Health
Information
and Quality
Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Regulation of
Health and Social
Care Services

The Need for Regulatory Reform

A summary of HIQA reports and publications examining the case for reforming the regulatory framework for social care services

February 2021

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Equality and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services** — Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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Introduction

As set out in the Health Act 2007, as amended (the Act), the objective of HIQA is to promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public. In addition, HIQA has a key role in informing and influencing evidence-based decisions at both local and national level. This report summarises HIQA's experience of regulating social care services over the past 10 years and the changes required to make regulation fit for purpose into the future.

The primary purpose of regulation is to protect the public. In line with other jurisdictions, and in line with reports into the failures of some services to protect vulnerable people, the State embarked upon a programme of regulating certain services, where it believed that people need to be protected and have their rights upheld. These may be older and dependant people, people with a disability,[*] or children in the care of the State. In line with its statutory obligation, HIQA has further enhanced its role in the promotion and protection of human rights of citizens in receipt of social care services, through its interpretation of the public sector duty to respect human rights under the The Irish Human Rights and Equality Commission Act 2014.

About the report

Social care in Ireland is changing. The institutional and residential approaches towards the provision of care for older people and people with a disability are being challenged. HIQA welcomes this challenge as it is reflective of how we, as a society, support our most vulnerable.

Since March 2020, Ireland has had to contend with the arrival of the highly infectious coronavirus, COVID-19. HIQA has witnessed first hand the profound impact that this has had, and continues to have, on the residents of designated centres and their families. In this regard, this report outlines some key components of regulatory reform that need urgent attention. Although COVID-19 has highlighted weaknesses in the legislation and in the regulations that provide the mechanism to regulate social care services in Ireland, many weaknesses were present over the last number of years due to the evolving nature and provision of social services.

This report provides a broad overview of the social care sector in Ireland and the regulations and standards that govern its provision. It sets out an argument for regulatory reform by illustrating the challenges that the Chief Inspector experiences when inspecting compliance with regulations that are not wholly effective. In a

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[*] The S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 apply to both children and adults with disabilities who live in designated centres.

sense, the regulations are not maintaining pace with the evolving nature of services. Furthermore, some regulations are not aligned with Sláintecare’s principal policy objective to get ‘the right care, in the right place, at the right time’(1) and alongside this, there is also a strong argument for an intregrated, comprehensive social care policy that complements Sláintecare’s social care expansion.

The report also highlights some key areas where greater accountability is needed in terms of the procurement and commissioning of social services. This report aims to assist policy-makers to design a regulatory system that is agile, receptive, reactive to change and proportionate in its response, while ensuring the rights of people using services are upheld.

Principally, this report is calling for:

- a comprehensive review of the current regulations pertaining to social care services in Ireland, and the establishment of a regular review process
- the reform of the Health Act 2007 to take account of the changing landscape in health and social care services
- the introduction of regulation into other forms of care that are currently unregulated and whose service users may be vulnerable
- a framework that makes a clear distinction between the purchaser and provider of services along with clear governance and accountability arrangements
- consideration to be given for the development of a comprehensive, integrated social care policy that considers social care in its totality alongside Sláintecare.

With regard to COVID-19, HIQA has submitted its views to Government on how regulations could be amended and enhanced with a view to strengthening key areas related to the pandemic, for example, infection control, staffing, governance and clinical oversight. This report should be seen as separate and distinct to any immediate or interim requirements related to COVID-19.

The social care sector

Social care in Ireland is a broad term which covers services for a wide range of people including children, people with disabilities and older people. Recently, the Department of Children, Equality, Disability, Integration and Youth took over responsibility for residential disability services. Irrespective of this restructuring, the direction, provision and objectives of social care in Ireland and the role of HIQA remain the same, with some services across departments being regulated and inspected by the Chief Inspector. The services that are subject to regulation are defined in the Health Act and are referred to as 'designated centres', which include:

- nursing homes
- residential services for people with disabilities
- children's special care units.

Regulation of designated centres encompasses inspection, registration, receipt of information and, when required, enforcement. Inspections involve HIQA staff visiting designated centres and gathering information on whether the service is complying with the regulations and meeting the needs of the people using the service. Registration of a designated centre means that the Chief Inspector has assessed a centre as sufficiently compliant with the regulations at the time of registration, therefore deeming the provider fit to deliver the service.

The Chief Inspector maintains a register of designated centres which have been inspected and deemed to meet the regulatory compliance required for registration. The receipt and review of information is a vital component in the regulation of services. The Chief Inspector receives, analyses and risk assesses information from a range of sources. Such information, which may be in the form of statutory notifications or unsolicited information, is used to identify potentially harmful events that have impacted or could impact the health, safety and wellbeing of people using services.

HIQA publishes reports of all inspections of designated centres.[†] The majority of services are well managed and provide good quality care. There are a range of options available where a service is found not compliant with the regulations. Such services may be subject to more regular inspections and closer monitoring, and service providers may be requested to submit information to the Chief Inspector on a regular basis, detailing how they are addressing non-compliances. In cases of serious non-compliance that compromise the health or wellbeing of residents, the Chief Inspector may place restrictive conditions on a centre, such as limiting the number of admissions. Ultimately, designated centres can have their registration

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[†] A very small number of inspection reports are not published if they contain identifiable information. This is to protect the privacy of residents.

cancelled, which means the service must cease operations or be taken over by an alternate service provider.

At present in Ireland, there is no overarching social care policy or legislation that outlines clearly what the State's role is in the identification and addressing of the social care needs of its elderly and more vulnerable populations. In some instances, it is this absence of clarity regarding the State's responsibility that has led to the irregularities that are described later on in this paper. The lack of clarity also inhibits the development of a coherent and strategic means by which to plan services for individuals and communities. The State's Sláintecare programme goes some way to addressing this when it speaks of person-centred care in the 'right place' and at the 'right time'. A comprehensive legislative framework for our system of social care which addresses the rights of individuals, as well as how services are planned and funded, is needed.

Regulations and standards

All designated centres are subject to regulations and standards which set out how they must operate their service and what a person should expect when using a service. The terms 'regulations' and 'standards' are often used interchangeably, but in the context of social care in Ireland, there are important distinctions. Regulations are devised and introduced by the Minister for Health by means of a statutory instrument. Essentially, they are central instruments through which the Government seeks to deliver its policy priorities. Regulations are legally enforceable and all designated centres must be in compliance with these. Regulations set out the basic requirements for a service and can be regarded as a minimum level of quality and safety.

Standards, on the other hand, set the bar for quality and safety somewhat higher than regulations. They are devised by HIQA through a process of research and consultation with a range of stakeholders and approved by the Minister for Health. Standards are not legally enforceable, but all designated centres should strive to meet the standards. The examples in Table 1 below illustrate some of the differences between regulations and standards for designated centres for older people.

Table 1 – Regulations and standards in nursing homes

	Regulations(2)	Standards(3)
Food and nutrition	18. (2) The person in charge shall provide meals, refreshments and snacks at all reasonable times.	2.2 Each resident's needs in relation to hydration and nutrition are met and meals and mealtimes are an enjoyable experience.
Activities and recreation	(2) The registered provider shall provide for residents — (*a*) facilities for occupation and recreation, and (*b*) opportunities to participate in activities in accordance with their interests and capacities.	4.2 Each resident is offered a choice of appropriate recreational and stimulating activities to meet their needs and preferences.
Staff training	16. (1) The person in charge shall ensure that — (*a*) staff have access to appropriate training.	7.4 Training is provided to staff to improve outcomes for all residents.

Overview of the social care sector

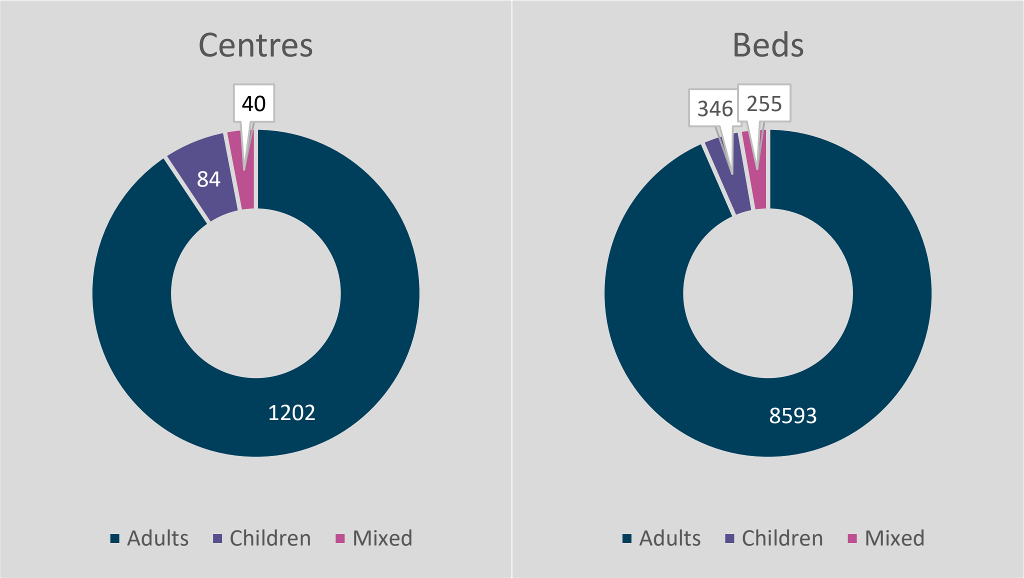
The following section offers a description of the types of designated centres that are registered and regulated by the Chief Inspector.

Designated centres for people with disabilities

HIQA commenced regulation of residential disability services in 2013. These centres are typically long-term residential or respite services that care for people with intellectual, physical or sensory disabilities. The majority of services are provided to adults; there are a small number of centres that are specifically for children and some that are a mix of adults and children. Currently,[‡] there are 1,326 registered centres providing a total of 9,194 beds.

[‡] Data correct as of 23 October 2020

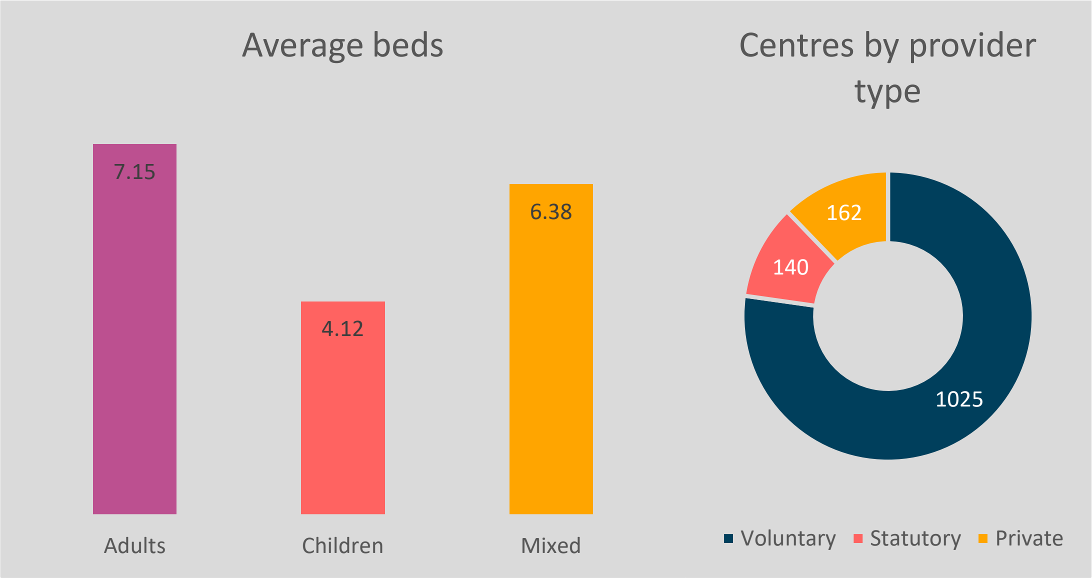
Figure 1 – Breakdown of disability services and beds



Designated centres for people with disabilities vary in size. The smallest centres provide a service to just one person; the largest centre is registered to care for 43 people. The average number of beds for each type of disability service is shown in Figure 2. However, it should also be noted that the provision of campus-based congregated care settings still exist. There are 14 campus-based settings in Ireland with more than 50 registered beds, with the largest providing 146 registered beds in one campus-based setting.

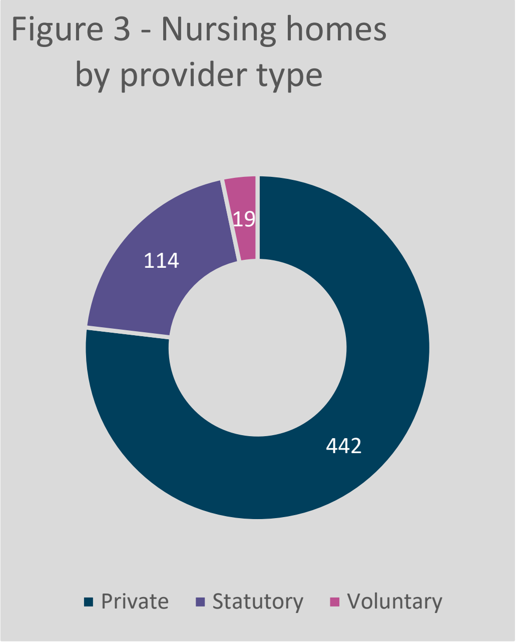
Disability services are mostly provided by voluntary, not-for-profit providers. These are funded via a block grant from the Health Service Executive (HSE) through what are known as Section 38 and 39 arrangements under the Health Act 2004. There are 68 voluntary providers that operate 1,025 centres across the country. There are 140 centres that are operated by the HSE. The remaining 162 centres, are operated on a private basis by 16 different providers (see Figure 2). In addition, under the current system, there is variability in what is included in the contract of care for residents within services and there are extra fees and charges across the sector.

Figure 2 – Disability services: average beds and type of provider



Designated centres for older people

HIQA commenced regulation of nursing homes in 2009. These centres typically provide residential care for older people. Most nursing homes provide for the basic needs of residents, including meals, personal care, nursing care and recreational activities. Some nursing homes provide additional services such as respite, or to meet the specific needs of people with dementia or acquired brain injury.



Nursing homes are primarily run by private operators and funded through the Nursing Home Support Scheme (also known as ‘Fair Deal’). The HSE and voluntary providers funded by the HSE also operate nursing homes. There are currently 574 nursing homes registered in the country, ranging in size from the smallest, which has nine beds, to the largest, which has 184. The average number of beds in nursing homes is just over 56.

Changing profile of the nursing home sector

The Chief Inspector has observed a trend in the nursing home sector towards consolidation. This means that there are several large providers with responsibility for multiple nursing homes, and these numbers are growing. The group providers are acquiring nursing homes owned by smaller providers and are also using external investment to build new facilities.

Aligned to this is the trend towards larger nursing homes. The average number of beds in nursing homes nationally has increased in each of the last five years. 2019 data show that new nursing homes tend to be larger in terms of bed numbers. Of the 10 new centres registered in 2019, eight had bed numbers in excess of the national average.

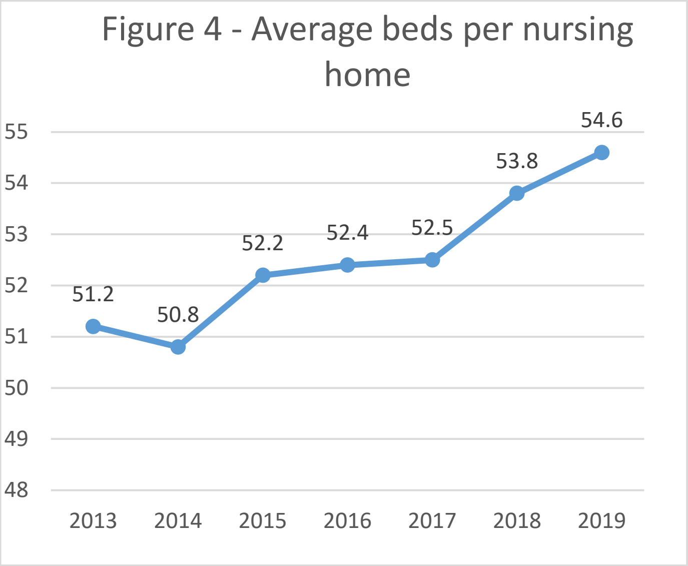


Figure 4 - Average beds per nursing home

The trend towards larger providers in the nursing home sector has continued throughout 2020. It is important to consider the potential implications of this. In 2011, a large care home chain in the UK providing care to 37,000 people went into liquidation. This chain had expanded by 1,000% in the previous 10 years. Although only a small number of facilities closed, it created a significant sense of anxiety and concern in the social care sector. If this service provider had failed it would have placed enormous strain on the social care system, with the final liability for providing care resting with the state. As a result, the UK's 2014 Care Act established a 'market oversight'(4) regime to observe certain providers financial viability. Nonetheless, in 2019, another large provider of in excess of 10,000 older people's placements also went into liquidation.

Given the UK experience and the growing trend in Ireland, it is important to acknowledge the risks involved in concentrating care facilities within a small number of large providers. These risks relate both to the impact on the social care system when services go into liquidation and the resultant anxiety experienced by residents and families when alternative care facilities have to be found. This consolidation in ownership has been identified as causing significant difficulties for regulators given the complex and changing ownership patterns.(5) Indeed, HIQA has experienced some difficulties recently in terms of identifying who is the responsible legal entity for providing a service. This development is therefore a very real and genuine concern for the Irish social care sector.

Notwithstanding the changing profile of care facilities in Ireland and the associated risks, the COVID-19 pandemic has strengthened the argument for the restructuring of models of care for older people in a way that provides for differing supports, at different times, based on individual ability and need. The requirement for models of care that are diverse and truly person centred is embedded in our argument for regulatory reform. The following is a short list of the various types of social care provided in Ireland at present and that are not formally regulated.

Supported and or assisted living and sheltered housing

The provision of accommodation to people with low level care and support needs. Typically co-located with other such accommodation units with a small number of staff on site.

Personal assistance

A personal service, usually for people with a disability, provided to facilitate the person to live as independently as possible. There is no accommodation provided and the care is on a one-to-one basis and directed by the service user.

Day services

A community-based service which is often provided in group settings where individuals come together to engage in supervised activities outside of their own homes or residences.

Homecare

The provision of one-to-one care and support services provided by trained staff in a service user's home. Homecare seeks to support people to remain living in their homes by providing assistance with activities of daily living.

Home sharing

Home sharing (sometimes referred to as adult placement) is a broad term which refers to arrangements, whereby a person with a disability stays with a host family. Other terms include ‘shared living’, ‘family-based respite’ or ‘home sharing short breaks’. Such arrangements are short term and facilitated by a voluntary organisation that matches a person with a disability to a host family.

Respite

Typically, respite care is a short-term residential placement provided to a person who is usually being cared for at home.

Short-stay or convalescence or step down units

These types of services are usually a temporary arrangement where patients recovering from illness can be accommodated without the need for acute care. These services are sometimes located adjacent to hospitals and are primarily state run.

Hospice and or palliative care

Most commonly provided in the voluntary sector, hospice and or palliative care aims to improve the lives of those people whose illness is incurable.

Live in service

This is a flexible type of service where a carer will ‘live in’ a person’s home and provide them with personal (for example, personal hygiene) and practical support (for example, household tasks) in exchange for payment and accommodation. This service requires the person to be comfortable with someone sharing their home and is generally provided to people with low-to-moderate support needs.

The need for regulatory reform

HIQA has been engaged in the regulation and monitoring of various health and social care services for more than 10 years. The experience of inspecting centres and assessing compliance with regulations and standards has produced a wealth of knowledge on the quality and safety of services. It has also allowed us to develop insights into how the regulatory framework is serving the interests of people who use and provide services. HIQA has shared these insights in the past number of years through various means, such as publications, annual reports, and in our engagements with a variety of key stakeholders. The following section will outline some of these insights and propose that, taken together, they comprise a persuasive argument for far-reaching reforms of the regulation of social care services in Ireland.

Definition of designated centres

The Health Act 2007, as amended, is the key piece of legislation governing the regulation of social care services. The Act sets out *inter alia* the powers of the Chief Inspector, the manner in which services are registered, and what types of services are subject to regulation. In order to be registered, services must meet the definition of a 'designated centre' as set out in the Act. What constitutes a designated centre differs depending on the type of care or support being provided.

In the case of nursing homes for older people, the Act relies on the definition of a nursing home from the Health (Nursing Homes) Act 1990: 'an institution for the care and maintenance of more than two dependent persons'.(6) Certain exclusions apply, such as, homes for 'mentally handicapped persons'[§] and places where the majority of people are being treated for an acute illness. This definition is relatively straightforward and leaves little room for interpretation. However, it should be noted that certain types of care present challenges to this definition, such as respite care for the elderly.

Similarly, services provided by religious orders for the sole purposes of accommodating older members of the religious community (for example, priests, nuns, brothers,) are specifically excluded from the definition, despite the fact that they are no less vulnerable.

The definition of a designated centre for people with disabilities is considerably more complex:

> 'designated centre means an institution[**]...

[§] 'Mentally handicapped persons' is the terminology used in the Health Act 2007 and it is not reflective of the terminology used by HIQA.

[**] 'Institution' is the terminology used in the Health Act 2007 and it is not reflective of the terminology used by HIQA.

(a) at which residential services are provided by the Executive, the Agency, a service provider under this Act or a person that is not a service provider but who receives assistance under section 39 of the Health Act 2004-

(ii) to persons with disabilities, in relation to their disabilities'.(7)

There are a number of key terms in this definition that need to be further explored in order to appreciate the complexity of defining a designated centre in the context of current and developing models of disability services. Firstly, an institution, a word that should now be avoided when discussing the provision of social care services, can mean several things. The Act specifies what is meant by an institution, stating it can be a 'home, unit, centre or institution or part of a home, unit, centre or institution'. The use of the word 'home' creates a difficulty: can a person simultaneously live in their own home and in a residential service? It is HIQA's view that a home in this context refers to a community or group home, similar in nature to the use of the word 'home' in nursing home. However, greater clarity within the legal definition would be beneficial.

A further complication with this definition is the absence of a definition for a 'residential service'. Traditional forms of social care for people with disabilities generally took the form of campus-based settings where many individuals lived and were cared for in a congregated fashion. This clearly fits with the concept of a residential service. Reforms to disability services have seen a move away from this model towards more dispersed, community-based services with smaller numbers of residents. These types of services can vary widely: seven-day, full-time residential care for people with complex needs; part-time (five-day/weekend) services where people also attend day services; or minimum support services where the residents can exercise a high degree of choice and autonomy. These are significantly different types of service with very diverse service user profiles. It is difficult to conceive how some of these services fit into the category of a residential service. HIQA has previously published guidance which defines a residential service as comprising both a care and accommodation component. However, this is also highlighted by acknowledging that some people who can exercise effective control over their daily lives may not be living in a residential service.

The definition provided in the Act also makes reference to care being provided to persons with disabilities 'in relation to their disabilities'.(7) This would appear to suggest that the service must be geared towards a person's specific needs relating to their disability. Ultimately, the difficulty in interpreting this definition has resulted in the need to formulate some key points on what is considered a designated centre.

It is:

a) a particular type of place, where
b) a particular type of service
c) is provided by a particular entity
d) to a particular type of person.

Points b) and c) are relatively straightforward in terms of the disability sector: the ‘type’ of service is one provided to a person with a disability in relation to their disability. The ‘entity’ is the registered provider that is legally responsible for providing the service. Interpreting points a) and d) underline the difficulty in defining a designated centre in the context of new and emerging models of care and support for people with disabilities. The ‘place’ can be the typical congregated setting where people often share bedrooms in a dormitory style. However, it can also mean an apartment where the person receiving care lives alone, receives minimal support and can come and go as they please.

This brings us on to d): the types of people living in designated centres are diverse individuals. There are people of all levels of need, ability, preference and ambition. Certainly, the Act and regulations as they were originally envisaged would have conceived of the type of person living in a designated centre as someone with high support needs requiring 24-hour care. The process of phasing out services which are delivered in congregated settings, as set out in the HSE’s ‘Time to move on’ policy,(8) means that services are now becoming much more diverse, person centred and less paternalistic. This presents a challenge to the current definition of a designated centre, because a substantial number of services could more realistically be regarded as assisted-living or home-support services. Such services are not currently regulated and do not offer the same protections to people who use these services. Moreover, people transitioning into these types of services will be moving from an environment that is regulated into one which is not.

The manner in which community-based services are being arranged and administered adds a further layer of complexity to this issue. HIQA is aware that registered providers are sourcing accommodation through a variety of means, such as leasing from private landlords, local authority housing and Capital Assistance Scheme funding. This means that the legal entity providing the accommodation is separate and distinct from the entity providing the care. Moreover, the fact that many service users rightly have tenancy agreements means that they have certain rights which are separate from the regulatory model.

In order to further explore this matter, HIQA carried out a survey of all inspectors to identify centres that may not meet the definition of a designated centre, that is, services where the residents have substantial control over their daily lives and might benefit from a different regulatory model. The survey found that of the approximately 1,300 designated centres, less than 1% (10 centres) already may not meet the definition. An additional 45 centres were worthy of review to determine if part of their service could be de-registered. Taken together, this represents a small proportion of services and service users. HIQA is of the view that some individuals who live in these buildings are potentially vulnerable and will continue to be when or if services are de-registered. It may be prudent to consider this potential vulnerability under the scope of homecare regulation in the longer term. This recognises that individuals with a disability have moved from institutional or residential settings into community or home settings which, as is the case in many other countries, should be brought within some form of regulation and protection.

As is the practice in other jurisdictions, a definition focused on the full range of care services that may be delivered, rather than one focusing on the type of physical location or institution, would be a better regulatory approach.

Regulating services as opposed to centres

HIQA published two documents in 2017(9, 10) which sought to reflect on the nature of social care regulation in Ireland and summarised the approaches in a number of other countries. Both documents, one specific to disability services and the other to older people's services, began with a discussion of the definition of a designated centre. Similar to the section above, the papers highlighted the shortcomings of the definition in the context of other forms of social care for vulnerable people. It then outlined the situation in a range of other jurisdictions in terms of what services are available and how they are regulated.

In general, it found that other countries have a more diverse range of social care services available to various populations, each with varying degrees of regulation or quality assurance mechanisms. Such services include the residential forms of care like nursing homes or residential disability services in Ireland. In addition, there are various forms of homecare, community mental health care, day care and assisted living. These services are comparatively underdeveloped in Ireland and many exist in a grey area in terms of regulation or independent quality assurance.

All of this is found in an environment where there is an ageing population in Ireland, which will require a substantially increased level of care and support over the coming decades. Ireland's homogenous social care system tends to funnel people into more traditional forms of residential care and support. This is despite the fact that it is Government policy to facilitate people to be cared for at home for as long as is reasonable. Indeed, the research also suggests that this is the preference for the majority of people. It is not the case that nursing homes should be phased out. Rather, they should be seen as one component in an expanded social care system for people in need of care. As stated in the recent Nursing Homes Expert Panel report: "Nursing homes should be part of a continuous spectrum of care of the older person in the wider healthcare system, with provision of multidisciplinary support."(11)

A further finding of HIQA's 2017 papers was that the regulatory framework in Ireland tends to put the emphasis on the physical place, where the care happens as opposed to the type of care or the needs of the people receiving care. This is exemplified by the fact that there are no specific descriptions or definitions of various forms of care in either the legislation or regulations governing social care in Ireland. This is in contrast to other countries which clearly outline and define such terms as 'personal care', 'homecare' and 'nursing care'. The current regulatory framework in Ireland is similar to a 'one-size-fits-all' approach. This means that people with a wide range of care needs and functional capacities are subject to the same regulations, be that in a nursing home or a disability service. It is also noted that there are large numbers of people in receipt of services that are entirely unregulated at present, for example, formal homecare and day services.

HIQA advocates for the reform of this model to one where the service becomes the focus of regulation. This has been the direction of policy in the UK for some time and was recently introduced in Wales:

> The proposal is to move from an agency and establishment model to a service-based regime. This model means that providers are required to register if they wish to deliver regulated services in Wales. While providers would still be required to identify the place(s) at, from or in relation to which a service is being provided, the new system would only require individuals or organisations to register once with the regulator. If a provider wishes to provide further services or the same service from different places then they would apply to vary their initial registration.(12)

In proposing to move to a service-based model of regulation, HIQA is also of the view that other forms of care be brought within the framework of regulation. This will mean that more care recipients and service users, many of whom are just as vulnerable and in need of support as those in residential care, will be protected through a system of independent regulation. Each distinct care setting should be clearly defined, with a bespoke set of regulations tailored to specify the needs and supports available for the people who use the service.

Regular review of regulations

Regulation is a key tool for governments to achieve policy outcomes that cannot be ordinarily achieved through voluntary arrangements. It is long established that good regulatory outcomes depend on more than well designed rules and regulations. There is substantial literature and evidence on how regulations should be introduced and reviewed to determine if they are meeting their objectives.(13-15) In 2004, the

Government published a White Paper entitled 'Regulating Better, A Government White Paper Setting out Six Principles of Better Regulation'(16) that set out a process toward enhanced regulation across a range of sectors. This white paper was, and continues to be, in line with the Organisation for Economic Cooperation and Development (OECD) regulatory policy of aiming to ensure that regulation is progressive, fit for purpose and conducive to the economic and social needs of citizens. The key objectives set out in the white paper remain relevant today. Moreover, the white paper outlined the following benefits of regularly reviewing regulatory frameworks, identifying that:

- regular reviews are a key element of ensuring high-quality regulation,
- such reviews would ensure that the regulations' original objectives are still valid and or being achieved,
- such reviews are an integral part of measuring effectiveness, and;
- reviews would allow regulatory objectives to be improved or removed in light of legal, economic or social changes.(17)

On a similar level, the OECD published a separate guideline on strengthening the capacity for regulatory quality and regulatory reform in 2012.(14, 18) Within this comprehensive publication, and where governments use regulation as a policy instrument, it advises that there should be a provision where there is a 'systematic...review...of...the stock of regulations periodically to identify and eliminate or replace those which are obsolete, insufficient or inefficient'.(14) The OECD recommends that these reviews should ensure that regulations remain up to date and that they deliver the intended policy objectives and that any reviews of regulations should be structured around the needs of those affected by regulation. Similarly, in 2019, the Health, Social and Regulatory Forum in Ireland also highlighted the need for regulation to be agile, robust and sustainable. In a submission to the Department of Health, it noted that regulators of health and social care professionals, services and or products were concerned that regulation was not always achieving the primary objectives of protecting the public. This was due to an ad hoc approach towards the design and implementation of policy and legislation, often in response to specific events or crises.

Considering these principles, a key concept that remains constant in the sphere of the regulation of social services in Ireland is that of effectiveness. This should determine whether the regulation (or set of regulations) that HIQA uses actually achieves the objectives for which it was introduced. This needs to be considered from two broad perspectives that have brought the concept of effectiveness into sharp focus.

Firstly, in the context of social care in Ireland, there are two sets of regulations which govern the care and welfare of older people and people with disabilities:

- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013(19)
- Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.(2)

The regulations governing nursing homes have been in place since 2009 and were revised in 2013, with an amendment in 2016. The disability regulations have been in place since the commencement of regulation of this sector in 2013. These regulations specify how care should be delivered, the rights of service users and the responsibilities of the person in charge and the registered provider. The regulations are a key tool that provide assurance to the public that people living in designated centres are receiving a safe, high-quality service.

However, HIQA is of the opinion that some of these regulations are outdated due to the evolving nature of the provision of health and social care services, changing preferences and practices and shifting social norms. Essentially, regulation, despite the best efforts to predict the effects of its implementation (through undertaking regulatory impact assessments),(20) is a dynamic process which is likely to produce intended and unintended outcomes. This underlines the importance of carrying out a comprehensive regulatory impact assessment (RIA) that engages a wide range of stakeholders. In outlining what they consider to be best practice, the OECD argues that the 'quality of the regulatory environment and the delivery of regulatory outcomes is strongly dependent on the quality of processes for designing regulations'. It argues that an RIA should be deployed across the whole of Government and that countries should look to develop cross-functional competencies located within or across Government departments to carry out this work.

Furthermore, the desirability of certain outcomes changes over time and is influenced by social norms, economic factors and evidence-based practice. An earlier section of this report has detailed the changing models of care that disability services are currently experiencing. Simply put, the expectations and preferences of the current generation are different to previous generations. These pressures should be welcomed and seen as an effort to improve the lives of all citizens, regardless of ability. One consequence of these changing expectations is that regulations should be regularly reviewed and adapted to reflect current trends.

HIQA published a report on the impact of COVID-19 in Irish nursing homes in July 2020, which outlined the experiences of residents, staff and families.(21) This report draws attention to a number of regulations which, in the opinion of the Chief Inspector, exposed weaknesses in the regulatory framework. Nevertheless, outside of the COVID-19 sphere there are many other regulations that can be perceived as weak and, to varying degrees, not wholly effective. To contextualise, as many of the regulations are process-driven due to the systems approach towards regulation, they do not sufficiently focus on implementation and the outcomes for residents. It is the experience of the Chief Inspector that, where regulations are heavily process-focused, there is a significant disconnect between the 'process' and intended 'outcome'.

For example, there is no regulation that explicitly sets out the standard of expected care in Ireland. Although, 'Regulation 5: Individual Assessment and Care Plan' and 'Regulation 6: Healthcare' set out the general provision of care more broadly, no regulation sets out the overarching principles. In contrast, in Wales,(22) there is a regulation that embeds the overarching requirements for standards of care and support. Essentially, the Welsh regulations stipulate that 'care and support is provided in a way which protects, promotes and maintains the safety and wellbeing of individuals'. Their approach takes greater account of the impact that care and support services have on people's lives and wellbeing. Additionally, comparing the Irish 'Regulation 9: Residents' rights' versus the Welsh equivalent 'Regulation 2:5 Respect and sensitivity', there is a greater emphasis on the sensitivity and protected characteristics of individuals that are protected in the Welsh legislation.

Other regulations, such as 'Regulation 26: Risk management', are also weighted towards the registered provider's role. While there is no doubt that this is of significant importance, there is also an evident gap between the process, the implementation, evaluation and ultimately, the outcome for residents. Essentially, the focus on the resident is lacking. A further example of this also concerns 'Regulation 7: Managing behaviour that is challenging'. Again, this regulation is general, weighted towards the person in charge and registered provider, not wholly resident-focused and possibly not at pace with current evidence-based practice.

Another critical issue concerning the effectiveness of regulations relates to staffing and staffing ratios. First and foremost, there is no agreed minimum staff-to-resident ratio in force in Ireland. Regulation 15(1) of the nursing homes regulations requires the registered provider to ensure that there is an appropriate number and skill-mix of staff to meet the assessed needs of residents. However, regulations and national standards for nursing homes in Ireland do not set out any required minimum number of staff that must be on duty, as this will largely depend on the profile of people living in the centre and their assessed needs. Essentially, it is the responsibility of each registered provider to assess the capability and capacity of the residents living in a designated centre and provide adequate staffing levels to ensure the safe care of those residents. Again, given the significant prevalence of absenteeism at the height of the COVID-19 pandemic in Ireland, this regulation was not wholly effective.

That being said, although designated centres can be found to be non-compliant in this regulation, it is important to illustrate that the responsibility rests with the registered provider. The Chief Inspector welcomes recommendation 14 from the Oireachtas Special Committee on COVID-19 Response which states that:

> ‘regulations regarding staffing and staff ratios in nursing homes need to be strengthened in order to protect patient health and to prioritise the setting of nurse-to-patient ratios in line with best practice’.(23)

The Chief Inspector also welcomes recommendation 5.4 of the Nursing Homes Expert Panel final report which states that the:

> ‘Framework for Safe Staffing and Skill mix (published 2018) should be prioritised and urgently developed to apply in nursing homes — public and private, nationally’.

This, however, does not change the fact that some of the current regulations governing older people and designated centres for people with a disability are not effective and regulatory reform is necessary.

Statutory notifications

The regulations pertaining to designated centres also set out a list of incidents or events that must be reported to the Chief Inspector. These are known as statutory notifications. The types of notifications can be split into two broad groups: those that must be notified within three days and those that must be submitted on a quarterly basis (every three months). Three-day notifications include instances where residents sustain a serious injury or where a staff member is the subject of an allegation of misconduct. A quarterly notification is submitted where a resident is the subject of a restrictive practice or where the fire alarm has been activated.

Over the course of 2019 and 2020, HIQA conducted research on notifications. Data was gathered on the types of notifiable events in other countries with a view to identifying any potential gaps in the regulatory framework in Ireland. HIQA found that the types of notifiable events required in Ireland are broadly consistent with what is found in other countries. However, there are differences, particularly in terms of the timescale within which reporting is required. Most of the jurisdictions covered by the review ask providers to notify immediately/without delay or within 24 hours of the incident happening. However, in Ireland, the regulations give service providers given three working days to make such a report. There were also incidents which require reporting in other countries which are not required in Ireland. For example, some states in the USA require a notification of ‘self-neglect’; in England, providers must notify the regulator if they have a high level of staff absence or vacant posts.

Incidents which are notifiable should be evidence based, with a clear link to quality and safety. This aids the regulator in using information provided by designated centres to build a risk profile which, in turn, informs the regulatory approach. It is HIQA's view that the suite of notifications required from designated centres should be reviewed. This should give consideration to the timescales of notifications, the merit of existing notifications, the inclusion of new notifications, and an evidence base for all of the above.

Escalation and enforcement

Another argument for regulatory reform considers the statutory powers of the Chief Inspector. Put frankly, the escalation and enforcement options available to the Chief Inspector are somewhat blunt. Although the Chief Inspector can attach a restrictive condition (as described earlier) to a registered provider's registration, the Chief Inspector can also go to the courts to seek de-registration of a designated centre in the case of serious non-compliance or a risk to the safety and wellbeing of residents. It is important to highlight that in many cases this is not a proportionate response to the level of non-compliance with the regulations. However, when these powers are necessary to enforce, it is the Chief Inspector's experience that they can be difficult to administer. By way of example, over the last number of years, the Chief Inspector has taken enforcement proceedings against three nursing homes. Of these, two nursing homes pursued judicial reviews against the Chief Inspector's function, resulting in lengthy legal proceedings.

The Chief Inspector is of the view that prosecution should be a last resort as its use does not improve the safety and welfare of residents or achieve regulatory compliance. Instead there should be some provision in the Act to issue designated centres with a compliance or improvement notice in order to: 1) improve the safety and welfare of residents, and or 2) come into compliance with the regulations. This is determined to be a more efficient, appropriate and proportionate response in many instances of non-compliance with the regulations. This provision is available to HIQA as a regulator of medical exposure to ionising radiation (Part 5 of the European Union (Basic Safety Standards for Protection Against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations 2018), but not to the Chief Inspector under the Health Act 2007 as amended. Improvement notices have also been included in drafts of the Patient Safety (Licensing) Bill.

Furthermore, registered providers have every right to challenge a decision of the Chief Inspector. However, it should be noted that during the course of legal challenges the concerns for the safety and welfare of residents persists. The Chief Inspector is also of the belief that the enforcement mechanisms in the Act are not wholly effective when dealing with the varying degrees of non-compliance that emerge. These mechanisms need to be reformulated, in other words, there is a requirement to develop legal arrangements that allow the Chief Inspector to deal with varying degrees of non-compliance. Taken together, the weak effectiveness of some regulations and the blunt enforcement powers in the Act somewhat dilute the statutory powers of the Chief Inspector. This requires immediate consideration and reform.

Accountability framework

There is some evidence that the provision of older persons care in Ireland is largely disconnected from the wider health and social care system. This was exposed by COVID-19. For example, at the early stage of the pandemic when the emerging evidence was identifying the profound impact the virus was having on older adults in residential care facilities, it became apparent that clinical oversight of older adult residential care facilities was largely absent and there were significant gaps in communication channels with the HSE. To contextualise, over 80% of nursing home beds in Ireland are provided by the private sector. Therefore, they are independent entities regardless of how nursing home placements are procured. Pre-COVID-19, this lack of oversight, while unsuitable, persisted due to the increasing need to provide residential services to an ageing population.

However, COVID-19 has revealed weaknesses in many organisations. While Standard 3.4 of the *National Standards for the Prevention and Control of Infection in Community Settings*(24) requires providers of residential care settings to have provisions and contingencies in place to proactively prevent and manage outbreaks of infection, contingency arrangements were generally not robust enough to deal with the highly infectious COVID-19 disease. In ‘normal times’, simply having a defined pathway in the event of an outbreak is sufficient; however, when this was tested in the context of a pandemic, it failed. Private nursing homes are largely independent and self-governing, which is concerning from a clinical oversight perspective, as observed during the COVID-19 pandemic.

Previous HIQA publications(25, 26) have outlined the importance of effective governance in the delivery of good-quality care. While the regulatory framework places the responsibility on the registered provider to deliver appropriate services, HIQA is of the belief that accountability must also lie at the point at which services are procured. There is an ethical, moral and fiscal responsibility for the purchaser of services (on behalf of the government) to be held to account.

Furthermore, HIQA is also of the belief that if these arrangements were instituted then more appropriate processes would be in place to provide an additional level of clinical governance towards older persons services. Indeed, such a proposal is included as a recommendation in the Nursing Homes Expert Panel report:

> The development, in the medium-term, of clinical governance models in the community should be explored further by the Department of Health in conjunction with the HSE, supported by an international evidence review of models of clinical governance in nursing home settings.(11)

The same is true of disability services where service-level agreements between providers and the HSE are now becoming the norm. These could be enhanced by introducing a form of care management arrangement which would entail the ongoing assessment of people's clinical and social care needs by the HSE on behalf of the State. Services would then be tailored to the specific needs and preferences of the individual.

HIQA is of the view that an accountability framework is of fundamental importance moving forward. Such a framework would explicitly separate out the role and provisions of the purchaser and the provider of services. HIQA considers that this would require the introduction of legislation to make not only the providers of services, but also those procuring them, accountable for their decisions.

The Chief Inspector welcomes recommendation five of the Oireachtas Special Committee on COVID-19 Response,(23) namely that the Department of Health urgently review clinical oversight and governance arrangements for private nursing homes. Furthermore, the recommendations outlined in the Nursing Homes Expert Panel report(11) describe the level of preparedness that is required to manage the resurgence of COVID-19; these recommendations are aligned to the necessary level of governance and accountability that is fundamentally necessary and required by residential care facilities. Notwithstanding this, HIQA is cautioning that it is critically important that the call for this accountability framework does not get lost in the guise of a pandemic that has had profound implications more broadly on society.

Sláintecare

Sláintecare is the result of a lengthy process of policy development in Ireland and represents a roadmap for the expansion and transformation of health and social care services. It enjoys widespread support across the political spectrum and is a long-term plan which would span the lifetime of several governments. COVID-19 has highlighted the pressing need to ensure that the recommendations from Sláintecare are delivered. Nonetheless, the resurgence of COVID-19 in Ireland presents a real challenge for the Government to advance the goals of Sláintecare in a timely manner, due to competing demands and pressures on the health service. The publication and implementation of the 'Service Continuity in a COVID Environment'(27) in June 2020 and more recently the 'Winter Planning within the COVID-19'(28) pandemic acknowledges the Government's responsibility to protect the health and welfare of older people by 'shifting services left' and prioritising primary care and community services.

Notwithstanding this, the current predominant model of care for older people in Ireland is through residential and nursing home services or through informal or formal homecare arrangements. This is problematic on two fronts. Firstly, COVID-19 has highlighted that residential care facilities (that is, nursing homes) deliver a social model of care, and are therefore not set up to manage a pandemic of a highly infectious virus like COVID-19. The management of COVID-19 in a residential setting requires ‘hospital-like’ precautions and while absolutely necessary in this context, it would be a regressive step in terms of the policy of moving nursing homes away from the institutional model of care. Such a move would be in direct opposition to the recent societal shift in Ireland, whereby nursing homes are connected, integrated and an integral part of their communities.

Secondly, Sláintecare’s principal policy objective is to get ‘the right care, in the right place, at the right time’.(1) This means that people with care needs should continue to live in their own homes and communities for as long as possible. At the present time, there is no statutory entitlement to formal homecare. Moreover, access and eligibility vary widely across the country. Although this is forthcoming with the publication of the Health (Amendment) (Professional Home Care) Bill in July 2020,(29) the European Commission suggests that internationally, the majority of homecare services are informal and provided by family, friends and neighbours.(30) This can be at least 80% of the total hours of care provided.(31) However, in Ireland, the percentage of informal homecare provided may be closer to 90% based on evidence from disability services.(32, 33)

Cost-control measures over recent years have meant the HSE has outsourced much of its homecare services to the highly competitive private market.(34, 35) This creates a situation where the HSE procure homecare services and monitor their effectiveness. The Nursing Homes Expert Panel has placed an emphasis on reforming this sector in line with Sláintecare’s objectives; HIQA too has long advocated for this approach. However, it is important to outline that a reform of homecare is not the solution in itself, but a vital component of broader reform that will need to include a range of community housing and day care options where services are smaller and integrated, as well as an accountability framework to ensure good governance. This will go some way towards ensuring a single-tiered universal health model which supports integrated care.

It would be remiss not to reinforce the critical need to expedite the introduction of homecare regulation. The international evidence suggests that the provision of homecare has an unintentional high tolerance for risk, given the increasing clinical complexity of older people, less than suitable working environments, the remote travelling nature of the role, the precarious nature of employment and the interdependency of informal care.(35-40) Such risks can be considered as mutually exclusive, meaning that they impact the care giver and recipient of care concurrently. These can be broadly defined from a physical (for example, musculoskeletal injuries, falls), spatial (for example, poor working environments), interpersonal (for example, inappropriate interactions that may constitute safeguarding) and temporal (for example, rushing which results from carers having to travel between homecare recipients) perspective.(41)

In line with Sláintecare's objective to deliver a universal health service that is inclusive and delivered within a primary and community sphere, investment in regulatory reform is needed to ensure that the services provided have the capacity and capability to deliver health and social services that meet the needs of the population in a manner that is safe and protects the rights of the citizens of Ireland.

On a final point, and notwithstanding the impact that the Sláintecare programme is having on health and social care in Ireland, there is also an argument to suggest that there needs to be an integrated, overall social care policy that considers social care in its totality. For example, currently, social care in Ireland is fragmented despite core objectives (such as, autonomy, independence and inclusion) being central within each sphere. In this vein, it may be worthwhile to consider an overall social care policy that sets out the principal policy objectives across social care more broadly. This would bring a degree of alignment, coherence and uniformity within the social care sector. Furthermore, it would also provide a solid foundation on which regulations could be developed. Such regulations would be reflective of social care policy and aligned with specific high-level policy objectives. Theoretically, this would complement the Sláintecare programme which is centred on expansion, reduce social care fragmentation and provide a solid footing on which regulations should be established.

Regulatory burden

A 2019 HIQA research paper assessed the issue of regulatory burden. This is an area of interest in the broad literature on regulation and is something which impacts on both the regulator and the service provider. It is acknowledged that some burden is an unavoidable by product of regulation. However, there are other aspects of regulation which could be reviewed and reformed in order to reduce the burden on all parties. Some measures may be administrative in nature, for example, a reduction in the number of forms and paperwork that must be submitted or retained by a service provider. Other measures might include a review of the regulations to ensure that redundant elements are removed.

The paper makes reference to a number of initiatives undertaken by the Chief Inspector to reduce regulatory burden. For example, most statutory notifications can now be submitted through an online portal as opposed to submitting a paper form via email. This streamlines the process for the service provider and also reduces the administrative effort on the part of HIQA as it automates the capture of the data.

Notwithstanding the above, there are a number of instances of persistent regulatory burden which could be addressed by changes to the legislative framework. One such example is the need to renew the registration of all designated centres every three years. There are currently almost 2,000 designated centres regulated by HIQA. The process by which they must renew their registration creates a significant burden in terms of time and paperwork for both the provider and HIQA. Moreover, there is a significant effort on the part of HIQA to process all of these applications. A move to a more flexible method of registration or one where the registration is permanent would remove a lot of unnecessary effort. The Chief Inspector could still retain the power to cancel or amend the registration of any centre at any time. This is one example of where there is regulatory burden within the system that adds no value for people who use services. It serves as another reason for reviewing and reforming the regulatory framework in order to address these inefficiencies.

Conclusion

As set out in the introduction of this report, HIQA recommends the following:

- a comprehensive review of the current regulations pertaining to health and social care services in Ireland, and the establishment of a regular review process
- the reform of the Health Act 2007 to take account of the changing landscape in health and social care services
- the introduction of regulation into other forms of care that are currently unregulated and whose service users may be vulnerable
- a framework that makes a clear distinction between the purchaser and provider of services along with clear governance and accountability arrangements
- consideration to be given for the development of a comprehensive, integrated social care policy that considers social care in its totality alongside Sláintecare.

The need for such reforms is underpinned by HIQA’s experience of regulating and monitoring health and social care services over the past 10 years. In that time, a lot has changed. Regulation was introduced at a time of economic uncertainty and austerity in the country. The additional burden of regulation caused a great deal of difficulty for some registered providers. Some managed to overcome these challenges to demonstrate a good level of compliance and a good quality of life for their residents. Other registered providers reconfigured or voluntarily closed their services, some were taken over by larger group owners and others were closed through regulatory action taken by HIQA. Disability service providers looked at ways to move people from congregated settings into services in the community, in line with national policy.

The past decade has also seen increased calls for a more diverse range of social care services, particularly those that allow people to remain in their homes or their community for as long as is feasible. The Sláintecare programme has outlined a roadmap for the expansion and transformation of our health and social care services and this will certainly have implications for how we care for those who need support. In addition to this, there is also a strong argument for the development of a social care policy that sets out the principal policy objectives across social care more broadly. The development and implementation of such a policy would help integrate diverse forms of social care and serve to complement the objectives set out in Sláintecare.

Equally, and more recently, the COVID-19 pandemic has also raised a number of questions about how we care for vulnerable people. It is now a suitable moment to reflect on the learning from regulation over the past decade and chart a path forward. To reiterate what was stated in the introduction, there is a separate effort required to enhance the regulatory framework in response to COVID-19 which requires more short-term measures.

This report outlines the challenges that we as a society face. It is difficult for any country to provide a universal, integrated health and social care service. In this context, the Chief Inspector is drawing on experience to illustrate the complexities of regulating a sector which is constantly evolving and in which some regulations are not wholly effective. COVID-19 adds many layers of complexity to the situation. Practices that were previously acceptable are no longer robust enough to safeguard the wellbeing of residents in the event of a further wave of COVID-19. Nonetheless, it is important to illustrate that COVID-19 has not in itself signalled the need for regulatory reform; rather it has shone a spotlight on an issue that was already in need of urgent consideration.

This report raises several important issues in the context of the regulatory framework in Ireland. It is HIQA's view that, taken together, these provide a persuasive argument for reform of the current regulatory system. Firstly, the manner in which a designated centre for people with disabilities is defined is no longer fit for purpose considering the many diverse models of care that exist. The practice of regulating a centre as opposed to a service should also be revisited. This is particularly the case where service providers are engaged in the delivery of a range of different services, often in the same physical location.

Secondly, all of the regulations and notifiable events pertaining to social care services should be reviewed as a matter of urgency. This report has illustrated that a number of regulations, particularly relating to the regulation of services for older people, are not wholly effective. There is clear evidence that regulations need to be regularly reviewed to determine their effectiveness. Although COVID-19 has exposed further weaknesses in the regulations given the significant impact it has had on nursing homes in Ireland, we cannot lose sight of the fact that these weaknesses have been present for a significant period of time. The pandemic has only served to highlight the critical importance of the need for regulatory reform.

In this regard, HIQA has been consistent in advocating for a review of the regulations and this is also something which was deemed good practice.(14, 16) Additionally, this should also include a review of the provisions of the Heath Act 2007, that give enforcement powers to the Chief Inspector. At the current point in time, the powers of the Chief Inspector are not consistent with the proportionality required in certain cases of non-compliance with the regulation and standards. There is a need to ensure that while the decisions of the Chief Inspector are open to challenge, this does not place residents at unnecessary risk. At the present time, lengthy legal challenges can dilute the enforcement powers of the Chief Inspector.

Furthermore, it is abundantly clear that there is a critical need for an accountability framework that includes contractual oversight with clear delineation between purchasers and providers. This will not only strengthen governance in the sector, but also provide a level of clinical oversight that is somewhat absent at present. In no other sector or sphere of society, more broadly, would a consumer purchase a service without ensuring that they were receiving what was set out in the initial contract during the course of that agreement. This consideration warrants immediate attention.

During 2019 and 2020, HIQA has also witnessed the emergence of a trend, whereby larger providers are entering the market, generally through acquisition and mergers with smaller dispersed nursing homes. It is therefore the view of the Chief Inspector that if a large entity were to fail this would place a significant burden on the HSE in already challenging times. This needs to be kept at the forefront of policy moving forward.

Finally, HIQA welcomes the Government's intention to make homecare available on a statutory basis with an accompanying set of regulations. The provision of good quality homecare should be a key component of any future social care system. Consideration should also be given to other forms of care such as assisted-living, sheltered housing and personal assistance and other discrete arrangements that may exist (for example, home sharing provision). HIQA has commenced research in this area and will publish this research in the near future. These diverse service models are welcomed and should be available to people as part of a continuum of care which meets the needs of individuals and their families. It is HIQA's view that all of the above should be subject to a regulatory framework which is fit for purpose, adaptable to changing needs and preferences, and responsive to risk and concerns for people's welfare. This may, in part, be achieved by developing a policy that considers social care in its entirety given that the principle issues are consistent across all populations who use social care sevices. It is hoped that the recommendations in this report form an integral part of the debate around how we can better care for all citizens into the future.

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