



**Health
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An tÚdarás Um Fhaisnéis
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Exploring the regulation of health and social care services

Disability services

March 2017

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Introduction

The concept of the 'designated centre' is a key feature of the legislation and regulations concerned with social care in Ireland. Any service which meets the definition in the Health Act 2007 is considered a designated centre, must register with the Health Information and Quality Authority (HIQA) and comply with the relevant regulations. Put simply, a designated centre is a place where a dependent person receives care **and** accommodation (the full definition as it appears in the Act is below).

Models of nursing and social care are evolving and they present challenges in terms of the suitability of the definition of a designated centre. Some of the emerging models, particularly in disability services, do not sit within the current definition. This paper is an opportunity to reconsider some of the Health Act's provisions with a view to making it more relevant to current and emerging care models.

HIQA's Corporate Plan 2016-2018 commits the organisation to delivering a programme of regulation which will safeguard service users, focused on human rights principles. In addition, HIQA has committed to informing and influencing policy across health and social care services. It is in this context of driving improvement and protecting vulnerable persons that we have undertaken this research. It is hoped this paper will highlight the need to review and expand regulation to have oversight and provide public assurance on the different models of care and service delivery.

The paper will outline the current definition of a designated centre as it is framed in the Health Act 2007, in addition to HIQA's interpretation of this definition. It will then look at current care and support models for people with disabilities and present relevant national policy or research in the area. There will also be a discussion of how similar regulatory frameworks are structured in other jurisdictions.

The conclusion will seek to outline HIQA's view on how care for people with disabilities could potentially be regulated into the future. In order to further inform HIQA's position, a range of informed and interested parties were invited to a meeting to discuss these matters. These stakeholders included representatives from advocacy and or service-user groups, service providers, housing providers and the

Health Service Executive (HSE). Their views and feedback from these meetings are discussed at relevant points in the paper.

Definition and Interpretation*

The Health Act 2007 provides the following definition of a designated centre:

"designated centre" means an **institution**—

(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—

(i) in accordance with the Child Care Act 1991,

(ii) to persons with disabilities, in relation to their disabilities, or

(iii) to other dependent persons, in relation to their dependencies,

or

(b) that is a special care unit,

(c) that is a nursing home as defined in section 2 of the Health (Nursing Homes) Act 1990, but does not include any of the following:

(i) a centre registered by the Mental Health Commission;

(ii) an institution managed by or on behalf of a Minister of the Government;

(iii) that part of an institution in which the majority of persons being cared for and maintained are being treated for acute illness or provided with palliative care;

(iv) an institution primarily used for the provision of educational, cultural, recreational, leisure, social or physical activities;

(v) a children detention school as defined in section 3 of the Children Act 2001,⁽¹⁾

The Health (Nursing Homes) Act 1990 provides the following definition of a nursing home:[†]

* This paper is only concerned with services for children with disabilities if the service falls within the definition of a designated centre.

† Nursing homes are primarily geared towards care of the elderly. However, they are included in this discussion due to the fact that some residents of nursing homes are there as a result of care needs arising out of a disability.

2.—(1) *In this Act, except where the context otherwise requires, "nursing home", subject to subsection (2), means an institution for the care and maintenance of more than two dependent persons excluding—*

- (a) an institution managed by or on behalf of a Minister of the Government or a health board,*
- (b) an institution in which a majority of the persons being maintained are being treated for acute illnesses,*
- (c) a maternity home carried on by a person who is registered under the Registration of Maternity Homes Act, 1934,*
- (d) a mental institution within the meaning of the Mental Treatment Acts, 1945 to 1966,*
- (e) an institution for the care and maintenance of mentally handicapped persons operated otherwise than for profit and to which grants are paid by the Minister or a health board,*
- (f) premises in which children are maintained in pursuance of an arrangement with a health board,*
- (g) an institution operated otherwise than for profit—*
 - (i) that is for the care and maintenance of physically handicapped persons a majority of whom do not receive whole-time nursing care in the institution,*
 - (ii) in the management of which representatives of the Minister or a health board and representatives of the persons being maintained in the institution participate with other persons,*
 - (iii) to which grants are paid by the Minister or a health board, and*
 - (iv) to which paragraphs (a) and (b) of section 333 (1) of the Income Tax Act, 1967, apply, and*
- (h) premises in which a majority of the persons being maintained are members of a religious order or priests of any religion (other than premises in relation to which a payment has been made under section 7), but maintenance by a person of his spouse or of a parent, step-parent, child, step-child, grandchild, brother, step-brother, sister, step-sister, uncle, aunt, niece or nephew of the person or of his spouse shall, for the purposes of this definition, be disregarded.⁽²⁾*

The definitions of a designated centre and a nursing home are somewhat broad and can be open to interpretation. They comprise a number of key terms including:

- institution
- residential service
- care and maintenance
- dependent person.

Nowhere in the relevant legislation is there a specific definition for residential services. HIQA's interpretation of this term in relation to disability services, in line with the most recent HIQA guidance document, is as follows:

A 'residential service' is one that is comprised of both accommodation and care/support services provided to people with disabilities living in residential settings, on a short or long term basis, whether or not it is their sole place of residence.⁽³⁾

The Health (Nursing Homes) Act, 1990 provides the following definition for a dependent person:

"dependent person" means a person who requires assistance with the activities of daily living such as dressing, eating, walking, washing and bathing by reason of—

(a) physical infirmity or a physical injury, defect or disease, or

(b) mental infirmity.⁽²⁾

Taken together, these terms and definitions are intended to capture all services which cater for the needs of vulnerable and or dependent persons in residential settings. The ultimate goal is that there is regulation and oversight of service providers and that the rights and welfare of service users are protected and promoted.

However, there is no definition in any of the relevant legislation of what is meant by 'care' or 'care and maintenance'. Other countries have provided a definition of care in their legislation, most often broken down into categories (personal care, nursing care). The following are some examples of such definitions:

Definition of Care

“Nursing care”

Any services provided by a nurse and involving—
(a) the provision of care, or
(b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a nurse;

“Personal care”

(a) physical assistance given to a person in connection with—
(i) eating or drinking (including the maintenance of established parenteral nutrition),
(ii) toileting (including in relation to the process of menstruation),
(iii) washing or bathing,
(iv) dressing, (v) oral care, or
(vi) the care of skin, hair and nails (with the exception of nail care provided by a person registered with the Health and Care Professions Council as a chiropodist or podiatrist pursuant to article 5 of the 2001 Order), or

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.

England



– The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Scotland



“Personal care”

Care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash).

– Regulation of Care (Scotland) Act 2001

“Personal care”

Includes the provision of appropriate assistance in counteracting or alleviating the effects of any of the matters mentioned in paragraph (1)(a) to (d) and, in particular, includes—

- (a) action taken to promote rehabilitation;
- (b) assistance with physical or social needs; and
- (c) counselling.

Paragraph (1) (a) to (d), referenced above, is as follows:

- (a) old age and infirmity;
- (b) disablement;
- (c) past or present dependence on alcohol or drugs; or
- (d) past or present mental disorder.

N. Ireland



– The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

Australia



“Care”

Services, or accommodation and services, provided to a person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain himself or herself independently.

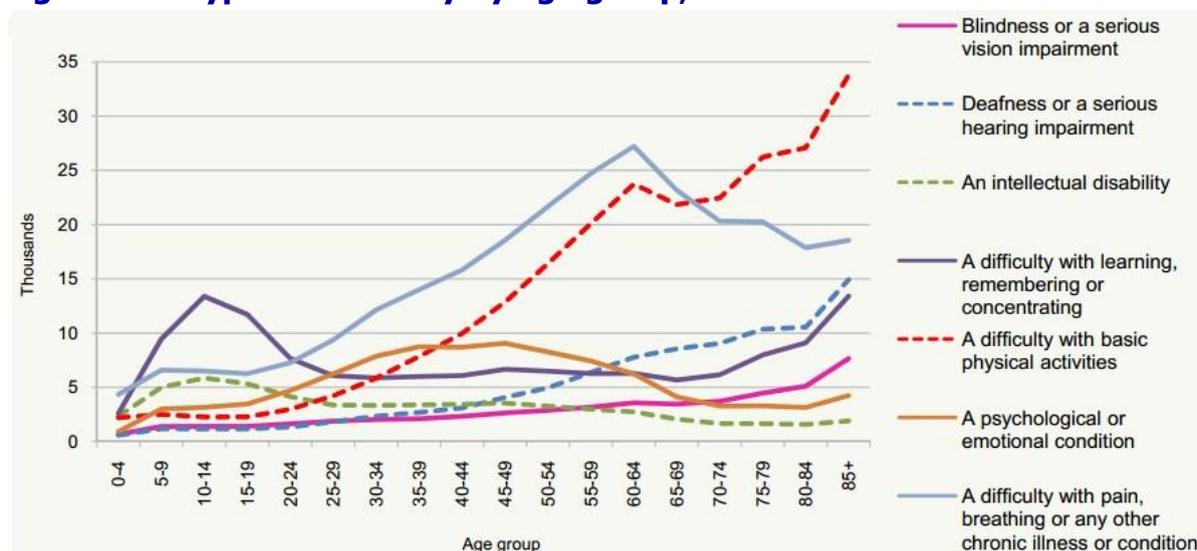
– Aged Care Act 1997

Demographics

According to the most recent Census data (2011), people with disabilities comprise around 13% of the population, numbering approximately 595,000.⁽⁴⁾ This number reflects the amount of people that self-identified as having a disability or ‘difficulty’ according to the questions that were included in the 2011 census (see Appendix 1). A 2006 National Disability Survey — using different criteria to that of the 2011 Census — found that 18.5% of the population had a disability.⁽⁵⁾

There may be a good deal of crossover in these figures in terms of the numbers of people identified as having a disability and those who are frail or infirm as a result of old age. Nevertheless, there is a sizeable portion of the population that are users, or potential users, of a range of disability services.

Figure 1 — Type of disability by age group, 2011



Source: CSO, 2012

As evident in the above graph, there has been a general increase in most disability types in older age groups. There are no demographic projections on how many people will have disabilities in the future, but it can be expected that the number will rise in tandem with the general rise in population. In addition, the expected increase in the numbers of people over age 65 in the coming decades is likely to see a correlated increase in the number of people with age-related disabilities.

The vast majority of people with disabilities in Ireland (92%) live in private households. The remainder (approximately 45,000) are accommodated in communal establishments which include nursing homes and children’s homes.⁽⁴⁾ The 2011 Census also allowed for a category of ‘other’ under communal establishments, which included hospitals, religious institutions and refuges and or shelters. Not all people with a disability living at home are in need of support. However, the numbers are

significant enough to suggest that there is a large potential pool of home and or community-based service users.

Most people in Ireland that self-identified as having a disability in the 2011 Census are classed as having a physical or sensory disability. When those with intellectual and or learning disabilities[‡] are removed from the figures, the remainder totals approximately 400,000.

The National Physical and Sensory Disability Database, managed by the Health Research Board (HRB), is a register of people in Ireland with a physical or sensory disability. The most recent data (2015) shows there was a total of 22,813 people registered on the database. This is significantly lower than the number recorded in the Census data and is likely due to the fact that registration with the database is voluntary. In addition, the database is only intended to record people who use specialised health and personal social services.⁽⁶⁾ The HRB provided a breakdown of the disability types of the 13,710 service users whose records were recently registered or reviewed:

- multiple disabilities (5,054 people, 36.9%)
- neurological disability (3,934 people, 28.7%)
- physical disability (2,290 people, 16.7%)
- speech and or language disability (1,033 people, 7.5%)
- visual disability (770 people, 5.6%)
- hearing loss/deafness (629 people, 4.6%).⁽⁶⁾

The HRB provides a further breakdown of the types of care and support services[§] availed of by those registered on the National Physical and Sensory Disability Database. This is set out in Figure 2.

[‡] There were two such categories in the 2011 census: an intellectual disability; a difficulty with learning, remembering or concentrating.

[§] The table excludes healthcare services such as physiotherapy, occupational therapy, audiology etc.

Figure 2 — Use of personal assistance and support services by age group, 2015 (5,021 records)

	Under 18 years		18–65 years		Total	
	n	% of 1,639	n	% of 3,382	n	% of 5,021
General services						
Personal assistant	11	0.7	390	11.5	401	8.0
Home help	51	3.1	407	12.0	458	9.1
Home care assistant	33	2.0	226	6.7	259	5.2
Twilight nurse	~		9	0.3	13	0.3
Driving instructor (adapted car)	0	0.0	37	1.1	37	0.7
Communication assistant	~		15	0.4	19	0.4
Peer support	71	4.3	299	8.8	370	7.4

Source: Health Research Board, 2016

The figures above give some indication as to the numbers of people with physical and sensory disabilities availing of care and support services. However, it only reflects those on the National Physical and Sensory Disability Database. There is no similar breakdown for the 400,000 people from the Census 2011 figures. The HSE’s service plan for 2017 proposes to provide 10.570 million home help hours in 2017.⁽⁷⁾ There is no breakdown available for the types of user of home help services. Home care packages are primarily geared towards services for older people.⁽⁸⁾

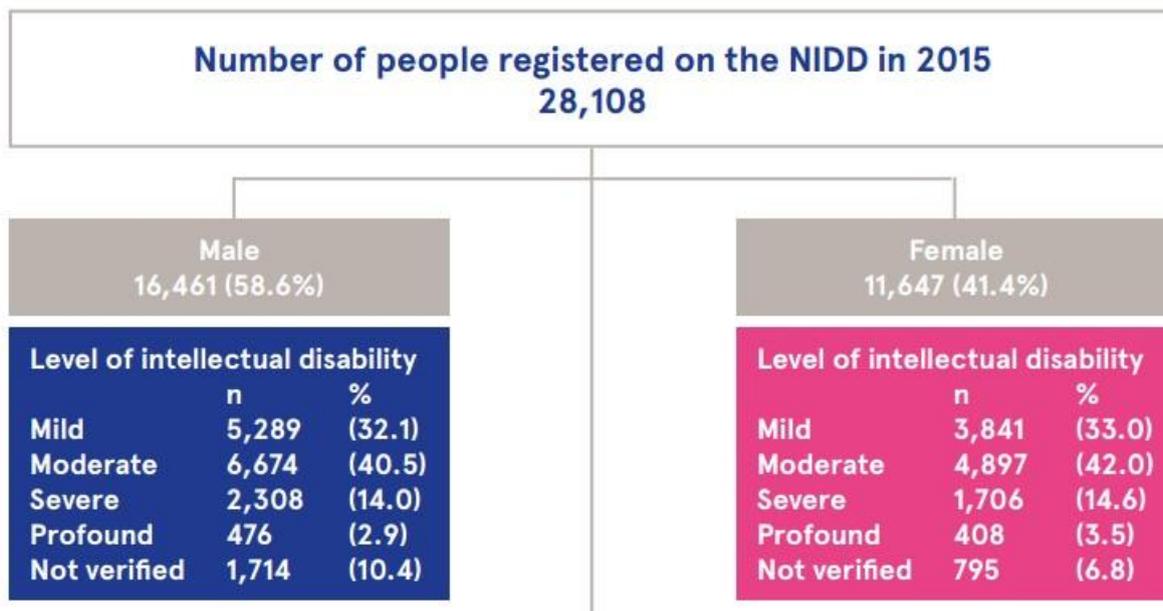
Most of the designated centres currently registered with HIQA provide services to adults and children with intellectual and or learning disabilities. The National Intellectual Disability Database, managed by the HRB, is a register of people in Ireland with an intellectual disability. The most recent data (2015) shows there were 28,108 people registered on the database.⁽⁹⁾ Census 2011 recorded 57,709 persons with an intellectual disability, comprising 1.3% of the population.

In Census 2011, there were a further 137,070 who identified as having a difficulty with learning, remembering or concentrating. As with physical and sensory disability figures, the inconsistency in these figures is due to a range of factors:

- differences in the definitions of intellectual disability used
- the data collection methods
- and, the fact that the National Intellectual Disability Database only registers data on people who are receiving specialised health services.

The following graph is a breakdown of the figures for 2015:

Figure 3 — Type of disability by age group, 2015



Source: Health Research Board, 2016
 Key: NIDD = National Intellectual Disability Database

The Census 2011 figures did not specify a breakdown of the level of disability for people with an intellectual disability.

Care and support service models

This section will describe the care and support service models currently evident in Ireland and discusses how they relate to the definition of a designated centre.

Congregated settings

This model of service is a legacy of how people with a disability (primarily an intellectual disability) were accommodated and cared for in Ireland in the 20th century. Often in purpose-built, campus-style settings, large numbers of people were accommodated in groups and received care which was traditionally based on a medical model. These settings remain a feature of the Irish system, but it is Government policy that they be phased out in favour of people being accommodated in the community.⁽¹⁰⁾ All congregated settings are currently registered as designated centres but, due to their size and for the purpose of registration, are sometimes split into several designated centres on one site.

Community/residential

Referred to in other countries as 'group homes', community-based services typically take the form of a house in a residential area that provides a service to people in a house-share arrangement.** The service users are supported by staff which are present in the house on a 24-hour basis. This is a social model of care^{††} where service users are supported to partake in activities similar to those of their peers. All such houses are currently regarded as designated centres and registered with HIQA accordingly.

Service providers typically group two or three houses together as one designated centre. It can be argued that the current regulations of relevance to disability services are not best suited to this service model. There are certain elements of the regulations which are in conflict with the idea that these houses are a person's home. In addition, many of the stakeholders who participated in discussion groups for this research criticised what they described as the 'one size fits all' approach to the regulations.

They further stated that the current regulations could potentially come into conflict with the Assisted Decision Making (Capacity) Act 2015. This Act replaces the Lunacy Regulation (Ireland) Act 1871, and it establishes a modern statutory framework to support decision-making by adults who have difficulty in making decisions without help.

** It is recommended in the HSE's *Time to Move On from Congregated Settings* report that shared arrangements such as these be limited to four people. The report refers to this type of service as 'dispersed housing'.

†† Some community services are nurse-led and there are some instances where nursing care is provided in these settings.

Respite care

Respite care follows a similar model to that of community or residential care, the key difference being the temporary nature of the service. Typically, respite care is a short-term residential placement provided to a person who is usually being cared for at home. The respite service will often be co-located with a residential service and is provided for periods ranging from one or two nights up to three weeks or thereabouts.

There are some circumstances where the existing regulations that apply to residential services may not be appropriate in respite services. For example, the regulations require a comprehensive assessment of the service user. This requirement was described as unduly burdensome by some of the participants at the discussion meetings for this research. Some respite beds are currently located in full-time residential centres as service providers can sometimes allocate a proportion of their beds to respite service users.

Supported and or assisted living

This model is provided in the community with a view to facilitating people to live independent lives. In such arrangements, service users sometimes have access to on-site support staff, if necessary. Services such as these are often purpose-built facilities and are largely provided in the voluntary sector. There is a degree of uncertainty around whether these types of services fall within the definition of a designated centre, and thereby whether they are regulated by HIQA.** While accommodation is part of the service, the level of care provided differs and it may be necessary to look at each service on a case-by-case basis.

In addition, at the discussion meetings for this research, some of the providers of this type of housing pointed out that they have no role in providing care. They stated that they simply provide the housing and that their staff may assist tenants to access care from third parties. Conversely, there are some providers of this type of housing that do provide a care service to their tenants. The system of regulation of this sector in Scotland was highlighted by participants as worthy of note. It is explored further in the section on Scotland later in this paper.

Personal assistance

This model of care usually involves a single dedicated person to provide one-to-one support to a person to live independently. A personal assistant (PA) provides support at the direction of the service user and this arrangement is most commonly found where the person has a physical or sensory disability. The level of service provided

** Providers of supported and or assisted living are typically registered with, and regulated by, the Housing Agency. They are referred to as approved housing bodies (AHBs). The Housing Agency does not regulate the care and or support provided to tenants.

differs on a case-by-case basis, but there is no accommodation component as the person is usually provided with this support in their own home.

The Health and Social Care Professionals Council (CORU) is responsible for registering certain health and social care professionals. One of the categories required to register are social care workers. As such, if a personal assistant is a social care worker, they would be registered with CORU. However, there is currently no requirement for personal assistants to be qualified as social care workers. The level of training or qualification required is at the discretion of the employer.

Day services

Day services are most often provided in group settings where individuals come together to engage in supervised activities. They are sometimes provided in congregated settings that are already registered as designated centres, mostly by voluntary agencies. HIQA inspectors are familiar with some day services in the context of speaking to residents of designated centres who attend these services. Indeed, they are often located adjacent to designated centres. However, inspectors have no power to enter or inspect these services. The most recent figures from the HRB found that 27,682 people with an intellectual disability availed of at least one day programme in 2015. Of this number, 7,700 were in full-time residential care.⁽⁹⁾ While HIQA would have some oversight of these service users as a result of them being residents in designated centres, the figures show that a majority of people with an intellectual disability using day services do so in an unregulated environment.

Home care

This model of care is provided in the person's own home, sometimes referred to as domiciliary care. It is normally for a set number of hours during the day and is concerned with assisting the person with activities of daily living and with community engagement. This service is provided by the HSE or contracted privately and is not currently considered to meet the definition of a designated centre. The HSE service plan for 2017 committed to providing 10.570 million home help hours and home care packages to 16,750 people.⁽⁷⁾ HIQA currently has no remit to regulate this sector but it has been identified by Government as an area that is under consideration for regulation. A 2009 consultation paper by the Law Reform Commission of Ireland recommended that the definition of a designated centre could be amended to include providers of home care, thereby bringing them under regulation by HIQA.⁽¹¹⁾

Nursing homes

While the majority of nursing homes cater for older persons, there are some residents that are accommodated in these services as a consequence of needs arising out of their disability, rather than infirmity due to old age. For example, a

young adult who was a victim of a road traffic accident may be in need of full-time nursing care. In such circumstances, this person will more often than not be cared for in a nursing home.

This setting may not be the most appropriate, particularly in the context of the person's social care needs. All nursing homes operating in Ireland are required to be registered with HIQA as they meet the definition of a designated centre. Nursing homes are funded mainly through the Nursing Home Support Scheme (NHSS or the 'Fair Deal' scheme) which is on a statutory footing. The NHSS budget for 2016 is almost €1 billion.⁽⁷⁾ Nursing homes are operated by a mix of public, private and voluntary operators.

Home sharing

Home sharing (sometimes referred to as adult placement) is a catch-all 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. An example of such an organisation in Ireland is the National Home Sharing and Short Breaks Network (NHSN) which provides services for both adults and children. Organisations facilitating home sharing services are regulated in other jurisdictions (such as in Northern Ireland and England).

Secure units

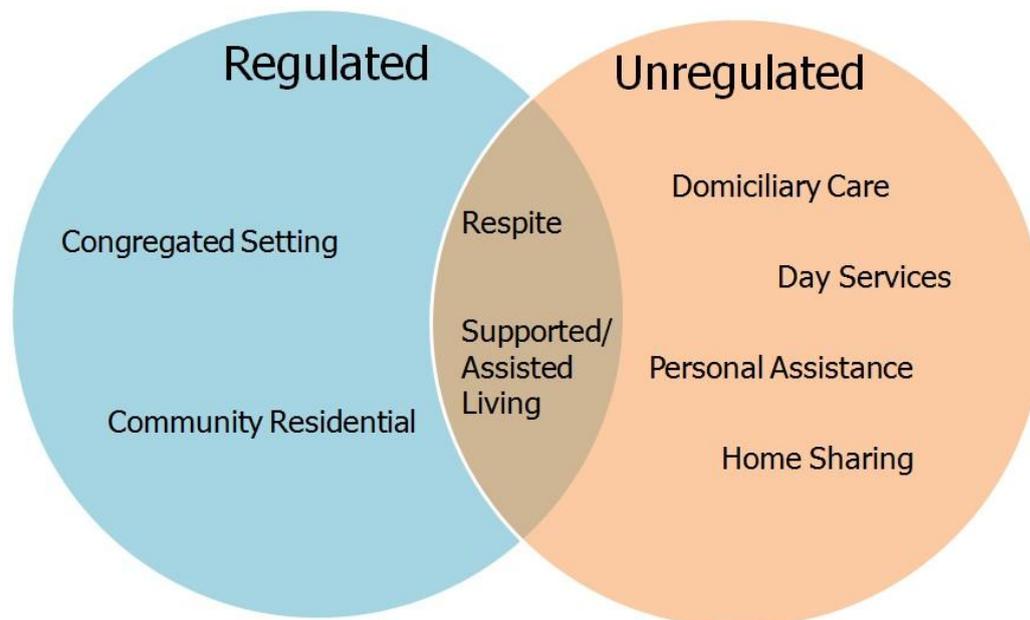
A small number of applications have been received by HIQA in the recent past to register designated centres for people with highly-specialised care needs. In many instances, the service users proposed to be accommodated in these centres have very complex presentations which require significant support interventions and can include a mental health condition along with a learning or intellectual disability — a dual diagnosis.

On inspecting these centres, there is evidence to suggest that there is extensive use of environmental restraints such as locked doors and high fences surrounding the centres. Providers have advised that these measures are necessary for the safety of the residents and the general public.

In considering the matter, it is HIQA's view that these centres fall within the definition of a designated centre under section 2(1)(a)(iii) of the Act. This states that a service is a designated centre if it is providing residential services to 'dependent persons, in relation to their dependencies'.⁽¹⁾ Notwithstanding this, these units require a level of service and expertise well in excess of the average designated centre for people with disabilities. This is primarily due to

the complex, high-level support needs of residents who often have dual diagnosis which may include psychiatric care needs. There are significant challenges in applying the current regulations to these kinds of environments.

Figure 4 – Venn diagram showing regulated and unregulated services



Research and policy development

As referenced earlier, the vast majority of disability services registered with HIQA are providing care, support and accommodation to people with intellectual disabilities. The practice for most of the 19th and 20th centuries was to house people with intellectual disabilities in large, institutional settings, often co-located with psychiatric patients. There were a number of reasons for this, including as one European study put it:

Many factors played a part in the original decisions to choose this model of care. It was believed that grouping people together in large numbers with (at least some) qualified staff was the most effective way to contain or perhaps even 'cure' people. Logistically, it helped to have the (very scarce) skilled professionals concentrating their work in one location. Institutional care was the preferred choice of many families who found it difficult or dangerous or (very commonly) socially embarrassing to live with their disabled relatives.⁽¹²⁾

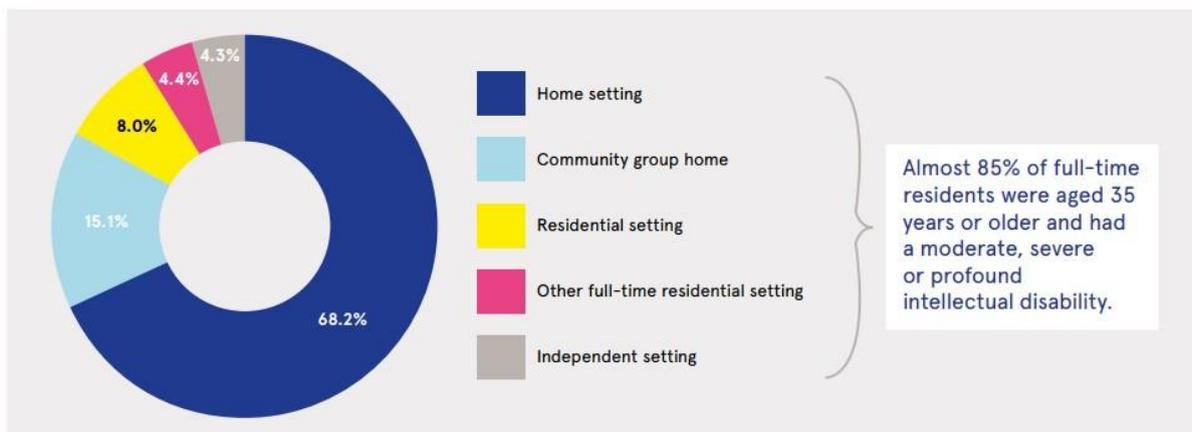
It is Irish Government policy to move away from the institutional model of care to a community-based model of delivery. This process is outlined in a 2011 report by the Health Service Executive (HSE) entitled 'Time to move on from congregated settings – A strategy for community inclusion'.

Among the report's recommendations are:

- all those living in congregated settings will move to community settings
- no new congregated settings will be developed and there will be no new admissions to congregated settings
- the move to community will be completed within seven years and minimum annual targets set for each year in order to reach that goal.⁽¹⁰⁾

The graph below (Figure 5) shows the breakdown of those on the National Intellectual Disability Database by type of accommodation.

Figure 5 — Main living arrangements of people with an intellectual disability



Source: Health Research Board, 2016

It is anticipated that the move away from congregated⁵⁵ settings will continue over the next number of years, thereby increasing the number of community-based services.

Several research reports have shown that people with disabilities prefer to be cared for in the home or in their locality:

Privacy, choice and control are the primary drivers of the decision to live an independent life; participants with intellectual impairments, in particular, were anxious to avoid institutional care, while those with degenerative conditions wanted to maintain independence for as long as possible.⁽¹³⁾

Disabled people and their families have played a leading role in recent years in developing new types of service. Probably the best example of this has been the growth of independent living for people with physical disabilities, which is promoted and led by disabled people and now occupies a prominent position in European policy action through the European Network for Independent Living.⁽¹²⁾

It is recommended that... a wide range of appropriate resources are put in place to address the needs of people seeking to live independently, including measures such as half-way houses, appropriate technology, structured links with the wider community, and a minimum of basic living and social skills etc.⁽¹⁴⁾

⁵⁵ Defined in the HSE report as accommodating 10 or more people.

The Government has identified home care as a sector that will likely be regulated by HIQA in the future.^{***} The move to community-based services and away from institutional settings is welcomed by most stakeholders. Research has argued that this model of care provides better outcomes for service users.^(12,15,16) The HSE has estimated that transitioning from congregated settings to community-based services will be a cost-neutral measure.⁽¹⁰⁾

Whilst there is some regulation in the community sector at present, it is limited to group housing and these services must meet the definition of a designated centre. Other models of service are unregulated, such as day services.^{†††} In 2015, 99.8% of people on the National Intellectual Disability Database attended at least one day-service programme.⁽⁹⁾ The HSE's own report on congregated settings argued for the need for standards in the community sector:

The HIQA standards for residential services are framed around quality of life, safety, rights, anti-discrimination, person-centredness, community integration, responsiveness of service. At a minimum, community-based accommodation for people with disabilities must meet the HIQA standards... standards now need to be developed that are based on the objectives of community inclusion and full citizenship for every person with a disability.⁽¹⁰⁾

As previously stated, most of the service users in designated centres for people with disabilities are people with intellectual disabilities. However, there is a sizeable portion of the population that have physical and or sensory disabilities, far in excess of the number of people with an intellectual disability. The majority of this group who need care or support tend to receive it in the home as opposed to a communal setting.⁽¹⁶⁾

The most recent significant overarching national policy for people with disabilities was the National Disability Strategy (2004). It set out the broad thrust of Government policy aimed at improving the social inclusion of people with disabilities. It also provided for key pieces of legislation (Disability Act 2005, Education of Persons with Special Educational Needs Act 2004) and required certain Government departments to develop sectoral plans in relation to people with disabilities.

The Department of Housing, Planning, Community and Local Government is responsible for housing policy. Much of the focus in terms of housing in the Department's sectoral plan was on providing financial assistance for housing adaptations and to housing agencies to deliver special needs housing projects. There

^{***} There was a commitment to this in the 2011 Programme for Government. A November 2016 press statement from the Minister for Mental Health and Older People reaffirmed this commitment.

^{†††} Some types of day services (such as special schools) may be regulated by another body.

was a further commitment in this plan to develop a housing strategy for people with disabilities.⁽¹⁷⁾

The National Housing Strategy for People with a Disability was published in 2011. This strategy outlines a plan for providing housing and accommodation to people with physical and or sensory disabilities, intellectual disabilities and those with mental health issues. The strategy sets out the following vision for facilitating independent living:

The range of supports necessary to enable people with a disability to live independently in their own homes can be extensive and range from physical adaptations to make homes accessible to the provision of healthcare related supports. The types of supports required will vary according to the nature of disability and personal preference and should be delivered in an integrated manner. The provision of necessary supports must be assured by the responsible agencies and underpinned by agreed service plans.⁽¹⁸⁾

To summarise, as is the case for people with intellectual disabilities, it is Government policy to provide supports to people with physical and or sensory disabilities to enable them to live independently in the community.

Country analysis

This section of the paper will examine how regulations and standards for different service models have been established in other jurisdictions.

Wales

In Wales, the Care and Social Services Inspectorate of Wales is the regulator for social care. Its reach is broader than HIQA's because as well as being the regulator for residential care services for older people and people with disabilities, it also regulates nursing agencies, domiciliary care and adult placement schemes. Until recently, under the Care Standards Act 2000, the Care and Social Services Inspectorate of Wales had adopted a similar approach to that found in Ireland, that is to say it registers establishments or centres. New regulations (Regulation and Inspection of Social Care (Wales) Act 2016) will give effect to a change in approach. Effective from 2018, the Inspectorate will now register what are described as 'regulated services'. These will include the following:

- (a) a care home service
- (b) a secure accommodation service
- (c) a residential family centre service
- (d) an adoption service
- (e) a fostering service
- (f) an adult placement service
- (g) an advocacy service
- (h) a domiciliary support service and
- (i) any other service comprising the provision of care and support in Wales as may be prescribed.⁽¹⁹⁾

Any organisation providing one of these services must register with the Care and Social Services Inspectorate of Wales. A service provider will only be required to register once in respect of any regulated service that it carries on. This is characterised as a 'service-based' model and is described in an explanatory memorandum accompanying the regulations:

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. Whilst 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.⁽²⁰⁾

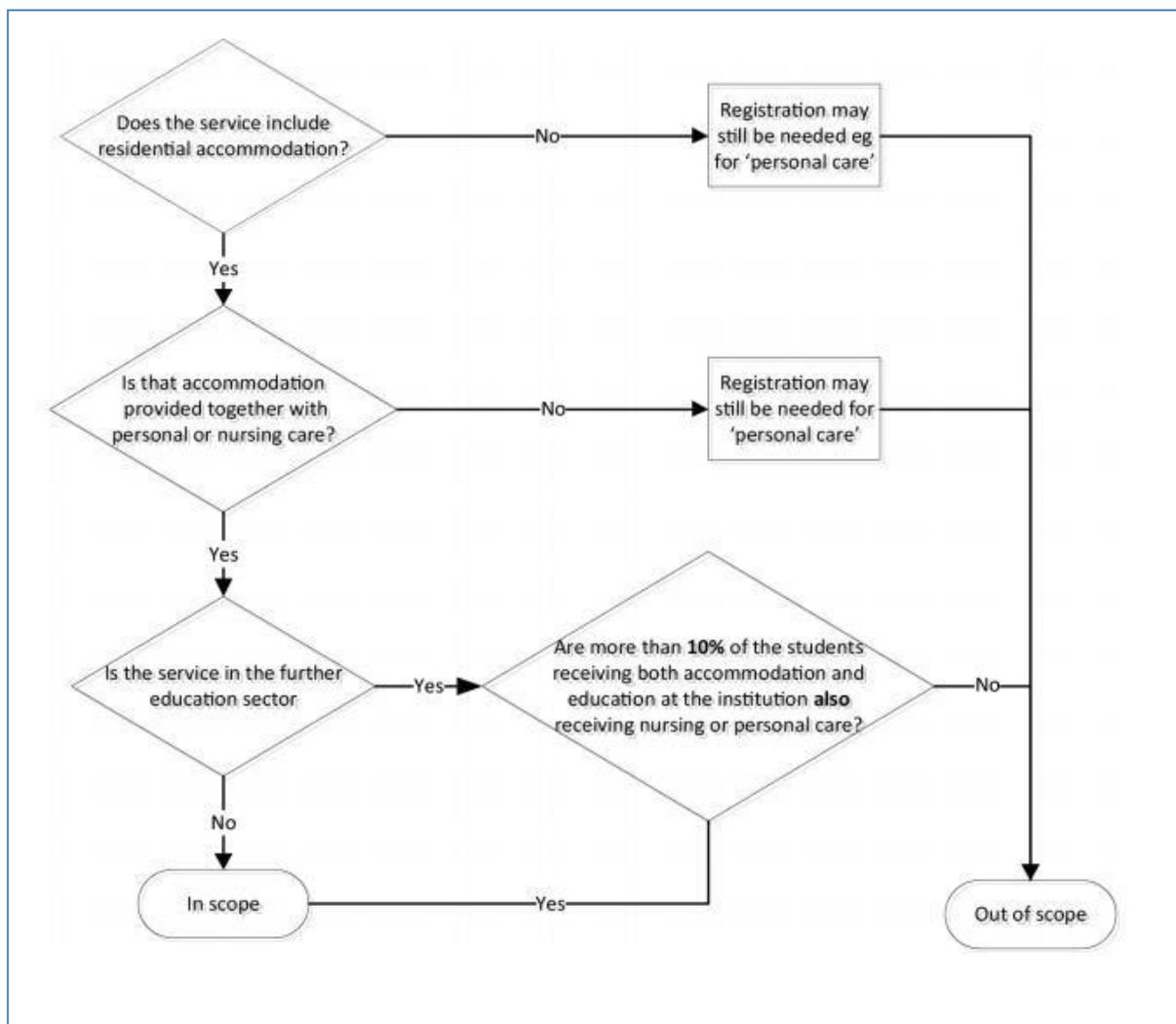
The policy change outlined above is intended to provide for greater flexibility and transparency in the system and to align Wales more closely to the regulatory systems in England and Scotland. In addition, a white paper published in 2013 stated that the move to registering services would better position the regulator to respond to emerging service models.⁽²¹⁾ Individual sites and or premises where the service provider operates the regulated service are included as a condition on their registration (known as 'sub-registration').

England

The Care Quality Commission (CQC) is the equivalent of HIQA in England. The CQC adopts a service-based approach to registration and regulation. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out each of the regulated activities that are to be regulated by the CQC. Therefore, it is the legal body that provides the regulated activity that must register with the CQC, as opposed to the location or care setting where it is carried on.

As well as registering as a service provider, an organisation must also register a manager who is in day-to-day charge of the regulated activity, or the regulated activity in a particular location. Guidance published by the CQC offers service providers advice on whether their service meets the definition of a regulated activity. For example, the following process flow chart in Figure 6 is provided for services that are considering whether they meet the criteria of 'Accommodation for persons who require nursing or personal care':

Figure 6 – Process flow chart in CQC guidance document



Source: Care Quality Commission, 2015

The CQC guidance document gives an overview of each of the categories of regulated activity and is intended to help providers find out if they must register as a service provider.⁽²²⁾

The service models relevant to this paper include:

- care home services with nursing
- care home services without nursing
- personal care
- domiciliary care services
- extra care housing services
- supported living services.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provide for 'fundamental standards' for all of the activities regulated by the CQC. These are intended to be 'catch-all' regulations that apply across the whole range of regulated activities. The headings of the fundamental standards are as follows:

- General
- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse and improper treatment
- Meeting nutritional and hydration needs
- Premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed
- Duty of candour
- Requirement as to display of performance assessments.⁽²³⁾

Guidance published by the CQC outlines how it will apply the regulations to the various service types:

...we will be proportionate in how we apply the regulations to different types of services. We will consider the size and type of services and the relevance of the regulation to the regulated activity provided. For example, when inspecting providers of personal care to people in their own home we would not assess Regulation 15: Premises and equipment, or when inspecting dentists we would not assess Regulation 14: Meeting nutrition and hydration needs, as they would not apply to these types of regulated activity.⁽²⁴⁾

There are additional registration regulations which deal with governance and management, notifications and fees and so on.

Scotland

The Care Inspectorate is the regulator for care and social services in Scotland. The Public Services Reform (Scotland) Act 2010 sets out the types of services that are to be registered and follows a service-based model. The Care Inspectorate regulates a wide range of services including adoption and fostering, childcare, nursing agencies and offender accommodation. The category most closely related to what is regulated in Ireland is known as 'care homes'. These are defined as 'a service providing

accommodation which includes nursing care, personal care or personal support to vulnerable children or adults'.⁽²⁵⁾ Care homes are subdivided as follows:

- care homes for people with physical and sensory impairments
- care homes for older people
- care homes for people with learning disabilities
- care homes for children and young people
- care homes for people with drug and alcohol misuse problems.

In addition to the above service types, the Care Inspectorate also regulates services provided in the home. These include nursing agencies, support services (personal care) and housing support services. Definitions for each of these are provided in the 2001 Act and are listed in Appendix 2 of this paper. All services are monitored against the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011. In addition, each of the categories of care has a separate set of standards.

The model of regulation for housing support services in Scotland is noteworthy. Some of the participants in the discussion meeting for this research spoke positively about Scotland's approach in this sector and felt it was a useful starting point for considering this type of regulation in Ireland. The standards for housing support services, monitored by the Care Inspectorate, provide the following definition for this service model:

Housing support services help people to live as independently as possible in the community. They can either be provided in your own home or in accommodation such as sheltered housing or a hostel for homeless people. Housing support services help people manage their home in different ways. These include assistance to claim welfare benefits, fill in forms, manage a household budget, keep safe and secure, get help from other specialist services, obtain furniture and furnishings, and help with shopping and housework. The type of support that is provided will aim to meet the specific needs of an individual person.⁽²⁶⁾

As evident in the above definition, this is very much a social model of care. The Scottish Housing Regulator is the agency with responsibility for registering and regulating 'social landlords'. Registered social landlords (RSLs) are not-for-profit bodies that provide social housing, similar to approved housing bodies in Ireland. There are certain circumstances where the regulatory activities of the Scottish Housing Regulator overlap with that of the Care Inspectorate. To this end, there is a memorandum of understanding (MoU) between the two bodies. The principal aims of the MoU are to ensure a coordinated approach to regulation and to avoid over-regulation in the sector.⁽²⁷⁾

Northern Ireland

The Regulation and Quality Improvement Authority (RQIA) is HIQA's equivalent in Northern Ireland. Registration of care providers, in line with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, is focused on an 'establishment or agency'. As such, all locations at which a service is provided must be registered with the RQIA. Therefore, the model of regulation here is that of establishment as opposed to service. The types of services regulated by the RQIA are much broader than those regulated in Ireland by HIQA.

Of relevance to this paper are the regulations governing nursing homes, residential care homes, nursing agencies, day care and domiciliary care. While the RQIA has an establishment approach, there are certain sectors where this is impractical. For example, in the case of domiciliary care, it would be unfeasible to register all of the locations at which this care is provided, that is to say people's homes. Instead, the domiciliary care service provider is registered and must comply with the relevant regulations.

Each activity regulated by the RQIA has its own set of regulations. Those relevant to this paper are listed below:

- The Day Care Setting Regulations (Northern Ireland) 2007
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Adult Placement Agencies Regulations (Northern Ireland) 2007
- The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003
- The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007
- The Residential Care Homes Regulations (Northern Ireland) 2005.⁽²⁸⁾

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 provides the following definitions for some of the above service types:

- "**day care setting**" means ...a place where persons in need of prescribed services may attend for the purposes of assessment, rehabilitation or counselling but where they are not provided with board or accommodation.
- "**domiciliary care agency**" means ...an undertaking which consists of or includes arranging the provision of prescribed services in their own homes for persons who by reason of illness, infirmity, disability or family circumstances are unable to provide any such service for themselves without assistance.

- “**nursing agency**” means ...an employment agency or employment business, being (in either case) a business which consists of or includes supplying, or providing services for the purpose of supplying, registered nurses, registered midwives or registered health visitors.
- an establishment is a **residential care home** if it provides or is intended to provide, whether for reward or not, residential accommodation with both board and personal care for persons in need of personal care by reason of—
 - (a) old age and infirmity
 - (b) disablement
 - (c) past or present dependence on alcohol or drugs; or
 - (d) past or present mental disorder.⁽²⁹⁾

New Zealand

The regulatory system in New Zealand is referred to as ‘certification’. While the terminology is somewhat different (for example, rest homes is the term preferred to nursing homes), the social care services which are subject to certification are broadly similar to those in Ireland.

Under the Health and Disability Services (Safety) Act 2001, service providers apply to be certified if they provide one or more of the listed service types. These include rest homes, residential disability care and psychiatric services. The certification system in place is similar in nature to that found in the UK, that is to say a service-based model. Service providers must then comply with standards^{***} that were enacted in 2008. There are four sets of standards as follows:

- Health and Disability Services (General) Standards
- Health and Disability Services (Core) Standards
- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- Health and Disability Services (Infection Prevention and Control) Standards.

The Act provides definitions for health and disability services under a number of headings, including the following relevant to people with disabilities:

services, provided to people with disabilities or people who are frail (whether because of their age or for some other reason), for their care or support or to promote their independence.⁽³⁰⁾

^{***} Standards do not have the same meaning as they do in Ireland. In effect, standards in New Zealand are equivalent to regulations in Ireland.

Standards New Zealand, a public body, develops a range of health and social care standards in addition to the four listed above. Among them are standards for Home and Community Support.

Australia (Queensland)

Regulation of disability services is the responsibility of individual states in Australia. Therefore, this section will focus on the system in Queensland. The Disability Services Act (2006) is the legislative framework for regulation of disability services in the state of Queensland. The Act defines what is meant by a disability service and includes the following:

- accommodation support services
- respite services
- community support services
- community access
- advocacy or information services or services that provide alternative forms of communication
- research, training or development services
- another service prescribed by regulation.⁽³¹⁾

Regulations set out additional services that are to be considered disability services:

- assistance with daily life-tasks in a group or shared living arrangement
- assistance with daily personal activities
- development of daily living and life skills
- therapeutic support
- early intervention supports for early childhood
- behaviour support
- assistance in coordinating or managing life stages, transitions and supports
- management of funding for supports under a participant's plan
- assistive technology specialist assessment, set up and training
- participation in community, social and civic activities

- training for independence in travel and transport
- interpreting and translation.⁽³²⁾

The Act sets out the rights of people with disabilities and also specifies what powers are available to 'authorised officers' in terms of monitoring compliance. Service providers must apply to the state to become 'approved service providers'; this makes them eligible to apply for funding from the state.

Canada (British Columbia)

As Canada is a federation of states, much of the legislation and regulation around disability services is the responsibility of individual states. This section will focus only on the regulatory system in the province of British Columbia (BC). Regulation of care for people with disabilities in British Columbia is organised via a licensing system. The types of services licensed include residential care, community care and assisted living.

British Columbia requires that the premises be licensed and, therefore, follows an establishment approach. Assisted living facilities must be registered with the designated assisted living registrar. All care is legislated for under the Community Care and Assisted Living Act (2002) and the Continuing Care Act (1996) and its associated regulations. There are three sets of regulations which apply to care in the province of British Columbia. These — including the scope of the regulations — are listed below,

- **Residential care**

(a) hospice, being residential care and short-term palliative services for persons in care at the end of their lives

(b) mental health, being residential care for persons who are in care primarily due to a mental disorder

(b.1) substance use, being residential care for persons who are in care primarily due to substance dependence

(c) long-term care, being residential care for persons with chronic or progressive conditions, primarily due to the ageing process

(d) community living, being residential care for persons with developmental disabilities

(e) acquired injury, being residential care for persons whose physical, intellectual and cognitive abilities are limited primarily due to an injury,

including persons suffering from brain injuries or injuries sustained in accidents.⁽³³⁾

- **Community care and assisted living**

(a) regular assistance with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene

(b) central storage of medication, distribution of medication, administering medication or monitoring the taking of medication

(c) maintenance or management of the cash resources or other property of a resident or person in care

(d) monitoring of food intake or of adherence to therapeutic diets

(e) structured behaviour management and intervention

(f) psychosocial rehabilitative therapy or intensive physical rehabilitative therapy.⁽³⁴⁾

- **Continuing care programs**

(a) home support services

(b) adult day services

(c) meals programs (including meals on wheels and congregate meal programs)

(d) continuing care respite services

(e) continuing care case management

(f) continuing care residential care services

(g) short stay assessment and treatment centres

(h) home oxygen program

(i) assisted living services

(j) home care nursing

(k) community rehabilitation services.⁽³⁵⁾

Related considerations for regulation in Ireland

Financial viability

Providing services to people with disabilities in Ireland is primarily a public and voluntary enterprise. The HSE is a significant provider but also funds voluntary bodies through what are known as Section 38 and 39 arrangements. Many of the voluntary providers are relatively large national organisations (Brothers of Charity, REHAB, St John of God). Currently in Ireland, there is nothing in the regulations relevant to disability services about the financial viability of an operator to fulfil its functions^{§§§}. This presents a certain level of risk in terms of the potential for service capacity to be reduced as a consequence of a provider ceasing operations at short notice.

Such a situation arose in England when Southern Cross Homes Healthcare PLC encountered financial difficulties in 2011. Southern Cross Homes Healthcare ran 752 care homes and provided services to 31,000 older people. Its collapse was attributed to high leasing costs and poor occupancy rates as a result of under-investment.⁽³⁶⁾ Ultimately, no resident was evicted from their care home and other providers stepped in to take over the running of its services. However, a 2014 report commissioned by the CQC found that the situation could have been much worse had another provider collapsed around the same time. It also warned that it was too early to judge whether the replacement providers would be financially stable in the long term.⁽³⁶⁾

As a consequence of the collapse of Southern Cross Homes Healthcare, there is now a 'market oversight' regime in operation in England, under the auspices of the CQC. Providers that are designated 'difficult to replace' must satisfy the regulator that they are financially sustainable. HIQA does not have any specific cause for concern in terms of the providers operating in the Irish market at present. However, it may be prudent, given what occurred in England, to introduce measures which would guard against a similar situation arising in Ireland.

Registration cycle

The registration period in Ireland for designated centres is valid for a period of three years, after which time the service provider must apply to HIQA for re-registration. HIQA has gone through two registration cycles with older person's services and is currently in the first cycle of registration of residential services for people with disabilities. In fact, the original three-year registration deadline for disability services was extended to five years due to difficulties encountered across the sector in meeting regulatory requirements.

^{§§§} Regulation 23 (a) makes reference to a centre having 'sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose'. This is not currently interpreted as requiring HIQA to carry out a test of financial viability. In addition, the regulation focuses on the designated centre as opposed to the registered provider.

The learning from the cyclical registration process is that the requirement to re-register a service is administratively burdensome, both for HIQA and for service providers. HIQA is also of the view that the requirement to re-register designated centres detracts from its ability to target resources where it has identified the highest level of risk. Service providers that attended discussions on this research also expressed the view that the registration cycle was overly burdensome and unnecessary. If the cyclical element of registration was removed, it would allow HIQA to pursue a more responsive regulatory approach. Service providers that have a good track record in terms of compliance and quality improvement would have their regulatory burden reduced. Conversely, centres where poor practice or where high risk has been identified would be subject to increased monitoring.

The removal of the registration cycle would have a knock-on effect in terms of the financing of HIQA's operations. At present, a portion of HIQA's work is financed by fees levied on service providers at registration. The cumulative figure for designated centres for older people and people with disabilities is approximately €300,000 per year based on the current number of centres. Two possible solutions to replace this loss in income are:

1. Create an annual payment equivalent which would replace the registration payment once every three years.
2. Increase the pre-existing annual fee that is based on bed numbers.

Discussion

So far, the content of this paper has described the definition of a designated centre under the Health Act 2007. It has set out the various models of non-acute care provided to people with disabilities in Ireland. It has also described some of the research and policy developments in this area, and reviewed how other countries regulate various services for people with disabilities. The question necessarily arises: what, if anything, should change now in Ireland?

HIQA's Corporate Plan is committed to protecting and safeguarding those who are vulnerable. In doing so, we look to take a human rights-based approach to our work. The evidence outlined in this paper shows that there are large numbers of people being cared for in a range of different care settings. There are currently a significant number of these settings that do not fall under the definition of a designated centre and are therefore unregulated. Service users in these unregulated sectors may be just as vulnerable as those being cared for in designated centres. They also have the same right to high-quality care as those people living in designated centres. As such, there is a need to review and expand regulation to have oversight and provide public assurance on the different models of care and service delivery.

Furthermore, regulatory oversight should also seek to ensure that public monies are spent appropriately. If the principal objective of regulation is to protect and promote the rights of service users, then it follows that the concept of the designated centre should be re-evaluated to include service models that are currently unregulated.

The enactment of the Assisted Decision Making (Capacity) Act in 2015 (herein referred to as the Capacity Act) also presents challenges to the current regulatory framework. This Act establishes a new framework of rights for people with limited or diminished capacity to make decisions for themselves. Many participants at the discussion meetings for this research also recognised the impact that this Act is likely to have.

The Capacity Act has the potential to impact on the current regulations in a number of ways. For example, service user advocacy groups have already questioned Regulation 24 (3)^{****} which allows a representative of the resident to sign a contract for service on their behalf. This provision could come into conflict with certain provisions in the Capacity Act. To summarise, the disability services regulations may need to be reviewed in light of the Capacity Act, regardless of any of the changes suggested in this paper.

**** Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) with Disabilities) Regulations 2013

There are a large range of service models deployed in caring for people with disabilities in Ireland. For some, such as congregated settings, there is no dispute as to whether they meet the criteria of a designated centre. Service models that have a less intensive care component, such as the different models of supported living, are somewhat of a grey area. In many cases, service providers can legitimately argue that these are not designated centres because the service users are not availing of care in the traditional sense (the matter is further complicated in the absence of a definition of care).

The reality is that these services are not uniform, and the needs of service users vary greatly. This was also reflected in the feedback from the various discussion groups that comprised part of this research. Some providers of sheltered housing had no role in providing care whereas others were engaged in providing care. As such, it may prove difficult to devise a definition of a designated centre that draws a line neatly between those who are living independently and those that require a level of care and support that would result in their service being subject to regulation.

In the case of home care, it has been signalled by Government that these services will come under regulation by HIQA in the future. To date, there has been no substantive detail on how such regulation would be configured.

It has been official Government policy for a considerable period of time that people with disabilities be cared for in the community and that congregated settings be phased out. Some people living in congregated settings have moved to group homes in the community. Most of these homes cater for the needs of people with an intellectual disability and are registered as designated centres. However, the availability of other service models such as assisted living or sheltered housing are only sporadically available and largely rely on the voluntary sector. Most stakeholders agree that there needs to be a greater emphasis on the provision of more diverse models of social care.

Another interesting finding from the discussion groups for this research was the difficulty being encountered in developing new, purpose-built sites for supported living and or sheltered housing for people with disabilities. Some participants explained that the cost of building such units is excessive. This is because they are being designed in line with the regulations for designated centres and therefore must have all related physical requirements such as extensive fire protection measures. The feedback from the discussion group was that this resulted in units that would be prohibitively expensive to build.

The examples of how other regulators define services shows that the majority follow a model of registering and or certifying the service provider as opposed to the physical location at which the service is provided. This approach offers a number of advantages:

1. It provides clarity to service users, providers and regulators.
2. Separate regulations can be tailored to the service model.
3. Service providers can be more flexible and innovative. For example, they could accommodate service users with different support needs in the same setting.
4. Administration would be reduced, both for the service provider and the regulator.

These advantages provide a persuasive argument for adopting a service-based approach to regulation. Participants in the discussion group for this research also favoured a service-based model of registration with an accompanying suite of regulations tailored for different service types. Moving away from an establishment to a service model of registration and regulation raises a number of issues. Firstly, the sections dealing with registration in the Health Act 2007 would need to be revised. In addition, the sections dealing with enforcement would also require review as the focus of an enforcement action would be on the service provider and not the designated centre.

Secondly, the Department of Health and or the Government would need to consider what service and or activities it wishes to regulate, that is to say, as 'regulated activities'. Under the current system, congregated settings and shared group homes are currently regulated because they are providing a residential care service. Given the analysis of the various care and support models in this paper and the types of services regulated in other jurisdictions, the following is a list for consideration as regulated activities:

- residential care for people with disabilities
- personal assistance services
- home care⁺⁺⁺
- sheltered housing and or assisted living
- day care
- home sharing
- respite care.

Each of the above would need a carefully devised definition. Consideration should also be given to whether each service model needs a separate set of regulations (such as in Northern Ireland) or an overarching set of regulations which are selectively applied depending on the service provided (as is the case in England with the 'fundamental standards').

⁺⁺⁺ It may be possible to regulate nursing agencies or other similar private provision of medical care in the home under this grouping. However, other jurisdictions have developed separate regulations for nursing agencies.

In such a model of regulation, providers would be required to register with HIQA if they were providing one of the regulated activities. They would be registered as a service provider and would notify HIQA of all the locations at which the regulated activity was being carried on. Whether or not the service provider should have to re-register after a certain period of time, or register once and be monitored on an ongoing basis from then on, would also need to be considered. HIQA research into licensing of healthcare in other countries showed that many regulatory systems do not require re-registration.

In any future scenario, the question of the fitness of the provider would be a key consideration when assessing the quality of a service. At present, there are separate regulations which govern the registration of designated centres. If the scope of regulation is to be expanded to include additional models of care, it may be useful to also have separate regulations which set out the governance and management requirements for service providers. Such regulations would be applied across all providers of regulated activities.

The above list of regulated activities captures most of the care and support models that are currently seen in Ireland. Providing clear definitions of each model and devising guidance for providers will limit confusion in terms of what is being regulated. However, it is inevitable that new service models will evolve that do not meet these criteria. For example, developments in technology could allow for remote monitoring and telehealth[‡] to become realistic options in terms of services for people with disabilities.

Therefore, if there are to be changes in the Health Act 2007, it may be worth trying to future proof the legislation as much as possible or frame it in such a way as to allow the law to respond to new and emerging models of care. One means of doing so would be to define what is meant by 'care'. There is currently no definition in the Health Act 2007 or its associated regulations. Such a definition would provide a benchmark against which any new service models could be measured.

Reform of health and social care services is a complex task requiring the input of a variety of stakeholders. This paper has set out the various models of care and support in Ireland and shown how other countries have approached regulation of these sectors. Based on this learning, the paper sets out a high-level overview of how services might be regulated in the future. HIQA recognises that this discussion is only one piece of a broader discussion on how we, as a nation, plan and deliver services to meet the needs of the population. Our most recent corporate plan outlines a commitment to inform and influence policy in Ireland. It is hoped that this research paper will contribute to this discussion.

[‡] Telehealth refers to the use of telecommunications technology to provide health and social care services e.g. virtual consultations, wearable devices, motion sensors.

Appendix 1 — Types of disability in Census 2011

1. Blindness or a serious vision impairment.
2. Deafness or a serious hearing impairment.
3. A condition that limits basic physical activities.
4. An intellectual disability.
5. Difficulty in learning, remembering or concentrating.
6. Psychological or emotional condition.
7. Other disability, including chronic illness.
8. Difficulty in dressing, bathing or getting around at home.
9. Difficulty in going outside the home alone.
10. Difficulty in working or attending school/college.
11. Difficulty in participating in other activities.⁽⁴⁾

Appendix 2 — Definitions in Regulation of Care (Scotland) Act 2001

2 Care services

(1) A “care service” is any of the following—

- (a) a support service;
- (b) a care home service;
- (c) a school care accommodation service;
- (d) an independent health care service;
- (e) a nurse agency;
- (f) a child care agency;
- (g) a secure accommodation service;
- (h) an offender accommodation service;
- (i) an adoption service;
- (j) a fostering service;
- (k) an adult placement service;
- (l) child minding;
- (m) day care of children; and
- (n) a housing support service.

(2) A “support service” is a service provided, by reason of a person’s vulnerability or need (other than vulnerability or need arising by reason only of that person being of a young age), to that person or to someone who cares for that person by—

- (a) a local authority;
- (b) any person under arrangements made by a local authority;
- (c) a health body; or
- (d) any person if it includes personal care or personal support,

but the expression does not include a care home service, an independent health care service, a service which provides overnight accommodation, an

adoption service, a fostering service or a service excepted from this definition by regulations, paragraphs (c) and (d) above do not apply where the provider is a health body acting in exercise of functions conferred by the National Health Service (Scotland) Act 1978 (c.29) and paragraph (d) above does not apply if the provider is an individual who personally and solely gives the care or support in question.

(3) A “care home service” is a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include—

- (a) a hospital;
- (b) a public, independent or grant-aided school;
- (c) an independent health care service; or
- (d) a service excepted from this definition by regulations.

(4) A “school care accommodation service” is a service which is provided to a pupil by an education authority or the managers of an independent or grant-aided school, or by any person under arrangements made by any such authority or managers—

- (a) for the purpose of the pupil being in attendance at a public, independent or grant-aided school; and
- (b) which consists of the provision, in a place in or outwith the school, of residential accommodation,

but a service may be excepted from this definition by regulations.

(5) An “independent health care service” is any of the following—

- (a) an independent hospital;
- (b) a private psychiatric hospital;
- (c) an independent clinic; and
- (d) an independent medical agency.

(6) A “nurse agency” is a service which consists of or includes supplying, or introducing to persons who use the service, registered nurses, registered midwives or registered health visitors; but a service may be excepted from this definition by regulations.

(7) A “child care agency” is a service which consists of or includes supplying, or introducing to persons who use the service, child carers; but the expression does not include a nurse agency and a service may be excepted from this definition by regulations.

(8) In subsection (7) above, “child carer” means a person who—

(a) whether or not for reward; and

(b) whether on a day-to-day or on an occasional basis, looks after a child wholly or mainly in the home of the child’s parents.

(9) A “secure accommodation service” is a service which provides accommodation approved by the Scottish Ministers in accordance with regulations made under section 29(9)(a) of this Act.

(10) An “offender accommodation service” is a service which consists of giving advice, guidance or assistance to persons who have been provided with accommodation under subsection (1)(b) or (c) of section 27 of the Social Work (Scotland) Act 1968 (c.49) (supervision and care of persons put on probation or released from prison etc.); but the expression does not include a support service.

(11) An “adoption service” is a service which is—

(a) maintained by a local authority under section 1(1) of the Adoption (Scotland) Act 1978 (c.28); or

(b) provided by a person other than a local authority and which consists of, or includes, the making of arrangements for or in connection with the adoption of children (whether the person functions generally or in relation to some service maintained, or to be maintained, as part of the Scottish Adoption Service).

(12) For the purposes of subsection (11)(b) above, the making of arrangements for the adoption of a child where the proposed adopter is a relative of the child is not an adoption service.

(13) In subsection (11)(b) above, “the Scottish Adoption Service” has the meaning given by section 1(4) of that Act of 1978.

(14) A “fostering service” is a service which is provided by—

(a) a local authority under paragraph (a) of section 26(1) of the Children (Scotland) Act 1995 (c.36) (fostering of children looked after by a local authority);

(b) a person other than a local authority and which consists of, or includes, the making of arrangements for or in connection with the performance of functions assigned to a local authority—

(i) under that paragraph; or

(ii) by virtue of section 5(2) to (4) of the Social Work (Scotland) Act 1968 (c.49) (regulations relating to performance of functions assigned to a local authority under that Act); or

(c) a local authority and which consists of, or includes, the functions assigned to the authority by sections 3 and 8 to 10 of the Foster Children (Scotland) Act 1984 (c.56) (ensuring well-being etc. of certain privately fostered children).

(15) The services mentioned in subsection (14)(a) and (b) above and registered under this Act may be collectively referred to as the “Scottish public fostering service”; and those mentioned in subsection (14)(c) above and so registered may be collectively referred to as the “Scottish private fostering service”.

(16) An “adult placement service” is a service which consists of, or includes, arranging for the provision of accommodation for an adult (that is to say for a person who has attained the age of eighteen years), together with—

(a) personal care;

(b) personal support; or

(c) counselling, or other help, provided other than as part of a planned programme of care,

by reason of the person’s vulnerability or need, by placing the person with a family or individual; but a service may be excepted from this definition by regulations.

(17) “Child minding” means, subject to subsections (18), (19) and (21)(a) below, looking after one or more children on domestic premises for reward and “act as a child minder” shall be construed accordingly; but a service may be excepted from those definitions by regulations.

(18) For the purposes of subsection (17) above, a person who—

(a) is the parent, or a relative, of a child;

(b) has parental responsibilities (within the meaning given by section 1(3) of the Children (Scotland) Act 1995 (c.36)) relating to the child;

(c) is a foster parent with whom a child is placed by a local authority;
or

(d) maintains a foster child (within the meaning of the Foster Children (Scotland) Act 1984 (c.56)),

does not act as a child minder when looking after that child.

(19) For the purposes of subsection (17) above, where a person—

(a) looks after a child for the parents of the child and the work consists of looking after the child wholly or mainly in the parents' home; or

(b) looks after a child for the parents of the child (the "first parents") and another child for the different parents of that other child (the "second parents") and the work consists of looking after the children wholly or mainly in the first parents' home or in the second parents' home, or in both those homes,

that work is not child minding.

(20) "Day care of children" means, subject to subsections (21)(b) to (25) below, a service which consists of any form of care (whether or not provided to any extent in the form of an educational activity), supervised by a responsible person and not excepted from this definition by regulations, provided for children, on premises other than domestic premises, during the day (whether or not it is provided on a regular basis or commences or ends during the hours of daylight).

(21) For the purposes of—

(a) subsection (17) above, a person does not act as a child minder;

(b) subsection (20) above, a person does not provide day care of children,

unless the period, or the total of periods, during which the service is provided exceeds two hours in any day.

(22) Where a person provides a service for children in particular premises on less than six days in any year, that provision is not day care of children for the purposes of subsection (20) above if the person has notified the Commission in writing, before the first occasion on which the service is so provided in that year, of the intention so to provide it.

(23) In subsection (22) above, "year" means the year beginning with the day on which the service is (after the commencement of this section) first

provided in the premises concerned; and thereafter any year beginning with the anniversary of that day.

(24) For the purposes of subsection (20) above, a service which consists of looking after children who are patients in a hospital and is provided as part of the medical treatment which they are receiving there is not day care of children.

(25) For the purposes of subsection (20) above, a person does not provide day care of children where—

(a) the children are of school age;

(b) the service is provided—

(i) wholly or mainly in a public, independent or grant-aided school; and

(ii) as part of the school's activities; and

(c) the person is—

(i) the education authority managing the school

(ii) the person carrying on the school; or

(iii) a person employed to work at the school and authorised to provide the service as part of the school's activities.

(26) Expressions used in subsection (3)(b), (4) or (25) above have the meanings given by section 135(1) of the Education (Scotland) Act 1980 (c.44).

(27) A "housing support service" is a service which provides support, assistance, advice or counselling to a person who has particular needs, with a view to enabling that person to occupy residential accommodation as a sole or main residence; but a service may be excepted from this definition by regulations and such residential accommodation does not include accommodation specified as excepted accommodation in regulations under section 91(9) of the Housing (Scotland) Act 2001 (asp 10).

(28) In this Act, unless the context otherwise requires—

"someone who cares for" (or "a person who cares for") a person, means someone who, being an individual, provides on a regular basis a substantial amount of care for that person, not having contracted to do

so and not doing so for payment or in the course of providing a care service;

“vulnerability or need”, in relation to a person, means vulnerability or need arising by reason of that person—

(a) being affected by infirmity or ageing;

(b) being, or having been, affected by disability, illness or mental disorder;

(c) being, or having been, dependent on alcohol or drugs; or

(d) being of a young age;

“personal care” means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash); and

“personal support” means counselling, or other help, provided as part of a planned programme of care.

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