Home care: delivering personal care and practical support to older people living in their own homes

NICE guideline: short version

Draft for consultation, March 2015

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

Introduction

Home care is one of several services that can be offered to people assessed as needing social care support. It can be funded by health or social care commissioners or by the person using services. Although the range and type of services that can be classed as home care varies, it usually encompasses:

- personal care, for example help to wash
- support with the activities of daily living, which might also include telecare (for example providing personal alarms)
- essential domestic tasks.

A number of recent reports have identified significant concerns about the quality, reliability and consistency of home care services. A themed inspection of home care by the Care Quality Commission (Not just a number: Review of home care services) also highlighted some specific key areas for improvement.

The Department of Health asked NICE to develop a guideline to help address these issues (see the scope). The guideline was developed by a guideline development group (GDG) following a detailed review of the evidence on home care.

This guideline focuses on older people receiving home care and their carers. It does not cover younger adults (although many of the recommendations may also be relevant to younger adults). This is because the largest group of people using home care is older people.

This guideline considers how person-centred home care should be planned and delivered. It addresses how those responsible for managing and providing home care should work together to deliver safe, high-quality home care services that promote independence.

This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014. While the Care Act and other legislation describe what organisations must do, this guideline is focused on ‘what works’ in terms of how to fulfil those duties, and deliver support to older people using home care and their carers.

Person-centred care

This guideline assumes that the practitioners using it will read it alongside the Care Act 2014. It is also written to reflect the rights and responsibilities that people and practitioners have as set out in the NHS Constitution for England.

Care and support should take into account individual needs and preferences. People should have the opportunity to make informed decisions about their care, in partnership with health and social care practitioners. Practitioners should recognise that each person is an individual, with their own needs, wishes and priorities. They should treat everyone they care for with dignity, respect and sensitivity.

If someone does not have capacity to make decisions, health and social care practitioners should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

If the person using the service agrees, families and carers should have the opportunity to be involved in decisions about care and support. Families and carers should also be given the information and support they need in their own right.

Recommendation wording

The Guideline Development Group makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost effectiveness.

For most recommendations the group was confident that the recommendation will be effective and cost-effective for most people and used verbs such as ‘offer’, ‘ensure’, ‘discuss’ and ‘record’ to reflect this.

Two words have special meanings in our guidelines.

The group used the word ‘consider’ to indicate that the practitioner (or other person that the recommendation is aimed at) should spend more time than usual discussing the various options with the person.

The group used ‘must’ or ‘must not’ when there is a legal duty to apply the recommendation or that the consequences of following it could be extremely serious or potentially life threatening.

1 Recommendations

The guideline is based on the best available evidence. The full guideline [hyperlink to be added for final publication] gives details of the methods and the evidence used to develop the guideline.

1.1 Ensuring care is person-centred

Recommendations for home care providers and commissioners

1.1.1 Ensure services support the aspirations, goals and priorities of each person, rather than providing 'one size fits all' services.

1.1.2 Ensure support focuses on what people can or would like to do to maintain their independence, not only on what they cannot do. Recognise:

- that people have aspirations and potential throughout their lives, and
- that people with cognitive impairment and those living alone might be at higher risk of having unmet social care-related quality of life needs or worse psychological outcomes.

1.1.3 Ensure everyone working with people using home care services and their carers treats them with empathy, courtesy, respect and in a dignified way by:

- agreeing mutual expectations
- always respecting confidentiality and privacy
- providing a reliable service that people and their carers can trust
- regularly seeking feedback (both positive and negative) about the quality and suitability of care from people using the service, including those who do not have a carer or advocate.

1.1.4 Prioritise continuity of care, using a core team of care workers, so that the person becomes familiar with them.

1.1.5 Ensure there is a transparent process for 'matching' care workers to people, taking into account:

- the person's needs, and
- the care workers' skills, and
- if possible and appropriate, both parties' interests and preferences.

1.2 Providing information

Recommendations for local authorities

1.2.1 In line with the requirements of the Care Act, local authorities must establish and maintain a service that gives people: information about how to access care and support, what support is available and who provides it; independent financial advice; and, details of how to raise concerns.

Local authorities should give people who use or who are planning to use home care services and their carers details of:

- Different funding mechanisms including the options available for people with personal budgets, for example having a managed budget, an individual service fund or direct payment, and ways to influence or manage them.
- Where to find information about the range and quality of services available, the activities they offer and how much they cost.
- What needs the home care services are expected to address, for example, personal care (help with tasks such as getting in and out of bed, washing and bathing, going to the toilet, dressing or eating and drinking) and help with housework and other services to help people remain safely at home and in their community.
- Other options, such as:
  - saving allocated hours to be used at a later date (sometimes known as 'timebanking')

    - options such as a live-in carer or 'shared lives' (where the person stays in the community by living with another person or a family)
    - employing personal assistants.

1.2.2 Offer people and their carers information about local and national support groups and networks.

Recommendations for home care providers and commissioners

1.2.3 Ensure people using services and their carers have information that supports them to make informed choices about their care, including:

- what to expect from the home care service, and
- their rights, and
- what they should do if they are not happy with the service.

Consider presenting this as part of a 'welcome pack' (or equivalent).

1.2.4 Offer the person a written summary of the information that has been provided to them (or provide this summary in another format that meets the person's needs). Be aware that the circumstances that lead people to need home care can be traumatic and people may find it difficult to take in a lot of information.

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

- easy to read and in plain English
- available in the person's language if needed
- available in different formats and media (including information packs, telephone hotlines and electronic media)
- made available in different venues, such as community centres or GP surgeries, as well as through face-to-face meetings with a social care practitioner

- provided in formats that suit people with different communication or capacity needs, for example, large-print, braille or audio versions.

1.2.6 Ensure that information is updated regularly. Design information in a way that allows it to be updated easily.

1.3 Planning and reviewing home care and support

Coordinating and planning home care as part of a multidisciplinary team

Recommendations for commissioners

1.3.1 Ensure integrated care and support is delivered to the person through a multidisciplinary team, where required. The team might include:

- healthcare practitioners
- social care practitioners, including home care workers
- people from voluntary and community organisations, befriending and specialist services
- advocates, including those appointed by the Court of Protection.

Recommendations for multidisciplinary teams

1.3.2 Ensure the person using services and their carers are involved in multidisciplinary team discussions about their care.

1.3.3 Consider identifying a lead practitioner from among the people involved in delivering support to lead home care planning and coordinate care for each person.

Recommendations for home care and health service providers

1.3.4 Ensure that support is delivered in cooperation with a multidisciplinary team, recognising the expertise, knowledge and commitment of all practitioners.

Planning home care and support

Recommendations for commissioners

1.3.5 Support home care as an important component of a care package for older people living in their own home, given that 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.

1.3.6 Consider offering home care support to older 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.

1.3.7 Ensure home care packages address social care-related quality of life and the person's wider wellbeing in addition to practical support, (for example home cleanliness and comfort). Recognise that people who use home care services often need support that goes beyond their personal care needs.

1.3.8 If a person chooses to take direct payments for home care, give them the support and information they need to manage the payments effectively. This should be regardless of whether they buy care through a regulated provider, directly employ a personal assistant or choose another way to meet the agreed need.

1.3.9 Consider asking people with experience of using a direct payment for home care to help provide training, support or advice to others thinking of doing so.

1.3.10 Aligned with the recommendations in Ensuring care is person-centred, ensure that lead practitioners and others involved in home care and support planning:

- understand the principles and importance of involving the person using services, and their carers if relevant, as an equal partner in specifying the support and services they receive
- know how to work in a way that maximises choice, control, dignity and respect for the person using services
- have an awareness of common conditions affecting people using home care services, for example, sensory loss, dementia, physical and learning disabilities, and stroke
- know about local organisations that provide specialist support
- know about the funding options available for care and support
- understand different funding mechanisms including the options available for people with personal budgets, for example having a managed budget, an individual service fund or direct payment.

1.3.11 Give lead practitioners relevant information about a person’s circumstances before the home care planning process is started.

Recommendations for lead practitioners (or other practitioners planning home care)

1.3.12 Before meetings to plan home care and support, give the person using services and their carer information about how the home care plan will be developed, negotiated and reviewed and the options available to them. Ensure people have enough time to understand this information.

1.3.13 Ask people if they want carers or advocates involved in their home care planning and support, and respect their choice.

1.3.14 Consider planning support that enables the person to take more responsibility, including for the financial arrangements, to increase their independence over time.

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

- empowers the person as much as possible, by recognising what they can and want to do
- explicitly addresses safety, wellbeing, independence and any specialist needs
- is informed by the experience, skills and insight of carers, as appropriate
- addresses the 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 (this could include, for example, support to help a person manage their own financial and personal affairs, do their own shopping and cooking, or socialise, or other help, depending on the person's needs and preferences)
- describes how success and outcomes will be measured
- is clear, concise and easy to navigate
- has a summary at the start, with links to more detailed information.

1.3.16 When assessing risk, balance the risk of a particular behaviour or activity with how it is likely to benefit the person's wellbeing and help improve their quality of life. The lead practitioner should:

- complete a risk plan with the person as part of the home care planning process and include this in the home care plan
- ensure the risk plan includes strategies to minimise risk, for example specialist equipment; use of verbal prompts; use of support from others
- ensure the risk plan includes the implications of taking the risk for the person and the care worker
- carry out risk assessments as part of home care planning and at relevant intervals, such as when significant factors change.

1.3.17 Liaise with healthcare practitioners and other professionals to ensure the home care plan promotes wellbeing, particularly for medicines management, pain management and pressure sore and moisture lesion prevention and care.

1.3.18 Write any medicines management requirements into the home care plan including:

- the purpose of, and information on, medicines
- the importance of timing and implications of non adherence.

1.3.19 Always discuss with the person and their carer whether telecare could complement their home care package (and any other services they are using).

1.3.20 Discuss the potential benefits of telecare, such as how it can provide reassurance to the person and their carer, while bearing in mind the rights of a person, particularly in relation to privacy, choice and control.

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

Recommendations for home care providers

1.3.22 Ask people:

- which elements of their home care service are a priority for them, and
- whether some home care time may be used flexibly (that is, used for a variety of jobs according to what is needed).

1.3.23 Give people and their carers if appropriate, a copy of their home care plan in a format that meets their needs.

1.3.24 Ensure all practitioners providing support complete the home care plan, and deliver support in an integrated way according to the plan.

1.3.25 Undertake an initial review of the home care plan after about 6 weeks, then review regularly at least annually. This should involve the person and their carers (if appropriate) in a meaningful way.

1.3.26 Consider working with other agencies to ensure that people who use home care services have a single home care and support plan rather than separate plans from each service or provider.

Planning telecare

Recommendations for lead practitioners (or other practitioners planning home care)

1.3.27 If the person wishes to use telecare, work with them to identify their preferred telecare options that maximise dignity and help them live in the way that they choose.

1.3.28 Ensure telecare does not replace personal contact, unless the person using services wants it to.

1.3.29 Record in the home care plan how the telecare equipment meets the person's needs and will help them achieve their desired outcomes.

1.3.30 Offer people using home care services information about options for telecare that could help them. Include information on potential risks and benefits, so they can make an informed decision.

1.4 Delivering home care

Recommendations for commissioners

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

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, for example.

1.4.3 Consider contracting and monitoring in a way that allows services to be delivered flexibly to ensure the person can identify what is a priority for them. This might include, for example, allowing providers (with the person's agreement or at their request) to use time flexibly.

Recommendations for home care managers and providers

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

1.4.5 Ensure there is a complaints procedure in place. Tell people about how they can make a complaint either in writing or in person.

1.4.6 Make the complaints procedure available on your website and in other ways appropriate to people using the service and their carers. Give information about escalating complaints if necessary (to the commissioning body and Ombudsman) or ensure this information is readily available.

1.4.7 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) – particularly given that this can ensure any risks or concerns are identified early – by:

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

1.4.8 Ensure home care workers are able to deliver home care in a way that meets the person’s cultural and language needs.

1.4.9 Consider the need for independent advocacy if a person lives alone, has difficulty expressing their views and aspirations or routinely lacks capacity.

1.4.10 Closely monitor risks associated with missed or late visits and take prompt remedial action. Recognise that people living alone (without carers or advocates) or those who lack capacity may be particularly vulnerable if visits are missed or late.

Recommendations for home care workers

1.4.11 Ensure the person who uses services (or their carer) is contacted if you will be late or unable to visit, as well as informing your manager, if appropriate.

1.4.12 Make every effort to avoid missed visits because these can cause major concern or have serious implications for people’s health or wellbeing.

1.4.13 Ensure the record you complete routinely on each visit is detailed enough to keep people, their carers and practitioners fully informed about what has been provided. Record any incidents or changes.

The record could form an additional part of the home care plan or could be a separate ‘care diary’.

Delivering telecare

Recommendations for the lead practitioner

1.4.14 Ensure that the telecare provider gives the person and their carer information about how to use the equipment, and confirm that the person can confidently use it.

1.4.15 Regularly review a person’s use of telecare to ensure they find it useful. Involve the person in the review and seek feedback from others, such as carers or call centres. During the review, tell the person about any new telecare options available.

1.4.16 Provide telecare call centres with all relevant information about a person’s circumstances (if the person agrees).

1.4.17 If providing alarm-based telecare, ensure response systems are in place. For example, the alarm can be linked to a warden, live-in carer, family member or contact centre.

1.4.18 If the alarm is set to alert a carer who does not live near the person, ensure there is a 24-hour, 7-days-a-week contact close by who is able to provide assistance.

1.5 Ensuring safety and safeguarding people using home care services

Recommendations for health care practitioners

1.5.1 Consider regularly liaising with home care workers about the person’s medication.

1.5.2 Write information and guidance for home care workers about medicines in the home care plan.

Recommendations for home care managers

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

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

1.5.4 Ensure home care workers are aware of the process.

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

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

Recommendations for commissioners

1.5.6 Recognise that safeguarding alerts can be a responsible element of providing home care, given that the home care worker may be the first person to spot abuse and should respond proportionately.

Recommendations for home care providers

1.5.7 Put policies in place that ensure home care workers are supported through any safeguarding process.

1.5.8 Home care providers must have a medicines management policy.

Recommendations for home care providers and home care workers

1.5.9 Ensure the person using the service, and their carers (if the person has involved them in their care), can direct the way home care is delivered. This is so that the person's safety, comfort, independence and sense of security are always promoted.

1.6 Recruiting, training and supporting home care workers

Recommendations for home care providers

1.6.1 Have a transparent and fair recruitment and selection process that:

- uses values-based interviews and approaches to identify the personal attributes and attitudes essential for a caring and compassionate workforce, and
- ensures workers have the necessary literacy and numeracy skills to do the job.

1.6.2 Consider involving people who use home care and their carers in recruiting and training home care workers.

1.6.3 Ensure that new home care workers are observed at work more than once during their probationary period.

1.6.4 Ensure home care workers are able to recognise:

- common conditions, such as dementia and sensory loss, and
- common care needs, such as nutrition, hydration and skin integrity, and
- common support needs, such as dealing with bereavement and end-of-life, and
- deterioration in someone's health or circumstances.

1.6.5 Make provision for more specialist support to be available to people who need it – for example, in response to complex health conditions – either by training your own home care workers or through partnerships with specialist organisations.

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

- what constitutes ‘safe’ care
- identifying and responding to possible or actual abuse or neglect
- identifying and responding to environmental risks
- safe care policies and procedures.

1.6.7 Use feedback from people using the service and their carers to assess training needs for the workforce.

1.6.8 Ensure home care workers have opportunities to refresh and develop their knowledge and skills.

Recommendations for home care managers

1.6.9 Managers should:

- respond promptly to workers when they request support to deal with difficult situations
- supervise workers in a timely, accessible and flexible way, at least every 3 months and ensure an agreed written record of supervision is given to the worker
- observe workers’ practice regularly, at least every 3 months and identify their strengths and development needs
- appraise workers’ performance regularly and at least annually. The annual appraisal should include a review of workers’ learning and development needs, and feedback from people who use the service and their carers.

Recommendations for local authorities

1.6.10 Develop workforce plans for the home care sector, in collaboration with providers, identifying current and future workforce needs.

Include training and how such needs might be met by prioritising available local authority resources in the plans.

Recommendations for healthcare professionals working in primary and secondary care

1.6.11 Liaise with home care workers to provide integrated, person-centred support that promotes wellbeing, particularly for medicines management, pain management and tissue viability care.

Recommendations for commissioners

1.6.12 Consider commissioning training to ensure health and social care practitioners understand how they should collaborate to provide integrated planning and delivery of home care and support.

2 Implementation: getting started

The Guideline Development Group has identified areas in this draft guideline that they think may have a big impact on practice, or which could be difficult to implement. The 3 areas identified as the biggest implementation challenges were:

- Delivering services that support the aspirations, goals and priorities of the person using them (recommendation 1.1.1).
- Working effectively in multidisciplinary teams coordinated by a lead practitioner (recommendations 1.3.1, 1.3.3 and 1.3.4).
- Helping people to determine which care options will best meet their needs and preferences (related to recommendation 1.3.10).

Further details on each of these areas are provided below.

How stakeholders can help us with implementation

During consultation we want you to let us know whether you agree with the 3 areas identified. If not, which other aspects of the guideline will have a bigger impact, or be more of a challenge to implement?

Please also send us suggestions about how implementation challenges could be addressed. You could, for example, share examples of good practice, or provide educational materials or other resources that you have found useful. This information will be used to write an implementation section for the final guideline.

Please use the comments form to send us your feedback.

Challenges for implementation

Delivering services that support the aspirations, goals and priorities of the person using them

Home care providers will need to review how they deliver services to see whether improvements are needed to ensure that they meet individual needs. Many services are built on a ‘one size fits all’ model and changing this will take time. It is likely to be a complex process because services will need to work across boundaries and be flexible. (Related to recommendation 1.1.1.)

Working effectively in multidisciplinary teams coordinated by a lead practitioner

Multidisciplinary working can be complex and challenging particularly if it involves working across traditional boundaries and professional specialisms. In the case of people receiving home care, a number of people are usually involved in their care and wellbeing (for example, carers, health and social care practitioners with diverse roles, and volunteers). Recognising each of these people as members of a multidisciplinary team, each with expertise to draw on when required, and identifying a single lead practitioner for the team needs commissioners and home care providers to change the way they work together. (Related to recommendations 1.3.1, 1.3.3 and 1.3.4.)

Helping people to determine which care options will best meet their needs and preferences

Lead practitioners will need to be confident of their knowledge and understanding of the different care, support and funding options. They should have the necessary skills to help people make informed and appropriate choices. This may involve a significant change in practice for some organisations where people often perceive that the role of the lead practitioner is limited to processing them through a system. Home care managers and commissioners may need to work together to explore how this can be achieved locally. (Related to recommendation 1.3.10.)

3 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve care for people in the future and improve NICE guidance.

3.1 Intensity of home care packages

What is the cost-effectiveness of different intensities of home care packages for older people with a range of care and support needs?

Why this is important

There is a lack of evidence on the cost effectiveness of different intensities of home care packages applicable to the UK. Additionally, the 2 included studies that consider the cost-effectiveness of different intensities of home care only consider home care costs rather than wider resource use.

3.2 Telecare

What types of telecare are most effective and cost-effective, when provided to older people as part of a package of home care?

Why this is important

There is limited evidence on the components of telecare used as part of a home care package for older people, and their impact. Studies should first collect information on different types of telecare in use, because costs and outcomes are likely to depend on the combination of different components.

Studies should then compare different telecare packages and determine effectiveness and cost effectiveness of individual components of packages, and combinations of components. This could include comparisons with home care packages delivered without a telecare component, or with packages that include other assistive technology. Outcomes for service users should be measured in terms of social care-related quality of life and wellbeing in addition to physical health, acceptability and accessibility (particularly for people with complex needs such as dementia). Studies should collect cost information from a societal perspective. They should include health and social care services, the contribution of carers in the form of unpaid care and out-of-pocket expenditure for privately purchased support.

3.3 Training

What are the effects of different approaches to home care training on outcomes for people who use home care services?

Why this is important

Workforce training is perceived to be beneficial in improving the delivery of home care services to both home care practitioners and people using home care services. The evidence reviewed for this guideline found a lack of evidence on the impact of home care-specific training on outcomes for people using home care.

Studies of comparative design are needed to evaluate different approaches to home care training, and their impact on home care workers’ practices in improving outcomes for people and their carers, including aspects of safety and safeguarding. A scoping study needs to be considered to identify the range and content of current training and ongoing support for home care workers, including both specialist and generalist training. Outputs of this work could inform the study design for further evaluation. Studies of qualitative design are needed to ascertain the views and perceptions of older people and their informal carers on worker competence. The views of commissioners and providers on their experiences of training should also be sought.

3.4 Specialist dementia support

What is the most effective and cost-effective way to support people with dementia living at home?

Why this is important

Dementia is one of the most common conditions in older people using home care services. Home care workers are expected to respond to a wide range of needs, providing both general support (for example personal care) as well as specialist needs. Some home care is delivered by dementia-specific services but there is a lack of evidence about the effectiveness of this approach on outcomes compared with non-specialist home care services (which may instead employ specialist workers or train some workers to develop specialist skills, for example). Future research could involve comparative evaluation or case control studies to determine how to structure the delivery of support so that both a person's specialist dementia needs and general support requirements are accommodated in the most effective way.

3.5 Safety and safeguarding

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

Why it is important

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

4 Other information

4.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the NICE Collaborating Centre for Social Care to develop this guideline. The Centre established a Guideline Development Group (see section 5), which reviewed the evidence and developed the recommendations.

The methods and processes for developing this guideline are described in the social care guidance manual.

5 The Guideline Development Group, NICE Collaborating Centre and NICE project team, and declarations of interests

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A technical team at the NICE Collaborating Centre for Social Care was responsible for this guideline throughout its development. It prepared information for the Guideline Development Group, drafted the guideline and responded to consultation comments.

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Associate Director, Health and Social Care Quality Programme

John McLean

Guideline Programme Manager

Nick Staples

Guideline Project Manager

Rita Parkinson

Guideline Coordinator

Peter O'Neill

Technical Lead

Tony Smith and Sarah Richards

Economists

Jaimella Espley

Editor

5.3 Declarations of interests

The following members of the Guideline Development Group made declarations of interests. All other members of the group stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Ajibola Awogboro	Director at Rembola Social Enterprises	Personal pecuniary interest	None
Ajibola Awogboro	Assistant Director at Business Support and Commissioning – Royal Borough of Greenwich	Non-personal pecuniary interest	None
Bobbie Mama	Inspector at the Care Quality Commission	Non-personal pecuniary interest	None
Nicola Venus-Balgobin	Project Manager at Older People with Dual Sensory Loss Awareness Program, Sense, a national charity for people who are deafblind. This post is funded by the Department of Health	Non-personal pecuniary interest	None
Bridget Warr	CEO of the United Kingdom Homecare Association, the professional association for homecare providers from all sectors, (employed for 4 days a week). Chair of 2 boards/committees at Sense and Chair of NHS England Continuing Health Care IRPs (SouthWest)	Non-personal pecuniary interest	None
Miranda Wixon	Director at The Homecare	Personal	None

	Partnership Ltd. Chair of Ceretas (voluntary). Chair of Brent Healthwatch (voluntary). Trustee of Action on elder abuse (voluntary)	pecuniary interest	
Max Wurr	Director of City and County Healthcare Group. As of December 2013, also holds an equity stake in the company	Personal pecuniary interest	None
Max Wurr	Senior manager of City and County Healthcare Group, a group of domiciliary care providers	Non-personal pecuniary interest	None
Max Wurr	A Board member of the United Kingdom Homecare Association	Personal non-pecuniary interest	None