), can be applied for at initial application or at any stage while a person is a resident in a nursing home. The person will apply for the Nursing Home Loan and provide written consent to have a Charging Order registered against the asset. Subject to the person giving consent, the HSE is responsible for making the charging order, registering it against the asset and making Nursing Home Loan payments to the nursing home on the person's behalf.

#### 1.5 Care Representatives

A Care Representative is only required when a person has reduced capacity to make decisions AND wishes to apply for the Nursing Home Loan. The Care Representative is appointed by the Circuit Court. Their role is to act on behalf of the person in respect of the NHSS and especially in respect of the Nursing Home Loan. They can also act on behalf of the person in relation to making an application for the Care Needs Assessment, State Support, or any other matter relating to the scheme. Care Representatives may apply to be appointed and will be prioritised in order of their relationship with the person applying e.g. spouse/ partner, parent, child, brother or sister etc. Care Representatives can also include Medical Practitioners or the owner of a nursing home in which the person resides, or is likely to reside.

#### 1.6 Outcome of Application Process

Once the Care Needs and Financial Assessments are complete, and it is established that the person requires long stay care, the HSE will advise of the contribution to care and if the person is eligible for the State Support. If the person has applied for the Nursing Home Loan, the person will also be advised of the outcome of this aspect of the application. The HSE will also provide the person with a full list of Residential Care Centres including public, voluntary and private (for profit) nursing homes. All of these centres will have been registered with HIQA in relation to the standards of care being provided. The person will then have the choice of nursing home and care provider. The choice of nursing home is not connected in any way to the level of the person's contribution to care, ie **the contribution the person will make towards the costs associated with their care remains the same under the terms of the Scheme, regardless of the care provider chosen.**

#### 1.7 Review & Appeals

If the Care Needs Assessment determines that a person does not require long term nursing home care, the legislation allows for a review to take place. The review will centre on any material change in the person's health or circumstances since the original Care Needs Assessment was undertaken. Financial Assessments can also be appealed, including the amount of the Nursing Home Loan.

#### 1.8 Repayment of the Nursing Home Loan

The Nursing Home Loan will become repayable after the person dies, or sells or transfers the property. Where the loan becomes repayable on the person's death the repayment of monies based on the **principal residence** only, can be further deferred or postponed in certain instances, this is called 'Further Deferral'. Some people who may qualify for a *Further Deferral* of the repayment of the loans include; the persons spouse or partner, any children under the age of 21, a relative in receipt of a disability or similar allowance etc.

These individuals must also satisfy the specific conditions including the asset in question must be their only residence and they must have lived there for more than 3 years preceding the original application for the Nursing Home Loan.

When the Nursing Home Loan falls due for repayment the HSE will write to the person responsible for the payment and will advise them of the amount due. The HSE will apply the consumer price index to the loan to take account of the time value of money, (inflation or deflation), since the loan was made.

#### **1.8.1 What is the responsibility of the Revenue Commissioners?**

Money owed under the Nursing Home Loan must be repaid to the Revenue Commissioners. They are charged, under the legislation, with pursuing the matter in the event that the repayment is not made. The Legislation provides specific timeframes with regards to repayments of the loan or otherwise interest will apply from date of death. *See 3.7 below for detail of payments received.*

#### **1.9 Further Information in relation to NHSS**

All of the above information is provided as a synopsis and there is significant additional detail with regards to each aspect of the process which is available and communicated in simple and Easy Read versions to members of the public. Notwithstanding this, the Scheme by its nature and underpinning legislation is quiet complex. It reflects the significant decision and funding requirements that relate to long stay care services. The HSE continues to improve its communication processes with the public understanding that decisions regarding entering long stay care are quiet significant for those involved including the person themselves and their families.