National Institute for Health and Care Excellence

Home care
Guideline Consultation Table

Date of consultation from 5th March 2015 to 16th April 2015

8 topic specific questions were asked in this consultation: Answers to these questions are marked as section Q1 etc.
Implementation questions were asked in this consultation: Answers to these questions are marked as implementation

Stakeholder	**Comment No**	**Document**	**Page number**	**Line number**	**Comments** Please insert each new comment in a new row.	**Developer's Response** Please respond to each comment
Action on Hearing Loss	1	Q1.			We will use the recommendations to lobby homecare providers and commissioners, as well as government and professionals, for better service provision for people with hearing loss.	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
Action on Hearing Loss	2	Q2.			Action on Hearing Loss welcomes recommendation 1.2.5: "To tailor all information for different audiences to ensure it is accessible and understandable" This is in line with the Equality Act 2010 and NHS England's soon to be published Accessible Information Standard (ISB1605). This is a positive step, which will make home care services more accessible for people with hearing loss. The inclusion of sensory loss in recommendation 1.3.10 which requires homecare commissioners to "have awareness of common conditions affecting people using homecare services" is	Thank you for your comments.

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					also very important. As stated in the recommendations, this is consistent with existing NICE guidance on person centred care and will ensure the planning and delivery of home care services reflects the need of people with hearing loss. We also welcome recommendation 1.4.4 which recognises that people with sensory loss will require longer care visits and recommendation 1.6.4 that home care workers must be aware of sensory loss. There is good evidence that these recommendations are necessary and should substantially improve the quality of home care services for people with hearing loss.	
Action on Hearing Loss	3	Q3.			Commissioners, home care providers and home care staff must do more to incorporate hearing loss into the planning and delivery of home care. There should be robust processes for recording instances of hearing loss and referring people for treatment. There also needs to be greater awareness of audiology treatment pathways, the benefits of hearing aids in terms of quality of life, health and wellbeing as well as the different types of equipment available to help people hearing loss in their own home.	Thank you for your comment. Sensory loss is referenced explicitly in the guideline as a common condition of older people receiving home care. Although we are unable to incorporate evidence which is not explicitly research (e.g. audiology pathways) into the Guideline, the Guideline Committee was very conscious of the likelihood that many users of home care would have sensory loss, and that hearing loss is very common in older people especially if they are living with dementia.

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						We have included reference to the particular needs of people with sensory loss in a number of recommendations, for example 1.3.8 (workers should be equipped to be aware and understand sensory loss); 1.4.4 (people with communication needs will need more time allocated to their home care package).
Action on Hearing Loss	4	Q6.			The guidelines are consistent with the requirements in the Care Act to promote wellbeing and design support services around individual needs. It is worth noting that Recommendation 1.2.5 also directly relates to requirements in the Equality Act 2010 to provide information in accessible formats for people with sensory impairments. We recommend making this point clear in the 'legislation, policy and guidance' section of the guidelines.	Thank you for your comment. The guideline aims to complement existing legislation rather than repeat it; however, the relationship between existing guidance and mandatory requirements and the recommendations in this guideline is likely to be something we will consider as part of implementation. The Care Quality Commission use NICE guidelines as evidence to inform the inspection process and NICE quality standards to inform ratings of good and outstanding. Please also see the sections on Introduction and Context in the guideline, which articulates the relationship between NICE guidelines and policy.
Action on Hearing Loss	5	Q7.			Yes, the guideline is consistent with Care Act 2014 Regulation and	Thank you for your comment.

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					Guidance	
Action on Hearing Loss	6	Q8.			The recommendations should improve the experience of people with hearing loss who use homecare services. The recommendations acknowledge that people with hearing loss often have higher social care needs compared to others and must be provided with appropriate treatment and support. However, to be effective, the recommendations need to clearly state what support and equipment is available and how this can be accessed. In this respect, our own information may be useful: http://www.actiononhearingloss.org.uk/supporting-you/products-and-equipment.aspx	Thank you for your comment. The recommendations relate to all older people using home care. The issue of people with complex needs (including, but not limited to disabilities) featured throughout Guideline Committee discussions and there are a number of recommendations about workforce skills and knowledge (general and specialist). The recommendations on person centred care and involving the person in their care (see recommendation 1.1.2) also depend on information being available to meet the person's needs (see recommendations 1.2.2-1.2.5).The need to ensure communication is appropriate for people with a range of needs (including, for example, sensory loss) features explicitly in 1.4.4 reflecting the need for people with disability or sensory loss to have more time with home care workers. The home care guideline could not fully discuss the need for all other services. However, as part of the guideline implementation work, we will seek to sign post to other relevant products and tools.

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Action on Hearing Loss	7	General	General	General	Action on Hearing Loss welcomes the opportunity to comment on the draft 'Home care: delivering personal care and practical support to older people living in their own homes' guidelines. As the largest U.K. charity working for people with hearing loss, including undertaking research, campaigning and providing services, Action on Hearing Loss would like to offer our expertise and support in developing this guidance. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to made public. More than 10 million people in the UK have hearing loss, about 1 in 6 of the population rising to 71% of over 70s . If not managed effectively, hearing loss can be highly detrimental to an individual's overall health and wellbeing. Hearing loss can cause communication difficulties and can lead to social isolation.. There is also evidence of a link between hearing loss and dementia . Action on Hearing Loss welcomes this NICE guidance on the planning and delivery of home care. We	Thank you for your comment. Sensory loss is referenced explicitly in the guideline as a common condition of older people receiving home care. Although we are unable to incorporate evidence which is not explicitly research (e.g. guidance, policy) into the Guideline, the Guideline Committee was very conscious of the likelihood that many users of home care would have sensory loss, and that hearing loss is very common in older people especially if they are living with dementia. We have included reference to the particular needs of people with sensory loss in a number of recommendations, for example 1.3.8 (workers should be equipped to be aware and understand sensory loss); 1.4.4 (people with communication needs will need more time allocated to their home care package).

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					support the recommendation that those "responsible for managing and providing home care should work together to deliver safe, high quality home care services that promote independence". As a general point, we would argue that this responsibility extends to recognising the needs of people with hearing loss and incorporating their requirements into an appropriate care plan. To avoid future high cost care interventions, homecare providers and care staff also must be acutely aware of the early signs of hearing loss and refer people for treatment at the earliest opportunity. In line with NICE's quality standard for the mental wellbeing of older people in care homes , homecare providers and care staff should be alert to the early signs of hearing loss, record instances of hearing loss and also be aware of the GP referral pathway for assessment and treatment. This homecare draft guidance should reiterate this argument. Action on Hearing Loss (2011). Hearing Matters http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/hearing-matters.aspx Lin et al. (2011) Hearing loss and	

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					incident dementia. Archives of Neurology 68(2): 214-220	
Action on Hearing Loss	8	Short	6	3-7	We agree that some recipients of home care will be particularly vulnerable or have specialist needs. Hearing loss is an important consideration in the management of other long term conditions. Evidence suggests that 71.1% of over 70s have some form of hearing loss and due to the ageing population, it is estimated that by 2031 there will be 14.5 million people with hearing loss in the U.K[1]. Since hearing loss can cause communication difficulties and lead to other conditions such as depression and dementia, it is important that proper management of hearing loss is included in this recommendation.	Thank you for your comment. The Guideline Committee debated whether to provide lists of specific conditions at several points throughout development. They agreed that, as it was not possible to provide a comprehensive list of all conditions affecting all people using home care, recommendations should instead focus on the need for care to be person-centred care and to make reference to a number of common conditions and 'umbrella' terms for groups of conditions likely to affect many people who use home care services.
Action on Hearing Loss	9	Short	8	10-12	We agree that home care staff lack knowledge and awareness of hearing loss. Our 2012 report on hearing loss in care homes 'a World of Silence' [2] demonstrated that care home staff were reluctant to advise care home residents that they might be	Thank you for your comment and the links to your resources which we will consider as part of the guideline implementation work.

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[1] Action on Hearing Loss (2011). Hearing Matters http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/hearing-matters.aspx

[2] Echalier, M. (2012). A World of Silence. Available at: http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/a-world-of-silence.aspx

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					experiencing hearing loss. Also, procedures for recording incidences of hearing loss were not always followed. Some care home staff relied on memory or residents informing them who wears hearing aids. They also admitted that hearing loss was sometimes overlooked compared with other conditions like sight loss, pain and safeguarding. There were also wide variations in the take up and understanding of hearing loop systems, TV listeners and amplified telephones. Many care home staff also lacked suitable training to carry out basic maintenance of hearing aids. Those responsible for the care of older people in their own homes and in residential settings should receive appropriate training to understand the needs of people with hearing loss and the benefits of hearing aids. Hearing aids improve communication and can have a very positive impact on the quality of life of people with hearing loss. There should also be greater awareness of the signs of hearing loss and treatment available. Care staff should be able to perform basic maintenance on hearing aids and be aware of other assistive technologies. For further information please see our World of Silence	

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					report: http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/a-world-of-silence.aspx and our 'Caring for People with Hearing Loss' nursing toolkit http://www.actiononhearingloss.org.uk/supporting-you/gp-support/nursing-toolkit.aspx	
Action on Hearing Loss	10	Short	8	22-23	We agree with CQC's findings that there are "shortcomings in the induction, supervision, and training" of care staff. In 'a World of Silence' we found that NVQ qualifications in social care focused exclusively on communication needs and neglected the viewpoints of people with hearing loss. Training programmes should be revised to incorporate good practice from elsewhere, notably in dementia training, so they can give staff an appreciation of what hearing loss feels like.	Thank you for your comments. There was insufficient evidence to make very specific recommendations on training of care staff: however there is a research recommendation on training.
Action on Hearing Loss	11	Short	11	15-17	When responding to the social care needs of people living alone, it is also important to recognise the link between hearing loss and dementia. People with mild hearing loss are almost twice as likely to develop dementia compared to people with normal hearing, and the risk	Thank you for your comment which we will consider as part of guideline implementation work.

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					increases threefold for people with moderate hearing loss[3]. This danger is particularly acute if hearing loss is misdiagnosed as dementia[4] or if dementia is underdiagnosed because of hearing loss[5]. Where both conditions are present one can exacerbate the other and both need to be managed effectively at an early stage. There is also extensive evidence that unaddressed hearing loss can lead to mental problems such as depression and anxiety[6]. Hearing loss often co-occurs with other conditions such as cardiovascular disease, diabetes, Parkinson's and sight loss. To ensure these conditions are properly managed, there needs to be better diagnosis of and treatment of hearing loss. Only one in three people who could benefit from hearing aids have them and 45% of people who report	

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[3] Lin et al. (2011) *Hearing loss and incident dementia.* Archives of Neurology 68(2): 214-220

[4] Burkhalter CL et al. (2009) 'Examining the effectiveness of traditional audiological assessments for nursing home residents with dementia-related behaviours'. Journal of the American Academy of Audiology 20 (9): 529-38

[5] Boxtel van MPJ et al. (2000) 'Mild hearing impairment can reduce verbal memory performance in a healthy adult population'. Journal of Clinical and Experimental Neuropsychology 22 (1): 147-154.

[6] Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58, 1, 93-7; National Council on Aging (2000). The consequences of untreated hearing loss in older persons. Head and Neck Nursing, 18(1)

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					hearing loss to their GP are not referred for treatment. [7]Please see our 'Joining Up' [8] report for further information http://www.actiononhearingloss.org.uk/joiningup.aspx	
Action on Hearing Loss	12	Short	14	1-3	To avoid confusion and misinterpretation of the guidance, we recommend giving further detail on the different communication formats available to commissioners and homecare providers. We recommend rewording the recommendation to include examples of communication formats relevant to people with hearing loss, such as: - Textphones - Text Relay - SMS Text - Instant messaging - Video Relay - Written material in plain English - Videos with subtitles and British Sign Language (BSL) interpretation - BSL translation of key written information - Communicating through a live or	Thank you for your comment. Recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list.

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[7] Action on Hearing Loss. (2013). Hearing Matters, Available at: http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/hearing-matters.aspx

[8] Action on Hearing Loss (2013) Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions. Available at: http://www.actiononhearingloss.org.uk/joiningup.aspx

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					remote communication support professional, for example a BSL interpreter, lips speaker, note taker or speech to text reporter - Communicating with the support of equipment such as a personal listener or a hearing loop system The recommendations should also make reference to NHS England's soon to be published Accessible Information Standard (ISB1605) will which require social care providers to identify, record and share the needs of people with hearing loss, sensory impairments and learning disabilities, in addition to improving information and communication support.	
Action on Hearing Loss	13	Short	15	12-16	We agree that "people who use homecare services often need support that goes beyond their personal care needs". We suggest the recommendations should be revised to include other sources of support available to the high proportion of people with hearing loss. For example: - Treatment for hearing loss, including audiology services (hearing aid assessment, fitting and after care) and local authority support services (lip reading classes, counselling or hearing therapy)	Thank you for your comment. The Guideline Committee agreed this should be a high level recommendation based on the evidence available.

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					- Products that may be available through local authority sensory services, for example: hearing loops, text phones, vibrating doorbell or smoke alarm sensors - Benefits available for people with hearing loss, including Personal Independence Payment, Disability Living Allowance, Employment and Support Allowance, Attendance Allowance, the Industrial Injuries Disablement Benefit, Carer's Allowance, the Community Care Grants from the Social Fund and the Armed Forces Compensation Scheme	
Action on Hearing Loss	14	Short	16	6-8	We suggest rewording the recommendations so that commissioners must also demonstrate awareness of other services and other sources of treatment and support relevant to people with hearing loss.	Thank you for your comment. Sensory loss was discussed throughout guideline development. The Guideline Committee reflected on specific conditions as part of Guideline Committee12 and agreed the recommendations, which are addressed to home care provider organisation, managers and workers involved in planning and delivering support.
Action on Hearing Loss	15	Short	20	14-17	We welcome the recommendation that homecare managers and providers should take account of sensory loss when carrying out care visits. This is consistent with the	Thank you for your comment.

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					Accessible Information Standard which specifies that people with communication needs will require longer appointments and must be allocated more time.	
Action on Hearing Loss	16	Short	24	17	We agree that home care workers should be able to recognise "common conditions, such as dementia and sensory loss" however as discussed in Comment 3, recognition should also encompass proper processes for recording instances of hearing loss and referring people for treatment and ensuring services are accessible. These are crucial to proper recruitment and training of home care staff.	Thank you for your comment. This recommendation now reads 'recognise and respond to'. The recommendation (1.6.4 in the consultation draft) is renumbered as 1.7.4.
ADASS	1	General	General	General	There are a large number of people who use homecare services but have no contact / relationship with local authorities, and there are a growing number of individuals who are commissioning their own homecare through Direct Payments. It is important that the guidance address and responds to these groups in addition to adult social care commissioners, providers and regulators. High quality homecare should be available to all wherever they fit within the care and support system and we suggest that specific	Thank you for your comment. The guideline is intended to be relevant to all older people using home care services, including those paying for their own care. NICE and the NCCSC will need to consider how best to reach different groups of people using home care, as part of implementation work. Following further discussion at the Guideline Committee meeting post-consultation, the guideline now makes explicit reference to nutrition, hydration and pressure sores.

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					sections are developed with these groups in mind, and described in ways which are accessible to these groups. Whilst the draft guidance provides some reassurances about safety and safeguarding practices and approaches, the guidance needs to go further. For instance, in relation to healthcare worker, the draft guidance only mentions medication, but makes no reference to nutrition, hydration, pressure sores, bruising etc. Secondly, for home care managers there is nothing about supporting carers to identify abuse or neglect - only what to do after they have concerns, and for commissioners, there is a key role in addressing the delivery of care if it is poor, abusive or neglectful. Finally we note the recruitment section needs to include draft guidance relating to employee references and Disclosure & Baring Service Homecare services spans both the NHS and Social Care and welcome this recognition with the guidance, although we feel that further work is required to understand the specific	The scope for the guideline did not include the aspects of safeguarding, commissioning and risk that you identify. Thank you for your commitment to supporting the implementation of the guideline. This is most welcome.

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					responsibilities that fall upon NHS and Adult Social Care commissioners Finally we note that the draft guidance would benefit from further exploration and explanation of managing the tensions of the "professional view of risk" and the "individual view of risk". This will require much more detailed work and ADASS welcomes the opportunity to work with NICE to inform this work.	
ADASS	2	Short	7	1.1.1	**Delivering services that support the aspirations, goals and priorities of the person using them (recommendation 1.1.1).** This principle is intrinsic in the approach taken by councils in meeting individual needs and improved outcomes. Adult Social Care is organised around the "social model of care", in which services are geared to maximise independence and supporting individuals live life on their terms in the context of their health and wellbeing. This" health and wellbeing" concerns the whole person and there is a need to focus on the individual's mental, physical and all other forms of health	Thank you for your comment. We have reviewed the recommendations at Guideline Committee12 and have made some edits to strengthen the focus on person-centred care and the provision of holistic support to help people live the way they choose.

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					and wellbeing, not just the dressing, washing etc. This whole person approach links to the research quoted in the NICE document about individual's highlighting "'the value of 'caring' characteristics and importance of 'being listened to'. So it's not just about how the tasks are done but also about trusting relationships, company, interest etc. In this context, we would suggest that the draft guidance expands upon the quality and experience of the service in terms of how homecare staff interact and relate to the individual in a caring supporting way.	
ADASS	3	Short	10	1.3.1 1.3.3 1.3.4	**Working effectively in multidisciplinary teams coordinated by a lead practitioner (recommendations 1.3.1, 1.3.3 and 1.3.4).** Whilst the overall intention is supported, these sections are quite unclear as to who the lead practitioner is and how this coordination will work in practice both from the perspective of the individual and the professionals involved. It is suggested these sections can be further improved	Thank you for your comment. This was discussed at Guideline Committee12 and has now been edited. The Committee thought the term 'multidisciplinary team' was ambiguous in relation to interaction with home care workers, and recommendation 1.3.7 aims to suggest who might be involved. Similarly the term 'named care coordinator' replaces the term 'lead practitioner (see recommendations 1.3.6 – 1.3.9, for examples). The Committee wanted to highlight flexibilities in who takes on roles and

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					in terms of enhanced transparency and we welcome the opportunity to work with NICE on this.	that the roles are themselves critical.
ADASS	4	Short	11	1.3.10	**Helping people to determine which care options will best meet their needs and preferences (related to recommendation 1.3.10).** ADASS fully supports this approach. Adult Social care has been at the forefront of implementing personalisation with public services over the last 10 years. Over this period, more people are now offered personal budgets as the default position, empowering the individual to exercise real choice and control (At 31 March 2014, 81% of all people receiving community based services were supported by Personal Budgets (PBs) or Direct Payments (DPs). The emphasis upon personalisation creates a proactive relationship between the individual and the service, and by design puts the individual at the centre and ADASS welcomes the emphasis within the Guidance that supports this approach.	Thank you for your comment and support for the guideline.
ADASS	5	Short	16	1.4.2	**Home care visits no shorter than**	Thank you for your comment.

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					30 minutes unless specific circumstance met (recommendation 1.4.2) ADASS welcomes the tone and wording of this draft recommendation and particularly the proposed specific circumstance as an exception to the recommended minimum 30 minute visits. These "exceptions" provide flexibility to meet individual need in accordance with personal preferences and appropriate tasks. On a more wider context, ADASS is supporting councils in moving towards outcome based commissioning as opposed to traditional "time and task" commissioning, and the new duties in the Care Act Section 5, 4.31 places new responsibilities upon councils to assure themselves that *"services support and promote the wellbeing of people who receive care and support"* Within this context it is important to note that providers have a direct responsibility to ensure their services are consistent with ensuring and promoting the wellbeing of individuals	The time allowed for visits was discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony. This is captured in the relevant table at the evidence to recommendations section 3.8 of the full guideline.
ADASS	6	Short	16	1.4.4	**Home care visits are long enough and include**	Thank you for your comment. The time allowed for visits was

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					sufficient travel time between visits (recommendation 1.4.4) ADASS welcomes these draft recommendations that align with the new duties in the Care Act Section 5, 4.31 which places new responsibilities upon councils to assure themselves that the service provider meets "statutory obligations to pay at least the national minimum wage ..“ Providers have a legal duty to meet National Minimum Wage regulations which also include regulations regarding travel time. This itself requires providers and commissioners to work together to ensure sufficient time between visits, promoting better quality of care and support.	discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony. This is captured in the relevant table in the evidence to recommendations section 3.8 of the full guideline. It is outside the remit of the scope and NICE guidelines to make recommendations on national minimum wage levels.
Agincare	1	Q1.			These guidelines will be used by promoting them to others we work with e.g. local authorities, which may aid in awareness raising. Although we don't always get it right, we have systems in place to meet all of these recommendations when those systems are used effectively. However, as a Provider we can be let down by partners in care specifically	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.

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					around planning to meet outcomes when visits are time and task restricted, which is still unfortunately the case. As a Home Care provider we will review our current procedures to see if they can be improved in light of the recommendations. Generally, we do or are working towards doing all the things contained although there are some specifics e.g. a supervision and observation of practice of care staff at least 3 monthly, at the moment our practice is a minimum 3 monthly meaningful 'in person' contact but this can be either a supervision or a check of practice, rather than this guideline of both. This is an example of where the guidelines risk being prescriptive and process driven rather than outcome led. If staff are competent, well informed and feel supported does it matter how this is achieved? There are a number of recommendations which are things we do but undoubtedly we could do them better. Recommendations regard observational practice will be met as part of the competency framework of ensuring the care certificate requirements are met; we are working on systems to implement	

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					these in line with our current processes for support although it will inevitably be more resource heavy. Challenges with current social care recruitment places pressures here and how commissioners and providers work together to tackle these and acknowledge the impact on care delivery and optimum good practice needs acknowledging. If all recommendations are met by commissioners and other practitioners there is a chance that provider led home care will improve but no one organisation can manage this in isolation. There is a danger that local authorities and other public bodies may use elements of the guidelines solely to place more pressure on Providers without acknowledging their part and use of the guidelines.	
Agincare	2	Q2.			The greater focus on the local authority commissioners role to work in partnership re: challenging issues specifically areas such as missed visit solutions and durations of calls commissioned. We feel that emphasising the role commissioners have is extremely important in driving up standards. We agree that multi-disciplinary teams working effectively together is especially important (but especially	Thank you for your comments.

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					challenging to realise). We feel that all of the recommendations around customer expectations of the service and realising personalisation are very important, although these are simply the same as have existed for a long time and which we have aimed to adopt quickly and well already (albeit improvement is always a focus). We particularly like recommendation 1.5.2 as this really would be helpful, safe and could encourage tangible collaboratively working. Recommendation 1.6 is very most important as, in essence, all others are covered by requirements of the Care Act. The Care Act, with the exception of information about sustainability of information, does not greatly refer to the difficulties in recruitment faced by most social care providers. The recommendations for local authorities and commissioners to support (1.6.10, 1.6.11 and 1.6.12) providers would enhance recognition not only of the skills and knowledge of the workforce but also of the pressures associated with poor pay rates – which in turn may support arguments for higher funding.	
Agincare	3	Q3.			Definitely in the 3 key areas described and of these especially	Thank you for your comment. The Guideline Committee

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					services meeting aspirations and/or a greater focus on establishing/communicating transparently the service expectations which can reasonably be expected and working towards resolving any gap between customers' expectations and the service as commissioned/possible to provide at the point of commencement. Also, working far more effectively in an integrated way between providers, heath and local authorities at a strategic and operation level. If there is a shortcoming in the NICE guidelines and recommendations we feel it is that it says largely the same things that are already said in existing regulations and in order to effectively change culture and practice there is a great deal to do to improve structures and processes to make these a reality without sufficient guidance on how this should be being done. The guidelines refer to 'lead practitioners' but as far as I can see, this isn't defined – planning and delivery of home care could be improved by appointments of a lead practitioner to liaise and work across	recognised, and discussed extensively, the need to manage expectations in terms of what support people need, what they can expect to receive and what services should be providing. To this end, the involvement of people in developing and planning their own care is a theme throughout the guideline and referenced explicitly in recommendations 1.1.1, 1.1.3, 1.1.6, 1.3.5 and 1.3.13. In general, the guideline aims to complement existing legislation rather than repeat it. However, there were some areas where the Guideline Committee thought it particularly important to reference and build on legislation. For example, recommendation 1.2.1 references the Care Act requirements of local authorities in respect of information provision, mainly to demonstrate how this guideline goes beyond the statutory minimum to provide more detail about what should be provided. The Guideline Committee also wanted the recommendations to address structure and process specifically (for example the role of the care coordinator, 1.3.6, and the need for integration, e.g. 1.3.7) as these were thought to be key

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					health and social care boundaries bringing the whole package together. Until the 'them and us' boundaries are breached between the 'professionals' and care providers/care staff, the recommendations of this guidance, the Care Act or of the fundamental standards will not be achieved in terms of person centred care, partnership working, involvement and information etc.	changes that could make a difference to the quality of, and people's experience of, care and support. The issue of professional boundaries and the need for the guideline to improve integrated working was discussed throughout the process. The Guideline Committee debated extensively the terminology to use when describing people providing care and support to users of home care. The term 'practitioners' was identified in order to recognise that a wide range of people contribute to delivering packages of home care including the voluntary and community sector, carers, personal assistants and others. The group thought that use of 'health and social care professionals' as a term could possibly lead to some workers not realising that the recommendations apply to them or being led to believe they do not. 'Practitioners' was intended to be more inclusive.
Agincare	4	Q4.			By commissioners who may have contracts/approved provider arrangements and used their purchasing power to achieve cost savings for their funded clients and/or residents generally.	Thank you for your comment which we will consider as part of the implementation work.

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					By care managers/social workers if they are involved in any initial assessment and by hospital discharge teams/hospital social workers in assessing the ability of patients being able to manage safely at home and provide telecare solutions to facilitate this. By social care providers (whether private or volcom) through their care assessment processes.	
Agincare	5	Q5.			Care documentation being IT led in order to create opportunities for staff to spend more time engaging with people than writing records. In terms of delivery, there are all sorts of telecare products from laser alarms to face time products to help in the delivery of call buttons, client operated confirmations on line of eg meds having been taken or simply confirmations they are well that day and no incident has occurred, life-styling monitoring and possibly the use of location devices. Contact/skype type devices, reminder alerts, heat and motion detectors, falls mats etc.	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. In addition, telecare is referenced in relation to the provision of information (see recommendations in section 1.2); planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4). We will also consider your comment as part of our guideline implementation work.
Agincare	6	Q6.			There could simply be the links to the key paras of the Care Act embedded. I disagree – apart from at the	Thank you for your comment. We have tried to highlight key areas where the recommendations build on

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					beginning saying the Care Act should be read alongside it (and who would actually read the Act – the guidance is more user friendly than any legislation!) it doesn't refer throughout to the new duties and responsibilities of local authorities or commissioners to actually do this stuff – which it terms 'recommendations' – surely any Act has associated regulations which are a legal 'requirement', not a recommendation – although it does clarify the terminology as those which are to be 'considered' and those which are a 'must'	requirements of the Care Act.
Agincare	7	Q7.			Yes, to those working in the industry it may clear but as above the links could be specifically embedded. Other legislation needs to be taken into account, so it should clarify also how the Regulated Activity Regulations 2014 (fundamental standard regs) under a different Act (HSCA) are embedded and how the Care Act and HSCA and Regs support each other, particularly in terms of regulation	Thank you for your comment. We have added a reference to the Regulated Activity Regulations into the Context section. We will also consider during the implementation phase whether people using the guideline might want a tool which specifically maps the recommendations to legislation and regulations.
Agincare	8	Q8.			They include requirements for information and guidance to be given to customers – this requirement already exists but it contributes to equality of opportunity re: service awareness, provided the information	Thank you for your comment.

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					provided is accurate. Agree overall, however this already exists from a provider perspective; it's the working with/collaboration that needs clarity so where brokerage for example arranges support, how much information do they currently give (and will this change) about the Providers they are recommending/contracting with?	
Allied Healthcare	1	Full	General	General	The draft is disappointing. Most of the recommendations are not supported by any evidence (at all) of effectiveness. Even where the recommendation is reliant on the preferences of those people looked after, their families/carers, or care work teams there is no comparative data on different models of delivery. As such the survey respondents have not been in a position to choose from a range of experiences.	Thank you for your comment. We agree that the evidence base for home care was limited. We systematically reviewed the outputs of rigorous searches of databases (see App A), and prioritised experimental or quasi-experimental studies, of which there are very few. However, the themes from qualitative studies reported within the guideline did seem consistent in terms of identifying 'what works for them', and from the user perspective it therefore appears that the way in which a service is delivered is rather more important than different 'models'. We did however find some good quality evidence, and also some strong, consistent themes, particularly from studies of user and carer views. In addition, the

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						Guideline Committee did make research recommendations which we hope will help to respond to the paucity of evidence on this topic at the current time.
Allied Healthcare	2	Full	General	General	Many of the recommendations are not even specific to home care but have the appearance of conventional wisdom on good management of any service (recruit the right people, provide relevant training, schedule work accurately, deal with issues that arise).	Thank you for your comment. The Guideline Committee did recognise that evidence was lacking or of poor quality in some areas. Many recommendations do relate to general good practice which includes good management of service because the Guideline Committee felt this is not happening consistently in home care.
Allied Healthcare	3	Full	General	General	There does not appear to have been any consideration of affordability nor cost-benefit analysis (e.g. offer care to those with lesser needs,).	Thank you for your comment. The Guideline Committee did consider cost and resources when making recommendations (please see section 3.8 evidence to recommendations).In addition recommendation 1.3.2 is about offering home care support to people with lower needs. This recommendation was informed by economic evidence (see also appendices C1, C2 and C3).
Allied Healthcare	4	Full	11	1.1.4	Prioritise continuity of care, using a core team of care workers, so that the person becomes familiar with them." Is insufficiently precise. It implies that a team of care workers is better than a single care worker and	Thank you for this comment. The Guideline Committee reviewed a wealth of evidence, much of which was on user and carer experience, showing that continuity of care was extremely important for a variety of

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					then gives no indication of team size – there is no evidence presented for either scenario.	social, practical, emotional and safety reasons. Please see the full evidence to recommendations tables in section 3.8.2 of the Full Guideline, which reflects some of the discussion and the scope of this point. The Committee was however mindful that it might well not be possible to provide a single care worker for a person needing intensive support, and that it was in the interests of the person being supported to get to know more than one person to cover holidays and other absences.
Allied Healthcare	5	Full	12	1.2	No merit in repeating the requirements of legislation. Compliance with legal duties is a pre-requisite. Some of the detail provided has no basis in evidence of effectiveness or cost-effectiveness. Some of this section is merely a summary of conventional wisdom on good communications without any evidence that it improves homecare (outcomes).	Thank you for your comment. Where possible we have referenced relevant legislation in order to help providers and commissioners build on the legislation to provide high quality home care. Although compliance with legal duties is mandatory, there may be different ways of fulfilling or building on requirements. We sought available evidence on information provision, but much of this concerned needs rather than efficacy. Please see the associated evidence to recommendations tables at section 3.8 for background and rationale to these recommendations

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						which, as you will see are informed by Guideline Committee members' extensive experience.
Allied Healthcare	6	Full	14	1.3	The purpose of this recommendation is not clear. Of course, there should be a "multidisciplinary team, where required". This could be equally said of any health or care activity reviewed by NICE. The specific recommendations are mostly without any evidence they improve homecare (outcomes).	Thank you for your comment. We have removed the reference to multidisciplinary teams throughout (except where it is used in cited quotations) because the Guideline Committee felt it was insufficiently explicit. Recommendations now include reference to practitioners supporting older people using home care, as appropriate. There remains however an assumption that an older person who is using home care will have healthcare needs, although evidence cited often does not specify who delivers it. The activities specific to healthcare practitioners that do not involve integrated working with home care workers are outside the scope of the guideline.
Allied Healthcare	7	Full	14	1.3.3	Although it seems sensible to have a "lead practitioner" there is no evidence that this improves homecare (outcomes).	Thank you for your comment. We highlight in the evidence to recommendations at section 3.8 of the full guideline tables that, while there was no effectiveness or cost-effectiveness evidence on multi-disciplinary team working, there was considerable evidence from views and experiences, and from Guideline Committee members' experience that led them to make recommendations

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						on this area. Both sources strongly suggest that people need to know who is 'leading' their care, and who they should contact if they have problems.
Allied Healthcare	8	Full	15	1.3.5	No evidence to substantiate… "is likely to have a positive impact on psychological wellbeing at a relatively low cost, and that it can help people to feel more in control over their daily lives."	Thank you for your comment. The evidence underpinning this recommendation came from the economic analysis undertaken as part of guideline development, the details of which can be found in Appendix C3.
Allied Healthcare	9	Full	15	1.3.6	No evidence to substantiate… "it may mean that they need less intensive support later on or may delay the time at which support is needed." It may not too.	Thank you for your comment. In addition, early economic analyses (Netten and Forder, 2007, Forder et al, 2013) suggests that home care might be more effectively allocated to include people with low to moderate needs for home care (possibly to prevent further deterioration). The Guideline Committee thought it important to emphasise the potential benefit of providing home care to people before their needs become critical, based on economic evidence above, their own experience and expert witness testimony that need for home care hours could fall if people were encouraged to regain independence and confidence, and were introduced to other community services and support networks. The

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						Committee noted too that this was aligned with the emphasis on prevention in the Care Act 2014. This is noted in the Linking Evidence to Recommendations table on **Planning and reviewing home care and support** on p170.
Allied Healthcare	10	Full	15	1.3.8/9	There is no evidence that the source of payment for a provider changes the effectiveness of homecare (outcomes).	Thank you for your comment, however, expanding choice is a key aspect of person-centred social care provision, and these recommendations are aimed at ensuring people have information about the choices open to them and support to exercise choice, so far as possible.
Allied Healthcare	11	Full	16	1.3.12	It is not always practicable to provide information before meetings. Often actions are needed quickly. There is no evidence that this improves homecare (outcomes	Thank you for your comment. This recommendation (now re-numbered as 1.3.10) was considered by the Guideline Committee as best practice, supporting person-centred care and involvement, and the evidence reviewed on what home care users and carers want. Although there will be circumstances in which it is not possible to prepare people in this way, the recommendations are aspirational.
Allied Healthcare	12	Full	17	1.3.15	It should be clear that the home care plan not only addresses preferences but also considers the effectiveness	Thank you for your comment. The recommendations on person-

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					of care (in improving outcomes). For example, people may need encouraging to act even when they prefer not to do something. For example, being encouraged to walk when they might prefer to stay seated.	centred care - and the person-centred focus to the recommendations on care planning - aim to make clear that the plan must be mutually agreed. There are also recommendations relating to the need to identify and negotiate mutual expectations and risks (1.1.3 and 1.3.15). The effectiveness of activities such as walking was outside the scope of the Guideline.
Allied Healthcare	13	Full	18	1.3.19	There is no evidence to substantiate the recommendation that telecare should "always" be discussed. This issue is overstated	Thank you for your comment. Given the nature of the telecare evidence base (discussed in detail in the full guideline), the Guideline Committee spent considerable time discussing this issue, informed by their experience and expert witness testimony. The evidence to recommendations section 3.8 of the full guideline (table) states that this recommendation was agreed by consensus, recognising that while the majority of home care users do not need 24-hour care, they may benefit from devices which provide 24-hour support of some type. They also noted that telecare can encompass a very wide range of technologies. The Committee recommended further research on telecare.
Allied Healthcare	14	Full	18	1.3.20	There is no compelling evidence in the draft that telecare confers	Thank you for your comment.

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					benefits in many circumstances nor that it provides reassurance.	Given the nature of the telecare evidence based (discussed in detail in the full guideline), the Guideline Committee spent considerable time discussing this issue, informed by their experience, expert witness testimony and evidence statements. In particular, there is evidence on: - impact of telecare on wellbeing (ES6.1) - hospital use and admissions (ES6.2) - impact on independence and perception of safety (ES6.3) - reassurance felt by carers (ES6.7) The focus in the guideline is on giving users of home care access to telecare should they wish to use it. The Committee has made a research recommendation to address gaps in evidence on effectiveness within home care packages.
Allied Healthcare	15	Full	19	1.3.25	There is absolutely no evidence that a review of a home care plan "after about 6 weeks" has any impact on effectiveness. This time period is arbitrary. The recommendation is far too specific.	Thank you for your comment. The Guideline Committee agreed, by consensus, that it was important to specify a time period to ensure that the recommendation is actioned. This was discussed again at Guideline Committee12. Committee members agreed, for 1.3.25, that six weeks is an

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						appropriate period – although changed the wording at Guideline Committee 12 to 'within six weeks - as they thought it sufficiently long to ensure care is established but soon enough to identify and respond to any care that is not benefiting the person. The Guideline Committee also highlighted that this period was aligned with standard practice in respect of reablement services, based on their experience.
Allied Healthcare	16	Full	19	1.4	The many recommendations have almost no evidence base (of contributing to effective homecare). Many of the specific recommendations here are simply a list of work procedures (e.g. don't miss a visit, let people know if you're late, have a complaints process, schedule accurately). These are all equally true of all services.	Thank you for your comment. The limited effectiveness evidence was supplemented by very extensive research evidence of what was important and what did not always happen from the perspective of service users and carers. This rich data was complemented by Guideline Committee members' extensive expertise in home care provision. The guideline aims to describe good practice, triangulating evidence from a range of sources. They may be "equally true" of most person-centred services, but the point of including these within this guideline is that attention to these provisions was considered to be essential to the delivery of high

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						quality home care services.
Allied Healthcare	17	Full	19	1.4.2	Whilst supportive of the principle that visits should meet both physical and psychological needs there is no evidence to support a specific duration (of 30 minutes as opposed to another duration).	Thank you for your comment. The time needed to deliver appropriate care and social and psychological support was discussed extensively and informed by expert witness testimony and by extensive research data from service users, carers and home care practitioners. These different sources corroborated the view that the time allotted for home care visits was often too short to deliver good care, respond to unexpected events and support older people who may need time to talk, wash, eat or dress. Recommendation 1.4.1 supports this general point The more specific point on timing was agreed as appropriate by the Committee, and takes into account the consultation comments. The consensus was that visits shorter than 30 minutes (often to a person who may be housebound) were inappropriate. The recommendation reached by Committee consensus now reads: 1.4.2 Home care visits shorter than half an hour should be made only if: • the home care worker is

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						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.
Alzheimer's Society	1	Q1.			Alzheimer's Society offers a homecare service and as such we would follow the recommendations as part of the service. We would also use them as a benchmark of minimum standards and good practice when providing people with information or advice. The guidelines would also be of use when we campaign on issues relating to good care in the home.	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
Alzheimer's Society	2	Q2.			The recommendations relating to person centred care are of particular importance to Alzheimer's Society as we believe people with dementia must have a say in the type of care they receive and also have an opportunity to discuss their aspirations and goals during the planning of their care package. It is especially important that people with dementia have a lead co-ordinator for their care services and we would suggest this role could be filled by a Dementia Adviser.	Thank you for your comment.
Alzheimer's	3	Q3.			•The provision of home care visits no	Thank you for your comment and

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Society					shorter than 30 minutes is supported by Alzheimer's Society and we strongly believe this must be regulated by the next government. •People with dementia and their carers must be involved from the outset in the development and planning of their care package. •It is vital that both health and social care work together to deliver a person centred, holistic care package for people with dementia. •Specialist training should be mandatory for all staff providing formal care to people with dementia, this is especially important for new staff that may not have any experience of working with people with dementia. This will promote the importance of dignified and compassionate care towards people with dementia. In addition, this training would help workers elicit the views and aspirations of the person with dementia which will assist in the planning of their care. •Commissioners should ensure frontline care staff have access to specialist support, for example	your support for this recommendation. Regulation is out of scope for the guideline, however, we anticipate that the recommendations will be of interest to those in regulatory bodies and will record this to follow up as part of our implementation work. The involvement of people in developing and planning their own care is a theme throughout the guideline and referenced explicitly in recommendations 1.1.1, 1.1.3, 1.1.6, 1.3.5 and 1.3.13. There was insufficient evidence to indicate that specialist training should be available to all staff, however, recommendation 1.7.4 identifies the need for workers to be able to identify and respond to common conditions such as dementia and 1.7.5 emphasises the need for specialist support to be available. Responding to the gap in evidence, there is also a research recommendation on the best models for training staff (2.3) and the most effective and cost-effective way to provide specialist dementia support (2.4).

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					through commissioning community and hospital mental health liaison teams.	
Alzheimer's Society	4	Q4.			People with dementia benefit from an early consideration of different types of telecare. Too many people are diagnosed late meaning they often do not receive appropriate or timely access to assistive technology including telecare. Early intervention is necessary and offers an excellent opportunity to enhance the quality of life of both the individual with dementia and their carer. Getting the right support in place early may mean that an individual can continue to live in an environment of their choice with independence and dignity, and help to ensure that the appropriate assistive technology package is provided to them. However, access to telecare should not require a formal diagnosis. It is important to remember some people with dementia may feel stigmatised by telecare so it is important that they are consulted on whether they are happy to use it.	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. Telecare is also referenced in relation to the provision of information (see recommendations in section 1.2) planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4). We will also consider your comment as part of our guideline implementation work.
Alzheimer's Society	5	Q5.			Alzheimer's Society knows that telecare such as sensory, gas or carbon monoxide alarms which alert a carer or warden can be very useful for people with dementia and can help to keep them safe. However, a	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. In

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					thorough assessment of needs should always be carried out to ensure people are not in receipt of technology that is neither of no use or any help to them. In addition, there is currently very good work on assistive technologies going on within the G7 group of countries, with Japan taking a particular lead on developing innovative technologies for people with dementia. Further information on Japan's assistive technologies projects can be found here http://www.rehab.go.jp/ri/kaihatsu/dementia/top.html. It may be useful to explore some of the ideas suggested as they could be adaptable for people with dementia in the UK.	addition, telecare is referenced in relation to the provision of information (see recommendations in section 1.2); planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4). We will also consider your comment as part of our guideline implementation work.
Alzheimer's Society	6	Q6.			The Alzheimer's Society welcomes the guidelines focus on making care person centred (Recommendation 1.1), a key principle of the Care Act, and believes people with dementia and their carers must be involved in planning and developing the care plan. The guidelines relate to the Care Act's requirement to provide information on care services available (Recommendation 1.2) and also covers the Care Act's requirement to safeguard adults (Recommendation 1.5). The	Thank you for your comments. Many of the recommendations provide some detail of how aspects of the Care Act can be supported (e.g. those on person centred care (1.1.) and provision of information about care options (1.2). However, the process of reaching recommendations (see section 3 of the full guideline) followed a process developed by NICE, beginning with research evidence, and the guideline aims to complement existing legislation rather than repeat it. The

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					guidelines touch on the requirement of the Care Act to provide independent advocates for people but this could be strengthened. People with dementia may need to use an advocate and an explanation of their role within this guidance would be supported by the Alzheimer's Society.	relationship between existing guidance and mandatory requirements and the recommendations in this guideline is likely to be something we will consider as part of implementation. Although we have referenced advocacy in several recommendations (e.g. 1.3.7 on who should be part of the coordinating group; 1.3.11 on offering advocacy), the Guideline is focussed on home care, and it has not been possible to explore all elements of support.
Alzheimer's Society	7	Q7.			Yes. The guidelines relate to both the Health and Social Care Act 2008 and the Mental Capacity Act. The Alzheimer's Society welcomes the guidelines introduction which advises all involved in the provision of home care to take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment. It would be beneficial to stress throughout the guidelines that they must be read in conjunction with the Mental Capacity Act 2005 as mentioning this at the beginning of the guidelines only may not be strong enough.	Thank you for your comment.

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Alzheimer's Society	8	General	General	General	Alzheimer's Society welcomes these guidelines and believe they recognise the importance of making home care holistic and person centred. Alzheimer's Society believes that people with dementia who wish to remain in their own homes should be supported to do so for as long as possible. Good quality care at home can reduce admissions to acute hospital care and early entry into care homes (Alzheimer's Society, 2011). We believe that home care services must be of high quality and ensure that people with dementia are treated with dignity and respect. Evidence gathered for the All-Party Parliamentary Group on Dementia inquiry in 2011 (APPG on Dementia, 2011) found that high quality services ensure that people with dementia can remain living in their own home longer than those who have insufficient support. In addition, delaying individuals' entry into a care home could save the NHS and local authorities around £72 million for each month of delay (APPG on Dementia, 2011) Alzheimer's Society believes that commissioners must prioritise spending on community dementia services to reduce pressure on long-term care and	Thank you for your comment.

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					acute services.	
Alzheimer's Society	9	General	General	General	The guidance makes inconsistent references to the person receiving care and 'their representative' either being given information or being consulted. Alzheimer's Society would welcome the addition of 'and their representative' to all recommendations relating to these issues as people with dementia may lack capacity to make informed decisions on their own. In addition, the guidelines should be clearer on who a representative is in the legal sense, for example who is a Health and Welfare power of attorney. It should also be emphasised that people who do not have these legal powers should still be involved to find out as much as possible about what the person would have wanted.	Thank you for your comment. We have reviewed the language to ensure we now use the term carer consistently throughout. We have also made explicit reference to the need to ensure the person using services can stipulate who they would like involved in their care and support (and whether any information should be shared with their carer). In addition, the section on person-centred care references the issue of consent and capacity. As the guideline is on home care, we were unable to provide detail in the many recommendations involving carers of the possible meaning of carer or representative.
Alzheimer's Society	10	Full	11	18	Considering that two thirds of people with dementia live in the community Alzheimer's Society would request that specific training on dementia is given to all home care workers. This will ensure dignified and person appropriate care is given.	Thank you for your comment. The Guideline Committee agreed the importance of ensuring condition-specific support is available, as appropriate and the following recommendations seek to address this (with 1.3.9 and 1.6.4 referencing dementia explicitly): • Recommendation 1.1.5 references the need for provider

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						organisations to ensure matching of people using services to workers takes account of the person's care and support needs. • Recommendation 1.3.9 makes clear that those involved in coordinating and planning care and support understand common conditions affecting people using services. • Recommendation 1.6.4 references the need for workers to be able to recognise and respond to conditions affecting the people they support. There is also a research recommendation on training and development.
Alzheimer's Society	11	Full	12	1	Alzheimer's Society welcomes the idea of matching care workers to people's needs and would support a focus on matching people with experience of dementia care to people with dementia.	Thank you for your comment. The Guideline Committee debated whether to provide lists of specific conditions at several points throughout development. They agreed that, as it was not possible to provide a comprehensive list of all conditions affecting all people using home care, recommendations should instead focus on the need for care to

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						be person-centred care. In two cases a small number of common conditions are provided by way of example. Dementia is referenced explicitly here.
Alzheimer's Society	12	Full	13	6	People with dementia living alone are more likely to become socially isolated and unable to access key services (Alzheimer's Society 2013). They are also more likely to feel lonely. Alzheimer's Society believes that having opportunities to interact socially and take part in activities are important to maintaining a good quality of life. Therefore we would welcome the addition of 'local support AND ACTIVITY GROUPS' as groups such as walking groups can benefit a person with dementia both mentally and physically whilst enabling them to keep socially active.	Thank you for your comment. We have now made reference to 'activity groups', as requested. Although there was no research evidence of required quality that demonstrated the impact of activity groups for people with dementia, the experience and consensus among the Guideline Committee was that these were useful to people with dementia and their carers.
Alzheimer's Society	13	Full	14	3	Alzheimer's Society endorses the guidelines recognition that information must be presented in different formats but feel that services providing information should also ensure that information is not just available digitally, but is accessible and useful to people with dementia. This point should be emphasised in the guidelines as Alzheimer's Society research suggests that less than 1 in 10	Thank you for your comment. We think recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list.

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					people with dementia use the internet.	
Alzheimer's Society	14	Full	14	15	Addition of 'befriending and specialist services INCLUDING DEMENTIA ADVISERS'. The Healthbridge evaluation report carried out by the Department of Health in 2013 found that Dementia Advisers had benefited people with dementia and their carers. The scheme was found to have 'helped people to find new meaning and purpose' and 'helped them to access other services and support through information about services and advice about day-to-day life.' Alzheimer's Society believes dementia advisers should be included in this recommendation so as to endorse the service.	Thank you for your comment. The Guideline Committee was familiar with the work of dementia advisers and therefore decided to include them. We did not find evidence of effectiveness or views in our searches on this topic.
Alzheimer's Society	15	Full	18	7	Recommendation 1.3.19 – it is important for home care providers to be sensitive to the fact that telecare only benefits some people with dementia if it is complemented by personal interaction and support.	Thank you for your comment. The reference to the complementary nature of telecare was intended to reflect the point that this type of support should not be seen as a replacement for personal contact. This is described in more detail in the account of the review work on telecare and the corresponding evidence to recommendations table at section 3.8 of the full guideline.
Alzheimer's Society	16	Full	18	7	In order for telecare to be most effective and useful, its implementation must be carried out	Thank you for your comment. We agree that telecare should be discussed early on in the planning

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					at the earliest opportunity. As such Alzheimer's Society would welcome the inclusion of 'AT THE EARLIEST OPPORTUNITY discuss the potential benefits of telecare…'	process, and this is the reason why it is referenced as part of both home care planning and delivery. Including it in both sections is intended to capture the point that (a) it should be both considered early on, and (b) its use and effectiveness should be reviewed on a regular basis.
Alzheimer's Society	17	Full	19	4	The word 'consider' to be replaced by 'Should' as it is vital people have only one home care and support plan.	Thank you for your comment (on recommendation 1.3.26). We have clarified the references to the home care plan throughout the recommendations. However, recognising that a home care user may have a number of other needs for support in the home, including health care, the Committee felt that it would be difficult to appear to insist that all parties should work to a single plan. There was also no strong evidence to support the proposition that shared home care and support plans produce better outcomes. It is agreed that a single home care and support plan held in the home is desirable, but would need to be negotiated with different providers. The verb 'consider' rather than 'must' or 'should' is generally used in such circumstances.

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Alzheimer's Society	18	Full	19	28	As part of the Alzheimer's Society's election manifesto we ask the government to 'Regulate that home care visits should be no less than 30 minutes' so would not support a home care visit less than 30 minutes under any circumstances for a person with dementia. A shorter visit may lead to increased stress and anxiety for a person with dementia. We feel this point should be strengthened within the guidelines as what is appropriate for one person receiving home care may not be appropriate for people with dementia receiving home care. Alzheimer's Society agrees that 'Delivering services that support the aspirations, goals and priorities of the person using them' and 'Helping people to determine which care options will best meet their needs and preferences' are important and will require a change of practice. In order to overcome any challenges the Alzheimer's Society recommends that home care workers involve the person with dementia and their carer at the earliest opportunity and make an effort to get to know the person's history, culture, likes and dislikes so that their goals and aspirations can be recognised and a person centred	Thank you for your comment. We received a number of comments on this recommendation. The time needed to deliver appropriate care and social and psychological support was discussed extensively and informed by expert witness testimony and by extensive research data from service users, carers and home care practitioners. These different sources corroborated the view that the time allotted for home care visits was often too short to deliver good care, respond to unexpected events and support older people who may need time to talk, wash, eat or dress. Recommendation 1.4.1 supports this general point The more specific point on timing was agreed as appropriate by the Committee, and takes into account the consultation comments. The consensus was that visits shorter than 30 minutes (often to a person who may be housebound) were inappropriate. The recommendation reached by Committee consensus now reads: 1.4.2 Home care visits shorter than half an hour should be made only if:

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					care plan can be drawn up. With regard to the recommendation 'Working effectively in multidisciplinary teams coordinated by a lead practitioner', the London Borough of Greenwich have developed a Dementia Strategy which concentrates on people with dementia staying in their own home for as long as possible and using a collaborative approach to do so. Their detailed plan can be found here: http://www.oxleas.nhs.uk/site-media/cms-downloads/Dementia_Strategy_2013-2016.pdf, with pages 9 and 10 of particular value. Alzheimer's Society would encourage a similar approach across the country.	• 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.
British Geriatrics Society	1	Q1.			They will make helpful guidelines for the expectations community staff can have of their colleague delivering care at home.	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
British Geriatrics Society	2	Q2.			1.3. Planning and reviewing home care and support. This is critical to ensure the right care is delivered at the right time. There needs to be flexibility within that delivery to increase or decrease at short notice. The focus needs to be on this planning taking place at home with people who know the person best. There also needs to be a stronger emphasis on the integrated working	Thank you for your comments. The need to ensure provision is flexible was discussed extensively and is reflected in recommendation 1.3.20. The need to involve everyone who has appropriate knowledge about the person's care and support needs (to include practitioners, carers and people using services themselves) is reflected in 1.3.6 and 1.3.7 and the role of the coordinator in ensuring

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					of health and social care as people using services often complain that they have very similar assessments completed by both. Communication between teams is key. 1.6 Recruiting, training and supporting home care workers. The training of care workers needs to include an understanding of what and when to escalate concerns, and to whom. This is crucial in the management of complex frail older people. The training needs to include an understanding of being part of a whole team who are working together for this individual. Care agencies must be able to offer assurances that their workforce is competent for the level of agreed work, before taking it on. Training must include assurance of competency to manage equipment, and alert process of equipment failure. Currently the Care Agencies may dictate what care they would like to offer, regardless of the needs of the individual. This has particular reference to the administration of prescribed medication- agencies differ in their approach, which makes	these people communicate regularly is now emphasised as part of 1.3.6. Recommendations 1.7.4 and 1.7.6 highlight the need for home care workers to be able to recognise and respond to a range of conditions, situations and support needs. The response may be to escalate concerns. The escalation of concerns is also addressed in recommendations 1.6.1-1.6.5 which relate to safeguarding and safety. Medicines management recommendations (1.5.1-1.5.3 and 1.6.6) highlight the need for providers to have relevant policies and procedures in place and to work together in an integrated way. The guideline is intended to be read alongside existing guidance on administration of medicines (such as the NICE guideline on Medicines Management and the forthcoming NICE guideline on Medicines management in community settings).

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					for complicated person centred management.	
British Geriatrics Society	3	Q3.			1.4.10 and 1.4.12 not strong enough. It is the agency's responsibility to deliver the care commissioned. If one individual is not able to deliver, the agency must support with another. Form of support. GPs often field calls when carers do not attend. This needs to be diverted to the agency to empower the person using the service. 1.4.13 and 1.5.2 There also needs to acknowledgment of the records of other Professionals involved in care of the individual. These must be read and action taken, or further clarification sought. 1.5.2 mentions health practitioners offering written information regarding medicine and care planning and 1.5.8 that each agency has a medicines management policy, but these need to be universal and shared, so each understands the expectations of the other, and can then communicate about variations. 1.6.4 ALL mandatory training needs to be delivered through an agreed and assessed training programme before starting work with people who	Thank you for your comment. Following further discussion with the Guideline Committee, we have updated the text in relation to missed or late visits to strengthen these recommendations. We have also emphasised the need for all those involved in providing care and support to be encouraged to contribute to the care plan and care diary, to help ensure information is shared. There was insufficient evidence to make very specific recommendations about training; therefore this is the basis of a research recommendation.

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					use services. This is the responsibility of the agency, and needs to be monitored, and this needs to include administration of prescribed medication.	
British Geriatrics Society	4	Q4.			Telecare must be considered at all points of review of care needs for a person using services. This may be at initial assessment, but then at every review. It would be helpful to at least reference Telehealth within this document, as while healthcare staff will be the overseers for any telehealth interventions, if a person using care services is also using telehealth, for alerts from providers, and also to monitor their own health, it is vital that care staff have a working understanding of this, and understand the escalation	Thank you for your comment. We recognise that other interventions such as telehealth may be used by healthcare practitioners but these interventions were not within the scope of this guideline.
British Geriatrics Society	5	Q5.			The most useful and most extensively used are the 'careline' systems to alert absent carers of falls. There has been good uptake of these because many health care professionals are aware of their value as a damage limitation as part of a falls prevention pathway. Many care homes supporting people with dementia use motion sensor equipment with very good effect to indicate when residents are moving	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. In addition, telecare is referenced in relation to the provision of information (see recommendations in section 1.2); planning of home care (see recommendations in section 1.3) and delivery of home care (see

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					about, although this is beyond the scope of this guideline. Monitors for people who lack capacity, but are being supported to live at home to alert of doors opening are also used, but would be considered specialist 'social services' equipment and have a slow time lag to issue. They would often not be considered as part of a discharge plan, as the time to install would be too slow to facilitate a hospital discharge, but would often enable a person to return home, rather than entering residential care.	recommendations in section 1.4). We will also consider your comment as part of our guideline implementation work.
British Geriatrics Society	6	Q6.			It is helpful having the Act embedded in the guidelines to encourage reading together.	Thank you for your comment.
British Geriatrics Society	7	Q7.			This is outlined, but could go further in terms of reference integration of Health and Social Care. This is an opportunity to really endorse integration of person centred care, and the document would be improved by ensuring that the integration in unequivocal.	Thank you for your comment. The importance of integrated working is referenced within the recommendations (e.g. recommendations 1.3.15 & 1.3.16; 1.5.1-1.5.3). However, in relation to this topic, the Guideline Committee had to consider how the home care worker might better liaise with the group of practitioners looking after the person, and could not fully include the topic of integration.
British Geriatrics Society	8	Q8.			Statement for equality of opportunity is clear.	Thank you for your comment.
Department of	1	Full	19	1.4.2	Current DH policy is to encourage a	Thank you for your comment. The

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Health					culture shift for commissioners to commission to meet personal outcomes rather than to commission for 'time and tasks'. Could you please consider an amendment to 1.4.2.: Our suggested amendment would be as follows: *"1.4.2. Home care visits must be of sufficient length to ensure that the care needs and personal outcomes of service users are met. Short visits – of less than 30 minutes - will normally only be appropriate if both:* - the visit is part of a wider package of support, and - it allows enough time to complete specific, time limited tasks (such as assisting someone to take medication) or to check that they are safe and well, for example. When these conditions are met and a short visit is used, it is particularly important that the home care worker is someone who is known to the person".	Guideline Committee reflected on this wording at and agreed to make it clear that both of these conditions need to be satisfied to render short visits appropriate. The recommendation now reads: 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. When these conditions are met and a short visit is used, it is particularly important that the home care worker is someone who is known to the person".
Independent Age	1	Full	General	General	We fully welcome these draft guidelines and the principles of excellent home care they seek to promote. We believe guidance in this	Thank you for your comments. It was not within the scope of the guideline to look at rates paid by commissioners for home care

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					area is prescient coming shortly after the implementation of the Care Act and at a time of great public concern for the treatment of older people in the care system. We think there is substantial evidence to suggest that financial pressures are jeopardising the quality of care services. We note the recent report *The Homecare Deficit: A report on the funding of older people's homecare across the United Kingdom* published by UKHCA in March 2015 which found that only 28 councils (of those surveyed) are paying a nominal rate of £15.75 per hour for care services which is the estimated rate for compliance with the NMW. Funding pressures can undermine excellent care services. We worry poor commissioning in particular could make it difficult for providers to meet these draft guidelines. Taking into account there is a new duty on providers to publish their CQC ratings, we encourage NICE to clarify how it anticipates CQC using these guidelines so that it can form judgements about which home care services can be rated as 'good' or 'excellent'.	services. The Care Quality Commission use NICE guidelines as evidence to inform the inspection process and NICE quality standards to inform ratings of good and outstanding. Please see the Introduction and Context sections in the guideline, which articulate the relationship between NICE guidelines, quality standards and the CQC.
Independent Age	2	Full	11	10	We welcome this recommendation and its clear relationship to the	Thank you for your comment. The Equality Impact Assessment

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					principle of wellbeing as defined by the Care Act. We agree that excellent home care focuses on maintaining people's current strengths or help with regaining lost abilities even if the care tasks take longer as a result. We recommend the guidelines refer to individuals with sensory impairment, as set out elsewhere in recommendation 1.4.4, as also being at increased risk of unmet social-care-related quality of life needs or worse psychological outcomes. There is considerable evidence adults with sensory needs don't necessarily always get their full range of social care-related needs met, including help with communication and taking part in social activities. RNIB's 2013 report, *Facing Blindness Alone* revealed that between 2005 and 2013, there was a 43 per cent decline in the number of blind and partially sighted people in England getting even the most basic types of council support - down from 55,875 people to 31,740, nearly 25,000 fewer people. The research, commissioned by RNIB using Health and Social Care Information Centre figures, showed that although care and support had declined for all adults with a physical disability (30	does reference the needs of people with communication difficulties, and/or sensory impairment, and although there was no research evidence which explicitly considered home care interventions for people with sensory impairment, there were many recommendations made which were relevant to addressing the needs of the many older people with sight, hearing and cognitive loss, whenever acquired. Time allocated to visits, to support increased help with everyday living, eating, etc. are clearly crucial. The Committee also considered that the home care package needed to draw on information about a person's aspirations and opportunities, and how they gained information about these. The recommendations focused on reducing social isolation are aimed at all groups of people using home care services.

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					per cent), people with sight loss had been the worst affected (43 per cent).	
Independent Age	3	Full	11	27	Full agreement - We recognise from our interactions with older people and carers the importance of maintaining as consistent a team of care workers as possible. We believe this guidance is particularly relevant to home care services for people with cognitive impairment.	Thank you for your comment.
Independent Age	4	Full	13	6	We welcome this recommendation as promoting the provision of good information and advice about support services as set out in the Care Act. We support recommendations made in the report produced by The Department of Health, ADASS, and SOCiTM *The development of online services for information and advice supporting the Care Act 2014* that information and advice should not be restricted to existing 'service users'. Information and advice services should in fact be made available more widely and need to effectively reach self-funders, carers and wider family and friends. Critically, local advice agencies and the voluntary sector need to have an opportunity of promoting their own information and advice on home care. We also agree with the point that disproportionate reliance on information and advice	Thank you for your comments. We did not find any evidence in relation to website design, or indeed highly specific to information formatting, but your comments will be passed on to the team dealing with implementation of the guideline.

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					only being made available through a local authority's website, or third party websites, is unlikely to meet all the authority's duties under the Care Act, or indeed, public bodies' responsibilities under the Equality Act 2010. To help with development of online services as DH, ADASS and SOCiTM have advised, we would recommend improved website design and ongoing monitoring of online services with the view to making appropriate improvements.	
Independent Age	5	Full	15	8	We support guidance that home care should be provided to individuals with low to moderate needs as defined by the Care Act. We recognise that councils have flexibility under the Care Act to be more generous in the level of needs they provide support for but are not required to do so.	Thank you for your comment.
Independent Age	6	Full	16	28	Full agreement - This criteria ensures that councils do not just prioritise personal care needs but also the general wellbeing and care planning of individuals with an emphasis on maintaining social connections and personal interests.	Thank you for your comment.
Independent Age	7	Full	18	19	We think this recommendation is particularly important for realising the objective of person centred care within home care and creating more responsive care services more	Thank you for your comment The Guideline Committee agreed that this was critical to person-centred (rather than task-centred) home care. The need to ensure the person's social

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					widely. We think that home care workers should be encouraged to ask more probing questions about what care services their service users might require in order to anticipate demand and signpost to relevant support agencies. We believe that home care workers should be encouraged to ask service users about their satisfaction with their current levels of social contact in order to avoid the negative impact of long-term loneliness, which the Campaign to End Loneliness among others have illustrated can have adverse health impacts.	needs are supported is referenced in 1.3.13. The need to provide people with information about how their plan can be negotiated and renewed is covered in 1.3.10. The need to ask people about the things that are important to them is referenced in recommendation 1.3.20.
Independent Age	8	Full	18	24	We support this recommendation but would welcome further guidance from NICE detailing the rare instances when the provision of a home care plan for carers might not be appropriate. We believe it is worth clarifying that in the majority of cases carers should be provided with a copy of the care plan for the person they support. We would also suggest the phrasing of this recommendation be revised to make it clear that the phrase 'if appropriate' refers only to carers receiving a copy of the home plan and not the care service user him or herself.	Thank you for your comment. We have edited this recommendation to make clear that the plan should be shared with the carer only with the person's permission.
Independent Age	9	Full	19	13	Despite the benefits offered by	Thank you for your comment.

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					telecare we know from our contact with older people, as well as their carers', that personal contact is the preferred model for delivery of home care services. We would support this guideline ensuring that personal contact with a care professional remains the standard way of delivering home care. We acknowledge that in some cases a combination of personal care and telecare may well be the preferable option depending on the needs of the person and the support the carer requires. We would encourage signposting to telecare services for those people who have suffered multiple falls in the home. However, for carers looking after someone with cognitive impairment, who becomes anxious when left alone, we would rather see the promotion of sitting services, as opposed to providing telecare alone.	The reference to the complementary nature of telecare was intended to reflect the point that this type of support should never be seen as a replacement for personal contact or for other more appropriate services. This is described in more detail in the detail of the review work on telecare and the corresponding evidence to recommendations section 3.8 of the full guideline. .
Independent Age	10	Full	19	23	We particularly recognise the need for NICE guidelines in this area. For care workers to deliver person centred care services time for travel between appointments needs to be incorporated into formal contracts between commissioner and provider.	Thank you for your comment.
Independent Age	11	Full	19	28	We welcome guidelines which	Thank you for your comment.

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					generally deter commissioning of visits that last for shorter than half an hour. We would recommend a clearer definition of what constitutes 'a wider package of support' for justification of visits under half an hour. We acknowledge short visits should be permitted if the total package of home care across the entire day meets the person's care and support needs in full. When short visits are approved by providers we would encourage careful monitoring of service users' needs, to ensure that an increase in need is matched with an increase in time for the appropriate level of care to be delivered.	The wording of the recommendation about shorter visits reflects the detail of the evidence available to the Guideline Committee from views and experiences of users, carers and providers and expert testimony. The principles of person-centred care, and of taking into account an individual's circumstances and preferences, underpin the whole guideline. Your specific points on what constitutes 'a wider package of support' (which the Committee also considered within the context of an entire day), and how often provision is reviewed against need, is well made. We will pass your comments on to our implementation team, where further guidance on how to interpret and implement the recommendations will be developed.
Independent Age	12	Full	20	11	We think it is essential for promoting person centred care for managers and supervisors of home care services to account for the time necessary for staff to travel between visits. We would support attempts by commissioners to define a minimum - *appropriate* - allocation of travel time between visits, based on local variables, when commissioning home	Thank you for your comment. The wording of the recommendation reflects the detail of the evidence available to the Guideline Committee, and in particular reports from service providers. We agree that this is a crucial point (for the reasons outlined in the recommendation), although as you point out, there will be local

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					care services.	variables which must be taken into account. We will pass your comments on to the team working on implementation of the Guideline.
Independent Age	13	Full	20	14	Full agreement - We welcome this recommendation as fundamental to the better coordination of care and the success of the integration of such services.	Thank you for your comment.
Independent Age	14	Full	21	12	We think this recommendation supports the delivery of excellent care services. However, we believe NICE should consider how such visits (e.g. late arrivals by care workers) should be reported to managers and what evidence would be sufficient to support such reporting. We think the risk of missed visits should be monitored and the delivery of services reviewed if problems persist.	Thank you for your comment. The recommendations on missed visits have been edited following Guideline Committee discussion to provide more detail. They now (1.4.10-1.4.13) include much more detail about the plans that should be in place in respect of missed calls, the fact that this information should be included in risk assessment, and ensuring that monitoring of missed and late calls is embedded in monitoring and quality assurance.
Independent Age	15	Full	23	9	We welcome this recommendation as it helps promote a culture of transparency and open dialogue within home care services. This is particularly important as there is substantial evidence that older people are consistently reluctant to raise concerns regarding care services (Healthwatch England has provided recent evidence to this effect). We believe providers should	Thank you for your comment. The recommendations on safeguarding have not been changed, but having an internal anonymous complaints process would be an option. We will pass your comments onto the implementation team. This is also an area that might be addressed in the Research Recommendation 'What

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					make staff aware of their own internal complaints process, which ensure staff feel able to raise concerns anonymously and to an identifiable and impartial member of staff.	safeguarding practices are most effective in improving outcomes for people using services?'
Independent Age	16	Full	25	10	We support the need for staff to receive ongoing training and CPD. We think it would be beneficial if NICE guidelines state that such training must be paid for by the employer and that staff are not required to take annual leave to attend training courses. We make this recommendation in accordance with findings from the report *The Homecare Deficit: A report on the funding of older people's homecare across the United Kingdom* published by UKHCA in March 2015 which suggested that allowances for training were being absorbed into other budgets in order to comply with the NMW.	Thank you for your comment. It is not within the remit of the scope to recommend that interventions should be paid for by any particular party. However, we will pass your comment on to the implementation team, as clearly lack of funding will affect ability to implement training for home care workers.
Independent Age	17	Implementation	General	General	We agree with the three areas which NICE have identified as having the greatest impact on practice and implementation.	Thank you for your comment.
Leonard Cheshire Disability	1	Q2.			Preventative approaches We welcome recommendation 1.3.6, that commissioners should consider homecare for people with low and moderate needs. This recognises the	Thank you for your comments. The wording of the recommendations on the length of visits is informed by the evidence presented to the Guideline Committee by the expert

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					value of preventative approaches in maintaining and improving people's wellbeing over the longer term. Social care is seriously underfunded and facing crisis. Since 2010 spending on adult social care has fallen by 12 per cent in real terms, at a time when the number of people looking for support has increased by 14 per cent (ADASS). Without increased funding for social care thousands of people will be left without essential support. Saving money by cutting and restricting support for disabled and older people is not fair or sustainable in the long term. As well as leaving hundreds of thousands of people without vital support and facing crisis, failure to invest in social care is uneconomical, leading to increased avoidable spending on health, social security and other public services. As such, increasing funding for and access to social care services is essential to improve individual and population outcomes and to relieve pressure on public services. Delivering homecare – short visits Action to end the scandal of flying	witnesses, and Guideline Committee consensus.

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					care visits for disabled and older people is long overdue and we welcome recommendations 1.4.1 and 1.4.2 as amongst the most important recommendations in this guideline. At Leonard Cheshire Disability, we have been campaigning to end undignified flying care visits, which too often leave people forced to choose between a cup of tea or going to the loo. Our recent research has revealed how widespread these visits still are. We found that over 70 per cent of councils are still carrying out 15 - minute visits, with 8 of these councils delivering more than a third of visits in 15-minutes or less. As such, we are delighted NICE has been so clear in this guidance that this this practice is inappropriate and incompatible with the delivery of effective, personalised support. The recommendations in this guideline complement the statutory guidance accompanying the Care Act 2014, which directs that 'short home-care visits of 15 minutes or less are not appropriate for people who need support with intimate care needs, though such visits may be	

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					appropriate for checking someone has returned home safely from visiting a day centre, or whether medication has been taken (but not the administration of medicine) or where they are requested as a matter of personal choice.' However, we feel that these two recommendations should be worded more robustly to ensure that this NICE guideline is fully compatible with the statutory guidance accompanying the Care Act. We have suggested two options for this below: 1. An additional recommendation specifically addressing the issue of 15-minute visits could be added after recommendation 1.4.2. We would suggest In addition, commissioners should consider that home care visits of 15 minutes or less are never appropriate for people who need support with intimate personal care, unless they are a matter of personal preference or for medication checks as part of a wider care package. 2. Alternatively, recommendation 1.4.2 could be reworded in the following way:	

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					Home care visits shorter than half an hour should be made only if: •the shorter visit is part of a wider package of support containing longer visits, and •the shorter visit is intended to complete specific, time limited tasks, for example to check someone is safe and well or has taken medication, or •the shorter visit is made at the specific request of the individual. We believe it is essential that people are able to build lasting positive relationships with the home care workers supporting them and get to know them well. This is particularly important where someone is being supported with intimate personal care, to ensure they feel safe and comfortable with those supporting them. However, while we believe that it is essential that commissioners adequately fund homecare packages to ensure that providers are able to recruit and retain a stable and skilled care workforce (see further below),	

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					we do feel that this specific issue is most appropriately addressed in the recommendations for commissioners. We do not believe that the home care worker being known to the person is a sufficient justification for a visit of 30-minutes or less. In addition, ensuring continuity and quality of care staff is an operational issue for providers and is therefore more appropriately a recommendation for home care managers and providers - as in recommendation 1.4.7.	
Leonard Cheshire Disability	2	Q3.			High-quality, personalised care and support relies on vibrant, diverse and responsive local care markets. As care commissioners, local councils play a key role in ensuring people can exercise meaningful choice and control over their support, both in their role arranging support for individuals and in their wider role meeting the needs of their local population. It is essential that councils work to build a sustainable and diverse range of properly funded care and support services to ensure high quality, personalised support to everyone who needs it. Reductions in local government funding over recent years and the resulting need to reduce spending on	Thank you for your comments, which will be shared with the implementation team. The Guideline Committee thought it important to ensure there are recommendations aimed at both commissioners and providers, recognising that action will be required by both sets of stakeholders to drive the improvements set out in the recommendations.

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					care has changed the way council's commission care and support. While it is understandable that councils need to commission services with predictable and controllable costs, the current preference for 'time and task' commissioning is often too heavily focused on lowering costs and can result in inflexible and/or inadequate support for people. The price paid by councils for the care they commission is a key determinant of the quality of care delivered to disabled and older people. When commissioning care and support, councils must ensure that contract terms, conditions and fee levels for providers are sufficient to provide high quality, personalised care that is safe and effective. Councils should ensure that they are paying a fair price for care and support. For care at home this should be at or above the £15.74 minimum recommended by the UK Homecare Association. Fees paid for care and support should always: •Fund high quality, personalised care and support that is flexible and fully meets people's individual needs,	

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					preferences and aspirations; •Fully cover the costs of the workforce delivering this support, including payment of the living wage and travel time as well as supervision, training and ongoing professional development; •Take account of local labour markets and be set at a level which allows providers to recruit and retain a skilled, experienced and stable workforce; and •Recognise operating costs including statutory regulation and the management supervision necessary to meet fundamental standards of quality and safety.	
Leonard Cheshire Disability	3	Q6.			Please see our comments in relation to recommendations 1.4.1 and 1.4.2 (above) and also in relation to 1.5.1 (below).	Thank you for your comment.
Leonard Cheshire Disability	4	General	General	General	We feel that these recommendations are equally applicable to people of all ages receiving homecare, and as such we would welcome an extension of the remit of this guideline to include 'disabled and older people/people of all ages living in their own home'.	Thank you for your comment. The largest group of people using home care in England is older people (79%, Community Care Statistics: Social Services Activity Health and Social Care, England. 2013-14. Final Release. Health and Social Care Information Centre (2014). The older population is growing, and there is evidence that users of home care are

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						becoming older, frailer and have more long term conditions. The rationale for the focus on older people is provided in the Scope (and associated Equality Impact Assessment) and this is also discussed in the guideline's Equality Impact Assessment. We also note in the guideline that many of the recommendations will be relevant to younger adults.
Leonard Cheshire Disability	5	Short	7	1.12	This recommendation would benefit from the addition of a reference to the importance of respecting individual preferences in planning and delivering person-centred care. We would suggest amending the second bullet to read: 'that people have **individual preferences**, aspirations and potential throughout their lives …'	Thank you for your comment. The reference to preferences has been included.
Leonard Cheshire Disability	6	Short	11	1.3.6	Please see comments in response to question 2 above.	Thank you for your comments.
Leonard Cheshire Disability	7	Short	12	1.3.13	This recommendation would benefit from the addition of: 'Where practical and appropriate provide support to enable this, for example support accessing	Thank you for your comment. We have referenced the need to ensure people are offered advocacy support in section 1.4.

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					independent advocacy services.'	
Leonard Cheshire Disability	8	Short	12	1.3.15	In reference to the recommendation that practitioners should ensure the home care plan 'addresses the range of practical support needed to help the person to live how they choose, **~~as far as possible~~**, rather than addressing only personal care needs.' We welcome the intention of this recommendation but have some concern around the inclusion of the phrase 'as far as possible'. Supporting people to live the way they choose throughout their lives should be a priority for commissioners and providers.	Thank you for your comment. This has been deleted.
Leonard Cheshire Disability	9	Short	15 and 16	1.4.1 and 1.4.2	Please see comments in response to question 2 above.	Thank you for your comment. The time allowed for visits was discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony. This is captured in the relevant table at the evidence to recommendations table in section 3.8 of the full guideline.
Leonard Cheshire Disability	10	Short	17	1.4.8	We would suggest amending the wording of this recommendation to the following: Ensure home care workers are able	Thank you for your comment. This recommendation (1.4.8) has been edited to read Ensure home care workers are able to deliver home care in a way that

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					to deliver home care in a way that meets the person's cultural, **religious** and **communication** needs.	respects the person's cultural, religious and communication needs.
Leonard Cheshire Disability	11	Short	17	1.4.13	It is slightly unclear what 'and changes' refers to in this context. This recommendation would benefit from being more explicit, for example outlining that this refers to changes to the usual routines outlined in the person's support plan.	Thank you for your comment. At Guideline Committee12, the Guideline Committee reflected on and updated wording of the recommendations related to the care diary.
Leonard Cheshire Disability	12	Short	18	1.5.1	To reflect the statutory duties of both local authorities and the NHS to promote and facilitate integrated working, we feel this recommendation should be strengthened to read 'Should, where appropriate, liaise regularly with home care staff about the person's medication.'	Thank you for your comment. 'Consider' was used here to denote a weaker recommendation, as there is no research evidence on this point. However, the Committee did feel this was an extremely area for a recommendation, but could not be sure of current practice.
Leonard Cheshire Disability	13	Short	20	1.6.3	We feel that **'more than once'** should be amended to **'routinely'** to emphasise the importance of adequately training, mentoring and supporting new staff.	Thank you for your comment. This was discussed extensively and the Guideline Committee thought 'more than once' was the most appropriate term. There was a paucity of evidence on the impact of training on outcomes and there is a research recommendation focused on this issue.
Leonard Cheshire Disability	14	Short	20	1.6.4	This recommendation would benefit	Thank you for your comment. We have added in a reference to

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					from the addition of: Common factors impacting on the person's health and wellbeing, for example social isolation, quality of personal relationships and access to education, employment and volunteering opportunities.	'common needs' and provided examples (the recommendation is now 1.7.4). However, we accept that your point concerns the wider quality of life of the person, and this is reflected throughout the guideline (for example at 1.1.2).
Medacs Healthcare	1	Short	10	1.3.1 1.3.2 1.3.4	1.3.1, 1.3.2 and 1.3.4 The 'lead practitioner' to lead home care planning and co-ordinate care for each person is in theory a very good idea but we think the logistics of this happening are going to be difficult as we constantly have problems identifying and liaising with these people.	Thank you for your comment which we will consider as part of guideline implementation work. The term 'named care coordinator' replaces the term 'lead practitioner (see recommendations 1.3.6 – 1.3.9, for examples). The Committee acknowledged your concerns, and wanted to highlight flexibilities in who takes on roles, and that the roles are themselves critical.
Medacs Healthcare	2	Short	15	1.4.1 1.4.2	1.4.1 – 1.4.2 Visits shorter than half an hour – We think it is impossible to provide safe, caring, and effective care within time constraints	Thank you for your comment. The time allowed for visits was discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony, as well as the many comments received through this consultation. This is captured in the relevant evidence to recommendations section 3.8 of the full guideline.) The recommendation reached by Committee consensus now reads:

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						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.
National Care Forum	1	Full	General	General	NCF has a mission to support our members to improve social care provision and enhance the quality of life, choice, control and wellbeing of people who use care services" The National Care Forum supports organisations providing care and support services throughout the UK. Our members are chief executives and senior directors of their respective organisations. NCF promotes the benefits of the not-for-profit model of care services provision. All our activities are to assist our members in keeping up to date with developments in the care sector and to promote improvements in the quality of services: more about NCF	Thank you for your comments. Within the scope of this guideline, the Guideline Committee has an explicit remit to consider what is important to users of home care and their carers, and to supplement research evidence with good practice recommendations based on their own knowledge and experience from practice. As you identify, NICE guidance is based on the best available evidence. We have prioritised experimental or quasi-experimental studies to respond to questions of s effectiveness and we have supplemented these with qualitative evidence on views and effectiveness and the Guideline Committee's own experience from practice. NICE does have an established process for

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					NCF welcome the acknowledgement by NICE that this is a first for them as they are used to providing evidence based materials that are backed by law on drug trials etc. NICE have added that they could only include evidence based materials in the guidance and acknowledged that research in social care is limited. This limits the ability to have the guideline modified as any modification has to be supported by research evidence. As has been the case with other NICE standards and guidelines for Social Care request have been made for NICE to adapt that which they will consider as evidence. Within Social Care are many good initiatives which are well documented including the benefits to people who use services. However, because these sit outside of the existing NICE criteria it is not acknowledged or recognised. The research that has been used does not distinguish between privately commissioned care and local authority commissioned care which would clearly affect the findings of the data used. On the whole most of the recommendations are commendable but to follow all would not be affordable for care providers,	updating guidance and will consider the most appropriate data to search for, taking into account the evidence base, at the time of any update. Funding is not within our remit and it is not within the scope of the guideline to explicitly look at the funding of home care services. However, there are recommendations aimed at commissioners. More detailed work will be undertaken at the implementation stage on commissioning and cost impact. Your comment is a helpful reminder that the implementation work will need to consider the potential impact of resources devoted to home care on resources invested in other services. The guideline will indeed complement a range of other resources and the work on guideline implementation will consider how best to promote dissemination and uptake, within the context of the guidance and standards already available to the sector. There is no intention to suggest in the guideline that all home care is low level and low cost: however, the

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					particularly those reliant on local authority or CCG commissioned work (NCF members experience in the main is that care is procured not commissioned). Given that NICE standards and guidance are not mandatory how will this standard complement the significant number of resources that already exist from organisations such as SCIE and Skills for Care? The Care Certificate and Quality Credit Framework enable much (if not all) of what the NICE guidance captures to be embedded in practice through different routes. The guidelines do not reflect the relationship between funding and the quality of service delivery or clearly acknowledge the role that commissioning plays in service delivery and outcomes, it is alluded to but does not fully acknowledge the responsibilities of commissioners. The guidelines appear to suggest that home care is low level care and low cost and does not reflect the reality of the complex care that is now delivered to people at home (in line with the current government's policy for people to receive care at home for as long as possible),	economic analysis work does indicate that home care can have a significant impact on costs and outcomes for older people and this is now explained in the evidence to recommendations section 3.8 of the full guideline on **Planning and reviewing home care and support** (p. 170) within the section on Economic considerations

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					especially for people who have dementia and other conditions.	
National Community Hearing Association and British Society of Hearing Aid Audiologists	1	General	General	General	The National Community Hearing Association (NCHA) represents community hearing care providers in the UK. NCHA members are committed to good hearing for all and are responsible for the majority of adult community hearing care services in the UK with an excellent record of outcomes, safety and patient satisfaction. The British Society of Hearing Aid Audiologists (BSHAA) is the professional body for hearing aid audiologists providing hearing care to NHS and self-funding clients. They practise in large, medium and small companies and as sole practitioners; and they provide a professional, convenient and local service to people with hearing concerns in every community in the UK.	Thank you for your comment.
National Community Hearing Association and British Society of Hearing Aid Audiologists	2	Q2 & Q3			We welcome that the guideline notes the need for a person-centred approach to care. It is important and right that the guideline makes specific reference to sensory impairment but we feel this could be improved.	Thank you for your comment. The Guideline Committee debated whether to provide lists of specific conditions at several points throughout development. They agreed that, as it was not possible to provide a comprehensive list of all conditions affecting all people using home care, recommendations should

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					This is because we know that the prevalence of hearing loss in the population that need home care is very high (>70%) but that there is a lack of awareness about hearing loss. The consequences of unsupported hearing loss include an increased risk of cognitive decline, depression and social isolation. Support for hearing loss can mitigate these risks. Hearing loss in this population is therefore an unrecognised public health challenge. Based on the prevalence of hearing loss in the population that need home care, the risks of unsupported hearing loss, current unmet need, and cost-effective solutions that are available, we feel that all people in need of home care should have access to hearing care in order to minimise health inequalities. The guideline would therefore be improved by specifically stating the need for people in this group to have access to hearing care (rather than be grouped with sensory impairment). This would also be aligned with ongoing work by NHS England and the Department of Health (cf. 'Action Plan on Hearing	instead focus on the need for care to be person-centred care and to make reference to a number of common conditions and 'umbrella' terms for groups of conditions likely to affect many people who use home care services. Thank you for your comments on implementation challenges which will be considered as part of our implementation work.

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					Loss', 2015) and Monitor (cf. 'Exploring how choice is working in NHS adult hearing services', 2015), and consistent with other NICE guidance (cf. Quality Statement 4 - QS50). ABOUT HEARING LOSS AND HOME CARE • there are 8 million people in England with a hearing loss (90% are aged 50 and over) • age-related hearing loss is the main cause of hearing loss • age-related hearing loss is a long-term and progressive condition, so both the prevalence and severity of hearing impairment increase with age • 71% of people aged over 70 have a hearing loss (NHS England and Department of Health 2015, p.8). This is why adult hearing loss is in the top ten disabilities in terms of years lived with disability (YLD) for those over 60 years in England (Murray, 2013) • most people accessing home care will be aged 70 and over and at least seven out of ten people will have some level of hearing impairment.	

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					THE CHALLENGE Most people needing home care will have a hearing loss but awareness of hearing loss and services to support them remains poor amongst carers and patients -e.g. • home care professionals in general do not have a full understanding of the existing assistive technology available to people with hearing loss (cited in: NHS England and Department of Health 2015, p.22), which increases the risk that people receiving home care might not get the hearing support that they need • a survey of 600 people with hearing loss found that after attending a GP appointment 26% had been unclear about the health advice they had been given (cited in: Ibid, p.11). It is therefore also likely that people with unsupported hearing loss will be unclear about advice they get from people delivering home care • Monitor the sector regulator found that despite the NHS commissioning home care, GPs were not always aware about these services (Monitor, 2015), highlighting gaps in knowledge which the current draft guideline does not address.	

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					This presents a serious public health challenge. For example NHS England and the Department of Health in their Action Plan on Hearing Loss note: "in older age, hearing loss becomes a major challenge and people with hearing loss can find it difficult to follow speech without hearing aids and are at greater risk of social isolation and reduced mental well-being. Social isolation has an effect on health and in older people there is a strong correlation between hearing loss and cognitive decline, mental illness and dementia." (NHS England and Department of Health 2015, p. 8) NHS England and the Department of Health also note that older people with unmanaged hearing loss are more likely to go onto expensive care packages (Ibid, p.10). WHAT THE NICE GUIDELINE ON HOME CARE MUST DO Barriers to successful implementation of the guideline on home care include ensuring there is training and accountability – i.e. issuing	

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					guidelines is not enough. For example despite the quality statement issued by NICE on recognition of sensory impairments in older people in care homes (Quality Statement 4 - QS50) knowledge of hearing loss is still poor and not all care homes make hearing tests available. Unless all carers understand both the scale and consequences of unsupported hearing loss in this population people needing care at home are also likely to suffer from health inequalities. Issuing guidance on sensory impairment therefore is not enough. We feel due to the large population of older people with hearing loss and the consequences of unsupported hearing loss requires the final guideline should specifically mention hearing loss and what can be done to access hearing care in a timely manner. Murray, C. et al (2013) Global Burden of Disease Study 2010. Lancet, vol. 380, no. 9859. Monitor (2015) NHS adult hearing services in England: exploring how choice is working for patients NHS England and the Department of	

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					Health (2015) Action Plan on Hearing Loss	
National Pensioners Convention	1	Short	7	1.1.3	There is an urgent need to develop a Dignity Code of practice that can be adopted by commissioners, providers and care staff that outlines what good care looks like. It should form part of contracts between commissioners and providers, as well as part of staff terms and conditions of employment. The NPC has already developed such a voluntary Code that has been adopted by over 40 local authorities, care providers and professional care bodies. Further details are available on request.	Thank you for these suggestions. As part of the guideline implementation work, we will seek to sign post to other relevant products and tools.
National Pensioners Convention	2	Short	8	1.2.1	When local authorities provide details of funding mechanisms for those using home care services, it is vital that the advantages and disadvantages of each option are fully explained. Evidence exists to show that older people, unlike their younger counterparts, do not always feel particularly comfortable with direct payments or personal budgets. It is therefore important that individuals making funding choices fully realise the implications of each option before deciding.	Thank you for your comment. The principle behind the recommendations on giving people support to understand different funding options is to ensure that they exercise choice and control. Recommendations 1.1.6, 1.2.1 and 1.3.10 (among others) are intended to make explicit reference to the need to make people aware of all their options, and are underpinned by the section on person-centred care,. The evidence base for the outcomes – specifically increased choice and control in what and how care is delivered – is relatively poor for older people, and does not suggest that the 'advantages and disadvantages'

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						have been established. We have emphasised throughout the recommendations that older people should be supported to take up whatever options best fulfil their needs. The level of support given may make a difference to how comfortable older people feel in exercising choice. Please see recommendations 1.3.4 and 1.3.5 on planning home care support.
National Pensioners Convention	3	Short	11	1.3.6	In recent years the vast majority of local authorities have reduced the amount of support available to those in the community with low and moderate care needs. This has had a dramatic effect on the number of people, estimated to be at least 800,000, who no longer receive assistance with getting out of bed, dressing and visiting the toilet. We strongly support the importance of preventative intervention in such cases and would urge that commissioners are encouraged to offer support at lower levels of care needs, rather than simply asked to consider it.	Thank you for your comments which we will consider as part of guideline implementation work. The relevant recommendation is now 1.3.2, but we have not been able to urge this, because there is not sufficient evidence on outcomes for older people who get home care at an earlier stage than is currently likely. The Research Recommendation 2.1, on the 'intensity' of care and for whom it is cost-effective, seeks to establish better evidence on this very point.
National Pensioners Convention	4	Short	11	1.3.7	We strongly support the principle of home care packages recognising and being related to the wider wellbeing of the individual.	Thank you for your comment.
National	5	Short	16	1.4.2	The recent growth of 'flying' 15	Thank you for your comment.

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Pensioners Convention					minute home care visits is not acceptable. The move towards a longer 30 minute minimum is therefore an improvement, but it is vital that the care package someone receives is properly assessed in relation to the time needed to actually deliver the package, rather than have a care package that bears no relation to the amount of time the care workers spends in the home. Visits should match the requirements of the individual and their needs, not an arbitrary time limit.	The time allowed for visits was discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony. This is captured in the relevant table in the evidence to recommendations section 3.8 of the full guideline. The Committee responded, among other evidence, to research from user, carer and home care workers who said that 15 minute visits are not uncommon. This is likely to reflect shortage of resources within the home care sector. The Committee did not intend to imply that 30 minute visits were sufficient, but to reduce the incidence of very short visits. The Committee felt that there may be circumstances in which a short visit may be justified. The recommendation reached by Committee consensus now reads: 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

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						limited tasks or to check if someone is safe and well.
National Pensioners Convention	6	Short	18	1.4.13	The time it takes to record a care diary should not be considered part of the time allocated to an individual's care package, particularly if there is a lot of information to be recorded.	Thank you for your comment. The Guideline Committee agreed it is important that people are encouraged to contribute to a care diary and this is reflected in the recommendation.
NHS England	1	General	General	General	no substantial comments to make regarding this consultation	Thank you for your comment.
Nutricia Advanced Medical Nutrition	1	Q1.			Would use as guidance and direction to ensure that we, as an organisation, continue to meet (and continue to innovate) to meet the needs of those individuals who need additional nutrition support/care in the community/hospital	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
Nutricia Advanced Medical Nutrition	2	Q2.			Empowering people to feel more confident in looking after themselves and guidance on prevention ad safety most important (all) in addition the fact that under the guidance future research is also outlined	Thank you for your comment.
Nutricia Advanced Medical Nutrition	3	Q3.			Empowering and informing people, provision of a seamless service is needed which meets the needs of individuals and that those who are supported in the community setting receive the right 360 care in a timely fashion. Those people who work in homecare should also be empowered to understand what signs to look out for regards malnutrition/falls risk and systems in	Thank you for your comment. Recommendations 1.7.4 and 1.7.6 highlight the need for home care workers to be able to recognise and respond to a range of conditions, situations and support needs. The response may be to escalate concerns. The escalation of concerns is also addressed in recommendations 1.6.1-1.6.5 which

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					place to be able to communicate any concerns back to the relevant organisation so that concerns can be acted upon in a timely fashion - so a need for the correct systems/process - some examples where this has been implemented are those such as in the Malnutrition Taskforce pilot site areas in England www.malnutritiontaskforce.org.uk	relate to safeguarding and safety. We can consider existing good practice, such as the example you helpfully suggest, as part of implementation.
Nutricia Advanced Medical Nutrition	4	Q4.			Depends on the needs of the individual as the telecare used should be to support care and therefore any face to face time can be maximised	Thank you for your comment. The reference to the complementary nature of telecare was intended to reflect the point that this type of support should not be seen as a replacement for personal contact. This is described in more detail in the detail of the review work on telecare and the corresponding evidence to recommendations table in section 3.8 of the full guideline.
Nutricia Advanced Medical Nutrition	5	Q5.			Text, telephone, skype	Thank you for your comment.
Nutricia Advanced Medical Nutrition	6	Q6.			No - no mention of nutrition which is integral to health and well-being as identified in NICE CG32, NICE QS 24, Care Act April 2015 (mentions importance of nutritional needs to be met), CQC criteria, Malnutrition TaskForce implementation guides and pilot prevention studies (funded by the Dept Health) www.malnutritiontaskforce.org.uk -	Thank you for your comment. Nutrition and hydration are now referenced explicitly in the recommendations: please see recommendation 1.7.4: "Ensure home care workers are able to recognise and respond to …. Common care needs, such as nutrition, hydration and issues related to skin integrity".

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					which should be specifically mention along with the need to empower people to understand at what point to be concerned and who to speak to ie section 1.3.15; Needs of local community should be identified and opinions on current service provision sought to ensure that the right nutritional care is being commissioned locally.; Section 1.3.17 should include ref to NICE CG such as Pressure Ulcers, COPD, Stroke which as examples specifically mention importance of nutrition being integral to their management of; Under recommendations for home care workers - nutrition (and hydration) education should be a top priority and safety related	The Guideline Committee felt it was not possible to identify the many areas where skilled support was needed, so gave examples. There is a Research Recommendation on training needs as there was little evidence on content, delivery and outcomes of training.
Nutricia Advanced Medical Nutrition	7	Q7.			If no how can this be improved? N/A	Thank you for your comment.
Nutricia Advanced Medical Nutrition	8	Q8.			As recommendations - very dependent on how they are actually implemented and therefore leadership within care - risk of geographical variations and dependent on public empowerment and awareness of; plus integration of health and social care - a joined up system which is seamless incl discharge process and vastly improved communication.	Thank you for your comment which we will consider as part of the implementation work.

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Nutricia Advanced Medical Nutrition	9	Short	10 onwards	1.3.15	No - no mention of nutrition which is integral to health and well-being as identified in NICE CG32, NICE QS 24, Care Act April 2015 (mentions importance of nutritional needs to be met), CQC criteria, Malnutrition TaskForce implementation guides and pilot prevention studies (funded by the Dept Health) www.malnutritiontaskforce.org.uk - which should be specifically mention along with the need to empower people to understand at what point to be concerned and who to speak to i.e. section 1.3.15	Thank you for your comment. We have now made explicit reference to nutrition and hydration (see recommendation 1.7.4, in which we reference the need for workers to be able to recognise and respond to common conditions or concerns (which may include liaising with other specialist workers). These include nutrition, hydration and a range of others.
Nutricia Advanced Medical Nutrition	10	Short	10 onwards	1.3.17	Section 1.3.17 should include ref to NICE CG such as Pressure Ulcers, COPD, Stroke which as examples specifically mention importance of nutrition being integral to their management of.	Thank you for your comment. We have listed a number of example common conditions and linked to the NICE guidance landing page.
Nutricia Advanced Medical Nutrition	11	short	General	General	Under recommendations for home care workers - nutrition (and hydration) education should be a top priority and safety related	Thank you for this comment. Nutrition and hydration are now referenced explicitly in the guideline: please see recommendation 1.7.4: "Ensure home care workers are able to recognise and respond to …. Common care needs, such as nutrition, hydration and issues related to skin integrity". The Guideline Committee felt it was not possible to identify the many areas where skilled support was

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						needed, so gave examples. There is a Research Recommendation on training needs as there was little evidence on content, delivery and outcomes of training.
Nutricia Advanced Medical Nutrition	12	short	General	General	We would use as guidance and direction to ensure that we, as an organisation, continue to meet (and continue to innovate) to meet the needs of those individuals who need additional nutrition support/care in the community/hospital	Thank you for your comment and your commitment to supporting the implementation of the guideline which is much appreciated.
Nutricia Advanced Medical Nutrition	13	short	General	General	Empowering and informing people, provision of a seamless service is needed which meets the needs of individuals and that those who are supported in the community setting receive the right 360 care in a timely fashion. Those people who work in homecare should also be empowered to understand what signs to look out for regards malnutrition/falls risk and systems in place to be able to communicate any concerns back to the relevant organisation so that concerns can be acted upon in a timely fashion - so a need for the correct systems/process	Thank you for your comments. The issues raised in your comments are widely reflected in the guideline. For example, section 1.1 of the recommendations on ensuring person centred care, and those in section 1.2 on providing information, are focussed on empowering informing people. Continuity and integration of care are also central to the guideline (see for example recommendations 1.1.4 and 1.3.7). The Committee felt that the knowledge and competencies needed by home care workers was broad, and this is reflected in recommendation 1.1.5 (on matching carers to service user needs) and elsewhere. The Guideline Committee

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					- some examples where this has been implemented are those such as in the Malnutrition Taskforce pilot site areas in England www.malnutritiontaskforce.org.uk	felt it was not possible to identify the many areas where skilled support was needed, so gave examples. There is a Research Recommendation on training needs as there was little evidence on content, delivery and outcomes of training.
Nutricia Advanced Medical Nutrition	14	short	General	General	Empowering people to feel more confident in looking after themselves and guidance on prevention ad safety most important (all) in addition the fact that under the guidance future research is also outlined	Thank you for your comment.
Nutricia Advanced Medical Nutrition	15	Implementation	General	General	As recommendations - very dependent on how they are actually implemented and therefore leadership within care - risk of geographical variations and dependent on public empowerment and awareness of; plus integration of health and social care - a joined up system which is seamless incl discharge process and vastly improved communication.	Thank you for your comment. We do recognise that implementation of recommendations is voluntary, and our implementation team is working on strategies to support and encourage implementation. This Guideline is one of a suite of guidelines in development which prioritise social care, as we are the NICE Collaborating Centre for Social Care, and it would not be appropriate for us to move into clinical territory. However, successful implementation of improvements may well depend in large part on integration with the healthcare sector (among others). We have included recommendations

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						– e.g. 1.5.1 and 1.5.2 on supporting home care workers to help the person manage their medicines – which depend on liaison with health services. In 1.7.4, we also included reference to the need for workers to be able to recognise and respond to common conditions or concerns (which may include liaising with other specialist workers). These include nutrition, hydration and a range of others.
Nutricia Advanced Medical Nutrition	16	Implementation	General	General	Needs of local community should be identified and opinions on current service provision sought to ensure that the right nutritional care is being commissioned locally	Thank you for your comment.
Nutricia Advanced Medical Nutrition	17	Implementation	General	General	Depends on the needs of the individual as the telecare used should be to support care and therefore any face to face time can be maximised	Thank you for your comment. The reference to the complementary nature of telecare was intended to reflect the point that this type of support should not be seen as a replacement for personal contact. This is described in more detail in the detail of the review work on telecare and the corresponding evidence to recommendations section 3.8 of the full guideline.
Parkinson's UK	1	Q1.			Parkinson's UK will use guideline recommendations to educate social workers about the importance of providing person-centred,	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.

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					Parkinson's-aware care. We will also disseminate the recommendations to the UK Parkinson's Excellence Network, the new network for professionals involved with Parkinson's care. The charity may also reference the guideline in our materials and on our website, if appropriate. We will communicate the messages to people with Parkinson's through our patient literature and online.	
Parkinson's UK	2	Q2.			For people with Parkinson's, recommendations around putting in place medicines management protocols for people receiving home care are essential in helping people manage their condition and live independently. These should be used to encourage people with Parkinson's to manage their own medication wherever possible. 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.'	Thank you for your comment.

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					We also feel that the recommendation to 'Consider offering home care support to older people with low to moderate needs' will be key in helping people with progressive conditions receive essential support, before they reach crisis point. This is of critical importance for people with Parkinson's, as research commissioned by Parkinson's UK found that people with the condition are often unaware of social care support until they need urgent help. An anticipatory approach to social care planning could put in place home care support in good time, to help people with Parkinson's retain their independence and prevent them reaching crisis point in the first place.	
Parkinson's UK	3	Q3.			Home care workers' degree of knowledge and understanding of Parkinson's requires significant improvement, as part of wider efforts to provide more 'person-centred' care. 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	Thank you for your comment. The Guideline Committee agree strongly that care and support should be tailored to meet the specific needs of the person, and that the person should be at the centre of planning and delivery of care at all times.

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					respondents believed that paid carers do 'not have a very good understanding' 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 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' In order for an adult home care worker to provide effective and sensitive care to individuals the condition and families of people affected by Parkinson's, they must understand the difficulties they face and provide true person-centred practice. It is therefore necessary for them to have a good understanding of a person's condition and the full range of possible symptoms as the condition varies for every individual. Given that Parkinson's is a condition that causes movement to slow or cease unpredictably, we feel that	

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					improvements are required in 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.	
Parkinson's UK	4	Q4.			Telecare should be considered in the initial development of care plans and at any care planning reviews, with the option to request telecare at any time if a person asks for it. The types of telecare should be discussed with the individual, as part of the overall package of care they are being offered and the outcomes they would like to achieve. There should not be a presumption that only a personal alarm, for example, should be offered at a particular point in the planning and delivery of home care, or that telecare would be appropriate for everyone. It is of critical importance that telecare is not offered in lieu of regular care appointments. It should also be noted that people with	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. In addition, telecare is referenced in relation to the provision of information (see recommendations in section 1.2); planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4).

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					Parkinson's can experience difficulties communicating, so telecare may not always be appropriate for them.	
Parkinson's UK	5	Q5.			For people with Parkinson's, fall detectors and personal alarms would be particularly helpful if they live alone, or their carer is frail. Any technologies that enable people with the condition, or their carer to raise concerns with social care providers at short notice will support them to maintain their independence for longer.	Thank you for your comment. While the effectiveness of specific telecare interventions was not in scope for this guideline, a number of the telecare recommendations focus on how technology could help them live in the way that they choose for longer (e.g. 1.3.26, 1.3.28).
Parkinson's UK	6	Q6.			Yes, the guidance clearly refers to obligations upon local authorities as set out in the Care Act.	Thank you for your comment.
Parkinson's UK	7	Q7.			Yes, the guideline explicitly refers to Care Quality Commission guidance, which in themselves reflect the requirements of key pieces of social care legislation.	Thank you for your comment.
Parkinson's UK	8	Q8.			If adopted by local authorities, the recommendations could improve equality of opportunity for people with Parkinson's that require home care, by enabling more Parkinson's-aware care to be provided. However, this is contingent on our recommendations being adopted, to make further Improvements to home care for people with the condition. *4,777 people were surveyed who	Thank you for your comment.

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					had either been diagnosed with Parkinson's or are family members or carers of a person with Parkinson's*	
Parkinson's UK	9	Full	3	20	We note that the draft guideline refers only to 'older people' and 'does not cover younger adults'. We are concerned that this neglects many people with Parkinson's, who may receive home care that are younger than 65 and may have different aspirations and care needs to those reported by studies which predominantly examined older people, for example the psychological impact of developing a condition such as Parkinson's in younger age, the impact of dementia related symptoms at younger age.	Thank you for your comment. The largest group of people using home care in England is older people (79%, Community Care Statistics: Social Services Activity Health and Social Care, England. 2013-14. Final Release. Health and Social Care Information Centre (2014). The older population is growing, and there is evidence that users of home care are becoming older, frailer and have more long term conditions. The rationale for the focus on older people is provided in the Scope (and associated Equality Impact Assessment) and this is also discussed in the guideline's Equality Impact Assessment. We also note in the guideline that many of the recommendations will be relevant to younger adults.
Parkinson's UK	10	Full	11	8-9	Although we welcome the ambition of a 'person-centred' service, we feel that an essential component of this is a good understanding of a person's condition, particularly in the case of complex, progressive conditions such as Parkinson's which includes both motor and non-motor symptoms. We	Thank you for your comment. The Guideline Committee agreed the importance of ensuring condition-specific support is available, as appropriate and the following recommendations seek to address this:

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					recommend that services are also expected to 'understand a person's condition'.	• Recommendation 1.1.5 references the need for provider organisations to ensure matching of people using services to workers takes account of the person's care and support needs. • Recommendation 1.3.9 makes clear that those involved in coordinating and planning care and support understand common conditions affecting people using services. • Recommendation 1.6.4 references the need for workers to be able to recognise and respond to conditions affecting the people they support.
Parkinson's UK	11	Full	12	3-5	We are concerned that this section does not go far enough to acknowledge the type of condition that a person has and the specific knowledge and expertise of care workers, who may have had training to help them deal more effectively with the complexities of Parkinson's. We feel these additional factors should be taken into account when 'matching' care workers and people with care needs.	Thank you for your comment. The Guideline Committee debated whether to provide lists of specific conditions at several points throughout development. They agreed that, as it was not possible to provide a comprehensive list of all conditions affecting all people using home care, recommendations should instead focus on the need for care to be person-centred care. In two cases

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						(recommendations 1.3.9 and 1.6.4) a small number of common conditions are provided by way of example. There is a research recommendation on training and development: "What are the effects of different approaches to home care training on outcomes for people who use home care services?" (section 2.3). The Guideline Committee has suggested that this should entail a scoping study of current practice and needs, which may well highlight the need to know how to support people with specific long term conditions, as well as evaluations of specific initiatives.
Parkinson's UK	12	Full	12	8	We support all of the recommendations on the provision of specific kinds of information set out in the draft guideline. However, we remain concerned that local authorities will sign-post people towards chargeable sources of independent financial advice. We recommend that the guidance clarifies that information provision should always be accessible, regardless of ability to pay.	Thank you for your comment. We have included detail of the information which the Care Act stipulates local authorities must ensure is available, and suggested detail of what should be covered (e.g. different funding mechanisms and personal budgets). However, it is for local authorities to determine how they implement the provisions of the Act. We will pass your comment onto the team dealing with guideline implementation team, as it reflects both implementation of the guideline and the Act.
Parkinson's UK	13	Full	13	14	We recommend that this information includes signposting to the local	Thank you for your comment. We have made reference to the need to

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					authority complaints service, the Local Government Ombudsman and the national social care appeals system, when it becomes available in future	provide information about the local commissioning body and Ombudsman in recommendation 1.4.6.
Parkinson's UK	14	Full	15	8	Parkinson's UK strongly supports this recommendation. However, under the Care Act, which requires local authorities put in place services to prevent needs from developing and exacerbating. Section 2.1 of the guidance to local authorities notes: *'To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible'*. We therefore feel that this recommendation should be strengthened, to note that this is a legal requirement.	Thank you for your comment. This recommendation indicates the type of support (i.e. home care) that could be offered to prevent needs from developing, rather than restating the legal requirement to put in place services to achieve this aim. It is based on weaker evidence and therefore the Guideline Committee agreed it should be a 'consider' recommendation.
Parkinson's UK	15	Full	16	9	We feel that it is insufficient for lead practitioners to simply *'know about local organisations that provide specialist support'*. Instead we recommend that they are able to signpost people with care needs on to these organisations, for example, Parkinson's UK information advisors and our local network.	Thank you for your comment. This recommendation is focused on the role of the lead practitioner at the planning stage. The Guideline Committee agreed that signposting to, and making best use of, specialist services is important. Recommendation 1.2.2 notes the need to offer people and their carers information about the local support

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						available. The important role played by voluntary and community sector organisations is referenced explicitly within 1.3.3 where it is noted that they may be part of the coordinated group supporting people using home care. In addition, recommendation 1.6.4 references the need for workers to be able to recognise and respond to conditions affecting the people they support.
Parkinson's UK	16	Full	16	23-24	We believe that the recommendation should go further than asking people if they would like advocates involved. Given that people who require advocacy support may lack capacity, lead practitioners should signpost people with care needs to the relevant local authority staff in order to arrange this, or recommend that the local authority offer advocacy directly.	Thank you for your comment. Advocacy was seen as important and was discussed by the Guideline Committee, and we have also referenced it directly within 1.4.9. We are mindful of the statutory provisions for providing advocacy within the Care Act, but these fall to Local Authorities (and need not be restated here). In relation to home care providers, there is not statutory duty, which is why the recommendation is to "consider".
Parkinson's UK	17	Full	17	5-6	We feel that the home care plan should also consider the impact on the carer too, so that too much emphasis is not being placed on	Thank you for your comment. We have included reference to the home care plan identifying the

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					them to provide 'top-up' care for free.	contribution of family or carers, and reviewing this regularly (1.3.14).
Parkinson's UK	18	Full	18	6	Parkinson's UK strongly supports requirements to write medicines management into home care plans, particularly timing of when medication is administered. However, we recommend that this should encourage home care staff to encourage self-administration of medication wherever appropriate and possible.	Thank you for your comment. The skills and competencies of home care workers in respect of medicines management was discussed in developing the recommendations in this guideline; however, the Guideline Committee agreed that it was not possible to define the home care workers' role further in this respect. The recommendations in this guideline seek to complement those in the existing NICE clinical guideline on Medicines Management, and may be revised in the light of the forthcoming NICE guidance on 'Managing the use of medicines in community settings for people receiving social care'. There is also a research recommendation on the scoping of training needs and interventions which may involve this area of expertise.
Parkinson's UK	19	Full	19	28	We do not agree that there should be any circumstances in which it is appropriate to schedule care appointments of less than thirty	Thank you for your comment. We received a number of comments on this recommendation. The time needed to deliver

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					minutes	appropriate care and social and psychological support was discussed extensively and informed by expert witness testimony and by extensive research data from service users, carers and home care practitioners. These different sources corroborated the view that the time allotted for home care visits was often too short to deliver good care, respond to unexpected events and support older people who may need time to talk, wash, eat or dress. Recommendation 1.4.1 supports this general point The more specific point on timing was agreed as appropriate by the Committee, and takes into account the consultation comments. The consensus was that visits shorter than 30 minutes (often to a person who may be housebound) were inappropriate. The recommendation reached by Committee consensus now reads: 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

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						allows enough time to complete specific, time limited tasks or to check if someone is safe and well.
Parkinson's UK	20	Full	20	25	We recommend that this includes placing care workers with a good knowledge and understanding of Parkinson's with people with the condition	Thank you for your comment. The Guideline Committee agreed the importance of ensuring condition-specific support is available, as appropriate and the following recommendations seek to address this: • Recommendation 1.1.5 references the need for provider organisations to ensure matching of people using services to workers takes account of the person's care and support needs. • Recommendation 1.3.9 makes clear that those involved in coordinating and planning care and support understand common conditions affecting people using services. • Recommendation 1.6.4 references the need for workers to be able to recognise and respond to conditions affecting the people they support.

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Parkinson's UK	21	Full	21	20	Care workers should notify a person with care needs in good time if they will miss their appointment and arrange for a replacement, to ensure continuity of care	Thank you for your comment. The recommendations on missed visits have been edited to provide more detail. They now (1.4.10-1.4.13) include much more detail about the plans that should be in place in respect of missed calls, the fact that this information should be included in risk assessment, and ensuring that monitoring of missed and late calls is embedded in monitoring and quality assurance.
Parkinson's UK	22	Implementation	General	General	Challenge one – We agree that *'Delivering services that support the aspirations, goals and priorities of the person using them'* requires further improvement, and could pose a challenge if home care providers are resistant to change, or unwilling to amend their practices to suit the people they provide care for. However, we are disappointed that the document suggests that *'Home care providers will need to review how they deliver services to see whether improvements are needed to ensure that they meet individual needs'*. Given that person-centred care is, by definition, specific to the needs of an individual, all home care providers will need to do more than merely 'review' their service delivery	Thank you for your comment. We did not identify any evidence that enabled us to make detailed recommendations in respect of training; however this is the subject of a research recommendation. The research recommendation aims to identify the effects of different approaches to home care training on outcomes for people using services, looking at different models of practice. We will also consider your comments as part of the implementation work.

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					to 'see whether improvements are needed' as true person-centred care will look different for each person with care needs, and needs to be developed collaboratively with the individual. To facilitate more person-centred care, we recommend that home care providers are recommended to undertake condition specific training, in order to provide care that reflects the needs and concerns of a person and their condition. This is of particular importance for people with Parkinson's, who can often experience a complex range of motor and non-motor symptoms.	
Parkinson's UK	23	Implementation	General	General	Challenge two – We agree that multidisciplinary team working is challenging, particularly in Parkinson's care, where some specialists such as speech and language therapists or physiotherapists are community based, in contrast with neurologists or a person's Parkinson's nurse specialist. The UK Parkinson's Excellence Network can help inform health and care professionals about Parkinson's care and facilitate collaborative working, through resources and	Thank you for your comment which we will consider as part of the implementation work.

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					information.	
Parkinson's UK	24	Implementation	General	General	Challenge three - We agree that encouraging lead practitioners to change their behaviour will prove challenging. However, the suite of information and resources available as part of the UK Parkinson's Excellence Network could help improve professionals' understanding of Parkinson's and the sorts of health and care support that would be most suitable for them. However, upskilling lead practitioners in the range of care, support and funding options available will require collaboration both with the clinical commissioning group and the local authority, to fully understand the range of options available in a given area. Communicating these options to people with care needs, who are often vulnerable, must be undertaken sensitively, with signposting to independent financial advice where appropriate.	Thank you for your comment which we will consider as part of the implementation work. It will be helpful for named care coordinators to have signposts to existing resources that can help them implement the recommendations in this guideline, particularly those aimed at ensuring coherent, comprehensive planning (e.g. 1.3.8 and 1.3.13) so thank you for highlighting the Parkinson's UK materials.
Royal College of General Practitioners	1	General	General	General	This is an impressive and thoughtful document, rather daunting in length. The literature is well summarised, much of it qualitative and I am uncertain if the papers were all peer reviewed, they are in low impact journals/grey literature. The working group might have included other disciplines-nursing occupational	Thank you for your comment. We sought to ensure there was representation from a diverse range of stakeholders on the Guideline Committee although were limited to 12-15 members, and also called expert witnesses, and searched for literature on relevant practitioners'

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					therapy, physiotherapy, general practice, geriatric medicine and psychogeriatrics.	views and experiences. The type of evidence which was reviewed was presented as research (detailing methods which could be appraised for quality), and in most cases (see references) was published in peer reviewed academic journals. Exceptions were typically surveys conducted by organisations such as UK Home Care Association (but again, methods were appraised for bias). We sought the best evidence, but there is a lack of experimental studies in social care. The qualitative data on views and experiences was presented and appraised as research. Appendix A details the search strategy and the databases used, which include the major health databases, but our systematic searching was intended to find evidence on home care delivered as social care, as that was what is in scope. The NICE Collaborating Centre for Social Care does not directly consider clinical or health care, although issues of integration and joint working are a concern.
Royal College of General Practitioners	2	General	General	General	Old age is in some regards in Britain a disease of poverty with less choice and less pleasure. While risk needs	Thank you for your comment. The Guideline Committee were keen to emphasise the importance of person-

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					to be assessed, some risk is part of being a human being. Being able to have and spend money on treats and presents is part of human dignity…and being foolish. "When I am old I will wear purple, etc…" The quality of the life needs to be measured, action agreed and implemented and then re measured. Some people are dying slowly and will want to die at home providing an extra challenge. Carers need to be able to do simple assessments of vision, hearing, dentures and feet; they need to ask about diet, bowels, exercise and alcohol. Their role is that of a caring relation with additional insights, experience and skills which need to be recognised and rewarded with a career structure. However they are there to enable the person to make some free choices and "spend my pension on brandy and summer gloves" too.	centred support that respects choice and preference throughout the guideline. Examples of recommendations that support this aspiration are: all the recommendations at 1.1 (person-centred care), e.g. 1.1 Ensure services support the aspirations, goals and priorities of each person, rather than providing 'one size fits all' services. 1.2 Ensure support focuses on what people can or would like to do to maintain their independence, not only on what they cannot do. 1.3.20 Ask people: which elements of their home care service are a priority for them. We have reflected the need for paid carers to be aware of and able to recognise common conditions in a number of recommendations (e.g. 1.3.8 on assessing care needs, and 1.6.4 on training needs).
Royal College of Nursing	1	Short	15	1.4.2	We believe visits not less than 30 minutes are the way forward to ensure quality.	Thank you for your comment. The time allowed for visits was discussed extensively and informed by both consistent evidence on views

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						and experiences, and expert witness testimony. This is captured in the relevant table at the evidence to recommendations table in section 3.8 of the full guideline.
Royal College of Nursing	2	Short	15	1.4	There is no mention of contingency. We consider that every provider should have a contingency plan in place if a call/visit is likely to fail.	Thank you for your comment. Recommendations have been updated following discussion at Guideline Committee 12 and now reference contingency planning.
Royal College of Nursing	3	Short	17	1.4.13	Suggest rephrase to: 'Record and report any incidents or changes.'	Thank you for your comment. At Guideline Committee12, the Guideline Committee reflected on and updated wording of the recommendations related to the care diary.
Royal College of Nursing	4	Short	20	1.6.3	*"Ensure that new home care workers are observed at work more than once during their probationary period."* This should be changed to until competent.	Thank you for your comment. This was discussed extensively and the Guideline Committee thought 'more than once' was the most appropriate term. There was a paucity of evidence on the impact of training on outcomes and there is a research recommendation focused on this issue.
Royal College of Nursing	5	Short	20	1.6.4	Suggest rephrase to: 'Ensure home care workers are able to recognise and know how to report'	Thank you for your comment. This has been edited to read 'recognise and respond to'.
Royal College of Speech and Language	1	Q1.			As a clinician working with elderly clients with communication and swallowing difficulties many due to	Thank you for your comment and commitment to supporting the implementation of the guideline. This

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Therapists					dementia – to support arguments to ensure that carers have appropriate knowledge and skills to support this group	is much appreciated.
Royal College of Speech and Language Therapists	2	Q2.			Person centred: Message to commissioners that supporting initiatives that help people with mild / moderate needs are invaluable – need a mixed economy of support that both self-funded clients and LA funded carers can access to help remain in their own home and therefore leading richer lives. It is imperative that funding levels ensure that home care workers are given enough time for meaningful engagement with their clients. Planning and reviewing: This is key. However, the guideline is unclear in this area. There needs to be one body identified to coordinate the care needs, who can act as the ongoing link between the client and carer, enabling the best possible tailored support for individuals and their families. Recruiting, training and supporting home care workers. This is key. Home care staff are working with complex clients in difficult circumstances. Commissioners need to fund packages to include time on the job supervision and the shadowing of	Thank you for your comment. The guideline is focused on what works in respect of home care interventions and the way they are delivered. Funding levels and commissioning arrangements are out of scope for NICE guidance. The guideline now recommends explicitly the need for a named care coordinator (1.3.6 and 1.3.7) to coordinate the care needs and act as a link between all parties involved in delivering care and support (which may include carers and the person themselves).

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					more experienced staff, as well as providing incentives to remain in the care field in order to use experience to support other workers. Note the research evidence that says that best workers tend to be older and have worked for over 5 years. Acknowledge that specialist skills are needed. Route for having experienced/staff with specialist skills recognised. Free professional online resources could be commissioned for all carers (irrespective of who is funding) to have access to.	
Royal College of Speech and Language Therapists	3	Q3.			We would welcome a stronger focus on training the wider workforce. • Speech and language therapists train the wider care workforce in how to communicate with people with dementia • SLTs provide training to care and residential homes to support the communication and eating, drinking and swallowing needs of individuals. This has shown to reduce unnecessary hospital admissions and can be effective in managing end of life care for individuals. • SLTs not only work with their client but also with the partner or carer to provide specific communication strategies to support interaction.	Thank you for your comment. There was insufficient evidence to inform detailed recommendations about training. The focus of the evidence search and recommendations was not based on speech and language therapy but, more broadly, on identifying evidence of impact of different approaches to training on outcomes for people using services and their carers. There is, as a result of the gap in evidence, a research recommendation (2.3) on this issue.

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					• SLTs improve communication skills of care workers in order to improve communication with residents with a broad range of communication disorders including deafness, aphasia etc. Speech and language therapists (SLTs) assess an individual's capacity to communicate and understand information and to advise on the most effective means of presenting information and choices to the individual, maximising their opportunity to exert free choice. This is essential to allow the individual to exercise choice in treatment, choice at end of life and dignity in life and death. Mark Jayes (SLT) is undertaking a Ph.D. -- related to identifying mental capacity particularly in those who have aphasia. -- being developed at Sheffield teaching hospitals foundation trust.	
Royal College of Speech and Language Therapists	4	Q5.			Numerous speech and language therapists already use telehealth to help people live independently in their own home. • Skype appointments are being used by some speech and language therapists to support individuals living at home-- and	Thank you for your comment. Telehealth is not in scope for this guideline. The Guideline Committee intended that 'telecare' within this guideline be interpreted broadly to cover a wide range of technologies that could support people to live independently in their own homes.

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					providing their rehabilitation at a distance. • Speech and language therapists use telehealth to support the remote screening and assessment of dysphagia into nursing and care homes. However, we are concerned that the phrase tele-care is sometimes used in a limited way. If the phrase 'high tech equipment' was used alongside tele-care this would provide clarification.	
Royal College of Speech and Language Therapists	5	SHORT	7	1.1.2	The second bullet is crucial focussing on the needs of people with cognitive impairments	Thank you for your comment.
Royal College of Speech and Language Therapists	6	SHORT	9	1.2.4	We would welcome a stronger focus on the importance of a written summary of the conclusions for people to read. This is only important for people with cognitive decline or communication problems who take longer to process information but for all people to review in their own time. Worth including here and/or within next point about importance of considering issues such as information carrying words and comprehension of concepts and grammar to inform language usage with people, and importance of	Thank you for your comment. The Guideline Committee sought to focus the recommendations on the principle of personalising information, rather than defining in detail what this may look like for people with particular needs. We have added in, however, additional reference to the need for workers to allow more time to provide support to people who have particular needs including ,for example, those with communication difficulties.

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					considering how to best meet someone's communication profile using a version of conversational analysis. e.g. how some people might require open/closed questions/forced alternatives e.g. how frequently people respond 'yes' or repeat last words in sentences when comprehension is reduced. Highlight the importance of universal strategies and screening for when targeted/specialist strategies are required, and then option to refer to SLT	
Royal College of Speech and Language Therapists	7	SHORT	9	1.2.5	People with communication needs will require information in a range of formats including: • "Easy Read" • Communication Apps (e.g. Proloquo2Go, Grids etc.) • Simplified language (in line with key word comprehension) and 1 or 2 key ideas at a time • Symbols • Talking Mats • Uses a signing support system such as Makaton, Signalong, (people do not only use Makaton)	Thank you for your comment. Recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list.
Royal College of Speech and	8	Short	9	1.3.2	It is important to ensure the MDT have the opportunity to discuss, at	Thank you for your comment. We have made reference to the need to

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Language Therapists					regular intervals, the care of an individual-and whenever appropriate that the individual and their carer are included. We recommend adding: consideration should be given to patient held records.	involve the person and their carer in discussions and decisions about their care. We have also made reference to the need to provide copies of information to the carer and to ensure the care diary is kept in the person's home.
Royal College of Speech and Language Therapists	9	SHORT	12	1.3.10	This identifies the skills that people involved in home care should have. We recommend adding to the third bullet communication and cognitive problems.	Thank you for your comment. This has been edited.
Royal College of Speech and Language Therapists	10	SHORT	12	1.3.12	Many people with cognitive difficulties or communication support needs will require longer to process information and to respond. Additional time should be made available at appointments.	Thank you for your comment. There is now reference within the recommendations to the fact that more time should be allowed to support people with cognitive or communication needs.
Royal College of Speech and Language Therapists	11	SHORT	12	1.3 .25	We suggest that the first review is done earlier than at six weeks and also other reviews more regularly than once a year--- people's needs often change more frequently than this-- should those be set as minimums?	Thank you for your comment. This has been edited to 'within six weeks'.
Royal College of Speech and Language Therapists	12	SHORT	15	1.4.1	Many people with cognitive difficulties or communication support needs will require longer to process information and to respond. Additional time should be made available at appointments.	Thank you for your comment. This was discussed at Guideline Committee 12 and has now been referenced explicitly in the recommendation 1.4.4.
Royal College of	13	SHORT	16	1.4.4	RCSLT supports this statement that	Thank you for your comment and

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Speech and Language Therapists					people with cognitive impairments or communication difficulties may need workers to spend more time with them to ensure they have the support they need.	support.
Royal College of Speech and Language Therapists	14	SHORT	16	1.4.9	The RCSLT support this.	Thank you for your comment and support.
Royal College of Speech and Language Therapists	15	SHORT	16	1.6.1	We recommend strengthen the section after "has sufficient to spoken". This needs more on the induction process particularly related to local information, communication skills.	Thank you for your comment. There was a paucity of evidence on the impact of training and induction. The Guideline Committee included a research recommendation on training and development.
Royal College of Speech and Language Therapists	16	Full	General	General	Safety and safeguarding - focus on medicines management – other areas to consider e.g. rather than nutrition put eating and drinking to reflect difficulties many people with dementia have in this area. Staff need to be able to identify risk and know how to manage. With complex clients skills for care and skills for health need to be combined. Need awareness of dysphagia as patient safety issue and suitable training	Thank you for your comment. We have now updated the text in recommendation 1.4.4 to ensure it is clear people may need extra support eating and drinking, following discussion about this point at Guideline Committee meeting 12. Details of the evidence and the Guideline Committee discussion behind the reworded recommendation can be found in the Linking Evidence to Recommendations table on **Delivering home care – contracting home care and delivering person-centred home care** at section 3.8.2 (p188) of the

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						guideline.
Royal College of Speech and Language Therapists	17	Full	General	General	Safety and safeguarding - focus on medicines management. Other areas to consider e.g. rather than 'nutrition' put 'eating and drinking' to reflect difficulties many dementia sufferers have in this area. Staff need to be able to identify risk and know how to manage. With complex clients, skills for both care and health need to be combined.	Thank you for your comment. We have now updated the text in recommendation 1.4.4 to ensure it is clear people may need extra support eating and drinking, following discussion about this point at Guideline Committee meeting 12. We have now referenced both care and support in recommendation 1.1.5. We have reviewed the range of needs and conditions that people may have updated text in recommendations 1.3.9, 1.6.4 and 1.6.11.
Royal College of Speech and Language Therapists	18	Full	General	General	Training in general – need to move towards more experienced carer, sharing skills while having access to a variety of training and support. The guideline is a little unimaginative in this respect. Commissioners could put more resources into developing e-learning through visual media, (as many carers do not have good literacy skills), these would be freely available so standardised training/experiential learning could be more easily accessed.	Thank you for your comment. The Guideline Committee have included a research recommendation on training and development, as they considered this to be important in improving the quality of home care services. Users of home care are likely to have a range of complex needs, and evidence from users and home care workers suggested that training needs are not currently adequately met. However, we found no evidence as to the effectiveness of specific

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						training elements, either in relation to content or to how they were delivered. Hence the Guideline Committee recommended research on this topic.
Royal College of Speech and Language Therapists	19	Full	General	General	Delivering services that support the aspirations, goals and priorities. There is no guidance or evidence looking at the full range of services (irrespective of provider) that will be needed, to fully enable person and family centred care. With limited services to signpost to, or services not developed with both the carer and client in mind; the care package inevitably, will not be optimally supportive. Good practice - (lost commissioning) Sheffield Carer Support for people with dementia – 1:1 support/small group, where trained carers are able to follow the client's interests and give 'care' a break for half/full-day e.g. swimming, walks in peak district or shopping, etc. Evaluated extremely well. Good care takes TIME which is generally expensive and this is where the dilemma arises.	Thank you for your comment. It has not been possible within the guideline to make explicit the wide range of services that might contribute to a care package, although we have been able to make a number of recommendations related to: information provision and workers' ability to signpost (see section 1.2); the need for integration and joint working and training (see sections 1.3 and 1.6); and, the need to support people in taking part in social and leisure activities of their choice (see section 1.3). The issue of allowing enough time to provide good quality care is also explicit in recommendations within section 1.4.
Royal College of Speech and	20	Full	General	General	Working effectively in MDTs and determining care options.	Thank you for your comment. We have now edited the wording in

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Language Therapists					To suitably develop these care packages, will need a person to consistently coordinate, facilitate and act as the link between services and family, and be reviewed on a regular basis. The guideline is unclear in this area, i.e. need to 'consider' electing the lead from MDT. It is imperative that there is a responsible lead/facilitator that is known to all parties, and one that will help facilitate communication, or practical facilitation between different agencies e.g. health and home care workers, voluntary groups etc. This should be available for **all** people accessing services or homecare, whoever is funding – the LA should not just provide information, but provide this as a free service.	recommendations related to coordinated working, following discussion at Guideline Committee meeting 12. NICE guidance uses the term 'consider' where the evidence is weaker.
Royal College of Speech and Language Therapists	21	FULL	11	8	**(Recommendation 1.1.1.)** This will depend upon individuals having a good understanding of what is available locally as well as their own potential -- which will need the care staff to have a good understanding of these in order to discuss these in an informed way.	Thank you for your comment. The Guideline Committee supported this over-arching recommendation for all home care, and it is complemented by the recommendations concerning the provision of information to people about support available, including non-statutory and local community services (see recommendations 1.2) and about the importance of care planning taking account of

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						opportunities and aspirations: see recommendations 1.3 and throughout).
Royal College of Speech and Language Therapists	22	FULL	14	9	**(Recommendation 1.3.1, 1.3.3, 1.3.4)** Multidisciplinary teams can only work effectively if they meet on a regular basis to discuss an individual's care and who is taking responsibility for particular areas as well as identifying goals and priorities. There are barriers to this which are sometimes associated with different approaches to confidentiality, shared record-keeping and identification of the multidisciplinary team leader for the purpose of decision-making.	Thank you for your comment. Recommendation 1.3.2 refers to the need for coordinated care, and for those involved in a person's care and support to meet routinely. Recommendation 1.2.23 refers to the need for those involved in a person's care to contribute to the day-to-day log of care and the care plan.
Royal College of Speech and Language Therapists	23	FULL	14	1	People with communication needs will require information in a range of formats including: • "Easy Read" • Communication Apps (e.g. Proloquo2Go, Grids etc.) • Simplified language (in line with key word comprehension) and 1 or 2 key ideas at a time • Symbols • Talking Mats • Uses a signing support system such as Makaton, Signalong, (people do not only use Makaton)	Thank you for your comment. Recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list.
Royal College of	24	FULL	15	25	**(Recommendation 1.3.10)**	Thank you for your comment.

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Speech and Language Therapists					This is only possible if: a. There is clear information regarding the options. b. there is enough time to discuss with other family members if desired **c.** the options can be reappraised as needs change	This recommendation is now 1.3.8: "Aligned with the recommendations in **Ensuring care is person-centred**, ensure that named care coordinators and others involved in home care and support planning…" The Guideline Committee were encouraged to make recommendations that were aspirational, and person-centred care involving the person was a key principle. It is recognised that there are implementation difficulties and day-to-day events which impact on ability to deliver. We will pass on your comments to the team working on implementation.
Royal College of Speech and Language Therapists	25	FULL	20	15	The RCSLT agrees with this. People with communication difficulties or cognitive impairments who will need workers to spend more time with them to ensure that they have the support to meet their needs.	Thank you for your comment.
Royal College of Speech and Language Therapists	26	FULL	52	2	The RCSLT recommends mandatory training for the wider health and care workforce. Staff will need to be supported in how to communicate with people with dementia. The RCSLT also recommends adding aphasia and dysarthria (particularly with Parkinson's disease).	Thank you for your comment. Although the Guideline Committee made some recommendations on training and supporting workers (see 1.7 recommendations), the desirable content, style and outcomes of training for this workforce are not supported by evidence. There is therefore a research recommendation on training and

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					Requirement for specialist support with knowledge and skills, plus importance of these being assessed/monitored (again could use literature about difference between knowledge and skills in the area, and studies showing improvements with training.	development: "What are the effects of different approaches to home care training on outcomes for people who use home care services?" (2.3). The Guideline Committee has suggested that this should entail a scoping study of current practice and needs, which may well highlight the need to know how to support people with specific long term conditions, as well as evaluations of specific initiatives
Royal College of Speech and Language Therapists	27	FULL	56	2.6	The RCSLT recommends mandatory training for the wider health and care workforce. Staff will need to be supported in how to communicate with people with dementia.	Thank you for your comment. There is a research recommendation on training as evidence (on scope, content, format, impact on outcomes) could not be found. Please see Research Recommendation 2.3 for detail (What are the effects of different approaches to home care training on outcomes for people who use home care services?).
Royal College of Speech and Language Therapists	28	FULL	138	1.2.5	People with communication needs will require information in a range of formats including: • "Easy Read" • Communication Apps (e.g. Proloquo2Go, Grids etc.) • Simplified language (in line with key word comprehension) and 1 or 2 key ideas at a time • Symbols	Thank you for your comment. Recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list.

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					• Talking Mats • Uses a signing support system such as Makaton, Signalong, (people do not only use Makaton)	
Royal College of Speech and Language Therapists	29	FULL	144	1.4.4	People with communication needs will require more time with workers to be able to communicate their wishes and needs.	Thank you for your comment. We have sought to reflect this in the recommendations. Please see the revised guideline, recommendations 1.2.8 (time and other adjustments to deliver good quality person-centred care to people with communication difficulties).
Royal College of Speech and Language Therapists	30	FULL	161		Recommendations People with communication needs will require information in a range of formats including: • "Easy Read" • Communication Apps (e.g. Proloquo2Go, Grids etc) • Simplified language (in line with key word comprehension) and 1 or 2 key ideas at a time • Symbols • Talking Mats • Uses a signing support system such as Makaton, Signalong, (people do not only use Makaton)	Thank you for your comment. Recommendation 1.2.5 makes clear that the information needs to be tailored to people's particular needs and preferences and we have provided a few examples but this is not intended to be a comprehensive list. The recommendations also consider the delivery of care which allows sufficient time and reflects the specific needs of people with communication needs (see recommendations 1.4.4 and 1.4.8).
Royal College of Speech and	31	FULL	161	Relative value of	We challenge this based on cost!	Thank you for your comment. The potential cost associated with

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Language Therapists				different outcomes		providing information in different formats – and the need to be proportionate in this respect - is highlighted in the table showing evidence to recommendations at section 3.8 on p166, as is the difficulty of ascertaining the relative benefit of this intervention owing to lack of data.
Royal College of Speech and Language Therapists	32	FULL	184	Recommendations	The RCSLT supports this.	Thank you for your comment.
Royal College of Speech and Language Therapists	33	Implementation	General	General	These three areas are implementation challenges. Delivering services that support the aspirations, goals and priorities of the person using them (recommendation 1.1.1). This will depend upon individuals having a good understanding of what is available locally as well as their own potential -- which will need the care staff to have a good understanding of these in order to discuss these in an informed way. Working effectively in multidisciplinary teams coordinated by a lead practitioner (recommendations 1.3.1, 1.3.3 and 1.3.4).	Thank you for your comment which we will consider as part of the implementation work. We agree care coordinators will need an understanding of local services to be able to plan comprehensive and appropriate care as per 1.3.13. We have also included recommendations that seek to ensure care provided is recorded in detail (1.3.22), reviewed regularly to ensure it continues to meet needs and preference (1.3.10 and 1.3.13, 1.3.25) and that family members or others are involved as appropriate (1.3.11)

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					Multidisciplinary teams can only work effectively if they meet on a regular basis to discuss an individual's care and who is taking responsibility for particular areas as well as identifying goals and priorities. There are barriers to this which are sometimes associated with different approaches to confidentiality, shared record-keeping and identification of the multidisciplinary team leader for the purpose of decision-making Helping people to determine which care options will best meet their needs and preferences (related to recommendation 1.3.10 This is only possible if a) there is clear information regarding the options, b) there is enough time to discuss with other family members if desired and c) the options can be reappraised as needs change.	
Royal Pharmaceutical Society	1	Full	General	General	The Royal Pharmaceutical Society, the professional body for pharmacists and pharmacy, welcome the NICE Home care guidelines. Many of the recommendations align well to the RPS professional standards and guidance including *Medicines Optimisation: Helping patients to make the most of medicines - Good practice guidance for healthcare*	Thank you for your comment and for your commitment to supporting implementation of the guideline, which is much appreciated.

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					professionals in England, *Transfer of Care* guidance *and Improving patient outcomes through the better use of multi-compartment compliance aids (MCA).* To support these guidelines, the RPS can consider reviewing our existing standards and guidance, and update as necessary.	
Royal Pharmaceutical Society	2	Full	13	28-30	Pharmacists and their healthcare team provide advice about the use of medicines to patients and the public in their day to day role and will offer signposting where necessary, thus provide the appropriate environment to support information provision. We would like to see pharmacies included in the list of venues where information is available from.	Thank you for your comment. We have now made reference to pharmacies in this list.
Royal Pharmaceutical Society	3	Full	14	7	We agree that home care planning and coordination involves a multidisciplinary team, including pharmacists.	Thank you for your comment. We have removed the reference to multidisciplinary teams throughout (except where it is used in cited quotations) because the Guideline Committee felt it was insufficiently explicit. Recommendations now include reference to healthcare practitioners supporting older people using home care, as appropriate. There remains however an assumption that an older person who is using home care will have

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						healthcare needs, although evidence cited often does not specify who delivers it. The activities specific to healthcare practitioners that do not involve integrated working with home care workers are outside the scope of the guideline. Please see recommendations 1.3.2 and 1.5.1-2. The area of medication management was felt to be particularly important, as Guideline Committee members noted that home care workers may have little training on supporting people to take their medication.
Skills for Care	1	Q1.			To support the home care workforce in improving their skills and knowledge to carry out their role effectively and sensitively. Ensure the guidelines are embedded in all future learning recommendations. Highlight and address gaps in current learning and development standards to ensure social care workers can implement the guidelines to the best of their ability	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
Skills for Care	2	Q2.			Section 1 – Recommendations for commissioners (throughout the document) –Unless commissioners are prepared to undertake the challenges set out in these guidelines there is danger that the implementation will not be fully successful. Commissioners must	Thank you for your comment. The guideline is focused on what works in respect of home care interventions and the way they are delivered. Funding levels and commissioning arrangements are out of scope for NICE guidance however

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					take on the responsibility of ensuring sufficient resources are provided to allow the service to actually be delivered effectively to support wellbeing. 1.2 Providing Information – this is a key demand contained within the Care Act and it is right that it is given emphasis within this document. Section 3.Research – to ensure all future standards and guidance are evidence based it is vital that more research is carried out into existing practices of home care delivery, drawing out in particular the experience people who access support services, their families and carers, as well as the social are workers and providers delivering the service.	we have corresponding recommendations where actions are needed in respect of both contracting and provision of services (1.4.1 and 1.4.4) reflecting the need for shared ownership of the recommendations.
Skills for Care	3	Q3.			Could there be reference to 'information sharing' between organisations / agencies as a key component of planning effective delivery of home care. This is an important issue in ensuring that the needs of the people accessing Care and Support can be properly assessed and an effective support plan can be developed and implemented.	Thank you for your comment. We have also emphasised the need for all those involved in providing care and support to be encouraged to contribute to the care plan and care diary, to help ensure information is shared.
Skills for Care	4	Q4.			At initial planning and all review	Thank you for your comments

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					points. Home care workers will need up skilling regarding 'Telecare' and other 'assistive technology' solutions that could be helpful to people who access care and support. Digital literacy for workers is key to ensuring widespread consideration and application	The evidence search for this review did not include identifying studies on training in respect of telecare, as this was not within the scope of the guideline: however there is a research recommendation on telecare (2.2) and also on training (2.3).
Skills for Care	5	Q5.			There is a wide range of 'assistive technology' in the form of general 'everyday technologies e.g. use of online shopping, banking, social media, home movies, photos, wearables in addition to, monitoring equipment, medication safety, tablet technology, apps, the digital care plan, the Telecare alarm systems, voice-led technology. The web pages on Skills for Care website refer further to the digital skills of workforce citing research recently carried out. In addition there are examples of how a range of assistive technologies have been put into practice in social care settings. These can be made available on request	Thank you for your comment and the signposting to additional examples. The Guideline Committee intended that 'telecare' within this guideline be interpreted broadly to cover a wide range of technologies that could support people to live independently in their own homes.
Skills for Care	6	Q6.			There could be much greater reference to specific sections within the Care Act which apply to the guidance, e.g. safeguarding definitions, 9 characteristics of	Thank you for your comment. We have tried to highlight key areas where the recommendations build on requirements of the Care Act.

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					wellbeing and advocacy considerations	
Skills for Care	7	Q7.			Please see above reference. Additional referencing to MCA 2005 and Health and Safety Act might support understanding and application	Thank you for your comment.
Skills for Care	8	Q8.			Unclear	Thank you for your comment. The recommendations relate to all older people using home care. In most respects, the evidence was not specific to disadvantaged groups, but the needs of people with complex needs (including, but not limited to disabilities) featured throughout Guideline Committee discussions. Please see the Equality Impact Assessment for more detail.
Skills for Care	9	Short	General	General	This is a very helpful document. The content looks sound, with a focus on person centred approaches, integrated working, an attitude of partnership with individuals and their carers, judicious use of telecare and other technologies, etc. The style is clear and readable.	Thank you for your comment.
Skills for Care	10	Short	General	General	There is a need for consistency about how 'carers' are referred to, and attention to how wording about carers fits within a sentence each time to avoid confusing the meaning. In social care language, general the	Thank you for your comment. We have reviewed the terminology to make sure it is consistent throughout.

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					term, 'carers' means the unpaid workforce, e.g. families, friends, neighbours etc. The term used for the paid workforce is 'social care workers' or 'care workers'. Throughout the document, might also add after 'carer', 'where relevant' – as there may not always be a carer. This is included on occasion but not consistently throughout the document	
Skills for Care	11	Short	General	General	'Telecare' is only one limited aspect of the whole field of 'assistive technologies'. Please can the wider terminology be used and some further examples of what that might include, e.g. wearables, apps, tablet technology etc.	Thank you for your comment. The Guideline Committee intended that 'telecare' within this guideline be interpreted broadly to cover a wide range of technologies that could support people to live independently in their own homes, and might complement a package of home care. It was not within the scope of the guideline to identify different aspects of telecare or assistive technology.
Skills for Care	12	Short	7	19	1.2.1 'ways to influence or manage them' –meaning is unclear. Perhaps some examples might help?	Thank you for your comment. The text has been edited.
Skills for Care	13	Short	9	21	1.25 'information' for different audiences' - Does there need to be a distinction made between general information about the service (which is what this point seems to be about) and information for or about the	Thank you for your comment. This point is about tailoring information to meet a person's needs and therefore relates to all the information a person is provided with.

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					individual person?	
Skills for Care	14	Short	10		1.3.3 this sentence reads awkwardly, needs some punctuation for clarity	Thank you for your comment. This has been edited.
Skills for Care	15	Short	11	3	1.3.5 Suggest replace word, 'support' here as it has been used in a different context throughout in terms of the support needs of the individual. Suggest, 'Value home care as an important ' ?	Thank you for your comment. This has been edited.
Skills for Care	16	Short	11		1.3.7 suggest reference is made here to the '9 characteristics of wellbeing' identified in the Care Act	Thank you for your comment. We have included reference to the Care Act in order to help set out the broad legislative framework.
Skills for Care	17	Short	12	9	1.3.10 4th bullet point – add after 'local'….'and national' These might be needed where there is a less common diagnosis or set of needs to offer advice and guidance.	Thank you for your comment. This has been edited.
Skills for Care	18	Short	14	5/6	1.3.18 suggest amplify 2nd bullet point for further clarity to: 'dosage, timing and methods for taking medication, the importance of these and the implications of non-adherence'	Thank you for your comment. We have edited this sentence.
Skills for Care	19	Short	17	15	1.4.9 May need to spell out reference to Mental Capacity Act 2005 here to give greater clarity to word, 'routinely'	Thank you for your comment. This recommendation has been amended and now uses the word 'regularly'. Reference to mental capacity is made within the 'Person-centred care' section of the guideline.

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Skills for Care	20	Short	19	23	1.5.6 Word, 'proportionately' –this may be misleading. It suggests a measure of judgement by the HC worker when their duty should be always to report any concerns to seniors?	Thank you for your comment. The recommendation now sits at 1.6.4. This was discussed extensively – both before and after peer review comments - and the Guideline Committee agreed the word 'proportionately' was appropriate. The preceding recommendations describe the importance of policies and training to recognise abuse and neglect and to know how to report concerns: but clearly there are differences in the urgency and severity of concerns which home care workers should be sensitive to (see section 3.4 of the guideline for a discussion of the evidence).
Skills for Care	21	Short	21	18	1.6.9 Word 'supervise' needs some clarification. Supervision is primarily a professional term and not always understood consistently throughout social are workforce.	Thank you for your comment. The Guideline Committee were happy with the word 'supervise', although they did recognise that 'professions' such as social workers may have a more distinct understanding of it than was intended here. The revised recommendation is now at 1.7.11. The term is used to refer to a consistent, individualised and timely intervention to support the home care worker's practice.
Skills for Care	22	Implementation	General	General	We agree with the three areas identified as priority areas.	Thank you for your comment.
Skills for Care	23	Implementa	General	General	These areas cannot be fully explored	Thank you for your comment. In

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		tion			without attention to (or at least acknowledgement of) the severe funding constraints affecting home care. This impacts on many of the guidelines in section 1 as well – e.g. the guidance on 30 minutes as minimum duration for a visit. Quality home care relies on sufficient resources to ensure wellbeing is at the heart of service delivery. Commissioners have a responsibility in resourcing service providers to ensure they are able to provide according to the standards. This is clearly one of the major challenges to implementation of the Standards.	respect of visit length, the Committee highlighted the importance of developing recommendations related both to the service contracting aspect of home care (1.4.1), and the provision of the service (1.4.4) recognising the shared responsibility for implementation. Your comment will be considered as part of the implementation work.
Skills for Care	24	Implementation	General	General	Skills for Care has numerous resources that can support employers delivering home care to achieve the priorities which could be made available on request	Thank you for your comment and commitment to supporting implementation of the guideline.
Skills for Care	25	Short	26	Research	Skills for Care already collect data regarding qualifications of the whole social care workforce including home care. In addition they have excellent engagement with lead organisations representing home care employers.	Thank you for your comment. The evidence that would be valuable to training in this context would concern the effectiveness of (different content, delivery and outcomes of) training, rather than data on qualifications. We have however made a Research Recommendation 2.3 on this topic, which may be supported by some scoping as well

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						as effectiveness research.
Solihull MBC	1	Full	General	General	There is much to welcome in the guidance, particularly the emphasis on carers' needs, the focus on wellbeing, and telecare in particular as part of an effective home care service. We will use some of the principles to inform our visioning of the next steps in terms of market development of homecare	Thank you for your comment and for your commitment to supporting implementation of the guideline, which is much appreciated.
Solihull MBC	2	Full	General	General	The workforce aspects are the most important. Training is referred to but not clear how this should be paid for. A reference to training as a core cost we should factor into value evaluations would be beneficial. This is especially important considering the increased integration with health and increased expectations around out of hospital non bedded care, discharge to assess models and end of life care.	Thank you for your comment. Funding is not within our remit and it is not within the scope of the guideline to explicitly look at the funding of home care services, although there are recommendations for commissioners, and resource use will be considered within guideline implementation work. The Guideline Committee agreed there is a need for more research into training and there is a research recommendation to this effect, which suggests both a scoping study to understand what is in use, and comparative studies to consider the effectiveness of different models of workforce training and development.
Solihull MBC	3	Full	General	General	We believe telecare should be considered at all points in the planning and delivery of homecare, and should be fully utilised from the	Thank you for your comment. The guideline only refers to telecare delivered as part of a package of home care (rather than as a possible

Stakeholder	**Comment No**	**Document**	**Page number**	**Line number**	**Comments** Please insert each new comment in a new row.	**Developer's Response** Please respond to each comment
					outset to prolong independence before the need for home care	alternative to home care). Telecare is referenced at different stages of developing a plan for support in the home: in relation to the provision of information (see recommendations in section 1.2), planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4).
Solihull MBC	4	Full	General	General	We would like to have seen more about who is best placed to produce the home care and support plan. The inference is that we could use good, well trained home care staff and give them time for relationship building, but this will require quite a shift in culture and thinking..	Thank you for your comment. Although we recognise the importance of this point, and the Guideline Committee did explicitly discuss the important point of who is best placed to produce the care and support plan with the person it is for and their supporters, there was no evidence to support a specific recommendation on who should take on this role. The Committee also noted that local arrangements and personnel vary, and that, therefore, some flexibility was required.
Solihull MBC	5	Full	General	General	Duty of Candour is really important and this should be uppermost- may be some concern that providers will be penalised and not receive incentives for meeting outcomes if they are honest where a potential safeguarding incident is declared.	Thank you for your comment. The issue of reporting safeguarding concerns and concerns around providers being penalised for these was discussed extensively in order to produce the recommendations 1.5.5 and 1.5.6.
Solihull MBC	6	Full	General	General	Very helpful to have all the research	Thank you for your comment and for

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					available in one place	your support.
Solihull MBC	7	Full	General	General	The layout is not very clear – I would like to see all the recommendations for commissioners pulled together, for example	Thank you for your comment. We considered a number of options in terms of presentation, guided by NICE Editors, and overall, the Guideline Committee thought it better to group recommendations by activity.
Spinal Injures Association	1	Short	General	General	References to the different options for a personal budget (managed budget, individual service fund or direct payment), for example in recommendations 1.2.1 and 1.3.10, should make explicit reference to the need to make people aware of the increased choice and control possible with a direct payment (where appropriate) over other methods, and the support available to diminish difficulties in managing a direct payment. This is necessary because of the widespread and self-fulfilling myth that older people do not want to be bothered with direct payments. This belief prevents older people being supported to make a genuinely informed choice. For example, there are instances where a large provider has not been successful in re-tendering to be a preferred provider,	Thank you for your comments. Recommendations 1.1.6, 1.2.1 and 1.3.10 (among others) are intended to make explicit reference to the need to make people aware of all their options, and are underpinned by the section on person-centred care,. The guideline fully agrees with your comments that older people should be informed and supported to consider taking up options such as direct payments. The evidence base for the outcomes – specifically increased choice and control in what and how care is delivered – is relatively poor for older people, but we have emphasised throughout the recommendations that older people should be supported to take up whatever options best fulfil their needs. Please see recommendations 1.3.4 and 1.3.5 on

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					so that those users who wish to continue with the same provider must take a direct payment: in these instances, many older people who have taken up a direct payment had subsequently diversify and varied their use of it, exercising choice and control in a positive way, which they had previously had no idea was possible. Our spinal cord injured members have a unique set of needs and risks, in some instances life-threatening risks, which require specialised and skilled support. This is often easier to achieve with the direct payment, allowing direct employment of one's own staff who can be trained (often by the service user) and/or of agencies specialising in spinal cord injury care. In this regard we welcome recommendation 1.3.8 regarding adequate support for direct payments users, but this can only be effective after somebody has made a genuinely informed choice and decided to start direct payments; if the option is not adequately explained this will never happen. Similarly we welcome 1.3.10 about maximising choice and control,	planning home care and support.

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					including around financial arrangements, and 1.3.14 about planning that "enables the person to take more responsibility, including for the financial arrangements, to increase their independence over time	
Spinal Injures Association	2	Short	General	General	Recommendation 1.3.10 urges practitioners to be aware of common conditions, but fails to urge them to seek guidance from someone with more specialist knowledge in the case of less common conditions, including spinal-cord injury. It should also be emphasised that the person with the condition may be very expert and have very specialised knowledge of their own condition; this can be particularly true of people with spinal-cord injury who've often spent long periods of time in extended rehabilitation in specialised centres, and have learnt a great deal about their particular needs and risks - in addition to their lived experience of having the condition. We welcome the recommendations in 1.3.15 to ensure specialist needs form part of the care plan, and in 1.6.5 to ensure workers have specialist training.	Thank you for your comment. We have now clarified in the recommendations the importance of providers ensuring that specialist expertise to support people with complex health conditions is available, either in-house or by working with specialist organisations.
Spinal Injures Association	3	Short	General	General	We welcome the reference to skin integrity in recommendation 1.6.4,	Thank you for your comment. We have now clarified in the

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					and to pressure sores in 1.3.17, because pressure ulcers are a frequent complication of spinal cord injury, which can develop quite quickly under unsuitable and insufficiently trained/specialised care, and can take and inexpensively long time to heal. Similarly we welcome recommendation 1.6.5's acknowledgement of the need for specialist training (spinal cord injury carries unique needs and risks including life-threatening risks)	recommendations the importance of providers ensuring that specialist expertise to support people with complex health conditions is available, either in-house or by working with specialist organisations.
Spinal Injures Association	4	Implementation	General	General	All three challenges identified in the short version of consultation (delivering person centred services that support aspirations goals and priorities, working multidisciplinarianly, and explaining different support and funding options, are confirmed as problem areas by the experience of our members. Probably the single most effective way to improve person centredness and effective information about support and funding options, is to involve people who use services and user led organisations of disabled people and carers, as much as possible in development and delivery; the more nearly this approaches genuinely equal partnership and true coproduction the better. Peer support and the	Thank you for your comment. We recognise the value of hearing first-hand from people who use/have used services about their experiences. Recommendation 1.7.3 is about involving people with experience of service use in training. We will also consider this as part of the implementation work.

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					knowledge and lived experience of disabled people is the single most valuable, and yet the most underused, asset of the social care system.	
The MS Society	1	Full	General	General	**About the MS Society** Established in 1953 and with over 38,000 members and 290 branches, the MS Society is the UK's largest charity for people affected by multiple sclerosis (MS) and the largest not-for-profit funder of MS research in the UK. There are over 100,000 people with MS in the UK and, with 50 new people diagnosed every week, it is one of the most common neurological conditions affecting young adults. We are committed to bringing high quality standards of health and social care within reach of everyone affected by MS.	Thank you for your comment.
The MS Society	2	Full	General	General	**Focus on older people** Although we welcome the decision by NICE to produce this guideline which addresses how those responsible for managing and providing home care should work together to deliver safe, high-quality home care services that promote independence. We were disappointed to see that this guideline is aimed only at older people.	Thank you for your comment. The largest group of people using home care in England is older people (79%, Community Care Statistics: Social Services Activity Health and Social Care, England. 2013-14. Final Release. Health and Social Care Information Centre (2014). The older population is growing, and there is evidence that users of home care are becoming older, frailer and have more long term conditions. The

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					Research from the UK Home Association found that 21% of people receiving home care services are under the age of 65.[9] By this guideline only focusing on older people, we are concerned that those responsible for managing and providing home care will not apply these recommendations to a fifth of those receiving home care services and that their needs will not adequately be taken into account. We recommend that NICE expand this guideline for all adults to ensure parity between age groups. This will ensure that all recipients of home care services will be able to benefit from these key recommendations.	rationale for the focus on older people is provided in the Scope (and associated Equality Impact Assessment) and this is also discussed in the guideline's Equality Impact Assessment. We also note in the guideline that many of the recommendations will be relevant to younger adults.
The MS Society	3	Full	14	6	**Multidisciplinary teams** We welcome the guidelines recommendation 1.3.1 that commissioners of home care should ensure integrated care and support is delivered to the person through a multidisciplinary team, where required. We particularly welcome that this recommendation echoes recommendation (1.3.1) made in the NICE clinical guideline for MS that	Thank you for your comment. We have removed the reference to multidisciplinary teams throughout (except where it is used in cited quotations) because the Guideline Committee felt it was insufficiently explicit. Recommendations now include reference to healthcare practitioners supporting older people using home care, as appropriate. There remains however an

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[9] UH Homecare Association (2015) *An Overview of the Domiciliary Care Market*. Available at http://www.ukhca.co.uk/pdfs/DomiciliaryCareMarketOverview2015.pdf (accessed on 10.04.2015)

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					care for people with MS should be done 'using a coordinated multidisciplinary approach. Involve professionals who can best meet the needs of the person with MS and who have expertise in managing MS.'[10] If employed effectively, the use of a multidisciplinary team of health and social care workers should provide a responsive and holistic package of home care for people with MS. We also welcome the reference that the multidisciplinary team might include 'people from voluntary and community organizations, befriending, and specialist services.' Voluntary and community sector organizations (VCS) can play a key role in developing, providing and monitoring the success of a service and where possible should be included to ensure their expertise are fully utilized.	assumption that an older person who is using home care will have healthcare needs, although evidence cited often does not specify who delivers it. The activities specific to healthcare practitioners that do not involve integrated working with home care workers are outside the scope of the guideline. Please see recommendations 1.3.2 and 1.5.1-2.
The MS Society	4	Full	15	8	**Moderate Needs** We welcome the guidelines recommendation 1.3.6 that	Thank you for your comments, and the information about potential healthcare savings.

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[10] NICE Clinical Guideline (2014) *Multiple sclerosis: management of multiple sclerosis in primary and secondary care*. Available at http://www.nice.org.uk/guidance/cg186/resources/guidance-multiple-sclerosis-pdf (accessed on 10.04.2015)

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					commissioners should consider offering home care support to people with low to moderate needs. This is because it may mean that they need less intensive support later on or may delay the time at which support is needed. This is a key recommendation which if implemented will see many older people with MS get the support they need when they need it and prevent people from reaching a crisis point. There is a substantial body of research which continues to highlight the benefits of investing in care and support for those with moderate needs. Most notably, the joint report by Scope, Mencap, National Autistic Society, Sense and Leonard Cheshire Disability, found that for every £1 spent on preventative social care support for people with 'moderate' care needs, an average of £1.30 goes back to the NHS, and local and central government.[11] This example is highlighted by the table below which shows the number of people with MS who were admitted into hospital in 2012/13 not as a	This recommendation (now 1.3.4) is based on cost-effectiveness evidence but uses the weaker 'consider' (providing home care) and 'may' (result in less or delayed needs) because the evidence we found was limited. However, we agree that this may be particularly relevant for people living with degenerative and fluctuating long term conditions.

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[11] Brawn, E., Bush, M., Hawkings, C., and Trotter R. *The other Care Crisis: Making Social Care funding work for disabled adults in England*. Available at: www.scope.org.uk/Scope/media/Documents/Publication%20Directory/The-other-care-crisis_1.pdf?ext=.pdf (accessed on 10/04/15). p.47

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					result of their MS, but because of preventable urinary tract infections.[12] **Table can be viewed on original submission too large for this section** Many of these costly hospital admissions could have been avoided by commissioners offering home care support to meet moderate needs. Likewise, a study which looked at hospital admissions and death certificate records for all of England in 1999-2010, found that people with MS are almost twice as likely to suffer from fractures verses the general population.[13] The study also found that people with MS suffered from particularly debilitating fractures including hip, leg and ankle fractures. If low level support, such the fitting of a hand rail or help with shopping or cleaning, is provided to a person with MS who has low to moderate needs, the chances of that person suffering a fracture would be reduced. Not only	

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[12] Secondary care data is taken from English Hospital Episode Statistics (HES) database produced by the Health and Social Care Information Centre (HSCIC, www.hscic.hov.uk/hes) Copywright 2010 – 2013, re-used with the permission of the Health & Social Care Information Centre.

[13] Ramagopalan SV1, Seminog O, Goldacre R, Goldacre MJ (2012) Risk of fractures in patients with multiple sclerosis: record-linkage study. Available at www.biomedcentral.com/1471-2377/12/135 (accessed on 10.04.2015)

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					would this reduce pressure on the NHS, but it would also reduce pressure on social services by preventing people from developing an increase in their needs and becoming more dependent on longer term and more expensive services.	
The MS Society	5	Full	15	17	**Direct Payments** We welcome the guidelines recommendation 1.3.8 that where a person chooses to take a direct payment for home care that commissioners should 'give them support and information they need to manage the payment effectively.' Regardless of whether they buy care through a 'regulated provider, directly employ a personal assistant or chose another way to meet the agreed need.' It is essential that people who receive a direct payment are given adequate information and advice, advocacy and brokerage support to make the most of it. For some people managing a direct payment can be a daunting but ultimately rewarding prospect, as long as they are able to access the right support. Inadequate support can undermine the positive aspects of receiving money for care and support in this way.	Thank you for your comments. The Guideline Committee chose not to specify who ought to provide advice and support, recognising the need for flexibility in local implementation. Voluntary and community sector organisations are referenced explicitly, however, as part of the coordinated group supporting people (in recommendation 1.3.19).

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					Members of the MS Society have told us: "I had some support from a local advocacy service, which helped me with things like making sure I got the right amount of care and deciding how many carers I would need. I had to find out about employment laws myself, and I now do rotas, wages, tax, sick pay, holidays, contracts and dismissal – all that is involved with being an employer." "I just didn't feel comfortable with my direct payment to start off with. Advice and information on how to use it is critical otherwise it's just a lump of cash." Although we welcome that the guideline recommends (1.3.9) that commissioners consider asking people with "experience of using a direct payment for home care to provide training support, or advice to others thinking of doing so," we would like this recommendation to be expanded to include Voluntary and Community Sector (VCS) Organisations. Many VCS organisations provide excellent support and advice on direct	

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					payments. Commissioners should utilise their knowledge to support people through the direct payment process.	
The MS Society	6	Full	15	25	**Involving the individual (person-centred care)** We welcome recommendation 1.3.10 that lead practitioners and others involved in home care and support planning 'understand the principle and importance of involving the person using services, and their carers if relevant, as an equal partners in specifying the support and services they receive.' It is vital that people living with MS and their carers (where appropriate) are involved in the planning of the support and services they need. Only by working with the individual will a package of care be designed that will best meet their needs and aspirations. Recommendation 1.3.10 also recommends that lead practitioners and others involved in home care and support planning should 'have an awareness of common conditions affecting people using home care services, for example, sensory loss, dementia, physical and learning	Thank you for your supportive comments on person-centred care. We have now made explicit reference to neurological conditions in recommendation 1.3.8 (which replaces 1.3.10) and in 1.7.4 (on training and supporting home care workers). This was discussed extensively in Guideline Committee meetings, and a consensus was reached on which examples of conditions should be cited, including neurological conditions.

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					disability and stroke.' We would welcome its expansion to include an explicit reference to neurological conditions. The Neurological Alliance's *Neuro Numbers* report in 2003 estimated that over a million people are disabled as a result of a neurological condition. With approximately 350,000 people requiring help for most of their daily activities. This will include most people with motor neurone disease (MND), many of those with primary and secondary progressive multiple sclerosis (MS) and other progressive neurodegenerative conditions.[14] In 2014 the Neurological Alliance reported that there are 12.5million people in England with a neurological condition, an increase of 2.5million since 2003.[15] As a result, a broader reference to neurological conditions would be welcome in this recommendation to ensure that commissioners are aware that a number of their clients will be affected by neurological conditions.	

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[14] Neurological Alliance (2003) *Neuro Numbers.* Available *at* http://www.neural.org.uk/store/assets/files/20/original/NeuroNumbers.pdf (accessed on 10.04.15)

[15] Nurological Alliance (2014) *Neuro Numbers.* Available at http://www.neural.org.uk/store/assets/files/381/original/Final_-_Neuro_Numbers_30_April_2014_.pdf (accessed on 14.04.15)

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The MS Society	7	Full	16 -19	28	**Home care plans** The guideline references a person's 'home care plan' in recommendation 1.3.15, 1.3.23, 1.2.24, and 1.3.25. However the guideline is not clear how a person's 'home care plan' relates to a local authorities duty to provide a person with eligible care and support needs with a care and support plan. The Care Act Guidance sets out a person's care and support plan 'must detail the needs to be met and how the need will be met, and will link back to the outcomes that the adult wishes to achieve in day-to day life as identified in assessment process and to the wellbeing principle in the Act.[16] The guideline should provide further clarity as to whether the home care plan referred to is a separate document or the same as the individual's care and support plan. It needs to be made clear how the two plans work together to ensure that a person's needs are being met as	Thank you for your comment. We have now added an explanation of the key term home care plan which describes that this is the written plan, compiled after an assessment that sets out the support providers have agreed with the person will be put in place, and what this comprises. While this may be underpinned by a local authority assessment of support needs and financial input, it specifically relates to what the home care provider and the service user and carers have agreed should be delivered. A person could have a home care plan if they are recruiting and funding the home care worker through their own resources. We have also specified in recommendation 1.3.22 what is meant by 'a care diary.'

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[16] Department of Health (2014) *Care and Support Statutory Guidance*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf (accessed on 10.04.15) p.173

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					intended. Furthermore, we recommend that a person's home care plan make 'comprehensive provisions' for those with fluctuating needs as recommended for care and support plans in paragraph 10.44 of the Care Act Guidance.[17] This is a key recommendation as it will set out in a person's plan what contingencies are in place in the event of a sudden change in their condition or emergency. This will ensure that their needs are adequately met if they change.	
The MS Society	8	Full	19	23	**Length of time of home care visits** We strongly support the guideline recommendation 1.4.1 around the length of time a home care visit can be. We particularly welcome the recommendation that the commissioner should ensure 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.	Thank you for your comment. The wording of the recommendation about shorter visits reflects the detail of the evidence available to the Guideline Committee from expert testimony and research data on the views and experience of service users, carers and home care practitioners. The principles of person-centred care, and of taking into account an individual's circumstances and preferences, underpin the whole guideline.

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[17] Department of Health (2014) *Care and Support Statutory Guidance*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf (accessed on 10.04.15) p.176

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					This is a welcome recommendation and is a key step to ending the commissioning of 15 minute care visits which have been on the rise since 2009. A freedom of information request published in December 2014 found that 110 local authorities (74%) commissioned 15 minute visits. On average 15 minute visits make up 14%, or one in seven, of all the homecare visits commissioned.[18] 15 minute visits are insufficient for people living with MS, visits should be shaped around need and not on an arbitrary time slot. This recommendation could also be strengthened by referencing the Care Act Guidance which also sets out local authorities should ensure effective, appropriate commissioned services that are adequately	

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[18] UNISON (2014) *15 minute home care visits in England on the rise.* Available at http://www.unison.org.uk/content/conNewsArticle/5637 (accessed on 10.4.1015)

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					resourced and meet the wellbeing principle of the Act.[19] However we would like to extend recommendation 1.4.2 which sets out when it is acceptable to have a home care visit shorter than half an hour to include only if 'a person has agreed that they are comfortable with a visit that is less than half an hour'. Including this will ensure that a person's own preferences are considered by commissioners when deciding the duration of a homecare visits.	
The MS Society	9	Full	20	25	**Continuity of Care** We welcome the guidelines recommendation (1.4.7) that home care providers should 'prioritise continuity of care so that the person knows the home care practitioners and they are familiar with how that person likes support to be given.' Between September and December 2014 the MS Society ran 6 focus groups across England. In all of the groups continuity of carers was	Thank you for your comment.

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[19] Department of Health (2014) *Care and Support Statutory Guidance*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf (accessed on 10.04.15) p.63 paragraph 4.100.

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					identified as a key area of concern for people with MS. For example, people told us: 'I mainly have the same carers but sometimes they introduce new ones – I need more notice of this change. You are letting people into your home.' 'If you need care then the last thing you want is to be telling people how to care for you every day.' Having a lack of continuity means there is little opportunity to build any sort of relationship between the individual that needs care and the staff commissioned to provide it. Continuity of carers will ensure that a relationship is able to be developed, and will encourage a higher level of trust and dignity. For example a person may not feel comfortable being washed by a stranger every day, but if it was the same person they may feel more comfortable. We welcome that this recommendation will encourage home care managers and providers to give more consideration to providing the same carers.	

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The MS Society	10	Full	22	1	**Telecare** The guideline recommends (1.3.19) that the lead practitioner should always discuss with the person and their carers whether telecare could complement their home care package and any other services they are using. Telecare may be beneficial for some people with MS and we welcome it being part of the process for planning and developing a home care package. However the guideline should stress that there should be no obligation on an individual to use telecare if they do not wish to do so or for telecare to be substituted for support that would be better delivered in person.	Thank you for your comment. The reference to the complementary nature of telecare was intended to reflect the point that this type of support should not be seen as a replacement for personal contact. This is described in more detail in the detail of the review work on telecare and the corresponding table in the evidence to recommendations (section 3.8) of the full guideline. The Guideline Committee agreed that people should be informed about telecare and make their own choices. As many people may agree to try it, the Committee thought it important to add the recommendation that use should be reviewed regularly, to ensure the person finds it useful (1.4.15).
The MS Society	11	Full	24	17	**Training** Although we welcome recommendation 1.6.4 that home care providers should be able to recognise 'common conditions, such as dementia and sensory loss' we would welcome (as mentioned in comment number 6) for this to be extended to include a reference to neurological conditions. People with neurological conditions will make up a large proportion of people who require home care support and it is	Thank you for your comment. We have added 'neurological conditions' to every recommendation that cites examples of common conditions which workers should have awareness of and some ability to help manage (e.g. 1.3.8, within the section on person-centred care). The issue of fluctuating needs and the need to review the home care plan is reflected at several points in the revised Guideline: e.g. at 1.3.14

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					important that home care workers are trained appropriately to recognise these conditions and their symptoms. We are also concerned that the guideline does not state that home care workers should be trained to recognise fluctuating needs. This is concerning as conditions that fluctuate such as MS and Parkinson's may require more support and expertise as a result of changing levels of needs. For example, if someone is able to do something in the morning, but is unable to do it again in the evening, it is important that homecare workers are flexible in the level of care that will be needed over a period of time. We strongly recommend that home care workers should be trained to recognise fluctuating needs. This would also be in line with the Care Act which has an emphasis on recognising fluctuating needs as part of the assessment and the care and support planning process.[20]	and 1.4.7. 1.3.13 highlights the need to review the plan if the family carer's circumstances change and affect their ability to care. There was little evidence in respect of training needs, and there is a research recommendation on learning and development.

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[20] Department of Health (2014) *Care and Support Statutory Guidance*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf (accessed on 10.04.15)

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UKHCA	1	Q1.			We will promote the value of the guidelines to our UK membership of over 2,000 care provider organisations	Thank you for your comment and commitment to supporting the implementation of the guideline. This is much appreciated.
UKHCA	2	Q2.			Recommendations 1.3 and 1.4 potentially have the most leverage	Thank you for your comment.
UKHCA	3	Q3.			Please refer to our comments in the General Comments table below which suggest how the guidelines could be used to incentivise local authority commissioning and how homecare could be positioned within the broader health and social care system to the considerable advantage of providers and service-users	Thank you for your comment which we will consider as part of the implementation work.
UKHCA	4	Q4.			The planning of digital care systems should be considered from the outset as an integral asset in maintaining people in their own homes and it will be increasingly important to embed Telehealth and Telecare within the broader health and social care system so that people can move smoothly between services	Thank you for your comment. The reference to telecare as part of both home care planning and delivery is intended to capture the point that it should be both considered early on, and reviewed on a regular basis. In addition, telecare is referenced in relation to the provision of information (see recommendations in section 1.2); planning of home care (see recommendations in section 1.3) and delivery of home care (see recommendations in section 1.4).
UKHCA	5	Q5.			Telecare could have considerable	Thank you for your comments. The

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					value in improving access to psychological therapies, improving accessibility to first contact services and can have a marked impact within an integrated care system or pathway by supporting people to remain at home and avoid the need for unplanned emergency hospital and care home admission. The caveat is that it cannot be a poorly resourced management fad and has to be regarded as a fully costed commissioning asset to achieve intended goals and outcomes	scope of this guideline does not include access to psychological therapy.
UKHCA	6	Q6.			Specific sections of the guidelines could usefully be cross-referenced to the elements of the Care Act and CQC inspection protocols	Thank you for your comment. We have tried to highlight key areas where the recommendations build on requirements of the Care Act and believe that they are certainly consistent. Many of the recommendations provide some detail of how aspects of the Care Act can be supported (e.g. those on person centred care (1.1.) and provision of information about care options (1.2). However, the process of reaching recommendations (see section 3 of the full guideline) followed a process developed by NICE, beginning with research evidence, and the guideline aims to complement existing legislation rather than repeat it. We will consider your comment in respect of the

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						implementation work to support this guideline.
UKHCA	7	Q7.			Specific sections of the guidelines could usefully be cross-referenced to the elements of the Care Act and CQC inspection protocols	Thank you for your comment. We have tried to highlight key areas where the recommendations build on requirements of the Care Act. We will also consider your comment in respect of the implementation work to support this guideline.
UKHCA	8	Q8.			People with 'eligible needs' within the meaning of the Care Act and those with 'protected characteristics' must be afforded equality within the guidelines: the guidelines appear to meet this requirement	Thank you for your comment.
UKHCA	9	short	3	General	The introductory description does not include the fundamental issue of quality of commissioning of homecare services	Thank you for your comment. We had a great deal of feedback welcoming the strength of focus on commissioners and what they should do, and this will inform the implementation stage.
UKHCA	10	short	7	1.1.2	The list could usefully include the limitations placed on peoples aspirations by the nature of their health-state	Thank you for your comment. The wording seeks to emphasise the importance of an asset-focused approach, irrespective of their health state.
UKHCA	11	short	7	1.1.3	The laudable values listed in the opening sentence will be very difficult to measure, quantify and rank	Thank you for your comment. The Guideline Committee thought it important that the guideline is aspirational but achievable and wanted to emphasise person-centred care up-front, as the guiding principle behind all the recommendations. The guideline responds to many

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						concerns raised by service users and stakeholders. The implementation team will consider how guideline implementation might be assessed.
UKHCA	12	short	8	1.1.5	The list could usefully include cultural and linguistic awareness or sensitivity	Thank you for your comment. We aimed to cover this point within the bullets relating to ensuring preferences are respected, and providing formats that suit people's needs. We have also now included a reference to the need to respect people's cultural and religious preferences.
UKHCA	13	short	10	1.3	The introductory narrative for this section could usefully elaborate on what is meant by 'integration' (x-ref to s1.3.10)	Thank you for your comment. We have added in a definition of integration.
UKHCA	14	short	10	1.3.1	The multi-disciplinary team listed should include representation from local authority Housing Dept (x-ref to s1.3.7)	Thank you for your comment. This was discussed at Guideline Committee12 and has now been edited.
UKHCA	15	short	10	1.3.3	The role of Lead for homecare services could usefully be elaborated upon, particularly for GP's and Nurses	Thank you for your comment. This was discussed at Guideline Committee12 when we agreed to add in a definition of lead practitioner and some examples of who may fulfil this role.
UKHCA	16	short	13 -14	1.3.15	The compulsory nature of a reablement programme could run counter to the sentiment within this	Thank you for your comment. Reablement as an intervention is out of scope for this guideline as it is the

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					section	subject of a forthcoming NICE guideline "Intermediate care – including reablement" to be published in 2017.
UKHCA	17	short	14	1.3.19	Telecare is not the only digital-system option for connecting with service users: skype, whats-app, etc. (x-ref to s1.3.27)	Thank you for your comment and the signposting to additional examples. The Guideline Committee intended that 'telecare' within this guideline be interpreted broadly to cover a wide range of technologies that could be used as part of a home care package to support people to live independently in their own homes. There is no agreed definition of telecare, and much of the evidence did not offer a definition, nor consider its relationship to home care.
UKHCA	18	short	14	1.3.21	This section is too nebulous, although laudable in intention: the vast majority of Carers are volunteers	The Guideline Committee agreed it is important to include reference to carers throughout, given the critical role they play in home care. This recommendation seeks to emphasise the importance of all organisations providing support involving carers, as appropriate.
UKHCA	19	short	15	1.3.24	The statement "and deliver support in an integrated way" is ambiguous: what does 'integrated' mean in practice? (x-ref to 1.6.11)	Thank you for your comment. We have included a definition of integrated in the guideline.
UKHCA	20	short	16	1.4.1	This statement is nebulous and leaves too much open to interpretation: what constitutes	Thank you for your comment. The time allowed for visits was discussed extensively and informed

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					'enough time'?	by both consistent evidence on views and experiences, and expert witness testimony. This is captured in the relevant Linking Evidence to Recommendations Table (see section 3.8 of the guideline). The Committee felt that there may be circumstances in which a short visit may be justified. We accept that the term 'enough time' may be unclear, but the remainder of the point gives examples. The recommendation reached by Committee consensus now reads: 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.
UKHCA	21	short	16	1.4.3	This statement is nebulous and leaves too much open to interpretation: 'consider' doing something carries little weight	Thank you for your comment. NICE guidance uses the term 'consider' where the evidence is weaker. There is only qualitative evidence of user views to suggest that flexible delivery or time-banking can be preferred by some people, while for others, such

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						as people who need consistent care throughout the day, it may be unsuitable.
UKHCA	22	short	16	1.4.4	The provision of homecare visit duration is at the discretion of Commissioners, rarely will a Manager have this option	Thank you for your comment. The time allowed for visits was discussed extensively and informed by both consistent evidence on views and experiences, and expert witness testimony. The revised recommendations (see 1.4.1-1.4.4) are now addressed to those contracting care, and aligned with the Care Act requirements on commissioners. This will be considered at implementation.
UKHCA	23	short	17	1.4.8	This comment duplicates section 1.2.5	Thank you for your comment. We may have mistaken your meaning, but 1.4.8 (on respecting cultural, religious and communication needs) is very different from 1.2.5 (on tailoring information).
UKHCA	24	short	19	1.5.5	The provision of a suite of case studies of detrimental impact of not reporting safeguarding would be advantageous	Thank you for your comment and your support. The implementation work will signpost to other resources, and may develop other tools.
UKHCA	25	short	19	1.5.6	Safeguarding issues are not confined to instances of abuse: self-neglect is an important consideration	Thank you for your comment. Neglect and self-neglect is now referenced in the recommendations: see recommendation 1.6.4.
UKHCA	26	short	20	1.6.5	Provision of additional specialist support in homecare is more properly the responsibility of Commissioners	Thank you for your comment. This was discussed again at Guideline Committee12 when members agreed that providers need to be able to

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						access specialist support or provide this in-house. The recommendation wording has been updated.
UKHCA	27	short	25	3.0	Of the five research initiatives listed, 3.1 'intensity' is seen as likely to contribute more to the whole care system	Thank you for your comment.
UKHCA	28	Implementation	General	General	1.3.10 – more detailed explanations concerning the limitations that will arise due to funding options and personal resources that will have a significant impact on the implementation of the guidelines may prove useful	Thank you for your comment which we will consider as part of the implementation work. In particular, it will be important that those involved in planning care, and providing information are equipped to handle queries about options available to people (e.g. as specified in recommendations 1.2.1, 1.3.8 and 1.3.13)
UKHCA	29	Implementation	General	General	GENERAL – a mobilisation model for the implementation of the guidelines would prove useful in defining the different roles and responsibilities across professional and administrative domains to successfully implement the guidelines	Thank you for your comment which we will consider as part of the implementation work.
UKHCA	30	Implementation	23	General	GENERAL – within the section 'challenges for implementation' mention is made of 'one size fits all' models of homecare and it is suggested that Providers should review how they deliver services. The structure of homecare services are frequently a consequence of local authority commissioning practices	Thank you for your comment which we will consider as part of the implementation work.

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					and the contracts that arise from competitive tendering. It is often the case that the services commissioned in this way are 'time and task' based to achieve the least costly option to that authority for providing care services, and frequently this gives rise to fifteen minute episodes of care. In this contracting environment it is rarely possible for Providers to promote quality issues when the lowest bidder is often selected on price alone. Electronic auctioning of spot contracts has emerged recently and concerns have been voiced over: (i) the quality of care that can be achieved at the fee rates on offer, and (ii) continuity of care deliverable through this fragmented approach and (iii) how investments in quality staff can be made when it is impossible to plan workloads ahead of unplanned spot demand based on the cheapest bid This is not 'flexibility' within the provider framework or care staff workforce but an ill disguised approach to reduce costs to local authorities to the absolute minimum.	

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					Implementation of the guidelines against this backdrop are likely to be frustrated because of (i) *discontinuity* of care between episodes because it could prove impossible to schedule the same staff, (ii) *disruption* to the forward planning of safe workloads that maintain choice and (iii) the *displacement* of quality, person centred care because the commissioning system creates the commodification of care	
UKHCA	31	short	General	General	Sector specific phrases used could usefully be explained, such as in 1.6.11 the use of "integrated" and "person centred" and "wellbeing" carry the risk of being proprietary expressions which could appear as jargon which would benefit from a definition or elaboration in a lexicon of terms	Thank you for your comment. We have included some additional definitions in the guideline, which can be read alongside those already provided in the NICE glossary.
UKHCA	32	short	General	General	The concept and utility of the Care Diary should be elaborated**:** the versatility of a tool common to all involved in the care and support of people in a home setting could provide a 'live document' held by the service-user that would aid communications and shared understanding of care activities. This proposal would be strengthened if there were more formal 'rules' on how and when to use it, making it clear that all parties involved,	Thank you for your comment. We have now included more detail about this, and a definition.

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					whether formal or informal, should routinely access it as a source of information, communications and records of actions. Service-users and their families should be actively encouraged to use this to establish preferences.	
UKHCA	33	short	General	General	The role of the Lead Practitioner could usefully be changed to include informal carers and families as able to take the Lead role. There is also ample scope for 'unqualified' homecare staff to assume this role. It would be advantageous to extend the description of this role to make note that it is not a formal, appointed position that can only be held by a qualified healthcare professional to the exclusion of others whom the service-user may prefer.	Thank you for your comment. We have clarified in the definition of lead practitioner that some of the tasks could be undertaken by people using services or carers.
UKHCA	34	short	General	General	The profile of the homecare sector has changed over the last five years: the scope of activities undertaken in a home setting coupled with the increased complexity of care programmes undertaken by homecare staff reinforce the critical role of the sector in the broader health and social care system. Homecare has become a key element in maintaining people in their own residences, both as a preventative measure and as an avenue of recovery after hospital	Thank you for your comment. There was a paucity of evidence on effectiveness and cost-effectiveness of different models of care (or components of models). However there are research recommendations that seek to address this evidence gap, for example, 2.1 on cost-effectiveness of different 'amounts' or intensity of home care, as delivered to people with different levels of need. New research will inform the update of the guideline.

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					stays and is not confined any longer to the traditional image of 'home help' and 'befriending'. The NICE guidelines could therefore emphasize**:** a) the evolving role of homecare by exploring the access criteria used by local authority commissioners in providing homecare that evidences the critical and substantial needs of those eligible for care and the skills necessary to meet these increased levels of need, including complex medications, PEG feeding, mobility and reablement schemes, resistant behaviour and people living with significant long term impact of conditions, such as Tier 3 dementia b) the value to the NHS as a reliable safety net for the discharge of medically 'fit' people from hospital who do not require further in-patient care but do need support in the community after discharge c) the value of homecare in maintaining people in their own residences in	

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					preference to expensive Nursing or Residential institutional care d) the enhanced skill sets required of homecare staff, their practice supervisors and provider organisations sufficient to meet the competencies as detailed in the new Care Certificate**:** this is now an important element in the CQC's new inspection regime of care providers e) the skills and situational awareness required of homecare staff to act as an early warning system and safety net for the broader health and social care system to prevent deterioration, exacerbation and risks management in a way that prompts early intervention to prevent unnecessary hospital or care home admissions f) how the 'positioning' of homecare within the spectrum of the broader health and social care system is important so that recognition of its underpinning role, its capacity to take or initiate	

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					preventative measures and the skills necessary to maintain safety and wellbeing in a home setting should form part of a 'big picture' of how different elements of health and social care can integrate and work together to create a seamless service**:** the multidisciplinary framework extensively noted in Section 2 'Implementation' of the guidelines To this end, the guidelines could adopt a more forceful approach to describing the structures, processes and anticipated outcomes of optimal homecare services. This could emphasize the gravity of the economic situation across the broader health and social care system and how domiciliary care could, with the skills, funding and commissioning disposition, be (i) a positive force for supporting the delivery of integrated care, could (ii) contribute significantly to the implementation of multidisciplinary coordination of care services and (iii) support alternative care models that are very cost-effective compared to unplanned or urgent uptake of institutional and emergency care	

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					services. If the guidelines were drafted in a way that reflected a broader 'whole systems' approach there may be encouragement for local authority commissioners to move away from short intervention 'time and task' contracts and undertake an investment driven approach through five or seven year contracts based on client outcomes (COBIC) rather than service inputs**:** progressively moving towards a 'client based pull' approach and away from the current and prescriptive 'system based push' method of delivering homecare	
Yorkshire and Humber Commissioning Support	1	Full	5	7	I believe that the Domiciliary Care Agencies Regulations 2002 in England were revoked in 2010 by SI 2010/807.	Thank you for your comment. This has been edited.
Yorkshire and Humber Commissioning Support	2	Full	5	1 -4	The way this paragraph is worded could be read to imply that registered providers do not have to comply with the Fundamental Standards which they must do. Would it also be helpful to include a link to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and its 2015 amendment?	Thank you for your comment. We have edited the sentence and hyperlink.
Yorkshire and Humber Commissioning Support	3	Full	9	2 -3	Person centred care is one of the fundamental standards (Regulation 9) for registered providers. Would it beneficial to add this in to the section	Thank you for your comment. This has been edited.

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Yorkshire and Humber Commissioning Support	4	Full	9	13 -14	It is my understanding that domiciliary care providers cannot use the Deprivation of Liberty Safeguarding process supervised by the local authorities as this route is only available to care homes and hospitals. If it is necessary to deprive someone of their liberty in their own home then they would need to go through the Court of Protection. Should this be mentioned in the guidance?	Thank you for your comment. This has been clarified.
Yorkshire and Humber Commissioning Support	5	Full	13	28 -30	This paragraph appears to indicate domiciliary care providers should provide information about their services at community centres and GPs surgeries. I do not think this is appropriate as the domiciliary care agencies are (in the main) private businesses and cannot be expected to provide independent advice. It would also give the impression that the GP practice is endorsing the providers who have information there. It would be helpful for local authorities to supply information in such places, for example, links to local authority advice routes. Would it be sensible to specify who would put information in GP surgeries and community centres?	Thank you for your comment. This was discussed at Guideline Committee meeting 12 and the group agreed that these are the sorts of places where information could usefully be available, and that information could relate to a range of services, it was appropriate to include. The recommendation does not imply any endorsement of information provided.
Yorkshire and Humber Commissioning	6	Full	14	4	It would be helpful to include some guidance on how often providers should update their information as a	Thank you for your comment. We did not identify any evidence that enabled us to make a

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Support					minimum.	recommendation in this area, and the Guideline Committee felt that this was an area in which local considerations would be very relevant – e.g. the current state of information provision, the identification of new language communities, the commissioning or closure of new services would all entail updates. We will pass this comment on to the implementation team to consider.
Yorkshire and Humber Commissioning Support	7	Full	17	28	It would be helpful to include guidance regarding minimum time periods between reviews of risk assessments.	Thank you for your comment. The relevant recommendation has been re-numbered as 1.3.14, although there are many other recommendations in which risk is a consideration. The Guideline Committee did discuss the timing of reviews (on which there was no research evidence), but concluded that risk assessments as part of home care planning should be carried out "at relevant intervals, such as when significant factors change".
Yorkshire and Humber Commissioning Support	8	Full	18	3 -6	We are firmly in agreement that medicines management requirements should be in the home care plan. We believe however that this should focus on the type and level of support the individual	Thank you for your comments. The recommendations in this guideline seek to complement those in the existing NICE clinical guideline on Medicines Management, and may be revised in the light of the

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					needs/wants to take their medication as prescribed, for example, are staff to administer the medication, just collect prescriptions and medication when requested etc. Provision of information on the purpose of the medication is the responsibility of the person prescribing it. It is unlikely that the lead professional will be have access to the person's medical records or the healthcare knowledge to write the purpose of and information on medicines in the care plan. It is also likely that this information could go rapidly out of date as a person's healthcare needs change with a subsequent increase in risk through the provision of inaccurate information. We believe that it is more practical to direct people to refer to the patient information leaflet which is provided with the medication for information or contact a relevant healthcare professional. We believe that home care workers should be enabled to give medicines as prescribed, provided with clear directions on the dispensing label or subsequent written information, and encouraged to contact the relevant healthcare professional if problems such as non-adherence or a change	forthcoming NICE guidance on 'Managing the use of medicines in community settings for people receiving social care'. The evidence reviewed by the Guideline Committee included research on the difficulties and lack of guidance that home care workers experienced in supporting the person to take their medication. While it was felt to be unfair to suggest the home care worker was wholly responsible for medication management, the Guideline Committee recommended that healthcare practitioners liaise – in person and through clear written instructions and updates – with the worker (1.5.1 and 1.5.2). The Guideline Committee also noted the importance of recording the purpose of medication in the home care plan in order that home care workers can explain to people why it is important they take medication. There is also a research recommendation on the scoping of training needs and interventions which may involve this area of expertise.

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					in the person's health are encountered. (see also comment 15)	
Yorkshire and Humber Commissioning Support	9	Full	18	26 -28	Does "all practitioners" include such professionals as GPs, Community Nurses and consultants? If so there is little the home care provider can do to ensure this. It also assumes that the healthcare professional will have access to the home care plan but this is not always the case. Health care is not always delivered in the person's home and the person is unlikely to take their care plan on a hospital visit, for example.	Thank you for your comment. We have edited the text so it no longer refers to all practitioners.
Yorkshire and Humber Commissioning Support	10	Full	19	4	Consider seems too weak a word here. Could this be an opportunity to say they "should" work together?	Thank you for your comment (on recommendation 1.3.26). We have clarified the references to the home care plan throughout the recommendations. However, recognising that a home care user may have a number of other needs for support in the home, including health care, the Committee felt that it would be difficult to appear to insist that all parties should work to a single plan. There was also no strong evidence to support the proposition that shared home care and support plans produce better outcomes. It is agreed that a single home care and support plan held in the home is desirable, but would need to be negotiated with different

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						providers. The verb 'consider' rather than 'must' or 'should' is generally used in such circumstances.
Yorkshire and Humber Commissioning Support	11	Full	20	13	Strongly agree that there should be travel time allowed in the care workers' working hours. The way the paragraph is written appears ambiguous to me. It implies the travel time is part of the allocated visit time. This means a 30 minute allocated visit time could actually be 15 minutes with the person and 15 minutes travel time. If the GDG intended that travel time should be in addition to the actual person contact time could this be clarified this in the document, for example, by putting travel time into a different sentence?	Thank you for your comment. This recommendation has been edited for clarity.
Yorkshire and Humber Commissioning Support	12	Full	20	1.4.6	Registered providers now have a "duty of candour" (fundamental standard regulation 20) if things go wrong. Would it be appropriate to include reference to this in the guidance?	Thank you for your comment on the CQC regulation 20. The issue of reporting safeguarding concerns was discussed extensively in order to produce the recommendations 1.4.6, 1.5.5 and 1.5.6. NICE guidance aims to complement rather than replicate existing mandatory guidance.
Yorkshire and Humber Commissioning Support	13	Full	20	20	Small point but not every domiciliary care agency will have a website.	Thank you for your comment. We agree that providers may not have a website, and the recommendation therefore suggests

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						the procedure should be available 'in other ways' to allow flexibility according to the service and the needs of the people using it.
Yorkshire and Humber Commissioning Support	14	Full	22	20	Should this read "healthcare" (one word) not "health care"?	Thank you for your comment. All references to healthcare have been updated so this is one word, as per NICE house style.
Yorkshire and Humber Commissioning Support	15	Full	22	23 -24	The healthcare professional may not have access to the home care plan. Not all health related activities occur at the person's home. Is the home care plan the correct place to document changes in medication? It is more likely to be in the person's ongoing care notes and MAR chart. Having written confirmation of changes is important, in many cases this is provided by the provision of a prescription. Where a new prescription is not needed it would be helpful for the practitioner to provide written confirmation for care workers and the person themselves. This would not necessarily need to be in the home care records, for example, healthcare professionals providing warfarin doses in the yellow book or via a clinic letter. This would allow home care providers to update their records accurately. See also comment 8.	Thank you for your comment. The Guideline Committee was fully aware that home care workers may often support a person to take medication. It was felt that the person should have a record in the home that home care workers can check, and that healthcare providers should, wherever possible, update this. It is realised that how this is achieved could vary (if no health staff visit the home, if the home care plan is not there). The recommendations in this guideline seek to complement those in the existing NICE clinical guideline on Medicines Management, and may be revised in the light of the forthcoming NICE guidance on 'Managing the use of medicines in community settings for people receiving social care'.
Yorkshire and	16	Full	24	23	Is it not the responsibility of relevant	Thank you for your comment. The

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Humber Commissioning Support				-26	healthcare professionals to identify and seek solutions to complex health care needs including the provision of support or training? This would be beyond the scope of most social care providers.	Guideline Committee sought to emphasise the need for professionals to work together collaboratively, making best use of their respective expertise and coordinated by the lead practitioner. To this end: • recommendation 1.3.2 refers to the need for coordinated care, and for those involved in a person's care and support to meet routinely. • recommendation 1.2.23 refers to the need for those involved in a person's care to contribute to the day-to-day log of care and the care plan.
Yorkshire and Humber Commissioning Support	17	Full	General	General	A separate section on "need for consent" may be helpful similar to one for person centered care.	Thank you for your comment. The issue of consent is covered within the Person-centred care section (p11, which follows the Introduction, section on Context, and underpins the guideline.