NICE Collaborating Centre for Social Care

Homecare social care guidance stakeholder scoping workshop notes

Break-out group discussions

Four facilitated break-out groups discussed specific aspects of the draft scope. The following themes emerged.

Age

There were strongly held but mixed views on the restriction of the scope's focus to older adults (those aged 65+). A central argument in favour of this approach was that this group can suffer particular discrimination in terms of quality and quantity of allocated resources for support, and access to care. While there was agreement that this was a real issue and that there was a risk older people could 'lose their voice' in guidance less focused, the counter-arguments included concern that creating this divide risked both reinforcing this discrimination through using an artificial distinction, and the difficulty of comparing older people's services with standard care provided to younger disabled adults. Some also thought that the focus on older people was inappropriate given the commonality of issues affecting older adults and particular groups of younger adults (e.g. those suffering with early onset dementia) and, indeed that guidance could help address such discrimination by highlighting common issues.

The implications for widening the scope to all age groups were discussed including the very real risk that this might make the scope unmanageably broad. Furthermore, it was acknowledged that the guidance needs to be specific enough to have meaningful impact, and that, in practice, homecare can involve very different things for different groups (including those belonging to different age groups). Nevertheless, many group members still felt there were enough common areas where guidance could make a difference across the range of people using homecare and support. Furthermore, it was suggested that the literature available on homecare will automatically lead to a focus on adults over the age of 65, which renders it unnecessary to use this as a search parameter. It was suggested that narrowing the scope in other areas could be an alternative (for example, by signposting rather than

conducting searches on areas where there is other guidance and information already, such as telecare).

Commissioning

The groups were asked to consider whether commissioning should be an issue covered in the scope and, if so, what aspects of commissioning in particular. There was broad agreement that it should be included in the guidance, but in specific ways. Firstly, there was agreement that the focus of the guidance ought to be on commissioning of homecare that supports person-centred outcomes. Several groups suggested that local authority commissioners over-use a "time and task" approach rather than starting from needs assessments and then exploring available services. Integration between the health and social care services in homecare was linked to this outcome-focused approach, with groups suggesting that integrated commissioning could lead to a more effective service and potentially a cheaper one. Comments were made, however, that social care staff already are increasingly expected to deliver services traditionally delivered by health professionals and that there are issues of accountability that the guidance will need to acknowledge.

There was consensus in the groups that any guidance on homecare commissioning needs to consider the current and future context within which commissioners are operating in order for it to be accepted in, and "future proofed" for the sector. Primarily this includes the fact that commissioners are facing significant financial constraints as well as considerable structural change over the next five years, particularly in terms of GP commissioning. Ensuring that commissioning is centred on choice for service users could, therefore, be constrained by local market conditions. All of the groups discussed the need for the guidance to reflect the move from macro to micro-level commissioning (i.e. the increase in self-commissioning and/or funding of homecare) and the challenges this will pose.

The groups all acknowledged that there are currently lots of resources on commissioning already, which the guidance could usefully signpost (such as TLAP good practice examples) but a common request was that the guidance should reference different commissioning models and how they can specifically drive up the quality in homecare commissioning. Better partnership working and communication across localities in commissioning was also highlighted as important.

Reablement

As reablement is being considered as a topic for a separate piece of social care guidance the NCCSC was keen to gauge opinion on whether it should be included in this homecare guidance. There was wide agreement across the groups that it was imperative for it to be included but broad consensus - and strong feeling - that reablement and homecare cannot be distinguished from one another, i.e. that reablement ought to be considered as an outcome and philosophy that should underpin all aspects and stages of homecare. Groups agreed that an outcome-focused approach was helpful here so that reablement could be considered in this guidance as an outcome of homecare rather than an intervention in its own right.

There was some discussion about whether this meant that certain elements of service provision considered to be part of a reablement package - such as occupational therapists (OTs) and physiotherapists - might also need to be included and the risk, again, that this could make the scope too broad. It was concluded across the groups that this was not necessary: these elements could simply be mentioned briefly, as appropriate, to make clear they could be part of a wider package of care.

There was a difference of opinion as to whether reablement should be considered in a separate piece of guidance with some groups concluding that this was not needed given the view that it should underpin all care packages. However other groups thought there might be some elements of interventions specifically labelled as 'reablement' work that could usefully warrant separate guidance. Finally, all the groups agreed that the issue of reablement ought also to be a consideration in the forthcoming social care guidance on the transition between health and social care.

Personal Assistants

Given the importance all groups placed in the guidance also referring to self-commissioned and/or self-funded services, the inclusion of personal assistants in the scope was discussed in some detail by the groups. The key area for discussion was whether the guidance should cover only regulated homecare services or also consider those unregulated services that are frequently part of homecare services. Most of the groups agreed that unregulated services should not be excluded and this therefore emphasised the importance of including personal assistants, considering them as a provider of care. However, it was acknowledged that it will be a challenge to disseminate this guidance to the self-commissioning and/or personal assistant audience. There were certain key messages such as providing information on choice in terms of personal assistants and direct payments for service users that were considered by the groups to be important. There were some concerns however, that by including them in the guidance, personal assistants may be granted a status that is not reflected in the nature of their work.

Links were made by the groups between this topic and the discussion on the age-limit being discussed by the guidance. Several groups queried whether personal assistants were used by older adults aged over 65 or whether it was more of a service employed by younger disabled people. However there was a feeling amongst some members of the discussions that this situation is likely to change, particularly as those younger adults currently using personal assistants get older. The prospect of managed personal budgets was also suggested as a way of enabling older people to use personal assistants more. There was general agreement that the market for personal assistants was likely to grow in the future.

There was some discussion in the groups over whether to restrict guidance on PAs to activities taking place within the home, given that areas such as prevention, social isolation and assisting individuals outside of the home are also a core part of their work. It was also pointed out that some regulated homecare agencies expand their remit outside of the home in order to provide a complete package of care. However,

if unregulated services outside of the home are also considered to be in- scope, this obviously broadens its focus hugely. There was disagreement on the extent to which these external activities and other agencies or individuals involved with these activities should be considered. One suggestion was, again, that they should not be a focus of the guidance but that it was important to refer to them.

Personalisation of care, choice and control

As in their discussions about commissioning, all groups agreed that the guidance should generally be structured around the principles of homecare being person-centred and emphasising the importance of choice and control. A suggestion was that the guidance should be restructured to consider outcomes first, thinking about the difference a service user will see as a result of the guidance. This could help shift focus away from particular activities and settings – the 'what' of homecare - and instead, more usefully offer practical advice on 'the how', i.e. the way in which frontline staff can fulfil their duties to ensure that an individual benefits in terms of the outcomes they want to see.

Stakeholders also thought that the scope should more explicitly refer to the importance of personalised care than was the case with the draft version, recognising also that this does not just refer to personal budgets and direct payments, but a full commitment, at all levels, to enabling choice and control. As such the guidance should attempt to capture how service users feel about their homecare services, as this may differ from the perception of the provider . The report from the CQC on what people disliked about homecare was recommended as a relevant source here.

Co-production was also mentioned as important in delivering true choice and control, using both the assets of individuals and the social capital within communities. To this end, the guidance needs to recognise the impact of unpaid care (e.g. the fact that family and friends provide care and support for people that otherwise would need to be provided by a package of local authority support, or via some other means, or might risk not being offered at all). The group emphasised the importance of providing holistic homecare support through a multi-professional team.

Workforce

All of the groups thought it important that the scope consider workforce issues, such as the impact that low wages, low levels of training and time pressures (so prevalent in the sector) can have on the ability of care workers to provide good quality homecare. It was thought that without this, the guidance might not be seen as relevant to the workforce. The need to consider the new HMRC directive that support workers be paid for travel time in order to comply with national minimum wage legislation was also highlighted as being likely to have an impact here.

The issue of care workers being increasingly called upon to deliver health care tasks previously carried out by nurses, such as PEG ('Percutaneous endoscopic gastrostomy') feeding, frequently without requisite training, was considered a particularly important issue. This was contrasted to the nursing tasks specified in the

scope which, instead, might reasonably be considered to be homecare tasks. The blurred boundaries in this area need to be addressed as does the lack of clear accountability this produces.

Training was another common topic of discussion, with reference to the fact that qualifications themselves are frequently not considered important by service users, so much as the skills and personal qualities – e.g. empathy - of workers, particularly in respect of personal assistants. Questions of support and supervision for these 'unqualified' staff will therefore be important to address. Conversely, others highlighted the problem of frontline workers having completing only short training courses but claiming expert status. It was stated that there need to be more opportunities for thorough, applied learning and this needs to be centrally funded in order to limit variation in practice.

Other areas of discussion

Apart from these key themes the groups fed back on the following issues:

- The groups requested that the guidance achieve a delicate balance between providing aspirational recommendations while acknowledging the realities of working conditions.

- Safeguarding: there was a detailed discussion in one group on issues of safeguarding particularly with the broad conclusion that, the large body of material on this topic already means this just needs signposting rather than studying in the guidance development process. The inappropriate use of safeguarding complaint procedures was also discussed and the tension between mitigating this and protecting the rights and safety of the individual. Standardisation and leadership in the workforce were considered to be important in dealing with this issue.

- While most of the groups thought that the key areas of the scope were broadly correct some felt that enabling social participation and the importance of personal relationships were omissions it was important to address.

- There was some feedback on the composition of the GDG, specifically, that it should be widened to 15-16 members (as opposed to the standard 12-15) in order to encompass the breadth of relevant expertise and perspectives in homecare. Suggested additions included local authority commissioners; sheltered housing providers and Shared Lives representatives. There was recognition that it would be a diverse group and could also usefully include service users in the older 'older' category e.g. aged 85+

- Clarification is needed on how the scope (and guidance) intends to address the Shared Lives (SL) scheme with the suggestion that it will need to be integrated with SL's own guidance and, if considered in detail, will need someone with SL experience on the GDG.

- The scope needs to clarify how it will look at the support needs of carers.

- The importance of accessing information on available care services and processes could be considered under ‘service delivery’ activities rather than ‘care provision’ section of the draft where it is currently.

- It was deemed important to acknowledge the effectiveness/cost effectiveness of low-level (below the threshold of needing homecare) interventions as well as the importance of timely reviews.

- Rural residents and Lesbian, Gay, Bisexual, Transgender and Intersex groups were said to be additional important sub-groups to consider.

Title Change

Finally there was some discussion in the groups about changing the title of the guidance from domiciliary care to ‘homecare’. The arguments in support of this suggested that: ‘homecare ‘ is more widely understood and/or that domiciliary care is perhaps too threatening and outdated a term. It was thought that such a title change may help to ‘future proof’ the guidance. Arguments voiced against the change included that this might lead to confusion with care homes; that domiciliary care is an official term used by commissioners and additionally that this might seem to automatically exclude any services that do not take place in the home but could be considered part of a homecare package. Further suggestions were that people actually prefer to refer to ‘homecare and support’ or that the title should be ‘care at home’. Further to these breakout groups the stakeholder group as a whole voted to make this title change and while there was majority support, it was agreed that a longer title would also be needed (as is standard practice for NICE) to minimise any confusion.