NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Home care for older people

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for home care for older people. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Home care NICE guideline NG21 (2015).

No review schedule presented.

2 Overview[1]

2.1 Focus of quality standard

This quality standard will cover home care for older people living at home assessed as needing social care support. While almost 80% of people using home care are over 65, the quality standard may also be relevant to some people under 65 such as those with early-onset dementia. The quality standard will not cover home care for younger adults or children using home care services.

2.2 Definition

Home care is one of several services that can be offered to people assessed as needing social care support. Home care usually includes support with personal care, activities of daily living and essential domestic tasks. This support can help people to stay independent and to take part in social and other activities. Home care is primarily funded by local authorities or the person themselves, but may also be funded by healthcare commissioners. Home care services are provided by independent home care agencies, local authorities and personal assistants.

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[1] Unless otherwise referenced, sections 2.2 to 2.4 are adapted from NICE guideline NG21 Home care (2015)

2.3 Incidence and prevalence

In 2013-14 around 372,000 people over 65 used home care funded by local authorities (79% of total). Despite the rising number of older people in the population the number receiving publicly funded care is decreasing. Within a context of reducing social care budgets, local authorities spent £1.8 billion on home care for older people in 2013-14 (around 20% of total social care expenditure).

Just over two-fifths (46%) of people receiving publicly funded home care get intensive support, defined as ‘more than 10 hours per week including overnight, live-in or 24-hour services’. Eligibility thresholds have risen over recent years and there is evidence that many local authorities now offer home care services only to those who have the highest levels of need.

An estimated 170,000 people fund their own home care and this figure rises to 270,000 when additional activities such as help with housework or shopping are included.

The majority of home care is provided by the independent sector, accounting for 92% of home care contact hours in 2013/14, compared with 81% in 2008/09. In March 2015 there were 8,186 home care agencies in England regulated by the Care Quality Commission. Home care also includes unregulated self-commissioned personal assistants or other home care workers directly employed by people who use services.

2.4 Management

A recent briefing from the UK Homecare Association[2] suggested there is considerable regional variation in the rates paid per hour by local authorities for home care. The report suggests that low prices paid for home care services carry a number of risks including poor terms and conditions for the workforce, insufficient resources to organise the service and insufficient training for the complex work that supports the increasingly frail and disabled people who qualify for state-funded support.

A number of recent reports have identified concerns about the quality, reliability and consistency of home care services. A themed inspection of home care by the Care Quality Commission (Not just a number: review of home care services) found that 26% of inspected services did not meet all the standards in question. The report identified important areas of improvement in a significant minority of agencies as follows:

- respecting and involving people who use services, and their carers
- care and welfare of people who use services

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[2] A Minimum Price for Homecare. UK Homecare Association 2015

- safeguarding people who use services from abuse
- providers' support for their staff
- how providers assess and monitor the quality of services they provide.

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** ***Outcome measures*** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those which are attributable to adult social care *Placeholder 2F Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life***

3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure *Placeholder 4C Proportion of completed safeguarding referrals where people report they feel safe*
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with dementia** *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*,*** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital*
4 Ensuring that people have a positive experience of care	**Improving the experience of care for people at the end of their lives** 4.6 Bereaved carers' views on the quality of care in the last 3 months of life **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Improvement areas*** **Reducing the incidence of avoidable harm** *5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers*
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	**Objectives and indicators**
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.18 Social isolation*
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.23 Self-reported well-being 2.24 Injuries due to falls in people aged 65 and over
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.13 Health-related quality of life for older people 4.14 Hip fractures in people aged 65 and over 4.15 Excess winter deaths
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 14 stakeholders responded to the 2-week engagement exercise 23/09/2015 – 08/10/2015. Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee. Full details of all the suggestions provided are given in appendix 2 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	**Stakeholders**
Providing information	HBF, SCM6
Planning and reviewing home care	
• Involving the person using services and their carers	HBD, HBF, RDSH, SCM5, SCM3
• Identifying support needs	SCM5, SCM6, AS
• Fire risk assessment	LFEPA
Delivering home care	
• Length of visits	HBD, SCM1, SCM2, HBF, AS, PU, SCM5
• Continuity of care workers	HBD, SCM5, HBF, RDSH
• Reliability - missed or late visits	HBD, SCM2
Supporting home care workers	
• Supervision of home care workers	SCM2, SCM6
• Safeguarding	SCM3
Co-ordination of care	
• Co-ordination/care co-ordinator	SCM3, RDSH, SCM6, SCM1, SCM2, AS
• Care diary	SCM1, SCM2
Additional areas	
• Skills and training	HBD, SCM2, SCM3, SCM4, AS, SCM5, PU, RCP
• Medicines management	PU
• Home care funding	SCM3
• Career pathways for home care workers	SCM4
• No lift policies	DCCG
• Carer assessments	PU
AS, Alzheimer's Society DCCG, Devon Clinical Commissioning Group HBD, Healthwatch Bradford and District HBF, Healthwatch Bracknell Forest LFEPA, London Fire and Emergency Planning Authority PU, Parkinson's UK RCP, Royal College of Psychiatrists RDSH, Rotherham Doncaster and South Humber NHS FT SCM, Specialist Committee Member	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 622 papers were identified related to home care. In addition, 8 papers were suggested by stakeholders at topic engagement and 10 papers internally at project scoping.

Of these papers, 14 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Providing information about care and support options

4.1.1 Summary of suggestions

There was a concern that information about care and support options is not accessible, particularly to frail elderly people who are housebound. In addition, it was felt that the information that is available to self-funders is not sufficient to help them to make informed decisions based on the quality of providers.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Information about care and support options	**Providing information about care and support options** NICE NG21 Recommendations 1.2.1 and 1.2.5

Providing information about care and support options

<u>NICE NG21 – Recommendation 1.2.1 [Adapted]</u>

Give people who use or who are planning to use home care services and their carers details of:

- Where to find information about the range and quality of services available (for example, the Care Quality Commission ratings), the activities they offer and how much they cost.

<u>NICE NG21 – Recommendation 1.2.5</u>

Tailor all information for different audiences to ensure it is accessible and understandable. Ensure information is:

- easy to read and in plain English
- available in the person's language if needed
- available in different formats and media (including, for example, information packs, telephone hotlines and electronic media)

- advertised or made available in different locations, such as community centres, GP surgeries and pharmacies, as well as through face to face meetings with a social care practitioner
- provided in formats that suit people with different communication or capacity needs, for example, large print, braille or audio versions.

4.1.3 Current UK practice

Research with people using home care[3] carried out to inform the Equality and Human Rights Commission (EHRC) inquiry into older people and human rights in home care found that respondents were not well-informed about many aspects of their home care. Information was not provided to them at a time and in a form they could fully take in. The right to an assessment of need by the local authority did not appear to be well known. This research was based on a small sample of 40 people who use home care.

A study of adults and older people who self-fund and employ their own care and support workers[4] found that although there is a wealth of information available online about organising and managing adult social care it can be difficult to find and is almost always online. It also tends to be directed at Direct Payment recipients rather than self-funders.

The Care Act 2014 includes new duties for local authorities to establish an accessible information and advice service for people in the area who need care and support.

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[3] Older people's experiences of home care in England Equality and Human Rights Commission 2011

[4] The workforce implications of adults and older people who self-fund and employ their own care and support workers Skills for Care 2013

4.2 Planning and reviewing home care

4.2.1 Summary of suggestions

Involving the person using services and their carers

Stakeholders highlighted the importance of involving the person using services and their carers (if appropriate) in planning and reviewing the home care service. This will ensure home care is person-centred with a focus on individual needs and priorities to maintain independence. It was emphasised that it is important that the process of involving people in reviewing home care results in action and changes to the home care plan.

Identifying support needs

It was suggested that there is a need to use outcome-based service planning in order to deliver person-centred care. This may include developing a holistic support plan that addresses a person's needs beyond personal care, for example, including home cleanliness and comfort. The support plan may also identify volunteer support to address social isolation. Individual needs may be linked to specific health conditions and therefore it was emphasised that the lead practitioner should have the necessary skills to help people make informed choices about their care, including any specialist support.

Fire risk assessment

It was suggested that a fire risk assessment should be included within the home care plan.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

It is important to note that there is some overlap with recommendations in Older people with social care needs and multiple long term conditions (NG22) and we will be developing a separate quality standard on this topic. The Committee should consider which is the most appropriate quality standard for any potential statements.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Involving the person using services and their carers	**Ensuring care is person centred** NICE NG21 Recommendation 1.1.3 **Planning home care** NICE NG21 Recommendations 1.3.8 and 1.3.13
Identifying support needs	**Planning home care** NICE NG21 Recommendations 1.3.8, 1.3.13 and 1.3.19
Fire risk assessment	**Recruiting and training home care workers** NICE NG21 Recommendation 1.7.6

Ensuring care is person centred

<u>NICE NG21 Recommendation 1.1.3 [Adapted]</u>

Ensure people using home care services and their carers are treated with empathy, courtesy, respect and in a dignified way by:

- involving people and their carers in discussions and decisions about their care and support
- regularly seeking feedback (both positive and negative) about the quality and suitability of care from people using the service, including those who do not have a carer or advocate.

Planning home care

<u>NICE NG21 Recommendation 1.3.8 [Adapted]</u>

Ensure that the named care coordinator and others involved in home care and support planning (in line with the recommendations in ensuring care is person centred):

- understand the principles and importance of involving the person using services, and their carer(s), as appropriate, as an equal partner in specifying the support and services they receive
- know how to work in a way that maximises choice, control, dignity and respect for the person using services
- understand common conditions affecting people using home care services, for example, dementia, diabetes, mental health and neurological conditions, physical and learning disabilities and sensory loss (NICE has produced a range of guidance on these topics and more).
- know about local and national organisations that provide specialist support.

NICE NG21 Recommendation 1.3.13 [Adapted]

Ask people about their aspirations, needs and priorities, as well as what gives them peace of mind, and makes them feel safe and unsafe. Ensure the home care plan:

- empowers the person as much as possible, by recognising what they can and want to do
- explicitly addresses safety, wellbeing, independence and any specialist needs
- is informed by the experience, skills and insight of carers, as appropriate
- addresses the full range of support needed to help the person to live how they choose, including practical support as well as personal care needs (this could include, for example, support to help a person manage their own financial and personal affairs, do their own shopping and cooking, or socialise, or other help depending on the person's needs and preferences)
- describes how success and outcomes will be measured.

NICE NG21 Recommendation 1.3.19

Consider addressing the potential negative effect of social isolation on people's health and wellbeing. Consider involving voluntary sector and community organisations to maintain family and local community links, working with the carer as appropriate.

Recruiting and training home care workers

NICE NG21 Recommendation 1.7.6 [Adapted]

Ensure home care workers have the knowledge and skills needed to perform their duties safely by providing, as part of the full induction and ongoing training package, specific training on:

- identifying and responding to environmental risks.

4.2.3 Current UK practice

Involving the person using services and their carers

The EHRC research[5] concluded that ‘the general picture is of a wider home care system in which older people are not effectively involved: which they do not understand, and which does not often make the extra effort required to involve them in ways tailored to their state of health and other needs.’ Among respondents there was widespread resignation and lack of expectation of being consulted on key matters that affected them. This research was based on a small sample of 40 people who use home care.

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[5] Older people’s experiences of home care in England Equality and Human Rights Commission 2011

The Care Quality Commission (CQC) themed inspection of home care[6] found that nearly half of carers that responded to their questionnaire said they had not been asked about the service for their relative. Larger providers were less likely to involve carers in decisions about care.

Identifying support needs

A small scale qualitative study of older people using council-managed personal budgets for home care[7] indicated that although choice and control over the type and range of tasks, when to receive them and from whom, were important to most of the people interviewed, the level of choice and control they felt they were able to exercise through managed personal budgets was restricted. Choices were severely constrained not only by the low levels of older people's personal budgets and local authority restrictions on what people could use their budget on but also by their lack of knowledge about the amount of their budget. Data from this small study also suggest that review and monitoring procedures may not be as proactive as they could be. The study concluded that more attention is needed to raise older people's awareness of the opportunities available to them to alter their support arrangements.

The CQC inspection of home care found that 28 out of 250 providers failed in the area of care planning. Some of the issues highlighted included: care plans that did not contain enough detail, individual choices and preferences not included, lack of information on how to deal with identified high risk care needs, out of date and poorly maintained care plans and no clear system for monitoring the quality and content of care plans.

Fire risk assessment

Analysis carried out by the London Fire and Emergency Planning Authority[8] found that 119 people died as a result of accidental dwelling fires in the period 2009-11and that 36 of those fatalities were people in receipt of some form of domiciliary care – 31 from a regulated provider and 5 from an informal carer. As a result of this analysis efforts have been made to ensure fire safety guidance is included in training requirements for home care workers.

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[6] Not just a number: Home care inspection programme - National overview Care Quality Commission 2013

[7] Choice and control for older people using home care services: how far have council-manged budgets helped? Rabiee and Glendinning University of York 2014

[8] Fire safety of people in receipt of domiciliary care London Fire and Emergency Planning Authority 2012

4.3 Delivering home care

4.3.1 Summary of suggestions

Length of visits

Stakeholders highlighted the need to ensure that home care visits are long enough to meet the needs of the person using the service and to ensure that care is not rushed and that the person is treated with dignity and respect. There were some suggestions that visits should be a minimum of 30 minutes, although others disagreed that this is always necessary. It was suggested that improved scheduling is needed to give care workers enough time to travel between appointments.

Continuity of care workers

Ensuring continuity of care workers was felt to be a priority for improvement as currently there are often too many care workers delivering care to any one individual. It was suggested that a small team of care workers is needed so that people can get to know their carers and the carers can get to know the individual’s needs. This is particularly important for people with dementia.

Reliability - missed or late visits

There was concern about the potentially serious consequences that can arise if home care visits are delayed or completely missed such as falls, dehydration and health deterioration due to missed medication. It was felt that missed or late visits currently occur more often than they should and there is often inadequate communication which exacerbates the situation.

4.3.2 Selected recommendations from development sources

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee’s discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Length of visits	**Contracting home care** NICE NG21 Recommendations 1.4.1 and 1.4.2 **Delivering person-centred home care** NICE NG21 Recommendation 1.4.4
Continuity of care workers	**Delivering person-centred home care** NICE NG21 Recommendation 1.4.7
Reliability - missed or late visits	**Managing risk associated with missed or late visits** NICE NG21 Recommendations 1.4.10, 1.4.11, 1.4.12 and 1.4.15

Contracting home care

NICE NG21 Recommendation 1.4.1

Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments. They should ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.

NICE NG21 Recommendation 1.4.2

Home care visits shorter than half an hour should be made only if:

- the home care worker is known to the person, and
- the visit is part of a wider package of support, and
- it allows enough time to complete specific, time limited tasks or to check if someone is safe and well.

Delivering person-centred home care

NICE NG21 Recommendation 1.4.4

Ensure home care visits are long enough for home care workers to complete their work without compromising the quality of their work or the dignity of the person, including scheduling sufficient travel time between visits. Take into account that people with cognitive impairments, communication difficulties or sensory loss may need workers to spend more time with them to give them the support they need. Some may need workers to spend more time helping them eat and drink.

NICE NG21 Recommendation 1.4.7

Ensure continuity of care so that the person knows the home care workers and the workers are familiar with how that person likes support to be given, and can readily identify and respond to risks or concerns, by:

- introducing people to new home care workers, and
- building teams of workers around a person and their carer, and
- informing people in advance if staff will be changed and explaining why, and
- working with people to negotiate any changes to their care, for example when visits will be made, and
- recognising that major changes (for example moving from home care to use of personal assistants) can make people feel unsafe.

Managing risk associated with missed or late visits

NICE NG21 Recommendation 1.4.10

Home care workers should avoid missing visits. They should be aware that missing visits can have serious implications for people's health or wellbeing.

NICE NG21 Recommendation 1.4.11

Closely monitor risks associated with missed or late visits and take prompt remedial action. Recognise that people living alone or those who lack capacity may be particularly vulnerable if visits are missed or late.

NICE NG21 Recommendation 1.4.12

Ensure plans are in place for missed visits. These plans could include:

- making arrangements for a family member, carer or neighbour to visit
- giving home care workers contact details for this person
- setting out clearly in the person's risk assessment what should happen if a visit is missed.

NICE NG21 Recommendation 1.4.15

Ensure home care workers contact the person who uses services (or their carer) if they will be late or unable to visit, as well as informing their manager, if appropriate.

4.3.3 Current UK practice

Length of visits

The CQC themed inspection of home care[9] raised concerns about rushed visits and identified examples of rotas that did not allow time for staff to travel between visits meaning that this time was shaved off the time allocated to provide care to people. They concluded that many care workers were frustrated with the way in which they had to work. CQC's 2013-14 annual report[10] expressed concern about "whether 15-minute home visits can truly deliver care and support that is safe, caring, effective and responsive to people's needs".

A UNISON survey of home care workers[11] found that 79.1% of survey respondents reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time.

The UK Home Care Association[12] indicated that "34% of providers reported concerns that their councils required them to undertake personal care in such short visit times that the dignity of service users was at risk, including 6% who were concerned that 'safety could also be compromised'".

The ADASS procurement survey[13] estimated that 75% of councils utilise 15 minute calls with 15% of all visits being that length. 90% of councils indicated that these short visits were for checking on the individual's wellbeing or that they have taken their medication. This survey had a good level of response with 119 out of 150 local authorities responding.

Continuity of care workers

Over a third (36.7%) of home care workers that responded to the UNISON survey reported that they were often allocated different clients affecting care continuity and the ability of clients to form relationships with their care workers.

The CQC inspection of home care found that some providers were failing to meet standards because clients had little choice with regard to the number of new or unfamiliar care workers who arrived at their home. On many occasions they received no advance notice that they would be visited by someone they didn't know. A frequently occurring theme throughout the programme was that people wanted the same care workers who know their preferences, needs and level of independence.

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[9] Not just a number: Home care inspection programme - National overview Care Quality Commission 2013
[10] The state of health care and adult social care in England 2013-14 Care Quality Commission
[11] Time to care: A UNISON report into homecare UNISON 2013
[12] Care is not a commodity UK Home Care Association 2012
[13] ADASS Procurement Survey Report 2014 Association of Directors of Adult Social Services (ADASS)

Reliability - missed or late visits

The CQC themed inspection of home care[14] found that the most common theme that dominated all the standards they checked was that some providers were failing to assess the impact of late or missed calls. They were not monitoring late or missed calls and could provide no evidence of any action taken to improve.

A survey of home care users and their carers carried out by Healthwatch Bradford and District[15] found that almost two-thirds of respondents said care workers are mostly on time, however many respondents raised concerns about rushed visits, unpredictable and variable timings of care and missed visits. A smaller number of people said that visits were sometimes missed completely. A significant number of people said that communication about delayed arrival times or cancelled care visits was poor.

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[14] Not just a number: Home care inspection programme - National overview Care Quality Commission 2013

[15] 'Come on time, slow down and smile' Experiences of older people using home care services in the Bradford District Healthwatch Bradford and District 2015

4.4 Supporting home care workers

4.4.1 Summary of suggestions

Supervision of home care workers

As home care workers are working with vulnerable older people in the community it was suggested that home care workers should have regular supervision including an observation of practice at least once every 3 months. Improving retention of staff was highlighted as a priority to ensure continuity of care is provided.

Safeguarding

It was suggested that more needs to be done to promote a safe environment and absence of abuse.

4.4.2 Selected recommendations from development sources

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Supervision of home care workers	**Managing and supporting home care workers** NICE NG21 Recommendations 1.7.11
Safeguarding	**Ensuring safety and safeguarding people using home care services** NICE NG21 Recommendations 1.6.1, 1.6.2. 1.6.3 **Safety and safeguarding** NICE NG21 Research Recommendation 5

Managing and supporting home care workers

<u>NICE NG21 Recommendation 1.7.11</u>

Supervise workers in a timely, accessible and flexible way, at least every 3 months and ensure an agreed written record of supervision is given to the worker.

Ensuring safety and safeguarding people using home care services

NICE NG21 Recommendation 1.6.1

Ensure there is a written process to follow in the event of a safeguarding concern and ensure that the process is aligned with local authority procedures. The process should include key contacts such as:

- emergency services
- the registered manager of the home care provider
- the local authority vulnerable adults or safeguarding helpline
- other sources of support, for example, the Care Quality Commission, Action on Elder Abuse, the local Healthwatch.

NICE NG21 Recommendation 1.6.2

Ensure home care workers are aware of the process.

NICE NG21 Recommendation 1.6.3

Build a culture in which reporting of safety and abuse concerns is understood as a marker of good care, not just as a negative outcome of poor care. Build such a culture by, for example:

- stating explicitly, as part of induction training, that safeguarding alerts are part of delivering a responsible home care service and that home care workers play a vital role in helping to safeguard a person using services, and
- providing case studies that demonstrate the far‑reaching effects of not acting on safeguarding concerns.

Safety and safeguarding

NICE NG21 research recommendation 5

What safeguarding practices are most effective in improving outcomes for people using services?

Why it is important

The Guideline Committee identified variation in organisational attitudes to, and perceptions of, risk in both provider and commissioner organisations. The review found a lack of evidence on the impact of different safeguarding practices on organisational culture, service delivery and outcomes. Studies of comparative design are needed to evaluate the effectiveness of different approaches to safeguarding in maintaining safety and wellbeing of service users and their carers. Analysis of routine monitoring data, for example from service audits, could illustrate how standards are being met by providers. Surveys and qualitative studies are needed to ascertain the views of older people, and their experiences in respect of safety and safeguarding practice.

4.4.3 Current UK practice

Supervision of home care workers

The CQC home care inspection report[16] concluded that staff meetings, development, appraisal and supervision are crucial given the increasing complexity of needs of people receiving home care but they are not happening consistently across services. Many staff felt they could be better supported.

Safeguarding

The majority of home care workers that responded to the UNISON survey[17] indicated that they had a clearly defined way of reporting concerns about their clients' wellbeing but 52.3% indicated that these concerns were only sometimes acted on.

CQC concluded that "most agencies had clear processes for recording safeguarding concerns to allow these alerts to be tracked and monitored, which ensures the necessary actions had taken place."

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[16] Not just a number: Home care inspection programme - National overview Care Quality Commission 2013

[17] Time to care: A UNISON report into homecare UNISON 2013

4.5 Co-ordination of care

4.5.1 Summary of suggestions

Co-ordination/care co-ordinator

Stakeholders suggested that improved co-ordination of care when several health and care services are providing care is important. A specific suggestion was made to appoint a named care co-ordinator when an individual is supported by a range of different services including home care. This will improve communication within the multi-disciplinary team and ensure problems are avoided.

Care diary

It was suggested that the co-ordination of care would be improved if all those involved in providing care contributed to a single care diary. This will provide an accurate record of all care received and will support the integration of health and social care services.

4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

It is important to note that there is some overlap with recommendations in Older people with social care needs and multiple long term conditions (NG22) and we will be developing a separate quality standard on this topic. The Committee should consider which is the most appropriate quality standard for any potential statements.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	**Selected source guidance recommendations**
Co-ordination and care co-ordinator	**Coordinating home care** NICE NG21 Recommendation 1.3.6
Care diary	**Access to and review of home care plans** NICE NG21 Recommendations 1.3.22, 1.3.23 and 1.3.24

Coordinating home care

NICE NG21 Recommendation 1.3.6

Consider identifying a named care coordinator from among the people involved in delivering care to:

- lead home care planning and coordinate care
- ensure everyone involved in delivering care and support knows what they should be providing and when
- ensure everyone involved in delivering care and support is communicating regularly.

Access to and review of home care plans

NICE NG21 Recommendation 1.3.22

Ensure a 'care diary' (or 'care record') is kept in the person's home. This is a detailed day‑to‑day log of all the care and support provided, which also highlights the person's needs, preferences and experiences. Offer the person a copy of it.

NICE NG21 Recommendation 1.3.23

Home care workers should ensure the care diary completed routinely on each visit is detailed enough to keep people, their carers and practitioners fully informed about what has been provided. Record any incidents or changes. Read new entries if you have not seen the person recently.

NICE NG21 Recommendation 1.3.24

Ensure all people involved in providing care and support have access to the home care plan and to the care diary. Encourage them to read and contribute to both documents, as appropriate.

4.5.3 Current UK practice

Care co-ordinator

No published studies on current practice were found for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Care diary

No published studies on current practice were found for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 18th November 2015.

Skills and training

Stakeholders were concerned that some home care workers lack the basic skills required to deliver person-centred care such as communication, hygiene, and food preparation. It was felt that basic training and professional registration are required to improve standards and increase public confidence. It was also highlighted that home care workers should have an understanding of common health conditions as this will improve the standard of care delivered and support people to stay at home as long as possible. Quality statements on staff training and competency are not usually included in quality standards.

Medicines management

It was suggested that it should be a priority to ensure medicines management protocols are included in the home care plan and in particular, confirmation of the timing of when medication is administered. This will be covered by a separate quality standard on ‘Medicines management: managing the use of medicines in community settings for people receiving social care’.

Home care funding

It was suggested that the low rates paid for home care by local authorities’ results in low pay rates for home care workers which in turn contributes to poor quality of home care. Reinvestment was felt to be needed in order to provide co-ordinated care to individuals in their own homes. Funding issues are not usually addressed with NICE quality standards and are not covered within the development source (NICE NG21).

Career pathways for home care workers

A stakeholder suggested that the development of career pathways for home care workers would help to overcome existing problems with staff retention and recruitment. Workforce structure is not usually addressed with NICE quality standards and is not covered within the development source (NICE NG21).

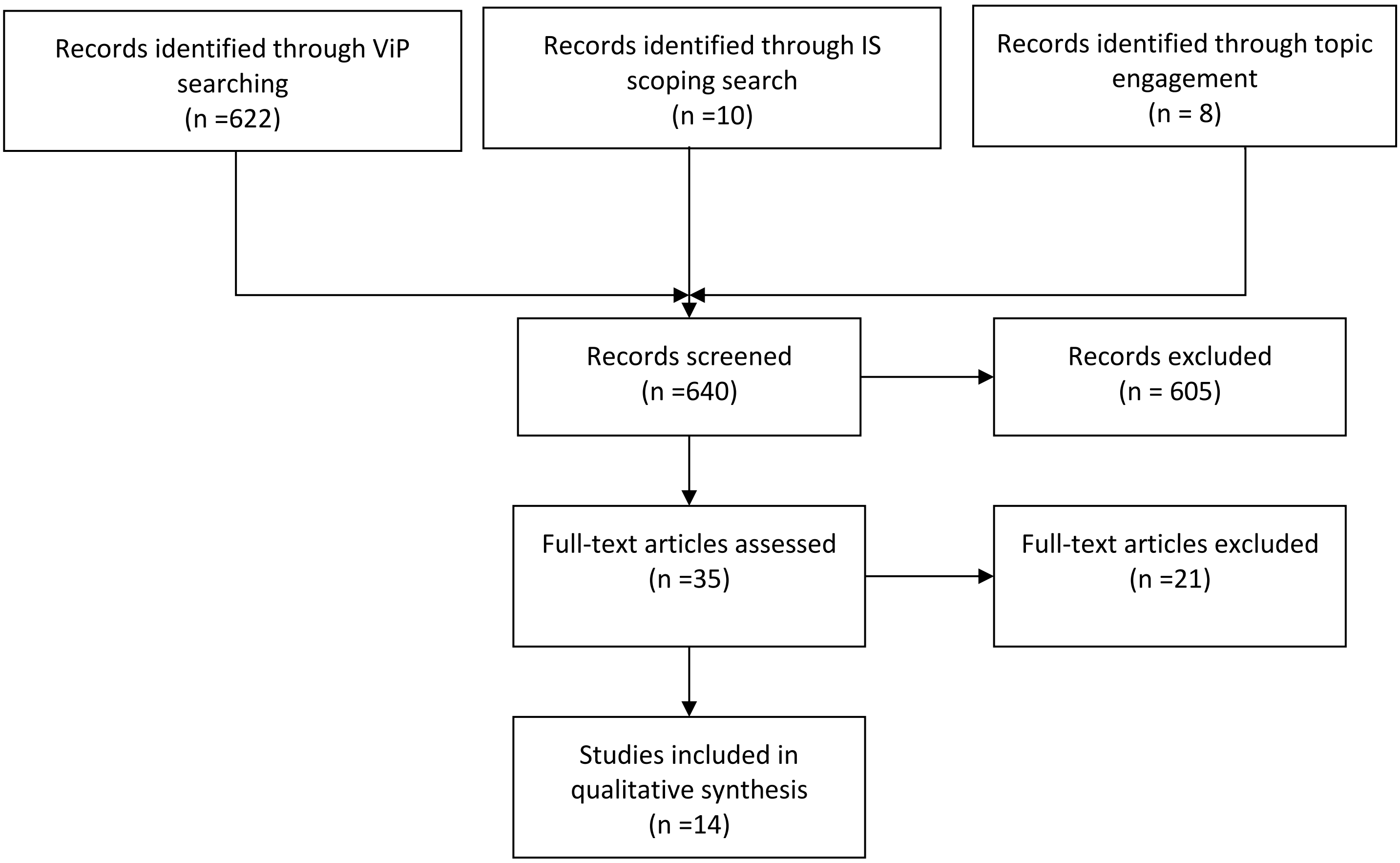
No lift policies

It was suggested that some home care providers have a ‘no lift’ policy which prevents carers from helping someone up after a non-injury fall. Instead they call 999 and the person may have to stay on the floor for some time before the ambulance arrives if the call is not prioritised as urgent. It was suggested that this is contrary to advice from the Health and Safety Executive. This area is not covered within the development source (NICE NG21).

Carer assessments

In order to support carers’ wellbeing it was suggested that carer assessments should be carried out regularly in accordance with the requirements of the Care Act. NICE quality standards will not usually address issues that are a legal requirement and the needs of carers will be addressed by other quality standards.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
01	4.1	Healthwatch Bracknell Forest	Providing information about care and support options	Without information an informed choice is not possible.	See supporting information.	“There is a lack of access to information unless a person/carer has direct contact with council services or is able bodied enough to go to libraries / use technology etc. Many frail housebound elderly- are unable to do this.” Family Carer. “Lack of information accessibility for frail elderly housebound needs to be addressed. When not eligible for council funding, it was basically 'here's a list of providers, we can't offer any advice as to who is a good provider'. Any monitoring by government bodies only provides a snap shot of a particular care agency, so is not really helpful”. Family Carer.
02	4.1	SCM6	Information about care and support	Because it remains very hard to access good quality information about care and support	LA cuts have meant that the requirements in the Care Act to provide proper, useful, accessible information to service users are not being met. The social care system remains fragmented and bewildering to many service users, especially older ones.	
03	4.2	Healthwatch Bradford and District	**Service Provider and Involvement of Service User-**	Overall support and effectiveness from the service generally received positive	There is a need to involve service users and families in reviewing needs, preferences and plans. We heard examples	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report,

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				commentary. There was some reference made to bad organisation and communication with some agencies.	of when cultural preferences and gender preferences were ignored. Our report recommends that service user experience is at the centre of planning, delivering, reviewing and improving home care.	"Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement.

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
04	4.2	Healthwatch Bracknell Forest	Acting on feedback / complains process	Collecting feedback from client is important, but more importantly is acting on this.	This is fundamental to ensuring that care is person centred and therefore good quality for that individual. Build agreed changes into the care plan to ensure that all know.	“Even when feedback from client is given a short improvement can be seen then quality lapses, it is very, very stressful, feeling one has to (politely) complain to agency to get even temporary improvements.” Family Carer. “Making a complaint is very stressful as it normally concerns the way the systems management operates. The carers themselves are brilliant” Family Carer. “Ensure complaints are readily accessible to be read. Paper form as well as electronically may improve the way care agencies operate.” Family Carer
05	4.2	Healthwatch Bracknell Forest	Include nominated primary family member / carer in process if applicable.	The guidance talks about ensuring health and social care practitioners working in primary and secondary care liaise with home care workers to provide integrated, person centred support, it does not mention including family members / carers in the process.	If the person agrees, in the instances where family are carrying out a lot of the support they should be included in the same way to ensure person centred support.	“Liaise with primary family carers. We need to be in the loop too!” Family Carer.
06	4.2	Rotherham Doncaster and South Humber	Key area for quality improvement 1 Full engagement with	To promote independence and to focus on what people	To give personalised care	NICE NG 21 Home care: delivering personal care and practical support to older people living in their own homes

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		NHS FT	people who use home care	can or would like to do to maintain independence		

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
07	4.2	SCM5	Key area for quality improvement 1: Ensuring Care is Person Centred; focusing on what people want to be able to achieve	There is good evidence that person centred care if the best way to deliver good quality care that supports the needs and aspirations of the individual, focusing on what they can achieve not what they can't. Person Centred Care is recommended within NICE guidance. The person's needs and wants should be at the centre of the delivery of homecare, they should be consulted at all stages and their views imbedded into ongoing practice. For people with specific needs such as sensory loss, carers should have the skills needed to provide care in a way that is relevant. They may for example need some specific communication training.	Evidence supports the fact that person centred care ensures a person is treated with respect, courtesy and in a dignified manner, with their confidentiality respected (Manthorpe, 2010, +) (CSCI, 2006, +). Person centred care enables a person and where relevant their carer to lead their care and receive care that meets their needs (not the need of the provider). The responsibility for person centred care does not lie exclusively with the provider however and commissioners have a duty under the Care Act to shape a market to ensure a diverse range of high quality support. The Care Act statutory guidance which states: "High quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this." (Care Act Guidance	Please see National Voices systematic reviews on ways to make personal care happen: http://www.nationalvoices.org.uk/evidence Although this is health focused it provides some good evidence on outcomes resulting from the provision of person centred care. In addition see evidence table from NICE Homecare Guidance.

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				There is a role not only for the provider in the delivery of person centred care but also for the commissioner.	paragraph 4.1)	

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
08	4.2	SCM3	Personalisation in care	The Care Act 2014 states that care needs to be delivered in a personalised way however many in the homecare sector are unsure as to what personalisation in homecare really means.	Personalisation and person centred have become common usage when council employees are looking at giving someone a personal budget however personalisation is greater than this. Quality of care is dependent on a true culture of personalisation where the person using services is truly at the centre of their care plan. We need to develop strategies dealing with the potential conflicts that occur when people start to express how they would like to personalise their services and this leads to safeguarding and penalties being levied on people who are only trying to achieved a level of personalisation in their care.	Care Act
09	4.2	SCM5	Key area for quality improvement 4 Ensuring lead practitioners have the necessary skills to help people make informed choices about their care.	NICE Homecare guidance recognises the importance of lead practitioners having the skills to help people to make informed choices about their care and in addition that this information should be provided in a way that	In many local authorities there is a move towards generic practitioners with a reduction in specialist workers. This is causing particularly acute problems for people with sensory loss who are losing the specialists who understand the impact of their impairments and the type of support which can	Vision Rehabilitation Services: what is the evidence, Parvaneh Rabiee, Gillian Parker, Sylvia Bernard and Kate Baxter York University's Social Policy Research Unit (2015). NICE Homecare guidance evidence table.

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				is accessible for the individual. This is likely to mean that the lead practitioner needs a good understanding of common condition effecting older people and how this might affect the care and support they are entitled to; such as specialist support for people who have a dual sensory loss or specialist rehabilitation support for people with sight loss.	help. Research into specialist rehabilitation support for visually impaired people found that: “A key concern among managers and staff in vision rehabilitation services was the impact of financial cuts on their ability to provide responsive and effective services. Cuts put pressure on the numbers and types of staff, waiting times and the type of support provided.” Vision Rehabilitation Services: what is the evidence, Parvaneh Rabiee, Gillian Parker, Sylvia Bernard and Kate Baxter York University's Social Policy Research Unit (2015).	

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
10	4.2	SCM6	Outcome-based service planning and delivery	Because despite over a decade of lip-service being paid to the idea of home care services being individually tailored and evaluated in terms of outcomes, virtually no such services exist in the publicly-funded home care sector.	Because it's hugely overdue; the very first point in the NICE Homecare Guideline says that service should "support the aspirations, goals and priorities of each person, rather than providing 'one size fits all' services" and yet we continually fail to achieve this in homecare, mostly because of the model of commissioning.	Although the Wiltshire Help to Live at Home model has yet to be properly evaluated, the work done would be worth looking at. http://ipc.brookes.ac.uk/publications/pdf/John_Bolton_Outcome_Based_Commissioning_Paper_April_2015.pdf
11	4.2	Alzheimer's Society	Key area for quality improvement 5 **Holistic packages of support** 1.3.3 Ensure home care packages address social care-related quality of life and the person's wider wellbeing (for example home cleanliness and comfort) in addition to practical support.	A YouGov poll for Alzheimer's Society (June 2014) found that 85 per cent of people would want to stay at home for as long as possible if diagnosed with dementia, rather than go into a care or nursing home. However we know that only two thirds of people actually do stay in their own home. The nature of dementia	Good quality home care which incorporates physical, mental and social care is best suited to people with dementia whose needs span all three areas. As experts in the field of dementia Alzheimer's Society believes that we have a duty to demonstrate that there is a way to do things better in dementia care and to lead the way in the provision of a specialist, high quality service that will support people affected by dementia to achieve the outcomes they	**Most people want to stay at home if diagnosed with dementia but less than half know how.** ALZHEIMER'S SOCIETY WITH YOUGOV (June 2014). http://www.alzheimers.org.uk/site/scripts/press_article.php?pressReleaseID=1138

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Recognise that people who use home care services often need support that goes beyond their personal care needs.	means that people may find tasks such as gardening or DIY difficult and as such home care should be able to provide support beyond just basic care. The extent to which a home care worker can support a person with dementia may be limited due to time or capacity. However, volunteers may be able to meet this need and address the gaps in support.	desire and remain living at home. To this end, we are currently designing and evaluating a new model of home care and support which will offer a holistic service for people affected by dementia and an added value service for commissioners. This model of support is called Home Focus and is currently being run as a pilot in the North of England. Within the model, paid staff will deliver all of the registered, personal care services that a commissioner purchases and trained volunteers provide additional specific hours of support. The volunteers deliver 'support' tasks, which may include: arranging GP/hospital appointments, gardening, household chores and helping to develop a healthy eating plan.	

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Volunteers and staff working within the service will also be trained to provide advice on Dementia Friendly Design around the home and to signpost people toward assistive technology, aids and adaptations. It is expected that this will deliver improved outcomes for people affected by dementia and efficiency savings for health and social care services through reducing hospital and care home admissions. The quality standard should promote the use of trained volunteers to support the provision of home care so that people with dementia can have all of their needs met whilst remaining in their own home.	

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
12	4.2	Alzheimer's Society	Key area for quality improvement 4 **Access to voluntary sector services to reduce social isolation** 1.3.19 Consider addressing the potential negative effect of social isolation on people's health and wellbeing. Consider involving voluntary sector and community organisations to maintain family and local community links, working with the carer as appropriate.	Studies have highlighted several personal characteristics which influence whether a person is lonely or not – many of which are common among people with dementia. Living alone (de Jong Gierveld et al, 2011) or living in residential care (The Residents and Relatives Association, 2010) are factors which are associated with loneliness. Poor health (Victor C et al, 2005), reduced mobility (Tijhus MAR et al, 1999) and cognitive impairment (Victor C et al, 2005) all increase in line with an older person's chances of being lonely. One study suggests that the risk of Alzheimer's disease more than doubles in older people experiencing loneliness (Wilson et al, 2007).	The following case study illustrates the impact of isolation and the difference accessing support made. *"Before my husband, Andrew, developed dementia we used to refer to our home as 'the railway station' because there were always people popping in and out. When Andrew's dementia progressed and his behaviour became increasingly unpredictable, friends and neighbours stopped coming around because they felt uncomfortable. People would look at me with pity. I was left alone grieving for the husband I'd lost while he still shared the same house as me. Grief like that isn't socially sanctioned. Sometimes I felt so alone I'd just walk in to another room and scream because I couldn't stand it anymore."* *"When I finally mustered up the courage to speak out and talk openly about Andrew's dementia things got so much better. We've*	**Dementia and loneliness** de Jong Gierveld, J et al (2011). Alleviating loneliness among older adults in Safeguarding the Convoy – A Call to Action, Campaign to End Loneliness. Abingdon: Age UK. The Residents and Relatives Association (2010). Together but alone: isolated older people in care. London: Voluntary Action Islington. Victor, C et al (2005). The prevalence of, and risk factors for loneliness in later life: a survey of older people in Great Britain. Ageing and Society 25 (3). Wilson, RS et al (2007). Loneliness and risk of Alzheimer's disease. Archives of General Psychiatry 64 (2). **Survey of people with dementia regarding loneliness** Alzheimer's Society (2013a). Dementia 2013: The hidden voice of loneliness. London: Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/download.php?fileID=1677 **Survey of population regarding loneliness**

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				A survey of 510 people with dementia, which found 38% of respondents said they are lonely and 12% don't know if they are lonely (Alzheimer's Society, 2013). Comparing the survey for this report with the YouGov public poll, it seems that people with dementia tend to be more lonely than the population as a whole. Among the oldest age group in the public poll – those over 55 – nearly a quarter (24%) said that had felt lonely in the last month. Social isolation also affects carers. It is estimated that there are currently around 670,000 carers of people with dementia in the UK, Their contribution, without which the health and	*formed a dementia friendly community which is all about social inclusion. People no longer see dementia before they see the person living with it. It's given Andrew a renewed sense of purpose as he volunteers at the local school and takes part in regular activities including singing and indoor bowls. Communities have become the families of old – I'm surrounded by a group of people I can reach out to and no longer settle for a life that is just about bearable."* Ann cares for her husband Andrew who has vascular dementia The Alzheimer's Society provide a variety of services that help address social isolation. These include Dementia Advisers Dementia Advisers offer a single point of contact for the person with dementia and the carer at the time of diagnosis and	YouGov Survey Information: Total sample size was 2287 adults. Fieldwork was undertaken between 14 and 16 January 2013. The survey was carried out online. The figures have been weighted and are representative of all UK adults (aged 18+). **Carers Mental health needs** Carers Trust (2013). A Road less rocky – supporting carers of people with dementia. London: Carers Trust. Downs, M, Ariss, S M B, Grant, E, Keady, J, Turner, S, Bryans, M, Wilcock, J, Levin, E, O'Carroll, R and Iliffe, S (2006), 'Family carers' accounts of general practice contacts for their relatives with early signs of dementia', *Dementia*, 5, 3, 353–373. Georges, J, Jansen, S, Jackson, J, Meyrieux, A, Sadowska, A and Selmes, M (2008), 'Alzheimer's disease in real life – the dementia carer's survey', *International Journal of Geriatric Psychiatry*, 23, 5, May, 546–551. O'Shaughnessy, M, Lee, K and Lintern, T

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				care system could not function, can often come at a personal cost to the individual caring for the person with dementia. Caring for a person with dementia is unlike caring for a person with any other condition and many will experience high levels of stress and depression. (Carers Trust, 2013) The emotional impact of caring on the carer changes as the person with dementia's needs evolve, with the greatest difficulties coping faced around diagnosis and end of life. In the early stages of dementia, many carers delay asking for support until their problems have mounted significantly (Downs et al 2006). In the latter stages of	immediately afterward. They provide tailored information, advice and signposting supporting them to navigate a complex web of health and social care services to access appropriate information and support to help plan for the future and self-manage effectively. Information and training for carers The Alzheimer's Society Carer Information and Support Programme (CrISP) improves the knowledge, skills and understanding of those caring for a person with dementia by providing effective support and up-to-date, relevant and evidence-based information. Independent evaluation has shown that the information provided on the CrISP courses supported caring practices and carers' needs, improved their understanding of dementia and its progression and helped them access practical suggestions for	(2010), Changes in the couple relationship in dementia care: spouse carers' experiences', *Dementia: The International Journal of Social Research and Practice*, 9, 2, May, 237–258. **Impact of loneliness** Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Holt-Lunstad J, Smith TB, Layton JB (2010) Social relationships and mortality risk: a meta-analytic review. PLoS Medicine 7(7). http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316 Ong AD, Rothstein JD, Uchino B (2012). Loneliness accentuates age differences in cardiovascular responses to social evaluative threat. Psychology and Aging 27 (1): http://www.ncbi.nlm.nih.gov/pubmed/22004517 Cacioppo JT, Hawkley LC, Berntson GG, Ernst JM, Gibbs AC, Stickgold R, et al. (2002). Do lonely days invade the nights? Potential social modulation of sleep efficiency. Psychological Science 13(4)

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				dementia carers can find themselves caring more than 10 hours a day and become increasingly socially isolated (Georges 2008). Spousal carers who care many hours over an extended period of time can find their sense of self had been subsumed by the role of the carer and they found it difficult to balance their own needs against those of their spouse (O'Shaughnessy 2010). Research has suggested that loneliness can lead to early death (Holt-Lunstadt et al, 2010). It has been shown to produce changes in the body that increase the risk of heart disease (Ong et al, 2012).It is associated with less restorative sleep and	support of the person with dementia. Befriending Side by Side is being piloted at Imperial College Hospital and Worcestershire Acute Trust to ensure people with dementia remain integrated and supported in their communities. The programme pairs volunteers with people with dementia on admission on hospital to support them during their stay and on their discharge home. The support can include help to access services, pursue leisure interests and develop social networks. The forthcoming evaluation of the pilot is expected to show support improves health and wellbeing for people with dementia and reduces unnecessary readmissions to hospital. By addressing social isolation as well as a range of other needs/aspirations, these services complement homecare	40 James BD, Wilson RS, Barnes LL, Bennett DA (2011). Late-life social activity and cognitive decline in old age. Journal of the International Neuropsychological Society 17(6) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206295/ Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. (2007). Loneliness and risk of Alzheimer disease. Archives of General Psychiatry 64(2) http://www.ncbi.nlm.nih.gov/pubmed/17283291 Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Holt-Lunstad J, Smith TB, Layton JB (2010) Social relationships and mortality risk: a meta-analytic review. PLoS Medicine 7(7). http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316 **Dementia Advisers** http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1249 **CrISP**

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				with daytime fatigue (Cacioppo et al, 2002), It can be linked to cognitive decline and dementia in older people (James et al, 2011). There is evidence that socially engaged older people experience less cognitive decline and are less prone to dementia (Wilson et al, 2007). There are a range of voluntary sector services that help reduce isolation and loneliness. These include information/signposting services, befriending, peer support groups, activity groups, projects to support volunteering. However, people affected by dementia don't always know where to turn to access this support. Home care can facilitate this.	and can improve outcomes for people with dementia and their carers. Access to other services is variable, prioritisation in the quality standards will enable people affected by dementia to receive more holistic support. Dementia Friendly Communities There are now over 105 communities working to become dementia friendly and several thousands of businesses and organisations, from local independent traders to national high street retailers all embracing the concept of becoming dementia friendly. The National Dementia Declaration for England (DAA, 2010) identifies that people with dementia want to live in communities that give them choice and control over their lives and provide services and support designed around their needs. Importantly, they want to feel valued, understood and part	http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1710 **Side by Side** http://www.alzheimers.org.uk/sidebyside **Dementia Friendly Communities** http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1843

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					of family, community and civic life. There is still untapped potential in the community to help people with dementia and their carers. Everyone, from governments and health boards to the local corner shop and hairdresser, share part of the responsibility for ensuring that people with dementia feel active, engaged and valued in their local area. By communities becoming dementia friendly this would complement effective home care and enable people with dementia to remain at home for as long as possible.	

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
13	4.2	Parkinson’s UK	**Key area for quality improvement 4** **Incorporation of medicines management protocols in home care plans, particularly timing of when medication is administered.**	Parkinson’s is a condition which requires medication to be taken at very specific times to an individual (maybe up to 5 or 6 times a a day). Missing doses of medication, even by a short period of time, can have a severe, detrimental impact on a person’s condition, which is not possible to recover from. When someone with Parkinson’s doesn’t get their medication at the time prescribed for them, their symptoms become uncontrolled – increasing their care needs considerably. A person may not be able to move, get out of bed or walk down the corridor. Once this balance of chemicals has been upset it may take hours, days or	A 2013 YouGov survey completed by 4,777 people who have either been diagnosed with the condition or are family members or carers of a person with Parkinson’s, found that of those having been in hospital or a care home, 30 per cent reported not receiving their medication on time. These findings demonstrate the scale of the difficulties facing people with Parkinson’s in receiving their medication on time, in all care settings. It is therefore of critical importance that people with Parkinson’s do not face these same difficulties in managing their medication in their own homes, and that the Home Care Quality Standard includes measures to ensure home care staff incorporate medicines management protocols in home care planning.	Parkinson’s UK and YouGov, *Survey of people with Parkinson’s and their friends, family and carers*, 2013 Parkinson’s UK, *Getting Parkinson’s medication on time*, 2012.

ID	Report Section	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				even weeks for a person's Parkinson's to stabilise. A carer of someone with Parkinson's explains: *'Maureen was unable to get her medication at the right times and her health went downhill rapidly. As well as developing problems swallowing, Maureen became rigid, which meant she wasn't able to have physiotherapy to help keep her moving. I can't overstate how crucial it is for people with Parkinson's to get their medication on time.'* We therefore strongly support Home Care Clinical Guideline recommendation 1.3.16 to *'Write any medicines management requirements into the*		

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				home care plan including the importance of dosage and timing, and implications of non-adherence.'		

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14	4.2	London Fire and Emergency Planning Authority	**home care for older people living at home assessed as needing social care support**	due to the prevalence of such individuals in the occurrence of fatal fires and those where injuries were serious enough to require lengthy hospitalisation.		The London Fire Brigade (LFB) have a particular interest in the area of **home care for older people living at home assessed as needing social care support** due to the prevalence of such individuals in the occurrence of fatal fires and those where injuries were serious enough to require lengthy hospitalisation. Our published evidence[18] shows that people with care and support needs arising from physical, mental and cognitive health issues are significantly at risk from fire. As such, we have worked with Skills for Care, the UK Home Care Association (UKHCA), the Care Quality Commission and the Prime Minister's Dementia Challenge Group to raise awareness of these fire risk factors and the means to reduce them.

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[18] Reports:
Fire Safety of People in receipt of Domiciliary Care – FEP 1952
http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=920

Fire Safety for people with Mental Health issues – FEP 2303
http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=3292

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						Our work with Skills For Care led to knowing how to identify and reduce fire risk for people receiving care and support at home being a requirement of the Care Certificate for care staff. We would like to see this developed further so that assessing fire risk as part of the care planning process is covered by the *Quality Standard For Home Care For Older People* as we consider this to be a key area with significant potential to improve the quality of care.

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15	4.3	SCM6	Contracting home care	Because the commissioning of home care is the single biggest determinant of how it looks on the ground.	Because the CQC still doesn't routinely inspect commissioning practice; this has led to woeful standards and poor services.	http://www.communitycare.co.uk/2015/02/12/evidence-warrant-cqc-inspection-local-authorities-says-minister/
16	4.3	SCM1	Visits normally not less than 30 minutes' duration	In order to meet people's needs in an sensitive, unhurried way to preserve their dignity	Many visits are currently commissioned by Local Authorities for less than 30 minutes; risking people's dignity and even safety. Homecare workers have little job satisfaction as they cannot provide care in the way they and the person receiving support want.	Commissioning by "time and task" leads to these inappropriate commissions. Wiltshire has piloted (and other LAs are now developing) an approach which focusses on individual outcomes (what the person wants to achieve) rather than stipulating time and task. This gives more control to the individual and supports close working with the homecare provider, but requires investment.
17	4.3	Healthwatch Bradford and District	**Delivering planned care**	Just over half of the people we spoke to said duties on the care plan are always followed, the remaining respondents felt there was insufficient time and/or carers' approach or skill level resulted in care needs not being met. Medication is a particular issue for some people.	Carer workers under too much pressure unable to deliver planned care, forced to miss tasks and cut corners. Some safeguarding issues relating to medication and personal care. Sometimes the lack of time was compounded by a poor level of worker skill.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement

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18	4.3	SCM2	**Length / duration of calls**	Care that is delivered in timeslots of less than 30 minutes is likely to be rushed and is unlikely to be delivered in a manner which supports the dignity and wellbeing of an older person. In addition it mediates against building up a relationship with the older person and is unlikely to reduce loneliness and social isolation.	Practice in specified length of calls varies considerably between commissioners and care companies e.g. some companies do not allow adequate time for travel between calls. Daily Mail (23/9/15) *Freedom of Information figures published in the Daily Telegraph in February showed rising numbers of appointments were taking place in a matter of minutes. Eight councils provided more than 593,000 care visits lasting five minutes or less in the three years from 2010/11 to 2012/13. Previous research in December from Unison found three-quarters of councils commission 15-minute visits.* Action: Monitoring and auditing lengths of visits.	NICE guideline recommends that visits of less than 30 mins should only be used as part of a wider package of support. (1.4.1)
19	4.3	Healthwatch Bracknell Forest	Delivering home care	Strengthening the support and processes for visiting care to enable them to carry out their job more efficiently.	It will enable more time to be spent with clients.	“Though self-funding, agency carers frequently tell us: 1 - They are not given enough time to drive from a-b and are therefore late 2 - Frequently require carers to double back on themselves to get to next client.

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				15 mins visits can work	Imposing a minimum time limit may have the opposite affect and mean less care.	Care agency systems do not appear to follow any logistics. Given our experience there is no indication that enough time is given to travel between clients or is this because we self-fund?” Family Carer. “We’ve had 15 mins care agency 'pop in visits' at tea time this gave enough time to make a sandwich and check she was o.k. 15 mins gives enough time to micro wave a pre prepared meal and IMPORTANTLY check mum is o.k. These visits work and are vital as the client prefers the face-to-face visit instead of telecare.” Family Carer.

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20	4.3	Alzheimer's Society	Key area for quality improvement 3 **30 minute home care visits** 1.4.1 Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments. They should ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.	There are around 850,000 people in the UK living with dementia (Prince et al, 2014), with over 42,000 developing the condition before they reach 65. It is believed that more than a third of people with dementia receive personal care from homecare workers, which would equate to about 300,000 people (Alzheimer's Society, 2014). Homecare providers estimate that some 60% of people using their service have some form of dementia (UKHCA, 2013), many of whom do not have a formal diagnosis. Nearly all people living with dementia will require care and support from both the NHS and social care system as a result of	From 2010-11 to 2014-15, adult social care budgets reduced by 31 per cent or £4.6 billion in real terms (ADASS, 2015). This year, adult social care budgets will be reduced by a further £0.5 billion. This has resulted in 400,000 fewer people receiving social care services since 2009-10 and, of those who are still supported, a significant number receive less care (ADASS, 2015). The repercussions of not being able to access good quality dementia care locally can be dire, not only for people with dementia but for the health economy. Between 2008/9 to 2012/13 the proportion of people with dementia admitted to hospital in an emergency increased by 48 per cent (Public Health England 2015). We know that people with dementia who go into hospital often stay too long and leave in worse health then when they were admitted (Alzheimer's Society 2009). The lack of accessible community care has meant that the number of people who do	**Prevalence rate:** Prince M, Knapp M, et al (2014). Dementia UK: Update. London: Alzheimer's Society http://www.alzheimers.org.uk/dementiauk **Numbers of people receiving homecare in community** Alzheimer's Society (2014a). Dementia 2014: Opportunity for change. London: Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2317 **Percentage of people receiving home care who have dementia; length of home care appointments** UK Homecare Association (2013). UKHCA Dementia Strategy and Plan, February 2013. Wallington: UK Homecare Association. http://www.ukhca.co.uk/pdfs/UKHCADementiaStrategy201202final.pdf **Dementia and co-morbidities:** Alzheimer's Society (2015). Dementia 2015: Aiming higher to transform lives. London: Alzheimer's Society. http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2700

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				dementia's combination of features of chronic neurological disease, mental illness and physical frailty that cross the boundaries of the health and social care system. In addition, Research indicates that around 70% of people with dementia live with up to six co-morbidities, (Alzheimer's Society, 2015). Characteristics of dementia can include forgetfulness, disorientation, anxiety and difficulties communicating. To provide high quality care that addresses the person's day-to-day needs and aspirations, but is also sensitive to the additional complexities that characterise dementia, requires a minimum of 30 minute home care appointments.	not return home following a stay in hospital has more than doubled between 2011 and 2013/14 (Alzheimer's Society, 2015). The cost for extended stays in hospital and early entry to a care home are significant. The annual impact on the NHS of unnecessary hospital bed days for people with dementia are estimated by CHKS as £265 million (CHKS, 2013), whilst it is estimated that £55 million could be saved across England, Wales and Northern Ireland if just 5 per cent of admissions to residential care were delayed by one year (Alzheimer's Society, 2013). 85% of people with dementia want to remain in their own home, yet it is believed that only two thirds of people with dementia do so. Inaccessible or inappropriate home care can cause avoidable hospital admissions, delayed discharge from hospital and early entry to a care home. One survey (UKHCA, 2013) reported that 16% of visits lasted only 15	**Cuts to social care budgets** ADASS 2015, ADASS Budget Survey 2015, http://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/resources/Key_documents/ADASS%20Budget%20Survey%202015%20Report%20FINAL.pdf **Rise in emergency Hospital admissions:** Public Health England, 2015, Reasons why people with dementia are admitted to a general hospital in an emergency, http://www.yhpho.org.uk/resource/view.aspx?RID=207311 **Effect of hospital stays on people with dementia's health:** Alzheimer's Society (2009). Counting the cost: Caring for people with dementia on hospital wards. London: Alzheimer's Society. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=787 **Cost of unnecessary bed days:** CHKS (2013). Insight report: An economic analysis of the excess costs for acute care for patients with dementia http://www.chks.co.uk/userfiles/files/Dem

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					minutes, while the results of a request made under the Freedom of Information Act in February 2015 showed that from 2010/11 to 2012/13, eight councils provided more than 593,000 care visits to pensioners lasting just five minutes or less (the Telegraph, 2015). This is clearly completely inappropriate for providing good care to someone who has a complex range of needs and might be confused or anxious. A quality standard to ensure service contracts allow home care workers enough time to provide a good quality service is essential to improve practice in this area.	entia_an_economic_analysis.pdf **Early entry to care home cost** Alzheimer's Society (2013a). Dementia 2013: The hidden voice of loneliness. London: Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/download.php?fileID=1677

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21	4.3	Parkinson's UK	Key area for quality improvement 1 **Person-centred home care planning and the proliferation of 15 minute care appointments**	Parkinson's is an extremely complex, progressive condition with over 40 motor and non-motor symptoms. Everyone with Parkinson's is different but symptoms include sudden freezing, tremor, muscle rigidity and slowness of movement, or less visible issues such as pain, fatigue and anxiety. Fluctuations can mean people have better days, or better hours. Treatment can also cause side effects and fluctuation. Everyone with Parkinson's is individual and statements on "average" progression are therefore unhelpful. Given that Parkinson's is such an unpredictable condition, we feel that	Given the progressive nature of the condition, people with Parkinson's require increasing social care support in order to prevent or mitigate the impact of their condition as it develops. Research commissioned by Parkinson's UK emphasised the importance of timely access to social care and receiving the full time allocated to them. The research also identified many cases of care workers only staying for five minutes when they were allocated a longer slot. This same research also emphasised the importance of an 'anticipatory approach' to social care, which increases in step with a person's growing needs. Fixed appointments of only 15 minutes or less, mean that it is not possible to meet a person's developing needs in such a short timeframe, nor will care workers spend sufficient time	Leonard Cheshire Disability - *'Ending 15 Minute Care'* - McDonnell, A et al (2014), 'Putting people with Parkinson's in control: exploring the impact of quality social care' Sheffield Hallam University Centre for Health and Social Care Research, available at: http://shura.shu.ac.uk/7965/

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				improvements are required in care planning, particularly with regard to the provision of home care appointments, as slots of 15 minutes or less are never appropriate in the case of personal care for someone with Parkinson's. In order for people with Parkinson's to feel adequately supported and able to maintain their independence, care appointments should also be scheduled, as far as possible, according to the daily routine of the person, not at the convenience of the home care agency. For these reasons, Parkinson's UK strongly supports the Home Care Clinical Guideline recommendation 1.4.4	with the person to understand when their needs are no-longer being met. Evidence by Leonard Cheshire Disability demonstrates that short care appointments are becoming more frequent, with 60% of local authorities now commissioning 15-minute visits. For these reasons, Parkinson's UK feels that a focus on person-centred care planning and appointment times of appropriate length should be included as a focus of quality improvement within the Home Care Quality Standard.	

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				that: *‘Home care visits are long enough for home care workers to complete their work without compromising the quality of their work or the dignity of the person, including scheduling sufficient travel time between visits. Take into account that people with cognitive impairments, communication difficulties or sensory loss may need workers to spend more time with them to give them the support they need. Some may need workers to spend more time helping them eat and drink.’*		

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22	4.3	SCM5	Key area for quality improvement 2: Delivering Homecare in a way which ensures home care visits are long enough to meet the needs of the client, taking into account individuals needs such as sensory impairment which may mean they need more time.	There is good evidence that recipients of homecare benefit from longer visits which allow time for flexibility, and care that meets their specific needs. People often report feeling rushed or that they don't get enough time to get the emotional support they require alongside there practical support. For people with sensory loss, short visits often mean that effective communication cannot be put in place, so it is crucial that visits lengths take into account the additional time needed to develop a strong communication relationship. The importance of ensuring service contracts allow home care workers enough time to provide a good	Short home care visits have long been reported as an issue in the delivery of good quality home care, practice in these areas varies from commissioner to commissioner and provider to provider. With a move towards person centred and outcome focused care it is important that homecare visits are timed in a way that supports this. Evidence gathered for the development of the NICE Homecare guidance found that older people felt that short time slots compromised the quality and scope of home care (CSCI, 2006, +; London Assembly, 2010 +/+; Netten, 2007, +; PCC, 2012, +/+). Older people with dual sensory loss often tell us that they find it difficult to communicate with the care staff who support them, and a result often feel they don't have control over their care. Where more time is available for visits home care workers have the time to ensure	NICE Homecare guidance evidence tables.

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				quality service was recognised in Homecare guidance. In addition it recognised the importance of providing additional time for people with sensory impairments and communication difficulties.	communication is in place.	

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23	4.3	Healthwatch Bradford and District	**Continuity of care workers**	Many respondents highlighted the need for the same care workers to visit regularly; this would help to deliver care accurately and familiarity would result in further efficiency i.e. service users with dementia.	Whilst continuity is not a high priority for everyone and is hard to deliver with large packages of care, for some clients, for example those with dementia, this is a big issue that affects the quality of care.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement
24	4.3	SCM1	People should receive care at home from a small team of homecare workers whom they know and who know how they like their care delivered.	This will ensure people have care and support in the way they want and will build their confidence and safety. Job satisfaction for the homecare workers increases with the time and relationship they can have with the individual.	The level of fees paid by the state and the way in which care is commissioned often militates against this as providers can only pay low wages and that, together with reduced job satisfaction and low status means that staff turnover in homecare is high. In turn this means continuity of care is very difficult to achieve for people supported through the state (as opposed to self-funders, who pay the appropriate amount for their care).	The way homecare is commissioned by the state is important in achieving this, as is the planning, training and management delivered to workers. The issue of rapid staff turnover needs to be addressed by all concerned.
25	4.3	Healthwatch Bracknell Forest	Ensure continuity of care	Clients/Family members need continuity from agencies to ensure that they are cared for.	See supporting information.	"About 2 years ago in desperation I asked Community Matron to speak to care provider as mum did not have a regular team of carers. This aspect improved for a short while but eventually

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						everything lapsed again. Agency cite carers off sick / leaving the agency /change of operations due to other carers' sickness etc." Family Carer. "Asked several times at review and on phone, why we're not informed of late visits/change of carer. Reason given by agency simply not enough time as the logistics of organising /phoning/emailing is too great, plus agency can't afford cost of keeping a bank of carers in case of emergencies. It is very stressful too when I am at my own home - for a break - not knowing, who the carer will be, will they be on time, has the timing changed. Knowing my mum is in bed waiting, waiting…." Family Carer. "Ensure plans for home care clients (especially self-funders who don't have council contact) are in place and clearly explained to client and primary family carer - if a care agency suddenly goes into administration. First care provider went bust and I was given half an hour's notice that care would stop immediately and they had no contingency plans. What if I had not been contactable?" Family Carer.

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26	4.3	Rotherham Doncaster and South Humber NHS FT	Key area for quality improvement 2 Consistency of staff entering people's homes	Care is inconsistent – people should be assigned a regular care worker – too many different cares in one day	Provides continuity of care	http://www.ageuk.org.uk/northern-ireland/for-professionals/health-social-care/who-cares-events-overview/domiciliary-care-staff-time-and-tasks/
27	4.3	Healthwatch Bradford and District	**Timeliness of visits** – eliminate problems around short, unpredictable or missed visits	Almost two-thirds of respondents to the Healthwatch Bradford study said care workers are mostly on time, however many respondents raised concerns about rushed visits, unpredictable and variable timings of care and missed visits	We heard that these had serious consequences – for example medication not received, meals or drinks not provided, going hungry to bed, incontinence pads not changed. Short visits and lack of continuity means little or social interaction, no emotional wellbeing, a failure to address loneliness of some older people. Care plans not delivered means outcomes not achieved.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement
28	4.3	Healthwatch Bradford and District	Improved **communication** about delayed or cancelled care visits	A significant number of people said that **communication** about delayed arrival times or cancelled care visits was poor	We had examples of a complete absence of communication of missed visits – no contingency could be made, families or friends could not be asked for backup, poor outcomes for older people.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement

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29	4.3	SCM2	**Reliability of home care service – missed and significantly late calls**	Missed or significantly late calls can represent considerable risk and have serious consequences – such as falls, dehydration, confusion and health deterioration (due to missed medication). This can also lead to breakdown of care in the community not least because people themselves and their family carers lose confidence in the service.	Reducing missed or significantly late calls thereby improving the reliability of home care services can enable more older people to stay at home for longer. This is both what most older people want and is also less costly that residential or hospital care. Action: Monitoring and auditing missed and significantly late calls.	NICE guideline recommends that companies monitor missed or late visits. (1.4.10 – 1.4.14) CQC inspections have reported the occurrence of missed and late calls.
30	4.3	SCM3	To promote a safe environment and absence of abuse	A culture of safeguarding reporting has developed where different organisations obviate their responsibilities to assist in raising standards by reporting on other parts of the organisation.	The CQC and local authorities acknowledge that the number of safeguarding referrals have increased significantly; this may in part be due to the processes that are in place with the regulator which means all concerns and complaints are recorded as safeguarding incidents. Lack of desire on the part of commissioners to deal with complaints and concerns has led to the proliferation of large safeguarding teams within	Action on Elder Abuse ADASS National Safeguarding Committee : Lead Liz Bruce.

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					councils with the focus on finding things wrong and not about the raising of standards that people receiving home care services wish to be assured.	

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31	4.4	Healthwatch Bradford and District	**Delivering planned care**	Just over half of the people we spoke to said duties on the care plan are always followed, the remaining respondents felt there was insufficient time and/or carers' approach or skill level resulted in care needs not being met. Medication is a particular issue for some people.	Carer workers under too much pressure unable to deliver planned care, forced to miss tasks and cut corners. Some safeguarding issues relating to medication and personal care. Sometimes the lack of time was compounded by a poor level of worker skill.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement
32	4.4	Healthwatch Bradford and District	**Care workers' attitude and approach –**	Service users rated the attitude and approach of staff overall as good and felt they were treated with dignity and respect. In some cases of care, staff would happily go the extra mile. But there was also a high number of respondents who made reference to poor communication and poor attitude of some care staff.	Care workers attitude, interpersonal skills and communication reported as important features of older people's experience. We heard some positive examples but also room for improvement in a large number of cases where there was a lack of respect and a loss of dignity.	Evidence from our work with 240 older people and carers receiving home care in the Bradford district: Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement
33	4.4	Healthwatch Bradford and District	**Training and skill level of care workers**	There was a high recognition of lack of skills and training	We heard about a high level of skills with some care workers but also heard about training /	Evidence from our work with 240 older people and carers receiving home care in the Bradford district:

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				among some care staff. A specific issue related to basic cultural awareness, housekeeping and culinary skills i.e. making a cup of tea or making the bed.	skill deficits in: • Hygiene and personal care • Supporting people with dementia • Food preparation • Support with medication • Housekeeping • Cultural awareness	Healthwatch Bradford home care report, "Come on time, slow down and smile" We heard how much people value and depend on their home care service – it is vital to help them stay independent at home. We heard about some good home care but some key areas for improvement

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34	4.4	SCM3	Competent staff to commence work in the sector	Unprecedented poor levels of recruitment of staff and low aspirations of applicants into the homecare sector make it a challenge to achieve the desired levels of competent workers to provide care to people living in their own homes.	Following the Francis review into the events at Mid-Staffordshire hospital Camilla Cavendish was asked by the government to review the findings. Her main recommendation was that ALL staff need to complete comprehensive training in order that they can work unsupervised. Central Government funding through the Skills for Health, Skills for Care and other public sector training agencies should make training available for all social care staff to complete the Care Certificate prior to commencement of work in the homecare sector.	The Francis Inquiry The Cavendish Review
35	4.4	SCM4	Key area for quality improvement 2 **Training and development for Homecare workers**	**Evidence suggests Homecare workers who are deemed professionals in their own right may build confidence from the public's perspective, attain higher standards in the workplace and it is envisaged a tangible improvement in the care provided for the**	**Presently no EU wide standard framework; No benchmark for quality; Can lead to a national professional registration with minimum standards, and allied to other health professions.**	Please see: **Elizabeth Care, University of Surrey degree course (Foundation degree).** **Koehler (2014) Key to Care** **Burstow Commission LGIU** **Guardian (2015) Vicious circle of low status homecare work must be broken 5/03/2015;** **WHO (2008) Homecare in Europe-the solid facts www.euro.who.int**

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				service user.		

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36	4.4	SCM2	**Training**	Workers who lack understanding of particular conditions can cause care in the community to falter or break down.	Training in common conditions such as dementia, sensory loss, skin integrity etc. will improve standards of care, increase people's confidence in the home care workforce and so maintain older people at home for longer. Action: Monitor and audit staff training.	NICE guideline 1.7 CQC report shortcomings in training and lack of staff knowledge and skill in respect of long term conditions such as dementia, sensory loss and residual stroke capacity.
37	4.4	Alzheimer's Society	Key area for quality improvement 2 **Dementia trained workforce** 1.7.4 Ensure home care workers are able to recognise and respond to: • common conditions, such as dementia, diabetes, mental health and neurological conditions, physical and learning disabilities and sensory loss	There are around 850,000 people in the UK living with dementia (Prince et al, 2014), with over 42,000 developing the condition before they reach 65. It is believed that more than a third of people with dementia receive personal care from homecare workers, which would equate to almost 300,000 people (Alzheimer's Society, 2014). Homecare providers estimate that some 60% of people using their service have some form of dementia	Better training enables the person with dementia to receive care in a dignified and person centred way. If care is delivered correctly a person with dementia should be able to stay in their home for as long as possible and remain part of their community. This is beneficial for the person and also helps to avoid costly hospital or care home admissions. Dementia training has been prioritised in the Prime Ministers Challenge on Dementia 2020 which advocated for a better aware, educated and trained NHS and social care workforce. He stated that Tier 1 training opportunities will be provided to	**Prevalence rate:** Prince M, Knapp M, et al (2014). Dementia UK: Update. London: Alzheimer's Society http://www.alzheimers.org.uk/dementiauk **Numbers of people receiving homecare in community** Alzheimer's Society (2014a). Dementia 2014: Opportunity for change. London: Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2317 **Dementia and co-morbidities** Adapting clinical guidelines to take account of multimorbidity. British Medical Journal, 345 (2004) http://eprints.gla.ac.uk/70694/1/70694.pdf

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			(see also [recommendation 1.3.8](#)) 1.7.9 Develop workforce plans for the home care sector, in collaboration with provider organisations, identifying current and future workforce needs. Include training and how such needs might be met by prioritising available local authority resources in the plans.	(UKHCA, 2013), many of whom do not have a formal diagnosis. People living with dementia often have complex needs related to the condition and the average number of other long-term health conditions a person with dementia lives with is just over four (Guthrie, Payne et al, 2012). It is important that home care workers are aware of the person's health conditions and how these interact with one another. At present there are three tiers of training for dementia which is delivered by Health Education England (HEE): - Tier 1 training is to familiarise	all NHS staff by the end of 2018. This will be supported by more in-depth (Tiers 2 and 3) training of expert leaders and staff working with people with dementia. As of April 2015 Health Education England (HEE) had trained 515,967 people in the NHS in Tier 1 & 2 dementia training. Going forward, there needs to be much greater focus on the roll out of tier 2 and 3 dementia training aims to further ensure that NHS staff continue to receive the most advanced support available. Furthermore, all undergraduate courses for health professionals would include education and training in dementia by September 2015 and all newly qualified staff who look after patients with dementia will receive Tier 1 training. This will undoubtedly include home care workers. The introduction of the Care Certificate for newly appointed	**Percentage of people receiving home care who have dementia** UK Homecare Association (2013). UKHCA Dementia Strategy and Plan, February 2013. Wallington: UK Homecare Association. http://www.ukhca.co.uk/pdfs/UKHCADementiaStrategy201202final.pdf **Definitions of Tier training** Guide to Dementia Training for Health and Social Care Staff in London (2014) http://www.slcsn.nhs.uk/scn/dementia/london-dementia-scn-core-elements-outcomes-training-062014.pdf **The Prime Ministers Dementia 2020 Challenge,** (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414344/pm-dementia2020.pdf

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				people with recognising and understanding dementia, interacting with those with dementia, and to be able to signpost patients and carers to appropriate support. This level is suitable for all staff working in health or social care; however, it does not provide sufficient information for staff who would be working regularly with people with dementia. - Tier 2 dementia training should be aimed at staff in general healthcare	healthcare assistants and social care workers on 1st April 2015, includes training on dementia and cognitive issues. The challenge of having a health and social care workforce trained in dementia is starting to be addressed through the various methods outlined above. However, in order to build on this the NICE quality standards should reaffirm the importance of quality and dementia specific training so as to make it a priority for all health and social care providers. They should also state the need for home care workers to have received Tier 1 and 2 training as a minimum.	

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				settings or who are in regular contact with people with dementia. It can also be seen as a starting point for staff who will develop more specialist knowledge. - Tier 3 is aimed at staff who will be working extensively with people with dementia and who are likely to be in a specialist or a decision making capacity. In accordance with these definitions home care workers should, at the very least, have received Tier 1 and Tier 2 training. It could also be argued that an investment in Tier 3		

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				training would ensure people with dementia are receiving the very best care at home. Better training enables the person with dementia to receive care in a dignified and person centred way. If care is delivered correctly a person with dementia should be able to stay in their home for as long as possible and remain part of their community. This is beneficial for the person and also helps to avoid costly hospital or care home admissions.		

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38	4.4	SCM5	Key area for quality improvement 3 Ensuring care home workers have appropriate training to be able to recognise and respond to common conditions such as sensory impairment.	NICE Homecare Guidance recognises the importance of appropriately trained homecare staff, and in particular the importance of staff being able to recognise and respond to common conditions including sensory loss.	Sense research confirms what we have long suspected, that the needs of older people with sight and hearing problems are often overlooked. Older people are telling us that this makes them lonely, depressed and unable to cope. Without help, people may be forced to give up their homes and move into residential care where – our research shows – few staff have the training to understand their needs. And yet, with the right support, older people with dual sensory impairments can continue to enjoy a reasonable quality of life. This may be in their own home, or in residential care. A survey carried out by Unison in 2012 also found that staff were critical of the standard and amount of training provided and that 41% of care workers had not been given specialist training to deal with their clients specific medical needs, such as dementia and stroke care. This chimes with a recent survey	NICE Homecare guidance evidence table. Sense “I don’t hear or see so well these days…” https://www.sense.org.uk/sites/default/files/older_people_report_june2013_0.pdf

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					carried out by Sense amongst care providers, where 57.5% of respondents said their staff didn't receive adequate training to support the needs of people with dual sensory loss. In spite of 36% respondents recognising that they supported people with this condition (a percentage that is probably far lower than the actual number of people supported).	

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39	4.4	Parkinson's UK	Key area for quality improvement 2 **Home care workers' knowledge of Parkinson's and other complex conditions**	In order for an adult home care worker to provide effective and sensitive care, both to individuals with the condition and families of people affected by Parkinson's, they must understand the difficulties they face, in order to provide true person-centred care. It is therefore necessary for home care workers to have a good understanding of a person's condition and the full range of possible symptoms as the condition varies for every individual, as mentioned above.	YouGov polling commissioned by Parkinson's UK in April 2013 found that 25% of people surveyed had received social care support in the previous 12 months. This same research also found that 20% of respondents believed that paid carers do 'not have a very good understanding' of Parkinson's, with three per cent reporting that they had 'no understanding at all'. Improved understanding of common Parkinson's symptoms and how they fluctuate could also address the misinterpretation that Parkinson's is a long-term condition with primarily physical symptoms. A friend of a person with Parkinson's explains: '*I think it's having that kind of perspective about him as a person in that very sort of holistic way, and recognising if you like all the different layers that Parkinson's*	Parkinson's UK and YouGov, *Survey of people with Parkinson's and their friends, family and carers*, 2013. 4,777 people were surveyed who had either been diagnosed with Parkinson's or are family members or carers of a person with Parkinson's

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					presents, not just the kind of physical stuff that most people know about, like tremors and rigidity, but the psychological stuff, sort of the anxiety and depression, the kind of cognitive stuff about sometimes lacking organising executive functions' Given the complexity of Parkinson's, it is vital that a requirement to improve home care workers' knowledge of the condition is included in the Home Care Quality Standard, in order to truly provide person-centred care.	

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40	4.4	Royal College of Psychiatrists	The ability to communicate with a person with dementia	It is important that the person with dementia is listened to and is involved in decision making, but home care staff must also be able to recognise when somebody lacks the capacity to make informed decisions.	Home care staff may take at face value that the person with dementia can wash themselves or has washed and dressed themselves when in fact the person with dementia may not in some cases realise they need support. It is important that home care staff are able to communicate in an appropriate way that allows them to engage with the person with dementia and encourage them to accept help but also allows choice.	https://personalisationanddementia.files.wordpress.com/2013/12/beyondlifehistories.pdf ***NCF: Key Principles of Person Centred Dementia Care*** ***NSF OP: Standard 2: Person Centred Care*** ***SCIE guide 52: Residents' entitlements and requirements*** ***NICE DP: Principals of care – need and preferences of people with dementia*** ***NHS OF: Domain 2 – Enhancing quality of life for people with long-term conditions***
41	4.4	Royal College of Psychiatrists	Improved knowledge about dementia and recognising signs of early dementia and delirium	All home care staff should be aware whether the person they are caring for has dementia and should also be knowledgeable about early signs of dementia and delirium.	Early support through early recognition could enable the person with dementia to stay living at home longer. In the same way recognising possible delirium could mean the difference between treating the person at home or going into hospital.	NDS: Objective 11: Living well in care homes NDS Objective 13: An informed and effective workforce ***NSF OP: Standard 7: Mental Health in Older People*** NICE QS50: Quality statement 4: Recognition of sensory impairment

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						NICE CG103 Delirium - recommendations 1.2.1 and 1.4.1. NDS: Objective 1: Improving public and professional awareness and understanding of dementia NDS Objective 2: Good-quality early diagnosis and intervention for all

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42	4.4	Royal College of Psychiatrists	Ensuring adequate nutrition and awareness of importance of loss of appetite and increased risk of swallowing difficulties in people with dementia	People with dementia can forget to eat their food or say that they have eaten or that they can cook themselves and if that is taken at face value this can mean that they can potentially become undernourished. Reduced appetite may be a sign of physical ill health or depression (both conditions often missed). People with dementia can develop swallowing difficulties at the later stages and are at increased risk of aspiration.	This is a key area for home care staff to be aware of how dementia might impact on nutritional input and in particular if they notice any swallowing difficulties that they know how they can seek advice and avoid aspiration. Reduced appetite may also be a sign of physical ill health or depression and home care staff need to be aware of this and seek advice as early detection should result in earlier treatment.	SCIE guide 15 :Eating and Nutritional Care NSF OP : Standard 7: Mental Health in Older People NICE QS50 - Quality statement 3: Recognition of mental health conditions
43	4.4	SCM2	Additional developmental areas of emergent practice **Supervision of home care workers**	Home care workers work in isolation with older people in the community. Some of these people are extremely vulnerable. For example, those with moderate-advanced dementia may be unable to communicate concerns about their	Supervision will maintain standards of care.	CQC report shortcomings in supervision.

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				care. Supervision is therefore essential. The NICE guideline recommends observing practice at least every 3 months together with regular supervision. (1.7.11-1.7.12)		

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44	4.4	SCM6	Recruitment and retention	Because staff turnover among home care workers runs at c.30% across the sector	Because evidence shows that continuity of care is a vital factor in the overall satisfaction of service users.	http://www.cqc.org.uk/content/cqc-finds-common-issues-undermining-majority-good-home-care
45	4.5	SCM3	Finding a place for homecare in the health and social care economy	Integrated care is an outcome that most people using services wishes to achieve however due to the silo mentality of health and social care few examples have been successful	National Voices published in their report that the lack of joined up care is the biggest frustration and conversely achieving integration would be the biggest contribution to quality and safety.	National Voices Principles of Integrated Care
46	4.5	SCM6	Coordination of home care services	Because services are not well-integrated	Because a joined-up approach benefits everyone. Whilst health, care workers and others operate in silos with separate information systems, service users get a raw deal. Furthermore, the Care Act and the recent (and little publicised Health and Social Care (Safety and Quality) Act 2015 actually require better integration – it's time providers and commissioners had the tools to achieve this.	http://www.legislation.gov.uk/ukpga/2015/28/contents/enacted
47	4.5	Rotherham Doncaster and South Humber	Key area for quality improvement 3 Sharing of crisis	Improves service in time of crisis.	Provide information for emergency staff who are dealing with people cognitive,	http://www.lions105w.org.uk/MIAB.pdf

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		NHS FT	information		communication impairments at times of crisis, about who to contact, medication, health details.	

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48	4.5	SCM1	Where several organisations are involved in supporting a person; one individual should be identified and recognised as a co-ordinator	People can become very confused when a number of different organisations are visiting their home. Tasks and responsibilities might overlap and duplication is wasteful. Conversely, there may be gaps in care resulting from a lack of communication or understanding of the different roles	Shortcomings in communication between people providing care are common and can lead to serious failures. All caring agencies; homecare, community nursing, domiciliary dentists and GPs as well as voluntary sector organisations share a responsibility to communicate and co-ordinate for the benefit of the person receiving the service,	The co-ordinator could be identified by the commissioner (where this is the LA or CCG) and could be any one of the people involved, including the person themselves (if they have the capacity); a family members, or any of the visitors involved in providing support. The important factor is that all involved know who it is and communicate effectively.
49	4.5	SCM2	**Coordinated and integrated care**	Appointing a named care coordinator improves the planning and delivery of overall care in that it should enable members of the MDT to work better together for the wellbeing of the older person.	Care coordination can reduce breakdown in community care. Action: Monitor and audit number of clients with named care coordinator.	NICE guideline 1.3.6 – 1.3.9, 1.5.
50	4.5	Alzheimer's Society	Key area for quality improvement 1 **Care co-ordinator within an MDT** 1.3.6 Consider	There are around 850,000 people in the UK living with dementia (Prince et al, 2014), with over 42,000 developing the condition before they	Current practice around care coordination within in a multidisciplinary team is variable for people living with dementia. However, areas of best practice are emerging.	**Prevalence rate:** Prince M, Knapp M, et al (2014). Dementia UK: Update. London: Alzheimer's Society http://www.alzheimers.org.uk/dementiauk **Numbers of people receiving**

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			identifying a named care coordinator from among the people involved in delivering care 1.3.7 Ensure integrated care and support is delivered to the person through a coordinated group of workers	reach 65. It is believed that more than a third of people with dementia receive personal care from homecare workers, which would equate to almost 300,000 people (Alzheimer's Society, 2014). Homecare providers estimate that some 60% of people using their service have some form of dementia (UKHCA, 2013), many of whom do not have a formal diagnosis. Nearly all people living with dementia will require care and support from both the NHS and social care system at some point as a result of dementia having features of neurological disease, mental illness and physical frailty that cross the boundaries of the health and social	The MDT should be built around need/aspirations of the person with dementia and should contain health and care professionals as required. Having a dementia expert, such as a Dementia Support Worker, in the MDT can improve outcomes. The Dementia Support worker provides tailored information, advice and signposting. They can support people affected by dementia to navigate a complex web of health and social care services to access appropriate information and can help them to plan for the future and self-manage effectively. This array of knowledge and skills makes them perfectly placed to play the role of care coordinator. Case Study: Preventing Admission to hospital for people with dementia Alzheimer's Society worked with commissioners in Berkshire to develop a support service for people with dementia at risk of	**homecare in community** Alzheimer's Society (2014a). Dementia 2014: Opportunity for change. London: Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2317 **Percentage of people receiving home care who have dementia** UK Homecare Association (2013). UKHCA Dementia Strategy and Plan, February 2013. Wallington: UK Homecare Association. http://www.ukhca.co.uk/pdfs/UKHCADementiaStrategy201202final.pdf **Dementia and co-morbidities:** Alzheimer's Society (2015). Dementia 2015: Aiming higher to transform lives. London: Alzheimer's Society. http://www.alzheimers.org.uk/site/scripts/download.php?fileID=2700

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				care system. In addition, Research indicates that around 70% of people with dementia live with co-morbidities, (Alzheimer's Society, 2015). High quality, personalised integrated home care is crucial to prevent avoidable hospital admissions, delayed discharge from hospital and early entry to a care home. Having a care co-ordinator, who can take an overarching view of care within in a multi-disciplinary team (MDT), is essential to provide holistic care and support.	admission to hospital. Establishing a Dementia Support Worker with professional status in the MDT has proved a successful model. By ensuring adequate home care and support, the Dementia Support Worker helped create savings of £127,511 in hospital care and £74,704 in residential care in the first year of operation. By the third year, the hospital waiting list was reduced to zero; the number of the people in the dementia ward was halved; the dementia team is now a mainstream service and the dementia ward the model of service had been extended to other areas e.g. people with other long-term conditions. Current practice around care coordination within in a multidisciplinary team is variable for people affected by dementia. Prioritisation in the quality standards would facilitate greater consistency across the country.	

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51	4.5	SCM1	A single “care diary” should be kept by all the people visiting to provide care and support. It should be available to the person receiving support at all times.	This will help with the co-ordination and quality of care and support delivered to the individual. Ensuring it is accessible will mean that the person remains in control wherever possible and that accurate information is passed on.	At present the care record maintained by the homecare workers is unlikely to contain information from, for example, the visiting GP or community nurse. This could lead to confusion and duplication of or gaps in record keeping.	It is recognised that this will require a significant change of approach in some areas, but it will help ensure all care and support providers genuinely work in the individual’s interest and understand and respect each other’s input. Recent discussions around hospital discharges support this approach. Some people keep all their information online and carry a tablet with them to inform, for instance, the hospital staff of their current issues.
52	4.5	SCM2	Additional developmental areas of emergent practice **Care diaries**	Detailed care diaries completed by all those involved in a care package including family carers or friends can support and encourage integrated care and communication.	Action: Monitor and audit observation and supervision Integrating care is likely to result in both more effective and more efficient care. Action: Monitor and audit use of care diaries.	NICE guideline 1.3.22- 1.3.24.
53	4.6	SCM3	Homecare is significantly under resourced	Quality is homecare is defined by the quality of staff who work within the sector. Andrea Sutcliffe the Chief Inspector for the CQC stated that the single largest contributor to poor quality is	Research carried out by the UKHCA showed that the majority of local authorities in England are paying providers of Homecare below the safe levels of reimbursement for care, the consequence being that quality is being compromised in each local authority area in the	http://www.theguardian.com/society/2015/aug/08/social-care-chief-inspector-system-failing-elderly http://www.pssru.ac.uk/project-pages/unit-costs/2014/index.php

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				demoralised care staff working long hours in difficult conditions for poor pay.	country. Significant reinvestment is required to create an infrastructure that provides coordinated health and social care delivered to individuals in their own homes.	

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54	4.6	SCM4	Key area for quality improvement 1 **Development of career pathways for Homecare workers**	**Within healthcare provision, graduates command higher wages, have greater opportunities and demand greater respect for their roles. Further evidence suggests this can lead to longevity of staff retention, which are highly valued and praised.**	**1 in 4 adults over 60 will require additional care in their homes by 2020;** **Care Act (2014) is facilitating changes to care in the community;** **Most health and social care employers are recruiting from the same workforce pool that is women;** **Impact on retention and future recruitment of homecare workers;**	Please see: **Institute for Women's Policy Research (2013) Improving career opportunities for immigrant women in Homecare Workers;** **Policy Link (2015) Why Washington state invests in Homecare workers- and your state should too! America's Tomorrow;** **Zacker (2011) Creating career pathways for frontline healthcare workers JFF.ORG**
55	4.6	Devon CCG	Inadequate response to non-injury falls - No lift policies	I believe and have evidence for a considerable problem within the home-care supplier market. Care Organisations are worried about Health and Safety Issues and despite guidance from the H&S Executive state that they have a "no-lift" policy in place.	This means that a cared-for person may have a non-injury fall, be conscious, unhurt and describing no adverse effects but one or two carers will refuse to facilitate that person getting back up off the floor. Instead they dial 999. As a non-emergency (and inappropriate usage) call the 999 services respond on an as-and-when basis which can mean a patient maybe on the floor for hours before being lifted. We are tackling formal and informal no-lift policies whenever we have the evidence but the	*No additional information provided by stakeholder*

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					issue of non-injury falls must also be recognised in the developing recommendations and is as important as some of the other standards in there.	
56	4.6	Parkinson's UK	Key area for quality improvement 3 **Carers' wellbeing as a result of their caring responsibilities**	Carers of people with Parkinson's are frequently friends and family members. A Parkinson's UK membership survey, conducted by YouGov found that a quarter of family members or carers surveyed were in full-time employment, with nearly six in ten not working at all. The survey also found that nearly a quarter of those in paid employment have had to reduce their working hours in order to look after someone with Parkinson's, and around 23% of those who were not working had to give up work to care for a person with	Research has found that increases in stress-related symptoms in those caring for a person with Parkinson's were associated with the number of tasks required of a carer. Caring impacted on their own health conditions and their financial status. A carer of a person with Parkinson's explains: *'Throughout the many years I have been my husband's full-time carer, the progression in severity and complexity of his condition has meant my caring role has had to alter and adapt to his ever increasing needs. All aspects of his wellbeing and safety rest squarely with me.'* Given the significant emotional and psychological impact on carers, carers should have regular assessments of their	Drutyte, G et al (2014) '*What impacts on the stress symptoms of Parkinson's carers? Results from the Parkinson's UK members' survey'* in *Disability and Rehabilitation* 6(3):199-204 available at: http://www.ncbi.nlm.nih.gov/pubmed/23586667 Department of Health, *Care and Support Statutory Guidance* (2014) available at: https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

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				Parkinson's. A carer of a person with Parkinson's explains: *'When someone is living with advanced Parkinson's your focus is on them and not yourself. In hindsight I now know my own health suffered, and I needed more support but didn't want to admit it.'*	needs. Local authorities should also be proactive in offering these assessments, in order to prevent carers of people with Parkinson's from developing care needs themselves. Care Act guidance to local authorities already requires councils to undertake assessments for '*any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation*' as set out in section 6.13. However, it is unclear to what extent local authorities are fulfilling this requirement, particularly in regards unpaid carers. The inclusion of carers' wellbeing in the Home Care Quality Standard would help to ensure that the needs of friends and family members, who provide care on an unpaid basis, are acknowledged and addressed by home care	

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					workers. It could also ensure that local authorities are fulfilling their requirement to offer needs assessments to carers.	