

19 Domiciliary Care Allowance

- 19.1** Domiciliary care allowance is payable to carers in respect of children under 16 who have a severe disability and who require constant care and attention substantially in excess of that required by another child of the same age. Responsibility for administration of the domiciliary care scheme transferred to the Department of Social Protection (the Department) from the Health Service Executive (HSE) in 2009.
- 19.2** Total expenditure on the scheme was €102 million in 2012. Eligibility for the allowance results in automatic entitlement to the respite care grant, resulting in associated expenditure of a further €45 million. In some cases, there may also be entitlement to carer and other supports.
- 19.3** Administration of the scheme was examined as part of the audit of the Social Protection Vote. The audit reviewed the controls in place for the scheme and examined information on departmental systems. A sample of cases was also examined.

Scheme Structure

- 19.4** To qualify for the full domiciliary care allowance, the claimant must provide care for the child and be habitually resident in the State. In addition, the child must
- have a severe disability that is likely to last for at least one year
 - be under the age of 16 and be ordinarily resident in the State
 - live at home with the claimant for five or more days a week
 - fulfil the medical criteria, which are not based on the type of impairment or disease, but on the extra care and attention needed as a result of lack of function of the body or mind.
- 19.5** The rate of payment is €309.50 per month and the scheme is not means tested. There is no restriction on the number of children in respect of whom the allowance may be claimed. Children who are being cared for on a full time basis in residential homes or other institutions are not eligible for the allowance. However, children in residential care who spend two or more days per week at home may receive a half rate payment.
- 19.6** There is a legal obligation on those in receipt of the allowance to inform the Department of any change in relevant circumstances.

Claimant Profile

- 19.7** The number of children in respect of whom the allowance was paid in 2012 was 26,500 in 24,700 families (see Figure 19.1). 93% of claimants were receiving payment in respect of one child. A further 6% were receiving payments in respect of two children.

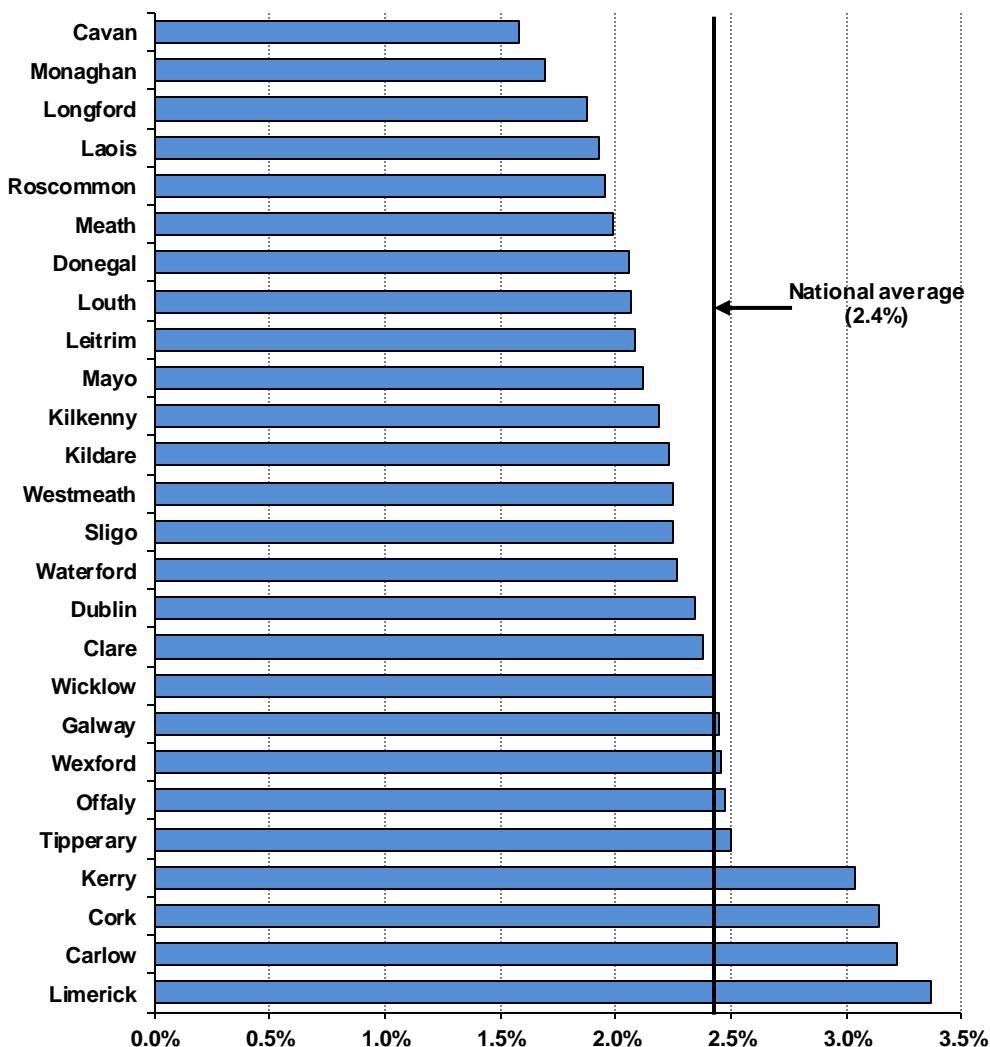
Figure 19.1 Number of families and child beneficiaries, 2009 to 2012

Year	Families	Children
2009	22,945	24,786
2010	23,428	25,234
2011	24,101	25,914
2012	24,699	26,516

Source: Department of Social Protection

19.8 Based on 2011 census data, it is estimated that the allowance is being paid in respect of around 2.4% of children nationally. The percentage exceeds 3% in four counties — Limerick, Carlow, Cork and Kerry (see Figure 19.2).

Figure 19.2 Percentage of children per county in receipt of DCA in 2012



Source: Department of Social Protection and the Central Statistics Office, Census of Population 2011

Scheme Administration

- 19.9** The Department began processing all new applications for the allowance from April 2009. From September 2009, the Department took over responsibility for the 25,000 claims which were in payment with the HSE at that time. The scheme is administered centrally in line with the Department's administration of existing medical based schemes.
- 19.10** An application form is completed by the parent/guardian and by the child's general practitioner. The application together with any additional medical reports or other supporting material is assessed by a departmental medical assessor. This assessment, together with other relevant documentation is examined by a deciding officer, who determines entitlement to payment. The applicant is informed in writing of the decision.
- 19.11** If a claim is refused on medical grounds, a claimant may supply further medical or other evidence and request a review of the decision. There is also provision for the applicant to appeal directly to the Social Welfare Appeals Office and request an oral or summary hearing.

Timeliness of Processing of Claims

- 19.12** At April 2013, the average time taken to process an application was 8 weeks (6 weeks in 2012). Where the claimant appeals a decision, it takes on average 32 weeks to complete all stages of the appeal process.¹
- 19.13** Over the three years to 2012, the average number of applications received each year was 5,000. The first decision in over 60% of cases was to disallow the application. In a number of these disallowed cases, provision of additional information results in the claim being allowed prior to a formal appeal. A high percentage of cases disallowed are appealed with, on average, 2,100 appeals received each year.
- 19.14** In just over 60% of appeals decided in 2012, the original decision was revised either by the Appeals Office, or as a result of a revised decision made by a departmental deciding officer (see Figure 19.3).
- 19.15** At the end of 2012, decisions had yet to be made in 1,113 appeal cases. In the majority of the cases (64%), the Appeals Office was awaiting information from the Department.

¹ Social Welfare Appeals Office Annual Report 2012.

Figure 19.3 Outcome of appeals decided, 2012

Status	Number of cases	
Appeals allowed		
Fully	874	
Partially	29	
Revised decision ^a	625	
	1,528	62%
Appeals disallowed	906	37%
Appeals withdrawn	24	1%
Total	2,458	100%

Source: Annual Report of Social Welfare Appeals Office 2012

Note: a Revised decisions made by deciding officers before the appeals were referred to an appeals officer.

Take On Controls

- 19.16** Entitlement is verified at application stage by means of checks of age, medical criteria, living arrangements and residency. Checks are also carried out to ensure the person claiming the allowance is resident in the State and providing the care.
- 19.17** For a sample of 25 claimants who applied during 2012, the audit found evidence that the required checks were completed in all cases.

Review of Claims in Payment

- 19.18** The review policy for claims put into payment by the Department involves reviewing the case on a date recommended by the medical assessor. In some cases, the medical assessor recommends that the case does not require review. A review process for cases transferred from the HSE has not been put in place.
- 19.19** A claim review involves the completion of a report by the parent/guardian explaining the current care being provided as well as an up to date medical report from the child's general practitioner. A departmental medical assessor reviews the information returned and provides an opinion on the child's continued eligibility. That opinion and a review of the other qualifying conditions are considered by a deciding officer to establish if a revised decision is warranted.
- 19.20** In June 2012, the Minister for Social Protection established a scheme review group comprising representatives from the Department, other relevant Departments, and parent/advocacy groups, as well as relevant experts. The terms of reference for the review included the policy objectives and legal provisions underpinning the scheme, and the administrative, medical assessment and appeals processes. Reviews of cases in payment were suspended pending the outcome of the scheme review. The group reported to the Minister in December 2012 and the report was published in April 2013. The review group's recommendations are set out in Annex A. The recommendations were brought to Government in April 2013 and it was agreed that the Department should implement the administrative changes recommended, with the policy recommendations to be considered in the context of the Budget.

19.21 The results of the claim reviews conducted for 2010 to 2012 are set out in Figure 19.4. Just over half of the cases reviewed in 2010 and 2011 were found to be no longer entitled to the allowance. Payments in these cases were ceased. Of the 143 reviews completed in 2012 prior to the decision to suspend reviews, 40% were identified as no longer entitled to the allowance. These cases remained in payment.

Figure 19.4 Results of reviews, 2010 to 2012

	2010	2011	2012 ^a
Continued entitlement	80	176	86
No longer entitled	54	224	57
Total number of reviews completed	134	400	143
Decision pending ^b	-	3	363

Source: Department of Social Protection

Notes: a 1,444 scheduled reviews were not carried out in 2012 due to the decision to suspend all reviews.

b Review carried out but awaiting further additional information.

Cases Transferred from the HSE

19.22 In February 2012, the Department reviewed a random sample of 91 cases transferred from the HSE. The purpose of this was to obtain information to assist the Department in developing a review policy for transferred cases. Returns were issued to parents and based on review of the information returned

- 45 were found to have continued eligibility
- 41 (45%) were deemed to be ineligible
- 5 (5%) did not complete the returns and payment was ceased.

19.23 However, further action on the 41 cases considered ineligible was postponed until a review process was put in place for all transferred cases.

19.24 The Department did not receive case files from the HSE for any of the transferred cases. A review as part of this examination of a sample of ten cases found that the Departmental records only contained basic case information. There was little information in relation to eligibility including medical condition and review dates.

Level of Irregular Payment

19.25 To date, the Department has not undertaken a fraud and error survey of the scheme and there is no proposal in the medium term to undertake a survey.

Conclusions and Recommendations

- 19.26** Responsibility for the domiciliary care scheme transferred from the HSE to the Department in 2009. About 70% of the 26,000 cases now in payment were originally processed by the HSE.
- 19.27** The transfer of responsibility for a welfare scheme from one State body to another presents challenges, particularly in ensuring that sufficient evidence to support continuing payment of individual claims is provided. The Department did not receive case files from the HSE and has little information in relation to medical eligibility for the cases transferred.

Recommendation 19.1: The Department should ensure that it obtains appropriate evidence to support the continued payment of cases originally processed by the HSE.

Accounting Officer's Response: Agreed. The cases transferred came with a certification from the HSE that they were all qualified for the allowance as of August 2009. As there were significant variations in the quality and type of data, and as the HSE needed to retain paper files, only electronic data was transferred. As a result, only approximately 50% of transferred cases have a medical condition recorded on the Department's systems. A similar number have a recommended review date. The HSE needs the original case files as it has a continuing responsibility for any query relating to claims processed and administered prior to April 2009. The review programme currently under development, will ensure that over time, the Department holds up to date evidence to confirm ongoing eligibility in all cases.

- 19.28** Medical review of cases is a key control in ensuring on-going eligibility of cases in payment and equity of treatment of persons in similar circumstances. The importance of this control is evident from the fact that reviews of cases processed by the Department since the transfer found that around 50% of cases reviewed were no longer eligible. Medical reviews of cases were suspended in May 2012 following the announcement by the Minister of a review of the scheme. Cases reviewed in 2012 and found to be ineligible remained in payment. No programme of medical reviews for cases transferred from the HSE has been put in place since the Department took over responsibility for the scheme. Review by the Department of a random sample of transferred cases identified that up to 50% could be ineligible. These sample cases remained in payment.

Recommendation 19.2: The Department should ensure that a standard medical review process is put in place for all cases as soon as possible.

Accounting Officer's Response: Agreed. The cases found ineligible in 2012 remained in payment as it was considered that to continue to investigate their entitlement when a review of the scheme had been initiated by the Minister would have been inappropriate and potentially unfair. The full review process was not completed for the potentially ineligible cases identified in the review of a random sample of transferred cases, as it was considered that to do so would have been unfair in the absence of a comprehensive review programme for all transferred cases.

While the risk of overpayments to no longer qualified recipients has always been a concern, the development of a robust and sustainable review policy will ultimately be of benefit to all parties. A review programme will be in place as soon as feasible.

A group has been established to oversee the implementation of the administrative changes recommended in the report of the review group. It is planned to have the system and administrative changes in place by the end of 2013 and to commence claim reviews immediately thereafter. The Accounting Officer stated that despite the suspension of medical reviews, the Department has continued to complete reviews of other aspects of eligibility.

Annex A Domiciliary Care Allowance Review — Report of Review Group, December 2012

Summary of Recommendations

In considering the desired policy and process change, along with areas for future work and research, the review group recommends that;

1. The terminology in use to describe the level of care required to qualify for domiciliary care allowance be retained.
2. Definitions for the words 'substantial' and 'severe' as set out in the medical guidelines form a good basis to assist parents/guardians in their understanding of the type and level of additional care required to qualify.
3. Definitions based on those used in the medical guidelines should be made available and included in all information documents and on the web.
4. (a) The retention of a single payment rate for the Domiciliary Care Allowance scheme.
(b) Acknowledges that this implies the retention of a higher level of care as a requirement to qualify for the allowance and the implications of this when defining the terminology used to describe the required care levels.
5. (a) The use of the new application form, designed as part of the review process.
(b) A review of information guidelines to ensure that parents/guardians are aware of the new application form and the benefit of providing succinct information on their child's care needs.
6. (a) The supplementary form to provide additional medical and care detail for children with pervasive developmental disorders is made available for completion by the relevant medical experts.
(b) This form should be completed and submitted with claims for Domiciliary Care Allowance where the child has a pervasive developmental disorder.
(c) The specific form should be made available through Citizens Information Centres and other information providers and should also be available on the web.
(d) Where the form is not submitted, the parent/guardian will be afforded an opportunity to supply this evidence prior to an unfavourable opinion being formed.
7. Additional information on opinions is provided by medical assessors (the newly designed form will assist with this) and that any case which has been subject to a case conference and/or consultation with other professionals should be noted accordingly.
8. That further cross agency work is undertaken, led by the National Disability Authority to research the potential use of care assessment tools, to determine their usefulness in an Irish context.
9. (a) That further research is undertaken in order to establish the suitability of such tools in assisting the decision making process, in an Irish context.
(b) Assuming a suitable tool is found, then a trial might be undertaken to determine the similarity of outcomes when using real cases.
(c) The desirability of implementing a care assessment tool will be informed by the results obtained from testing the new medical forms.
10. That minor changes are required to the medical guidelines and recommends that these are made and that the revised guidelines are published promptly.

11. The lists which detail the conditions that are more or less likely to qualify, are removed from use and not referred to in any guidelines for use in the assessment process.
12. That the Centre for Disease Control (CDC) age of attainment data be used for attainment comparison purposes on children aged 0 to 18.
13. That as much information as possible is provided to parents/guardians along with, or as part of the decision on their claim, including in the case of pervasive developmental disorders the medical report completed by the medical assessors.
14. That the Department explore the feasibility of putting in place a multi-disciplinary panel, comprising professionals working in the area of children's disability that can be consulted by medical assessors to support them in forming their opinions.
15. (a) A review policy is an appropriate and necessary part of the management of the scheme.
 - (b) Most claims will have review dates set for a three or five year interval but it is acknowledged that it may be appropriate to review some claims in a shorter/longer time frame.
 - (c) Some claims will continue to be classified as 'do not review' due to the severity of the child's condition and its expected duration.
 - (d) The improvements implemented in relation to notice of review dates and advance notice of review should continue to operate.
 - (e) Parents/guardians receive an additional communication from the deciding officer to give them an opportunity to provide additional information before the review decision is made (21 day notice) in cases where the deciding officer is considering terminating payment.
16. (a) The full reason for a revised decision on appeal, positive or negative, should be provided to parents/guardians and deciding officers to allow for an understanding of how the revised decision was arrived at, as this information will inform the decision process.
 - (b) The Social Welfare Appeals Office (SWAO) should be briefed on the changes being introduced to the scheme administration.
 - (c) The most helpful way of providing the required information on decisions may be in the form of a template document.
17. A redesign of communications on the domiciliary care allowance scheme to ensure that parents/guardians have timely access to information, clarity on the process and full information on all decisions made on their claims.
 - (a) Clear definitions on the level of care required in order to qualify for domiciliary care allowance be included in all information on the scheme.
 - (b) Decision letters should be reviewed to include as much information as possible on the decision reason.
 - (c) Wording of communications should be reviewed with better use to be made of empathetic language
 - (d) Use should be made of the Department internet site to make all relevant information available, including clear definitions on terminology in use.
18. The link between domiciliary care allowance and carer's allowance should be removed, with the required legislative change to be made to decouple the allowances. This will eliminate the automatic medical exemption for carer's allowance for future domiciliary care allowance applicants.

19. Legislation should provide that the withdrawal of domiciliary care allowance on review should not lead to the immediate withdrawal of carer's allowance, with a recommendation that the carer's allowance continues in payment for a maximum defined period (possibly 6 months), subject to continuing to fulfil all other conditions.
20. The payment of domiciliary care allowance continue to age 18 years and change the commencement age for disability allowance should be changed to 18 years, as this would be a positive development for children and their families alike.
21. (a) In the event of increasing the domiciliary care allowance age to 18, it is also recommended that information on all available options should be communicated to the people concerned at age 17, giving them sufficient time to prepare for transition from domiciliary care allowance.

(b) Over time the range of training and activation measures available for people with disability should be developed and targeted at this customer cohort.
22. A process will be developed and put in place to monitor the implementation of the recommendations from the report, with
 - (a) an implementation plan to be developed following acceptance of the report by the Minister and,
 - (b) a group to be convened (with representatives from the main agencies and representative groups) some 3 months after the Minister approves the report, to receive an update on the implementation plan and progress made.