Submission to the Oireachtas Special Committee on Covid-19 Response

1. INTRODUCTION TO SAGE ADVOCACY

Sage Advocacy is a support and advocacy service for vulnerable adults, older people and healthcare patients. In 2019 we received 1,570 referrals for advocacy and dealt with 3,964 information and support issues. Some 46% of our work related to people living in the community, 27% related to nursing homes and 23% to acute hospitals.

The origins of Sage Advocacy go back to the Leas Cross scandal in 2005. Since then the development of advocacy services has been influenced by the Aras Attracta scandal in 2014 and by the HIQA report on Portlaoise Hospital in 2015. Since it was first established in 2014, with funding from the HSE and The Atlantic Philanthropies, Sage Advocacy has consistently had to deal with uncertainty regarding funding and the lack of a coherent framework for the development of independent advocacy services. The achievement of a 'common home' for advocacy with formal legislation recognising its role and practice, national quality standards and equitable funding will, in our view, only be achieved when legislation regarding Safeguarding Adults and Protection of Liberty in Places of Care is passed and a National Support and Safeguarding Agency is created under which would sit the Mental Health Commission, the Decision Support Service a National Safeguarding Service independent of the HSE and independent advocacy services.

The mission of Sage Advocacy is to promote, protect and defend the rights and dignity of vulnerable adults, older people and healthcare patients. We support and advocate for people independently of family, service provider or systems interests and much of our work involves people whose decision making capacity is in question. Our approach is to collaborate where possible and to challenge where necessary and our motto is 'Nothing about you / without you'. We operate to Quality Standards developed in 2015 and we are currently discussing the development of national quality standards for all independent advocacy services with HIQA.

Since Sage Advocacy first started issues regarding home care, care in congregated settings and the transition from acute hospital to homes and nursing homes have been constant. In 2016 we organised a Forum on Long Term Care for Older People with Third Age, Family Carers Ireland and Alone informed by a public opinion survey by Amárach. In June and July 2017 Sage Advocacy contributed to the work of the Citizens Assembly when it addressed the question, 'How we best respond to the challenges and opportunities of an ageing population'.

The *Report of the Forum Responding to the Support & Care Needs of our Older Population: Shaping an Agenda for Future Action* (July 2016) was followed by four discussion documents:

- The Nursing Home Support Scheme: Charges and Related Issues (December 2016)
- Contracts of Care for Nursing Home Residents: Issues for Policy & Practice (September 2017)
- A New Deal - A discussion document on funding long-term support & care. (May 2019)
- Delivering Quality Medical Care in Irish Nursing Homes: Current Practice, Issues and Challenges. (February 2020)

2. CONTEXT FOR THE CRISIS

2.1 An ageing Ireland

Ireland is ageing and more people are living longer and better lives. A minority of older people – probably one in five – require some form of support. While at any one time less than 5% of older people live in some form of congregated setting, such as a nursing home, one third of women and one quarter of men are likely to spend time in a nursing home before they die.

With appropriate supports many older people can live, and die, in the place of their choice which, for the majority of older people, repeated surveys indicate is their own home. However, lack of resources and supports for people in their homes means that long-term care is now synonymous with nursing home care. There is a need for innovation in the development and provision of supports and services for older people and an urgent need for a comprehensive legislative framework supportive of a continuum of care across the full spectrum of need, including regulation of homecare, informed by values such as equity, self-determination and social solidarity.

While there is broad acknowledgement of the principle of enabling people to exercise their will and preferences in the way care is provided, people regularly end up in nursing homes against their will because of a lack of community-based alternatives. In effect this is deprivation of liberty and the point at which care can be experienced as custody. This is in no way a criticism of those who provide care in congregated settings such as nursing homes. It is rather an expression of the hard reality that lack of options is a key issue when it comes to seeking support and care for that section of older people that require it in differing ways as they move along the life cycle.

Our population over 65 is forecast to increase from 629,800 persons to nearly 1.6 million by 2051 and the population over 80 from 147,800 to 549,000 in the same period[1]. This will result in greater need for assisted living as our average life expectancy also increases. While greater provision of community services will allow more older people to continue to live at home and has led to reduced age-specific percentages needing nursing home care, the greater older population will result in substantial increases in absolute numbers needing such care. To date there has been little by way of a national plan to address this need that is cognisant of funding, infrastructure or clinical training.

2.2 Long Term Care & Support

In many European countries long-term care is understood in its broadest sense as the support and care that may be needed over a lifetime, in the case of some people with a disability, or in later years of life, in the case of some older people; regardless of location. In Ireland long-term care is synonymous with residential care in a congregated care setting such as a nursing home or institution. For older people care is divided up into an regulated statutory system (Nursing Home Support Scheme) for 'nursing homes' for which co-payment is required and an unregulated non-statutory Home Support Service system which is currently free of charge. The outgoing government had been planning a new but separate statutory scheme for home care which Sage Advocacy believes will only add to the difficulties with siloed funding to the detriment of older people.

[1] Central statistics Office (CSO) 2016. Population and labour Force Projections 2017-2051
https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/populationprojectionsresults/

The HSE Service Plan for the Nursing Homes Support Scheme (NHSS) was projecting that it would be support 24,379 people by December 2020. In April there were 575 centres registered with the regulator HIQA with a combined capacity for 32,062 residents[2]. There are 3 categories of providers:

HSE	114	19.83%
Nursing Home 1990 Act	442	76.87%
Sect 38 & 39	19	03.30%
TOTAL	575	100%

Costs of private nursing home care are negotiated with providers by the National Treatment Purchase Fund (NTPF) on behalf of the state. Public nursing homes, run by the HSE are allowed to charge at cost but not above it[3]. Governments have twice given a derogation to the HSE regarding their need to meet HIQA standards for the physical environment. Stated simplistically, public nursing homes are more likely to have shared accommodation, higher costs and have a higher level of nursing staff and allied health professional support for residents.

The regulator HIQA sets the standards but has no role in setting the price for what is being bought to meet these standards. It inspects nursing homes but does not have the power to investigate specific issues; unless at the request of the Minister for Health. Independent advocacy services work well with many private providers but have been barred by some. The buyer, NTPF, has no specific focus on quality or the meeting of standards but it is understood that it has access to the books of all nursing homes[4]. In short the 'architecture' of nursing home care provision is complex, lacking in transparency and without an effective system of overall governance. The extent of profit taking by private providers is, largely, unknown and the differing approaches by the state to the different types of providers is questionable whether one takes a moral or a market perspective.

In addition to the NHSS the HSE Service Plan for 2020 provided for 4,980 long stay and 1,720 short stay public residential care beds to be available in the course of the year and for transitional care approvals to increase to support 11,335 people, mainly in private nursing homes, following discharge from acute hospitals and to assist them to go home or during the period in which a long stay placement is being organised.

Home Support Services, which are currently unregulated, are provided by a wide range of providers with private operators predominating. Within the HSE budget allocation for older person's services in 2020 it was anticipated that over 53,700 people will be in receipt of home support services, at any one time to a total of 19.2m hours including approximately 235 people who will receive intensive home support packages to a level of 360,000 hours. Some 28,000 places per week will be provided across 300 day care centres.

[2] HSE facilities have a registered capacity for 5,696 'beds', Section 38 & 39 funded agencies have 1,049 'beds' between them. The largest private provider is currently Mowlam Healthcare which has 1,003 'beds'. With regard to size of nursing homes: 10% are 100 rooms / beds or more; 41% are between 50 – 100 and 49% are less than 50. There are 10 nursing homes (of all types) with 150 or more residents and the largest has capacity for 184 residents. Of HSE facilities 11 are 100 'beds' or more while 9 have 20 or less 'beds'.

[3] Insert details re range of private and public charges.

[4] "The objective of the NTPF is to agree a price with each nursing home that offers value for money to the State having regard to the following criteria: the costs reasonably and prudently incurred by the home and evidence of value for money; the price(s) previously charged; the local market price; and, budgetary constraints and the obligation of the State to use available resources in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public."

3. SAGE ADVOCACY PERSPECTIVES ON THE CRISIS

Sage Advocacy is currently bringing together feedback and reflections from staff, volunteers, supporters, service providers, service users and their families and members of the public and we hope to have this ready for publication in July. Some general observations are made below followed by ones specific to: Home & Community; Acute Hospitals & Nursing Homes; Nursing Home Outbreaks; Deaths in Nursing Homes; Training in Nursing Home Medicine.

3.1 General Observations

Over the past two decades the state's approach to residential care of older adults has been one of divestiture to private providers, with the remaining public units providing care mainly to the more frail and complex care needs population. This has resulted in a wide range of models of care from large institutional units, to small family run businesses to larger chain type operations. The state, having outsourced the service, practiced 'sectoral distancing' and its links with the providers were mainly through the regulator, HIQA. Although there is some evidence of increasing moves towards larger facilities, and evidence of consolidation linked to foreign and domestic investors, the sector is still characterised by many relatively small providers with little access to the type of supports that would be required in a pandemic.

Shortage of staff and competition for staff among nursing homes and between nursing homes and the HSE are frequently spoken of. The initial warning signs regarding a Covid 19 pandemic were generally recognised by private nursing homes. However, because of the lack of effective working relationships with the HSE, and the focus at state level on an expected surge and resultant threat to the acute system, the dangers to the most vulnerable who were in nursing homes did not become centre stage until the systemic weaknesses of the outsourced system became clear. The development of such a significant 'blind spot' at statutory level is something that requires considerable reflection.

One further issue is rarely spoken of; the extent to which ageism may have affected the perspectives of those who came to the fore; both as leaders and commentators in responding to the crisis[5].

3.2 Home & Community

- Hospital discharges requiring Home Care Packages (HCP) were organised at unprecedented speed. In one case a person remained in hospital for almost a year awaiting a HCP and suddenly it was organised within 48 hours.
- Reprioritising home care by the HSE was meant to allow for families to step in and provide support where care needs were relatively low. In some cases people without family or wider circles of support were cut off but in many areas supports were maintained where there would have been concerns. Some people felt that home supports had actually improved.
- In many cases families did step in and provided substantial levels of support and care but, in some cases, families overruled the wishes of their parents to retain their home care service giving rise to safeguarding concerns.
- There is anecdotal evidence of a 20 – 25% drop in home care provision. Much of this would seem to be due to older people fearful of becoming infected. However, some would seem to be due to lack of clarity around approaches and systems between the HSE and service providers

[5] On a panel discussion on the 'Weekend on One' programme broadcast on RTE Radio 1 on Sunday March the 8th 2020 a medical commentator contrasted the 'moribund' old in nursing homes with the 'productive' young and spoke of hard decisions needing to be taken.

leading to unwillingness to provide service. The need for and the availability of PPE was a major issue.

- People with dementia who are cared for at home by family have found the restrictions around Covid- 19 very difficult. For people whose attendance at day support services have stopped it has taken weeks for a new routine to be established at home.
- Some people using day care services rely on them for basic personal care, such as a shower. The loss of such supports has had a major impact on quality of life and mental health.
- Useful ideas on the potential for use of 'live in' care were presented by some home care providers but the extent of take up, if any, is not currently known.
- Safeguarding Protection Teams of the HSE were in some areas affected by the reallocation of staff to other areas. Safeguarding Ireland and the Banking and Payments Federation did much useful work in warning of the potential dangers of temporary agents in handling the finances of vulnerable older people. Initial indications are that a small but significant group of vulnerable older people will have come under the coercive control of family members with regard to finances and assets.
- While the vast majority of people 70 years and over adhered to the 'cocooning' guidelines a significant number felt they were being further marginalised simply because of their age. Not every older person has 'underlying conditions' and both the benefits as well as the risks associated with exercise within a 2 Km radius of home needed consideration.

3.3 Acute Hospitals & Nursing Homes

- There was a significant effort by most acute hospitals to make as many safe discharges of patients as possible in preparation for an expected influx of Covid 19 patients from the community. In the absence of a robust testing system it is most likely that there would have been some transfers of Covid 19 positive patients into nursing homes. The reverse is also true; that residents with Covid 19 were transferred to acute hospitals without knowledge of their status as the asymptomatic nature of Covid 19 in vulnerable older people was not understood in the early stages. Data on the levels of transfer from acute hospital to nursing homes and provision of HCPs by region has been sought from the HSE.
- Some nursing homes not only restricted visiting from early March but also refused to take any patients from acute hospitals.
- A recent study has shown that almost 28% of patients in acute hospitals in Ireland lacked decision making capacity[6]. As the great majority of these are older people it is important that transfers from acute hospitals to nursing homes be followed up to ensure that their options with regard to future return to home or remaining in a nursing home or, indeed, transferring to another one are explored and that issues regarding possible deprivation of liberty are addressed.
- Medical supports to nursing homes were patchy. In some areas nursing homes found it difficult to get a GP to visit and in others a clear strategy had obviously been worked out by group practices.
- Residents in some nursing homes where there were no outbreaks or a small number of cases which were well managed were still able to see a relative in controlled circumstances. The design of buildings was often a key factor in facilitating this.

[6] Ruth Murphy, Sean Fleming, Aoife Curley, Richard M. Duffy & Brendan D. Kelly (2019) Convergence or Divergence? Comparing Mental Capacity Assessments Based on Legal and Clinical Criteria in Medical and Surgical Inpatients, Journal of Legal Medicine, 39:3, 213-227, DOI: 10.1080/01947648.2019.1622476. https://doi.org/10.1080/01947648.2019.1622476

3.4 Nursing Home Outbreaks

- 'On Call for Ireland' was seen as a support mechanism for the public health system alone. Staff transfers from the public sector to the private sector were on a voluntary basis, negotiations took up valuable time and delivered little. From the perspective of one person involved, 'The cavalry never came'.
- Staff shortages in some cases led to risk taking with staff in some facilities having to continue to work while ill and in other cases encouraging people back from isolation. Other staff, frightened for their own health and aware of the Covid 19 payments, chose to stay away with the result that some nursing homes were so short staffed that phone calls from extremely concerned and distressed relatives went unanswered; in some cases for days.
- When the HSE were called on to intervene there was a presumption that they had large numbers of suitable people to provide 'boots on the ground' and that almost anyone would be suitable to work in nursing homes. While complete data is not yet available there is anecdotal evidence that in the hardest hit areas it was hospital staff from public hospitals rather than home care staff from private home care companies that were involved in supporting private nursing homes.
- With an estimated 70% of nursing homes residents experiencing some or other form of dementia the ability of some residents to remain in their room was limited. Some nursing homes worried about the human rights of residents while others had to consider sedation.
- All areas of the broader health and social care sector suffered from a shortage of PPE in the initial period and it is not clear who had responsibility for supplying PPE for private nursing homes; the nursing homes themselves or the HSE. Much like the staffing issue there would seem to have been competition for resources before collaboration became the norm

3.5 Deaths in Nursing Homes

Deaths in nursing homes and other residential care facilities are understood to account for more than 60% of the 1,604 deaths caused by Covid-19 in the state[7]. Almost a third (32%) of all clusters / outbreaks have been in nursing homes. [8]

The head of the World Health Organization's Europe office has said up to half of coronavirus deaths across the region have been in nursing homes and has called it an "unimaginable tragedy." The International Long Term Care Policy Network has estimated that deaths of care home residents during the COVID-19 pandemic have accounted for 54% of all excess mortality in England and Wales[9]. Similar reports from across Europe suggest broadly similar trends. It is worth noting that the death rate among people who are Wards of Court in Ireland is twice the same period for last year.[10]

The Network also published a study on International measures to prevent and manage COVID19 infections in care homes[11]. Homes are ill-equipped to deal with the crisis, they say, because of chronic staffing shortages, lack of protective gear and the paucity of testing for the virus. "Care homes are places where physical distancing is almost impossible. It's like a perfect storm: a

[7] https://www.hpsc.ie/news/covid-19-latest-number-of-cases.html

[8] https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/epidemiologyofcovid-19inireland/

[9] Accessed on 170520 at: https://ltccovid.org/wp-content/uploads/2020/05/England-mortality-among-care-home-residents-report-12-May-2.pdf

[10] Irish Times 180520

[11] Accessed on 170520 at: https://ltccovid.org/wp-content/uploads/2020/05/International-measures-to-prevent-and-manage-COVID19-infections-in-care-homes-11-May-2.pdf

susceptible population, not being able to implement the measures and the staff are not well supported and trained enough. Many of the staff are care assistants with very little medical knowledge," said Adelina Comas-Herrera, one of LSE's data researchers.

Key findings

- While both the characteristics of the population in care homes and the difficulties of physical distancing in communal living mean that care home residents are at high risk of dying from COVID-19, these deaths are not inevitable.
- Countries with low-levels of infection in the population typically also have low shares of infections in care homes.
- The response to COVID-19 in care homes needs to be coordinated across all relevant government departments and levels, and with the acute health sector response.
- Timely data on the impact of COVID-19 in care homes is essential to ensure that opportunities for preventing large numbers of deaths are not missed.
- Evidence of asymptomatic transmission and atypical presentation of COVID-19 in geriatric populations should be reflected in guidance documents and testing policies.
- While there are infections local to care homes, regular testing of residents and staff will be essential, ideally followed by contact tracing and effective isolation.
- Most countries have restricted visitors but this policy alone has not protected care homes from infection. Countries are increasingly considering how to make visits safer, recognizing their impact on wellbeing.
- Staff pay and living conditions may be an important barrier to effective infection controls, particularly if staff do not have access to sick pay or need to work in multiple facilities (or live in crowded accommodation).
- Access to healthcare and palliative care (in terms of personnel, medicines and equipment) needs to be guaranteed, particularly for homes without nursing or medical staff.
- Not all care homes are suitable as isolation facilities. Technical support and alternative accommodation may be required in some cases.
- Measures to address the psychological impact of the pandemic on both staff and residents need to be put in place, particularly as many staff and residents will have experienced trauma and grief. For some residents, particularly those with dementia, the disruption in their normal lives by the measures may have significant negative impacts.

It is important to note that many nursing home residents have dementia, history of strokes, or other health issues that may mask manifestations of COVID-19 infection. It is also worth noting a small study recently reported through the International Long Term Care Policy Network.[12] "In this French care home, leaving dependent care home residents to themselves and without assistance for food and drink intake accounted for more deaths than the infectious disease itself. The authors of the research letter labelled this the "disease linked to confinement" of COVID-19 cases. An excess number of deaths in care homes can be prevented by providing basic care".

It is also worth quoting from a recent paper 'COVID in Care Homes – Challenges and Dilemmas in Healthcare Delivery'.[13] "These dilemmas lay bare the interdependency of health and social care. The

[12] https://ltccovid.org/category/evidence/

[13] Adam L Gordon, Claire Goodman, Wilco Achterberg, Robert O Barker, Eileen Burn, Barbara Hanratty, Finbarr C. Martin, Julienne Meyer, Desmond O'Neill, Jos Schols, & Karen Spilsbury (2020) 'COVID in Care Homes – Challenges and Dilemmas in Healthcare Delivery' Age and Ageing, https://doi.org/10.1093/ageing/afaa113

arbitrary distinction between these sectors has long been challenged by academics and clinicians. The losses and difficulties faced by the care home sector have simply emphasised systemic issues - endemic underfunding, failure to integrate needs-based health care paradigms into policy and practice, lack of integration between the public and private sectors, and lack of recognition and regard – all of which are obstacles to good healthcare in care homes. For each UK example reported in this commentary, there are similar experiences in the Republic of Ireland and the Netherlands and reports from the care home sector internationally suggest that there have been similar experiences in many countries."

3.6 Training in Nursing Home Medicine

The report into Leas cross nursing home in 2006 brought the issue of care in nursing homes into sharp focus. In his report Professor Desmond O'Neill identified weak policy, legislation and regulation; deficiencies in funding; speed of growth in the private sector and capacity of the regulatory bodies to keep pace as key challenges to ensuring good care in nursing homes[14]. All nursing homes are now inspected regularly by HIQA athough we understand there are concerns within gerontology about the content of the inspection standards and that under the standard of 'leadership and governance' they are relatively agnostic of clinical input and pathways of gerontological care and not specific enough about the training and multidisciplinary team (MDT) clinical practices of care within nursing homes.[15] Indeed despite the recommendations 8, 9 and 10 dealing with senior geriatrician input, gerontological training of attending medical staff, and provision of MDT care to older people, this still remains an area of concern. In research into primary care and nursing homes with GPs conducted in 2006 and 2011, most felt they had inadequate training in gerontology; most were unsure of their role in the HIQA inspection process and over a third had witnessed substandard or deficient care but in most cases this was only reported to the nursing home owner.[16] [17]

In addressing a strategy for nursing home care going forward, clinical training of medical, nursing and health and social care professional staff will be a core consideration. Although nursing home medicine is well established in many European countries and shown benefits in standards of care[18], it is only exists in embryonic pilot sites in Ireland. There is currently no educational facility in Ireland to teach *nursing home medicine* and care of the complex older person in such settings to the multidisciplinary team.

When the sale of Mount Carmel Hospital occurred there was a unique opportunity to acquire and transform the hospital, which had a large resident older population in its environs, to be such a teaching facility and to be a model of such a teaching nursing home. This was proposed to the then Minister for Older Persons, together with a pre-arranged agreement that the governance would be shared by the departments of geriatric medicine in the three catchment hospitals, namely St James, Tallaght University and St. Vincent University Hospitals, and across two universities to benefit a wide range of clinical disciplines. Mount Carmel was indeed acquired by the state but it's purpose became one of providing a vaguely defined model of 'transitional care' for patients deemed to no longer needing an acute hospital bed. This care was contracted to a private provider and a significant opportunity was lost.

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[14] Leas Cross Review. Professor Desmond O Neill 10th Nov 2006 https://www.hse.ie/eng/services/publications/olderpeople/leas-cross-report-.pdf

[15] Health Information and Quality Authority 3rd May 2016. https://www.hiqa.ie/reports-and-publications/standard/national-standards-residential-care-settings-older

[16] Caring for Nursing Home Patients--A Primary Care Perspective. Corroon Sweeney E, Murphy C, Collins DR. Ir Med J. Nov-Dec 2009;102(10):317-20

[17] Primary care in nursing homes revisited: survey of the experiences of primary care physicians. Gleeson, LE;Jennings, S;Gavin, R;McConaghy, D;Collins, DR. Ir Med J MJ 2014 107(8);234-236

[18] Nursing home and nursing home physician: the Dutch experience.
Schols JM, Crebolder HF, van Weel C.J Am Med Dir Assoc. 2004 May-Jun;5(3):207-12

An opportunity to build such teaching nursing homes on green field sites would be preferable of course, given the importance of incorporating modern design and care concepts into the clinical and social care, and enablement of our older most vulnerable members of society and would also serve to bring in the wider educational benefits of age-friendly design and architecture and gerotechnology onto a new campus , bringing the importance of care of older people to a wider interdisciplinary academic and business community with opportunity for resident, clinicians and designers alike . Opportunities for such new campuses exist on several sites already in HSE, voluntary sector or local authority ownership.

4. 'SHED A TIER' - AND MOVE FORWARD

Research and policy documents in Ireland have continually stated the primacy of community or home-based care over residential care. The emphasis in all policy documents since the late 1960s has been on enabling older persons to live in their homes for as long as possible. This principle was strongly stated in The Years Ahead (1988)[19], in successive reports by the National Council on Ageing and Older People (NCAOP)[20] , in various Health strategy documents, in particular, the Shaping a Healthier Future, A Strategy for Effective Health Care in the 1990s[21] and in all government programmes and health and care strategies since. At the Forum on Long-term Care for Older People in 2016 there was remarkable unanimity of opinion which could be summed up in a question; "Why, despite decades of policy reports and recommendations to government, is there still a systemic bias towards care in congregated settings and no formal legislative basis for support and care in the community?"

The Report of the Forum spoke of the need to 'develop a vision for long-term support and care which is as compelling as that of the hospice movement at its best'. It spoke of 'commissioning based on outcomes, rather than block grants and outsourcing for particular aspects of care. The percentage of older people being supported and cared for in the places of their choice according to their will and preference and their changing needs – this has to be seriously considered as one of the objectives of commissioning' it said. In terms which are as applicable to 2020 as 2016 it said that 'Far from the money following the patient the patient currently follows the silo where the money is' and it asked the question "Where is the 'Fair Deal' in going where you don't want to go?"'

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The Covid 19 public health emergency has shown some of the great strengths of Irish society. It has also shown weaknesses in our systems of health and social care. We have a two-tier healthcare system which means that those who can afford it get it ahead of those who cannot and we have a siloed approach to the long-term support and care of older people which is biased towards congregated settings. We owe it to ourselves, and to those who have sacrificed so much, to do better. Let's shed a tier and set about building Sláintecare; a single tier national health service with an integrated system of social care focused on home.

[19] Department of Health (1988), The Years Ahead: A Policy for the Elderly. Report of the Working Party on Services for the Elderly. Dublin: Stationery Office.

[20] The NCAOP was previously known as the National Council for the Elderly and prior to that, The National Council for the Aged.

[21] http://lenus.ie/hse/bitstream/10147/46579/1/1688.pdf

5. RECCOMMENDATIONS

Issue	Timeframe	Lead
1. Develop a single tier integrated statutory system of long term support and care covering domestic homes and nursing homes, and a much wider variety of options in between. The system should be deliberately biased towards home; which is where the vast majority of people want to live, and to die. Plans for a standalone statutory system for home care separate from the Nursing home Support Scheme should be dropped.	**Short - Medium Term**	**DoH**
2. Legislate for Adult Safeguarding and protection of liberty in places of care and develop safeguarding services independently of the HSE organised on a multi-disciplinary basis blending social work, policing, public health nursing, financial and legal skills. The service should be free to operate across all care settings regardless of whether they are in the public or private sector.	**Short – Medium Term**	**DoJ&E DoH**
3. Provide legal recognition, national quality standards and training and equitable funding for independent advocacy services to enable them act on behalf of vulnerable adults independent of family, service provider and systems interests.	**Short – Medium Term**	**DoJ&E DOH DEASP**
4. Integrate private nursing homes into the wider framework of health and social care, ensure clear responsibilities for oversight over all congregated care facilities for older people at both regional and national level and arrangements for intervention and re-deployment of relevant staff across sectors in line with future pandemic planning.	**Short - Medium Term**	**HSE**
5. Develop clear guidelines on the level of nursing staff and medical care required in congregated care settings related to the needs of residents. Plan for improved palliative care as well as infection control.	**Short Term**	**HIQA ICGP DOH**
6. In planning the six new health regions arising from Sláintecare incrementally develop a network of world class community hospitals as teaching facilities and centres of excellence in each region.	**Medium – Longer Term**	**HSE & Advisory Group**
7. Review the resilience of the private nursing home sector and promote a wider range of ownership models for both homecare and nursing home care with the objective a achieving a 'mixed economy' of care in which social enterprise plays a significant role.	**Medium – Longer Term**	**NESC NTPF DoH DPER**
8. Review the role of An Garda Síochána and An Post in supporting vulnerable citizens, and the potential of both organisations to work collaboratively with local authorities and the voluntary sector in developing models for integrated responses to future pandemics and emergencies.	**Medium Term**	**NESC NECG**