NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Home care for older people

Date of Quality Standards Advisory Committee post-consultation meeting:
23 March 2016

2 Introduction

The draft quality standard for home care for older people was made available on the NICE website for a 4-week public consultation period between 26 January and 22 February 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 30 organisations, which included service providers, commissioners, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1-3.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 3: Over what period of time would it be meaningful to monitor the consistency of the home care team for older people using home care? Please explain your answer.

5. For draft quality statement 4: What impact would there be on home care services and older people if this statement were implemented? Please explain your answer.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Stakeholders welcomed the quality standard and there was broad support for the areas identified for quality improvement.
- It was, however, suggested that most of the quality statements are already covered by existing legislation and regulations.
- It was suggested that the quality standard should make it clear what the roles and responsibilities of commissioners and home care providers are in improving the quality of home care.
- The quality standard may not be achievable without investment in new ways of working.
- Although there was support for including carers in the statements it was suggested that the term ‘carers’ could be confusing because it could refer to family/friends or home care workers.
- The measures need to focus more on quality rather than just monitoring if something is done.
- The quality standard should make reference to the requirements in NHS England’s Accessible Information Standard throughout to ensure the communication needs of people with a disability are met. It was suggested that specific measures could be included in the statements to ensure communication needs are addressed.
- It was felt that the quality standard is not as easy to read as the Home Care guideline (NG21) and it was suggested that a more consolidated structure and more straightforward measure statements could improve the document.

Consultation comments on Introduction

- It is important to make it clear that the quality standard does not relate to short term reablement services.
- Durability should be included as a dimension of quality given the need to address current challenges in the home care market.

- Additional long term conditions should be identified including frailty and hearing loss.

Consultation comments on data collection

- Stakeholders generally agreed that it should be possible to collect the data if appropriate systems are in place.
- It needs to be clearer who is responsible for collecting, collating, analysing and acting on the results of the data.
- Collecting data in a standardised format may be difficult as different providers have different systems and may work across different local authority areas. It was noted, however, that these issues have been tackled successfully in the National Drug Treatment Monitoring System.
- The cost of development of appropriate systems could be contentious in a sector where margins are narrow and under pressure.
- Much of the data should already be collected, with the following exceptions noted:
  - In areas where home care is not commissioned on the basis of call duration some data may not be available.
  - In areas that do not have electronic call monitoring it will be difficult to collect some data.
  - Some data will require the input of the service users and carers and it will be important to ensure appropriate methods are developed to capture this.
- Due to the resources required, commissioners indicated that sometimes the data may be collected on a sample basis to give an indication of achievement rather than a complete audit.
- It will take time to make changes to contracts with home care providers so there will need to be a realistic timescale for implementing data monitoring and reporting.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Older people starting to use home care, and their carers, are involved in developing a home care plan that is focussed on their personal priorities and outcomes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- There was general support for the statement and some stakeholders indicated it is already in place and being monitored locally.
- Stakeholders suggested it will be important to clarify the definition of the home care plan and the link to the older person's needs assessment:
  - what is the role of other professionals (e.g. health) in developing and delivering the home care plan? It needs to be clear who is leading the plan and how different services are co-ordinated.
  - who has the final say about what is included in the plan – service user, provider or commissioner? Should it be signed by the service user?
  - should the home care plan include technology options, leisure activities and a fire risk assessment?
  - the link to anticipatory or urgent care plans should be clear.
- It needs to be clear who is responsible for collecting the data for process measure a) as it could be both the local authority and provider.
- There was a concern that the process measures may not be useful as they do not reflect the quality of person-centred planning.
- It was queried if it is appropriate to use the HSCIC surveys as a data source as it may not be possible to differentiate the outcomes for different services.
- More emphasis is needed in the audience descriptors, definitions and equality and diversity considerations on the need to provide support with communication and information for those with sensory loss.

5.2 Draft statement 2

Older people using home care, and their carers, are involved in a review of their home care plan within 6 weeks of starting to use the service and then at least annually.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- There was some support for this statement and stakeholders suggested it is achievable and already being monitored in some local areas.
- It is important to clarify who is responsible for carrying out the review – the provider or the local authority or both? Some local authorities only carry out reviews for people that they fund. It should also be clear if health professionals should be involved in the review.
- There was some concern that the statement wording may not be aspirational. Some older people will require more frequent reviews and it was suggested that this should be emphasised more in the rationale. It was queried whether the statement could require a review to be undertaken within 6 weeks of a change in the care plan.
- It was suggested that it would be better if the statement focussed on the need for providers to continuously review and develop the home care plan rather than on formal reviews undertaken by the local authority. It was clear that some providers already carry out more frequent reviews.
- There was a concern that the process measures do not reflect the priority for quality improvement and could become outdated.
- It was felt to be inappropriate to suggest that older people and their families should be responsible for requesting a more frequent review.

5.3 Draft statement 3

Older people using home care receive care from a consistent team of home care workers who are familiar with their needs.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Although there was support for this statement it was acknowledged that it could be challenging to achieve.
- It was suggested that the title ‘continuity of care’ may not match the current statement as continuity is not necessarily dependent on workforce consistency or stability. It would therefore be useful to clarify the focus.
- Feedback from commissioners suggests that although consistency of staff is not currently monitored for individual service users, this may be possible with detailed analysis of data from electronic call monitoring systems.
- It was suggested that the process measures may need a time frame.
- It was questioned whether the outcome measure on perception of safety is relevant.
- Improved job satisfaction for home care workers and staff turnover were identified as possible additional outcomes.
- It was suggested that it may not be practical for providers to ensure that new home care workers are introduced to the older person by someone they know before visiting on their own given the current pressures on the service. It would be more realistic to alert the service user or family members beforehand by telephone.

Consultation question 4

Stakeholders made the following comments in relation to consultation question 4: *Over what period of time would it be meaningful to monitor the consistency of the home care team for older people using home care? Please explain your answer.*

- Some stakeholders felt it will be difficult to set timescales because there are so many different factors at play and any timescale would be arbitrary.

- It was identified that as care packages are likely to change quite a lot at the outset it may not be helpful to measure the consistency of the home care team until the care package has become established. It was suggested that an assessment could be made at the first 6 week review, after 3 months or after 6 months.
- Some stakeholders made a range of suggestions for the most appropriate monitoring period for consistency of the home care team ranging from monthly to an 8 week, 3 month (mentioned most often) or 6 month monitoring period and even 12 months for people with Parkinson's disease. It was suggested that the monitoring period needs to be long enough to include day to day variations such staff holidays or sickness but short enough to ensure a timely response can be made to any issues identified.
- It was suggested that rather than monitoring the number of carers over a specific time period it may be more appropriate to regularly monitor consistency via the perceptions of the person using the service and their family members.

5.4 Draft statement 4

Older people using home care only have visits of less than 30 minutes when short visits for specific tasks or checks have been agreed as part of their home care package.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Most stakeholders were in support of this statement and recognised the potential positive impact on older people who use home care.
- There was, however, some concern that specifying visit times may conflict with the principles of person centred planning and outcome based commissioning. It was suggested that the statement may be difficult to implement in areas that do not use task and time support plans.
- It was suggested that the current statement wording is not clear enough:
  - It could be interpreted to mean that a care package where all visits are shorter than 30 minutes is acceptable if everyone agrees to it.
  - 'part of their home care package' needs to be defined so that it is clear how often shorter visits can be made.
  - It is important that the statement reflects all the criteria for shorter visits identified in NG21 recommendation 1.4.2 and the emphasis on dignity and respect in 1.4.4.
- Monitoring for this statement would be easier if there was a definition of tasks that could or should not be allocated to visits of less than 30 minutes.
- There was a concern that data collection and monitoring for this statement could be resource intensive, particularly where electronic call monitoring is not in place.
- It was questioned whether the outcome measure on perception of safety is relevant.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5: *What impact would there be on home care services and older people if this statement were implemented? Please explain your answer.*

- Several stakeholders emphasised that this statement would have a positive impact on older people using home care because it will ensure visits are not rushed, support good communication and promote dignity and independence.
- A stakeholder was concerned, however, that it could lead to increased charges for service users who pay for their own care. They may be unwilling to pay for longer visits and may therefore choose to go without care.
- It was suggested that it is important that older people can choose to have shorter visits as they may not want the carer in their home for longer than necessary.
- Reducing the number of 15 minute visits is likely to have a positive impact on home care providers because 15 minute visits do not necessarily reduce costs, make it difficult to remunerate staff adequately and put pressure on profits. 15 minute visits are also often more time of day sensitive and can be more difficult to fit into a rota.
- It was suggested that the statement could lead to a short term workforce shortage and the need for increased recruitment, which could be a challenge. It may, however, reduce staff turnover as a result of increased job satisfaction.
- It was suggested that ensuring 30 minute home care visits may encourage alternative options to be given more consideration, such as using assistive technology to replace check calls.
- There was some concern about the potential resource impact of this statement for local authorities in terms of increased costs for care packages and increased workload to assess if short visits are appropriate. It was felt that budget pressures faced by local authorities and the impact of the introduction of the national living wage may mean that visits of at least 30 minutes are currently unachievable.

5.5 Draft statement 5

Older people using home care, and their carers, agree a plan for how their home care provider will respond to missed or late visits.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders suggested that the focus of the statement may need to be refined as having an individual plan for missed or late visits is not necessarily the priority for quality improvement. Other suggestions made were:
  - Provider policies and procedures to ensure missed or late visits are identified and addressed.
  - Ensuring missed or late visits are avoided.
  - Ensuring plans for missed or late visits are implemented.
- It was suggested that the plan for missed or late visits should be part of the home care plan in statement 1.
- Stakeholders suggested that missed and late visits should be separated, as they are dealt with differently in practice. Missed calls are dealt with as safeguarding incidents or complaints and late calls are only likely to be considered a problem if they impact on meeting the service user's needs. It may be necessary to identify calls that are urgent or critical and also to clarify what should be included as a missed visit e.g. extreme weather.
- Stakeholders indicated that the statement should emphasise that the local authority is responsible for agreeing and managing the approach to missed or late visits and ensuring that service users' needs are met when they are responsible for arranging home care.
- It was suggested that the process measures are unclear and there was a query about whether the outcome measures relating to safety are directly relevant.
- It was suggested that the equality and diversity consideration should refer to 'those who have cognitive impairment' rather than 'those who lack capacity'.

5.6 Draft statement 6

Older people using home care have a care diary in their home to which everyone providing care and support to them at home contributes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- There was support for this statement and recognition of variation in practice.
- It will be important to clarify which organisation is responsible for the care diary. Any organisational barriers to having a joint record will need to be resolved. There was some concern that the care diary may create duplication.
- Stakeholders made suggestions for the format of the care diary as follows:
  - Partner organisations should agree the format for the care diary.
  - It was queried if there is a standard template for a care diary.
  - The care diary should include the care plan.
  - Online care diaries and digital pens have the potential to make this a paperless record.
- There was concern that collecting the data for this statement may require physical inspection of the care diary in people's homes which would be resource intensive.

5.7 Draft statement 7

Home care workers supporting older people have a supervision meeting at least every 3 months.

Consultation comments

Stakeholders made the following comments in relation to draft statement 7:

- Although the supervision of home care workers was recognised as important it was suggested that this is already being monitored and many providers already comply.
- Stakeholders suggested that every 3 months is a minimum and there should be more emphasis on carrying out more regular supervision meetings as soon as any concerns are raised so that these can be addressed as quickly as possible.
- The definition of supervision should include:
  - the promotion of learning and development opportunities
  - identifying individual development needs such as communication and recording skills
  - updating on policy, legislation and learning from best practice
  - responding to feedback from service users and carers.
- There was a concern that auditing individual staff member records across many home care providers could be resource intensive.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Information for service users about the service
- Care packages
  - Ensuring there is a focus on reablement
  - Supporting social activity and interaction
  - Sight testing
- Staff
  - recruitment and retention
  - terms and conditions
  - training including how to use assistive technology
  - Ensuring home care workers are familiar with the person's care plan and outcomes
- Delivering care
  - Respect for individuals and their home
  - Infection control
  - Meeting the communication needs of those with sensory loss.
- Safeguarding
  - Process
  - Protection against financial abuse

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	Skills for Care	General	It doesn't seem clear who 'carers' refer to – in some statements it could mean family/friends or could mean the social care worker. The sector reserves the term, 'carer' for those family, friends who are unpaid and those who are paid are usually termed 'social care workers' There needs to be consistent use throughout the standard.
2	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
3	Baxter Healthcare Ltd	General	Baxter Healthcare Ltd welcomes the NICE Quality Standard consultation on homecare. We would like to seek clarity on whether the clinical aspects of home care are out of the scope of this quality standard. Home care requires a multi-disciplinary approach. We would highlight the need for the whole patient pathway to be taken into consideration, which would help deliver on the NHS outcomes framework. Would NICE consider aligning this quality standard with the following in order to achieve better patient outcomes: NICE CG182 Chronic Kidney Disease NICE QS5 Chronic Kidney Disease NICE QS72 Renal replacement therapy services for adults NICE CG125 Chronic Kidney Disease (Stage 5): Peritoneal Dialysis
4	Elizabeth Homecare	General	The nature of homecare has changed over the last few years with more short term services being required, this has an effect on long term services for continuity of care as homecare workers with different skill levels in an area may be taken on and off clients to help with skills requirements for other clients who have those needs. Homecare providers offering short term services could be adversely affected.
5	Action on Hearing Loss	General	Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care, develop technology and treatments and campaign for equality.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
			We are happy for the details of this response to be made public. General comments Action on Hearing Loss welcomes the creation of Quality Standards for Home Care, and similarly to our comments on the Home Care guideline, published in September 2015, we want to ensure that the importance of meeting communication and information needs and addressing hearing loss is highlighted through these Standards. We also want to ensure that the Home Care Quality Standards are developed in line with the requirements of the NHS England Accessible Information Standard[1], which becomes mandatory on 31st July 2016 and places a legal requirement on health and social care providers to identify, record, flag, share and meet communication needs of people in their care and to set up an environment that facilitates good communication. Hearing loss is a long term condition which affects more than eleven million people in the UK, about a sixth of the population. The prevalence of hearing loss increases with age, so with the ageing population the number of people with hearing loss is set to grow – by 2035 there will be approximately 15.6 million people with hearing loss in UK, a fifth of the population. Over 71.1% of over 70 year olds have some form of hearing loss, and given the correlation between hearing loss and those needing to access home care, many people receiving care support at home will have addressed or unaddressed hearing difficulties. Hearing loss reduces someone's ability to communicate, which, particularly if left unaddressed, can lead to social isolation, difficulties accessing services and difficulties preventing and managing other physical and mental health conditions[2]. There is evidence to show that social isolation is a significant risk for people with a hearing loss[3], which impacts psychological and emotional wellbeing, in particular increasing the risk of depression. Older people with hearing loss are more than twice as likely to develop depression as their peers without hearing loss, the risk increasing threefold with moderate hearing loss[4]. There is a growing body of evidence that has identified a strong association between all levels of hearing loss and decreased cognitive functioning and dementia[5], and studies have found hearing loss to be independently associated with increased health care use and burden of disease among older adults[6], and with an increased risk of cardiovascular disease[7], diabetes[8], stroke[9], sight loss[10], reduced mobility and more frequent falls[11]. It is therefore essential for home care providers to have processes in place to ensure staff are aware of the prevalence and impact of hearing loss, and are able to recognise hearing loss and support people in their care to manage it effectively. We know that people wait on average 10 years to seek help for their hearing loss, and research also suggests that GPs currently aren't referring 45% of those reporting hearing loss to hearing services[12], so it is

ID	Stakeholder	Statement number	Comments[1]
			likely that there will be many people with unaddressed hearing loss that are more susceptible to develop other physical or mental health conditions. These Quality Standards also need to ensure that the communication and information needs of people with hearing loss are met, so that people are able to participate in decisions around the planning and delivery of their care, and so that the home care they receive is in line with their needs and preferences on an ongoing basis. The Quality Standards particularly need to align with the NHS England Accessible Information Standard[13], which, along with similar requirements in the Equality Act 2010, from 31st July 2016 will make mandatory the need for health and social care professionals to be able to identify, record, flag, share and meet communication needs of people in their care and to set up an environment that facilitates good communication, undertaking any training necessary to enable this. Alongside legislation, guidance and best practice resources should be promoted and adopted amongst home care providers and staff. To ensure this is the case, the Quality Standards should list in relevant places the need to identify and meet communication needs alongside practical support and personal care needs. These Quality Standards must ensure that the hearing needs of those receiving home care are addressed. Our 2012 report on hearing loss in care homes, 'a World of Silence' [14], demonstrated that care home staff were reluctant to advise care home residents that they might be 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 and they also admitted that hearing loss was sometimes overlooked compared with other conditions like sight loss, pain and safeguarding. There needs to be greater awareness of the signs of hearing loss and treatment available. 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, which improve communication and can have a very positive impact on the quality of life of people with hearing loss. Care staff should be able to perform basic maintenance on hearing aids and be aware of other assistive technologies. Our report showed that many care home staff lacked suitable training to carry out basic maintenance of hearing aids and showed wide variations in the take up and understanding of hearing loop systems, TV listeners and amplified telephones. Action on Hearing Loss has produced a nursing practice toolkit[15], with many simple steps that can be applied in settings other than wards, including by social care practitioners, to improve the home care of older people with hearing loss. This includes: training for staff on hearing aid maintenance and understanding hearing loss, communication and hearing aid maintenance equipment; the use of hearing aid storage boxes and other assistive listening equipment; the need for staff to be able to use hearing screening devices; and putting a protocol in place to

ID	Stakeholder	Statement number	Comments[1]
			ensure steps are taken to address hearing loss and refer patients to appropriate services and support. The Action on Hearing Loss World of Silence report[16] and information about assistive listening equipment[17] also gives more detail on what care staff need to be able to provide to meet the needs of those with hearing loss, and it would be useful to reference these resources in the Quality Standards. In general, the Home Care Quality Standards should: Be aligned with the requirements of the NHS England Accessible Standard[18], which becomes mandatory on 31st July 2016. Stress the need for providers and staff to take responsibility for identifying and addressing hearing loss, namely: ensuring staff have an awareness of the prevalence and impact of hearing loss and the link between hearing loss and other conditions; ensuring staff are trained in how to recognise the signs of hearing loss and how to support people to make the most of their hearing aids; and ensuring staff have a knowledge of wider support available, including assistive listening technologies, wider social care support and any other local support services to which they can signpost. Highlight the importance of meeting communication and information needs as well as broader practical support and personal care needs, and stress that home care staff need to receive adequate training in best practice and national and local policy in order to do this.
6	Action on Hearing Loss		References [1] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard [2]Action on Hearing Loss (2015) Hearing Matters, available at: www.actiononhearingloss.org.uk/hearingmatters [3] Herbst et al (1990) Implications of hearing impairment for elderly people in London and in Wales. Acta Oto-laryngologica. 476: 209-214; Du Feu and Fergusson (2003) Sensory impairment and mental health. Advances in psychiatric treatment. 9: 95-103; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Barlow et al (2007) Living with late deafness: insight from between worlds. International Journal of Audiology. 46(8):442-8; Hétu et al (1993). The impact of acquired hearing loss on intimate relationships: Implications for rehabilitation. Audiology 32(3): 363–81; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623; Echalier (2010) In it together – the impact of hearing loss on personal relationships. Available at: www.hearingloss.org.uk/~/media/Documents/Policy%20research%20and%20influencing/Research/Previous%20research%20reports/2010/In%20it%20together/In%20it%20Together.ashx National Council on the Aging. (2000) The

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			consequences of untreated hearing loss in older persons. Head & Neck Nursing. 18(1): 12-6; Fellinger et al (2007) Mental distress and quality of life in the hard of hearing. Acta Psychiatrica Scandinavica 115: 243–245; Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. International Journal of Audiology 42(2): 17-20; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; [4] 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 [5] Lin et al. (2011) Hearing loss and incident dementia. Archives of Neurology 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299; Lindenberger and Baltes (1994) Sensory functioning and intelligence in old age: a strong connection. Psychology and Aging. 9: 339-355; Lindenberger and Baltes (1997) Intellectual functioning in old and very old age: cross-sectional results from the Berlin aging study. Psychology and Aging. 12: 410-432; Uhlmann et al (1989) Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. Journal of the American Medical Association 261: 1916-1919; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45: 323-323; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. Alzeimer's and Demebtia Journal, 11 (1), 70-98 [6] Genther et al (2013) Association of hearing loss with hospitalization and burden of disease in older adults. Journal of the American Medical Association 309(22): 2322 [7] McKee et al (2011) Perceptions of cardiovascular health in an underserved community of deaf adults using American Sign Language. Disability and Health 4(3): 192-197; Margellos-Anast et al (2006) Cardiovascular disease knowledge among culturally Deaf patients in Chicago. Preventive Medicine 42(3): 235-9; Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions. Available at www.ucl.ac.uk/dcal/documents/Joining_Up_long_term_conditions_report.pdf [8] Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. Otology and Neurotology 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. Diabetic Medicine 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. Diabetes Education 36(6): 956-64 [9] Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. Stroke 40(4): 1496–1498 [10] Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. Archives of Ophthalmology 124(10): 1465-70

ID	Stakeholder	Statement number	Comments[1]
			[11] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371; Viljanen et al (2009) Hearing as a predictor of falls and postural balance in older female twins. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 64(2): 312-7; Rumalla et Al (2015) The effect of hearing aids on postural stability Laryngoscope. 2015 Mar;125(3):720-3. doi: 10.1002/lary.24974 [12] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health Technology Assessment, 2 (42). [13] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard [14] 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) [15] Action on Hearing Loss (2015) Caring for older people with hearing loss: a toolkit for change (Available at: http://www.actiononhearingloss.org.uk/nursingtoolkit) [16] 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) [17] Action on Hearing Loss, information about assistive listening equipment: http://www.actiononhearingloss.org.uk/supporting-you/products-and-equipment.aspx [18] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
7	Optical Confederation and Local Optical Committee Support Unit	General	The Optical Confederation welcomes this quality standard. We fully support the aim to ensure that those in need of home care receive services that help to enhance their quality of life and, where possible, delay and reduce their need for care and support.
8	Royal college of General Practitioners (RCGP)	General	Funding is crucial for the training and retention of carers, and their career structure, for the costs of care and for capital cost of home modifications e.g plugs, sockets, smoke alarms, grab rails, bathing/lavatory.
9	United Kingdom Homecare Association (UKHCA)	General	NG21 follows a very structured and detailed method of cataloguing the important issues within the homecare sector, and is easy to read, follow and grasp the direction of travel in securing quality care in the sector. Conversely, the "Home care for older people NICE quality standard – draft for consultation" document does not reflect the attention to detail of NG21 and a different format and sequence of issues has been used which has meant that it has taken a considerable amount of time to rationalise the two and cross-reference, which has not been helpful.
10	AGILE	Introduction	Given that the majority of people that homecare will be provided for will have frailty then this section should formally recognise the need for carers to be trained in the detection and management of frailty at a level appropriate to their role. (note frailty being formally considered as a long term condition as set out in the BGS papers Fit For Frailty parts 1 and 2) :-

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			Part one (clinicians):- http://www.bgs.org.uk/campaigns/fff/fff_full.pdf Part two (commissioners) http://www.bgs.org.uk/campaigns/fff/fff2_full.pdf
11	Elizabeth Homecare	Introduction	The three tables are identified by the three types or bodies that they fall under, the measures that are described in each are reasonable but it seem that the practicalities of achieving (eg. social measures need to have the nhs measures acted upon) this will need greater levels of communication available between homecare providers and NHS bodies, GPs, district Nurses, and Hospitals. There is not the level of trust for example to allow e-mails (hiding behind Data Protection issues) and other communication is time of day/week critical.
12	United Kingdom Homecare Association (UKHCA)	Introduction	We note that on page 2 of the draft for consultation there is the statement that “NICE quality standards are [...] designed to drive measurable improvements in the three dimensions of quality ….” We are concerned that one of the most important factors in a quality system, that is, durability has not been included. UKHCA members have very considerable concerns that the current fragility of the homecare market, with near monopsonistic local authority purchasing of homecare, challenge the durability of the homecare system and this constitutes the single biggest threat to quality standards, which we further elabore on below. Within the introductory statement, at paragraph six, there is the statement that “A number of recent reports have identified concerns about the quality, reliability and consistency of home care services”. It would be useful if the sources were referenced. Later in the same paragraph it is stated that “This quality standard is therefore focused on improving the planning and delivery of person-centred home care ..... ”. UKHCA has always identified that state-funded homecare is a joint enterprise between local authority commissioners of state funded domiciliary care and the provider of that care. Therefore to standardise the delivery of care divorced from the commissioning role in this statement could be seen as an oversight that misses the importance of the intimate structural connectivity between commissioner and provider in the co-production of a safe, effective and sustainable homecare market. Within the introductory narrative under the sub-heading “How this quality standard supports the delivery of outcome frameworks” there are three listed “dimensions of quality”, namely “safety, experiences of people using the service and effectiveness of the care services”. UKHCA contends that this misses an additional and profoundly relevant element of a safe homecare services, that is, durability. Of very great concern within the combined health and social care sector is the sustainability of care services. UKHCA has expressed via a number of media and reports that the current commissioning disposition and fee rates of many local authority commissioners of state funded homecare

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			directly threaten the durabilty of the local market and this challenges the provision of a safe and effective care sector in a number of localities, that we have identied in recent reports, A Minimum Price for Homecare and The Homecare Deficit, available on our website. .
13	Kirklees Council	Introduction	We feel that clarity is needed (in relation to the statements and the guideline as a whole) as to whether the guideline covers long term home care or Reablement. Kirklees Council currently provide a Reablement Service of up to 6 weeks where the assessment and support plan are refined before the service user goes in to long term home care. We feel that currently the guideline is more appropriate to long term home care. In Kirklees, long term home care is delivered by the independent sector. We understand that a number of Councils also operate a short term reablement service.
14	Action on Hearing Loss	Introduction	We welcome the consideration of “recommendations in the development source on specific types of training for the topic that exceed standard professional training” during the development of quality statements. In order to meet the needs of those experiencing care, it is important that professionals are continually trained and developed in line with new legislation and updated best practice. The Accessible Information Standard for example, which becomes mandatory on 31st July 2016[19] requires health and social care staff to carry out any necessary training to be able to identify, record, flag, share and meet communication needs of people in their care, and to set up an environment that facilitates good communication. Care staff should also have an awareness of the prevalence and impact of hearing loss and be trained in how to recognise symptoms, refer someone for hearing aids, and carry out basic maintenance so that people make the most of their hearing aids. Care Staff must also have a knowledge of wider support available, including assistive listening technologies, wider social care support and any other local support services to which they can signpost. Our World of Silence report[20], nursing practice toolkit[21], information about assistive listening equipment[22] and policy statements[23] are resources we feel it would be helpful to reference in the Quality Standards to ensure the highest quality care is provided.
15	Action on Hearing Loss		References [19] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard [20] 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) [21] Action on Hearing Loss (2015) Caring for older people with hearing loss: a toolkit for change (Available at: http://www.actiononhearingloss.org.uk/nursingtoolkit) [22] Action on Hearing Loss, information about assistive listening equipment:

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			http://www.actiononhearingloss.org.uk/supporting-you/products-and-equipment.aspx [23] Action on Hearing Loss guidance on communication support and access to services (available at: http://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/policy/policy-statements/access-to-services.aspx)
16	Action on Hearing Loss	Introduction	Development sources It is also important that the quality standard is considered alongside NHS England's Accessible Information Standard[30], which will become mandatory from July 31st 2016 and will affect all health and social care providers in England. [30] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
17	Royal College of General Practitioners (RCGP)	Introduction	Voluntary services/carer should be included e.g Church, Mosque and visits from particular groups where there is a connection depending on the problem e.g. British Diabetic Association.
18	Alzheimer's Society	Introduction	'The quality standard is expected to contribute to improvements':- comments from our service users include the importance of the consistency of support workers. It's vital when supporting people with dementia that the same support worker visits wherever possible. This enables a bond of trust to be built up between the person receiving care and the home care worker. It is also important for family carers (such as a spouse or sibling) to know that the person with dementia is receiving care from the same person and that the care worker is familiar to the family as well.
19	Disabled Living Foundation (DLF)	Questions for consultation - Question 1	While there is some limited mention of the training requirement for home care staff to understand and support the safe and effective use of assistive technology (e.g. in relation to moving and handling equipment), it is not covered sufficiently in existing core competency requirements to ensure home care staff support the use of the broad range of equipment used by disabled and older people. There is therefore anecdotal evidence that home care staff will not support the use of automated pill dispensers or communication equipment if it is outside their competency and training nor will they flag up to colleagues when equipment is not working. The lack of basic training and support to understand the range of technology in each individual's home provided to home care staff becomes a barrier to new ways of working, is disempowering to the individual and needs to be addressed.
20	North East Lincolnshire Clinical Commissioning Group	Questions for consultation - Question 1	Aside from funding, the priority areas for NEL are consistency of staff, missed calls, capacity due to staff recruitment in relation to both numbers and quality of staff, medication management. As mentioned in the NICE background document, funding, recruitment etc is not covered by this. Planning and coordination is important, in NEL due to make up we feel this is managed wel. The quality standard covers the priority areas.
21	North Lincolnshire Council	Questions for consultation - Question 1	Other issues that have been raised by service users and carers that are not addressed include: Workforce recruitment, retention, remuneration of staff.

ID	Stakeholder	Statement number	Comments[1]
			Respect, of individuals and of their home Practice of support plans and outcomes, ensuring the care worker is familiar with the detail of the service users care plan. Care worker being aware of the need to provide relief for the service user's carer. Infection control, reducing chances of service user and carer being infected by a care worker who is ill. Wellbeing policies Understanding safeguarding and how to raise an alert, care provider providing a list of who will be visiting the service users in advance. Outcome focus, meeting individual need
22	NHS Sheffield CCG	Questions for consultation - Question 1	Answer - This draft standard does reflect the key areas for quality improvement but these may not be achievable without changes being made to the way Home Care services are commissioned and investment being made in the sector to support new ways of working in the provision of their services.
23	Parkinson's UK	Questions for consultation - Question 1	Yes, Parkinson's UK strongly agrees that consistency of care providers, regular reassessments of an individual's care needs and an end to care appointments of 30 minutes or less reflect key areas for quality improvement, with regard to home care. We also welcome the fact that many of the quality measures refer both to people with care needs and their carers.
24	Rotherham Met Borough Council	Questions for consultation - Question 1	7 statements are good indicators of quality. But collecting numbers eg number of supervisions undertaken only tells us the supervisions have been done – not what is the quality of them, what outcomes were achieved/improvements made for services users etc.
25	NHS England	Questions for consultation - Question 1	I agree that this QS has identified the key improvement areas.
26	Skills for Care	Questions for consultation - Question 1	Yes
27	National Community Hearing Association (NCHA)	Questions for consultation - Question 1	The draft quality standard does not sufficiently highlight the importance of the communication needs, including hearing, of older people receiving home care. Hearing care is important to this cohort because: 71% of people aged over 70 have a hearing loss

ID	Stakeholder	Statement number	Comments[1]
			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[i] (thus older people are likely to have more severe hearing loss) adult hearing loss is the 6th leading cause of years lived with disability in England[ii] unsupported adult hearing loss increases the risk of depression[iii], social isolation[iv], loneliness[v], cognitive decline[vi], and reduced quality of life[vii]. NICE has previously accepted unsupported hearing loss is a challenge for people needing home care. For example NICE published guidance on the mental wellbeing of older people in care homes in which it states *"hearing losses are a common feature of ageing and may go unnoticed for some time, but can have a serious effect on a person's communication, confidence and independence. Older people in care homes are cared for by staff who recognise needs that occur because of sight or hearing problems and record these as part of their care plan"*. Unfortunately when NICE introduced performance metrics in the same standard it only measured number of sight tests. This in our view missed an opportunity to reduce inequalities in access to hearing care for this particularly vulnerable group – e.g. further isolation and loneliness is more likely with unsupported hearing loss. Awareness of hearing loss and services to support older people 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[viii], 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[ix]. This is likely to apply to older people receiving home care as well Monitor found that despite the NHS commissioning home care, GPs were not always aware of these services[x], highlighting gaps in knowledge which the current draft quality standard does not address. Hearing loss is a public health challenge. 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."[xi]* The draft quality standard address sensory impairment in the 'equality and diversity considerations' section under

ID	Stakeholder	Statement number	Comments[1]
			each quality statement. However, sensory impairment is only mentioned in reference to 'personal priorities and outcomes' in quality statement 1 – person-centred planning. Due to the impact of unsupported hearing loss and the prevalence of hearing loss in the population that this quality standard is for, hearing loss should be specifically mentioned as a particular challenge in each quality standard rather than grouped in with other long-term conditions as 'sensory impairment'. Otherwise, as outlined above, hearing loss is likely to be overlooked due to the lack of awareness of the prevalence and impact of hearing loss in older people.
28	National Community Hearing Association (NCHA)		References [i] NHS England and the Department of Health (2015) Action Plan on Hearing Loss, p.8 [ii] Murray, C. et al (2013) Global Burden of Disease Study 2010. Lancet, vol. 380, no. 9859 [iii] Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. Archives of Gerontology and Geriatrics, 52(3), pp. 250-252. [iv] Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. Archives of Gerontology and Geriatrics, 49(1), pp. 88-92 [v] Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. Ann N Y Acad Sci. 2011;1231:17-22 [vi] Lin, F. R. et al. 2011. Hearing Loss and Incident Dementia. Archives of Neurology, 68(2), pp. 214-22; [vi] Lin, F. R. et al. 2011 Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. Neuropsychology. 2011; 25(6):763-770. [vii] Appollonio, I. et al. 1996. Effects of Sensory Aids on the Quality of Life and Mortality of Elderly People: A Multivariate Analysis. Age and Aging, 25(2), pp. 89-96. [viii] NHS England and the Department of Health (2015) Action Plan on Hearing Loss, p. 22 [ix] NHS England and the Department of Health (2015) Action Plan on Hearing Loss, p. 11

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			[x] Monitor (2015) NHS adult hearing services in England: exploring how choice is working for patients, p.4 [xi] NHS England and the Department of Health (2015) Action Plan on Hearing Loss, p. 8
29	AGILE	Questions for consultation - Question 1	In part yes. However there is a clear need to add a standard around 'reablement'. All care packages should focus on the reablement of the patient where the patient has re-ablement potential. This will enable effective resource management because care can be reduced / withdrawn if the person is sufficiently re-abled. It will also ensure better quality of life for older people. Evidence on the importance of reablement in relation to effective health and social care systems for older people in :- NHS England published Safe, Compassionate Care for Frail Older People Using An Integrated Care Pathway that provided practical guidance on a best practice service (2014). https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf David Oliver, Catherine Foot and Richard Humphries describe how to "make our health and care systems fit for an aging population" (2014) providing good practice examples which have been reviewed inform the pathway design. https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf
30	British Geriatrics Society	Questions for consultation - Question 1	Yes
31	United Kingdom Homecare Association (UKHCA)	Questions for consultation - Question 1	The Quality Standard (QS) reflects the topics contained within Guideline NG21 sections 1.1 to 1.7 and creates a formula for defining performance against these standards. However, the QS does not establish a benchmark rate for each of the items 1.1 to 1.7 as the formula only calculates the number of instances of compliance. It is appreciated that the inclusion of a benchmark rate may be the subject of considerable discussion, but having embarked on defining standards it may be advantageous to substantiate the scale of performance deficit that is implied in a low score. It would also be useful to develop a document that can be closely related to the Care Quality Commission ratings approach to the provision of care services embodied in their five Key Lines of Enquiry (KLOE) so that the QS could function as an adjunct tool for both the Regulator and the regulated. There are some elements of the Quality Standard – draft for consultation that are repetitious, presumably on the basis of maintaining the same format throughout the document. It may be that the way the Donabedian structure > process > outcome approach has been used could be consolidated into a less disjointed format to ease the flow of the document and to highlight the importance of this method of identifying issues for service-development.

ID	Stakeholder	Statement number	Comments[1]
			The formula for determining the compliance with the standard used throughout the document based on numerator divided by the denominator could be seen as cumbersome and it may be that a straightforward statement – that is, the answer to the numerator divided by the denominator - would be more easily grasped as being the intended output for the equation.
32	College of Occupational Therapists – Specialist Section Older People	Questions for consultation - Question 1	Yes – this draft quality standard does accurately reflect the key areas for quality improvement.
33	The relatives and residents association	Questions for consultation - Question 1	Although the Quality Standard Statements (QSS)reflect some of the areas where the improvements are needed, or need to be maintained, most are already part of the Regulations already in place through legislation used by the regulator, the CQC. The QSS need to be used in conjunction with the guidance in place e.g. NICE guidelines [NG21] or the CQC's Guidance for the Regulations, otherwise they risk being seen as too broad to be useful other than as a checklist for people using the service or their relatives It is the quality of the elements of each Standard which makes the difference to the person using the service and how they are monitored. An example would be the care plan. It may appear to be person-centred, but is it actually being continued in accordance with the person's wishes and when is this checked? A review in six weeks may find improvements are required, but how is this monitored until the next review? With the exception of Statement 4, which reflects the practice that has developed over the last few years of people receiving short calls, the other six Statements are those which should already be in place and known to home care providers as part of their registration and inspection requirements.
34	Home Instead Senior Care	Questions for consultation - Question 1	No
35	Age UK	Questions for consultation - Question 1	A major omission is safeguarding. This is an important issue for homecare providers, and forms a section of the NICE Homecare guidelines (Home care: delivering personal care and practical support to older people living in their own homes). It is included in the Adult Social Care Outcomes framework, so it is not clear why the standard should not be consistent with the guidelines. A specific aspect of safeguarding which is referred to in the Care Act and is important for home care providers is

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			protection against financial abuse. It is important for providers to have safeguards in place to ensure that service users are not subject to abuse by home care workers, and also to ensure that home care workers know how to spot and report possible financial abuse.
36	Age UK	Questions for consultation - Question 1	The standard does not refer to information that the service user should receive, though some of this could be included in statement 5 referring to the care plan. Service users should be made aware of the respective responsibilities of the provider and the commissioner, should be aware of how much they are paying for the service, what needs the service is intended to meet and what they can ask home care workers to do, who they can contact if they have questions or concerns, and how they can use the providers' or the statutory complaint systems. It is essential that service users have all of this information if they are to be able to exercise control over their services, so a reference to information in the standard would support achievement of outcome measures in domain 1 of the Adult Social Care Outcomes Framework. The standard should also be consistent with the NICE Homecare guideline, section 1.2 on provision of information about care and support options. This includes reference to people having information about what to expect from the home care service, their rights, and what they should do if they are not happy with the service.
37	West Sussex County Council	Questions for consultation - Question 1	The quality standards included focus on involvement in home care plans, plans being in the home, review of plans, consistent teams of care workers, short call durations, responding to missed/late calls, and supervision. Overall we agree that these standards can generally reflect the key areas for a focus on quality improvements in home care. A further key area, or for inclusion within each of the current draft areas, though, would be to include a greater focus on workforce quality. For example this could include standards on terms and conditions for staff (to support recruitment and retention), training requirements (in particular including training around areas such as End of Life and Dementia) and ensuring sufficient travel time (to ensure care workers are enabled to spend sufficient time with customers). It is not entirely clear throughout the document as to what the role of the local authority compared to the role of the provider is in ensuring standards are met and in gathering and reporting the data. Alongside this, when implementing the standards, and the data monitoring / reporting requirements, consideration must be given to the time, resource and cost it may take to make any changes to current contractual arrangements both between Local Authorities and Providers and between private customers and providers. This is not to say it shouldn't be done but a clear and realistic timetable must be set that both balances the need for an assurance that people are receiving the right quality support with the need to implement change in a managed way.
38	Alzheimer's Society	Questions for	The quality standards recognise the importance of involving people with dementia and their family members and

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		consultation - Question 1	carers in their care plan. Alzheimer's Society also welcomes the quality standards focus on the importance of consistency in home care workers. A recent YouGov poll for the Alzheimer's Society (2014) found 85% of people would want to stay at home for as long as possible if diagnosed with dementia, rather than go into a care or nursing home, and it is recognised that changes of environment can be particularly unsettling for people living with dementia. This emphasises the importance of ensuring home care provision is appropriate and enables people with dementia to remain in the community for as long as possible. An area absent from the quality standards is the importance of social activity and interaction which can help people with dementia stay involved in their community and remain active. Social interaction with a familiar home care worker can meet this need but home care workers should also be enabling people with dementia to attend groups such as walking or attend religious services if they so wish.
39	Optical Confederation and Local Optical Committee Support Unit	Questions for consultation – Question 1	We welcome the recognition throughout the document, under "Equality and diversity considerations", that people with communication difficulties or sensory loss should be offered appropriate support to enable them to participate in determining their care priorities and developing their care plan. However, it would be helpful if the Standard (or supporting guidance) could go further and draw attention to the importance of ensuring that regular sight testing is a core component of all home care plans. Good eye care should be a part of everyone's regular health routine and is particularly important in older age when eye health can be neglected because other health conditions are prioritised. Good sight can make an enormous difference to a person's sense of wellbeing and independence; as examples, regular eye care ensuring a person has good sight has been shown to help reduce the risk of falls, while it is particularly important that elderly people at greater risk of dementia attend regular eye examinations as symptoms of dementia can mask symptoms of sight loss. Regular sight tests can also lead to the detection of eye diseases, such as glaucoma, allowing early intervention and treatment which can reduce the risk of avoidable sight loss. For these reasons, people who are not able to attend an optical practice to access eye care are entitled to domiciliary eye care in their own home, funded by the NHS. Home care workers need to be trained to recognise and understand the needs of people with sight loss and also those with sight loss and co-morbidities, such as dementia and sight loss. Home care workers also need to be aware of domiciliary sight care services and how to access them, and that everyone has the right to their own choice of eye care provider (whether they are in their own home or a residential care home).
40	Elizabeth Homecare	Questions for consultation	Yes does cover the key areas to be measured, it could give suggested improvements when standards have been measured to help on an improving model.

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		- Question 1	
41	North Lincolnshire Council	Questions for consultation - Question 2	Yes standards 1 and 2 use data from PSS Survey which we do undertake. Standard 4, We do not commission care based on call duration so do not have this data available. Standard 6, Care diary, this information is not readily available. Standard 7, Supervisions in the last three months, yes, we could establish this at contract monitoring meetings
42	NHS Sheffield CCG	Questions for consultation - Question 2	Answer - As stated in my comments above it should be possible to collect data for all of the proposed quality measures, but this may have to be in the form of samples being indicative of achievement, as opposed to comprehensive data evidencing complete compliance. .
43	Parkinson's UK	Questions for consultation - Question 2	Yes. However, we note that data collection for many of these quality measures will rely on people with care needs, their carers and care workers providing an appraisal of whether such measures have been fulfilled. For example, the degree to which older people and carers who are starting to use home care are involved in the development of a care plan is something which can only be self-reported. Parkinson's UK recommends: Local authorities and home care providers consider the development of an anonymous, online survey to encourage self-reporting
44	Rotherham Met Borough Council	Questions for consultation - Question 2	Who would be responsible for collecting, collating and analysing the data? How will deficiencies be acted on, who decides if met the quality measure or improvements made? Also collating numbers eg supervisions only tells us the supervisions, reviews of care plans have been done – not what is the quality of them, what outcomes were achieved/improvements made for services users etc.
45	Skills for Care	Questions for consultation - Question 2	Yes- would need to implement systems in the first place though so this could be complicated
46	Elizabeth Homecare	Questions for consultation - Question 2	Collecting of data should not be too difficult if appropriate IT systems are in place to allow effective interrogation of that data.
47	National Community Hearing Association (NCHA)	Questions for consultation - Question 2	For community based adult hearing care (AQP pathway) outcome data is already being collected where this service has been commissioned. Key service outcomes for the AQP pathway are 90% of patients referred to the service should be assessed within 16 working days of receipt of referral 90% of patients requiring hearing aid fitting should be seen within 20 working days of the assessment 90% of follow-up appointments should be within 10 weeks of fitting

ID	Stakeholder	Statement number	Comments[1]
			90% of patients should be able to access aftercare within 2 working days of a request 95% of responses received from patients sampled via a service user survey should report overall satisfaction with the service"[xii]. Not all of these specific indicators might be applicable to home care but it serves to illustrate that it is possible to collect data to benchmark and improve NHS care. However, for this to be useful the quality standard should specifically include communication needs, including hearing, as a key quality measure. [xii] Department of Health (2011) Any Qualified Provider Adult Hearing Services Implementation Packs, p.25-26
48	British Geriatrics Society	Questions for consultation - Question 2	Yes
49	United Kingdom Homecare Association (UKHCA)	Questions for consultation - Question 2	Availability of systems and structures would support the collection of data but the critical factor is the time it would take to submit the information. Homecare staff rarely have an excess of time during a domiciliary care episode and this role extension would have to be accounted for in the commissioning of services. The cost of providing systems and structures could also be contentious in a sector where margins are continuously narrow and under exceptional pressure in the current financial climate.
50	College of Occupational Therapists – Specialist Section Older People	Questions for consultation - Question 2	Yes – if adequate available systems and structures in place it should be possible to collect the requested data. Are current systems currently collecting adequate, accurate and appropriate data? Are existing systems robust?
51	The relatives and residents association	Questions for consultation - Question 2	We would consider that in home care provision, the collection of quantitative data should be fairly simple to collect as most providers will have computer systems able to provide the data required. However, as previously stated, the qualitative data also needs to be available to show the effectiveness and satisfaction of people using the services. The systems for showing if people are receiving sufficient allocated time for the task e.g. shorter than 30 minute calls, would have to be looked at in some depth as there may be reasons for this – See Question 5.
52	Home Instead Senior Care	Questions for consultation - Question 2	Much of the data should already be being collected to meet CQC requirements and organisations who take LA contracts will be providing information in line with these contracts. However there may be an extra administrative burden for some organisations who don't currently have appropriate systems in place. There may also be additional resources required to keep the focus on data collection and compliance, as quality monitoring is often given a lower priority when day to day focus in needed on the delivery of clients' care and recruitment of care givers. Systems to collect qualitative data may be harder to implement and analyse than those for quantitative information, e.g. impact of moving to hour visits on health and wellbeing.
53	West Sussex County Council	Questions for consultation - Question 2	The measures are focused largely on 'local arrangements and data collection'. It is not clear whether this means local as in being the responsibility of the provider or local as in being the responsibility of the local authority. As well as different providers having different management information collecting and reporting structures, a large number of

ID	Stakeholder	Statement number	Comments[1]
			providers will cover more than one authority and this could create difficulties for them if different Authorities want the provider to report in a different way. Perhaps there is a need for some nationally agreed consistent across the whole provider network data collection, leaving local areas to add additional if they wish and it can be agreed with providers. A good example of this nationally is the National Drug treatment Monitoring System. The cost to providers (which may be passed on to funders – either the Local Authority or the private customer), as independent providers and in the current economic climate, must also be considered. Whilst the need for good information and data is key to supporting the home care market in local areas, there will be a cost to collecting additional data / information. There are a number of areas under each quality statement where we have queries on the possibility of collecting data. These are outlined below;
54	Alzheimer's Society	Questions for consultation - Question 2	Alzheimer's Society expects that this data will be collected from providers of care. This would need to be fairly regular, comprehensive and with a clear line of communication to a central 'data hub'. This would place strain on providers who are under resourced or unfamiliar with data collection. Additionally as there is not a CQC or legal requirement to collect any of the data that would be required providers may not feel they need to. The Society recognises the importance of speaking with people living with dementia who use care services. The data that NICE would like to collect could come directly from people using the services as they are best placed to answer some of the questions e.g. whether they are involved in their care plan or the contingency plan should a home care workers miss or arrive late to a visit. However, this may not always be possible for people with dementia because of issues with capacity and as such this would lead to care providers self-assessing on some quality standards which may not provide the most accurate data.
55	North East Lincolnshire Clinical Commissioning Group	Questions for consultation - Question 2	Yes
56	North East Lincolnshire Clinical Commissioning Group	Questions for consultation - Question 3	Not from the contracting point of view.
57	North Lincolnshire Council	Questions for consultation - Question 3	No, we have not implemented the NICE guidance, so have no examples.
58	NHS Sheffield CCG	Questions for consultation	Answer – one of our CCG commissioned Home Care Providers has partially undertaken the baseline assessment for the NICE guideline. This is still work in progress. .

ID	Stakeholder	Statement number	Comments[1]
		- Question 3	
59	Skills for Care	Questions for consultation - Question 3	No
60	National Community Hearing Association (NCHA)	Questions for consultation - Question 3	Barriers to successful implementation of the quality standard include ensuring there is training and accountability. 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 remains poor and not all care homes make hearing tests available. Unless all carers and health and social care professionals understand both the scale and consequences of unsupported hearing loss in this population hearing health inequalities will remain unaddressed. Due to the large cohort of older people with hearing loss, the final quality standard should specifically mention hearing loss in the quality statements.
61	British Geriatrics Society	Questions for consultation - Question 3	No
62	United Kingdom Homecare Association (UKHCA)	Questions for consultation - Question 3	UKHCA is not a provider of homecare services and we have not been in a position to survey our membership on this topic in the time available.
63	Home Instead Senior Care	Questions for consultation - Question 3	Our model is very closely aligned to the proposed NICE guidelines: our clients are placed at the centre of our model, care packages are designed around their individual specific needs; our calls are a minimum of an hour, to allow time to care; Our CAREGivers are matched to clients based on shared interests and hobbies, allowing a strong relationship to develop; we have continuity of care and all CAREGivers are introduced to clients prior to delivering care. This approach to delivering high quality relationship care has been recognised by a number of external bodies, including LaingBuisson, where we consistently top their care compliance monitor, and the CQQ. We are the only homecare provider in the UK to have been awarded three outstanding ratings. One of the first outstanding ratings was awarded to our West Lancashire and Chorley office in 2015 and this year our Wimbledon and Kingston and Durham offices have just received notification of their ranking. Their reports provide great examples of how we are implementing the NICE Guidelines and can be found using the following links. Home Instead Wimbledon and Kingston http://www.cqc.org.uk/location/1-2239302350#accordion-1

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			Home Instead Durham https://www.cqc.org.uk/location/1-1924959828 Home Instead West Lancashire and Chorley https://www.cqc.org.uk/location/1-407814605
64	West Sussex County Council	Questions for consultation - Question 3	Consistent data recording over a number of providers – the National Drug Treatment Monitoring System
65	Royal college of General Practitioners (RCGP)	Statement 1	A sensible and workable approach with respect for the person involved, their primary carer and family. The initial assessment of need should have access to Occupational Therapy, Nursing, Medical and Social expertise in developing a tailored care plan regularly revisited and updated.
66	Disabled Living Foundation (DLF)	Statement 1	To ensure the outcomes in the home care plan are personalised it would be necessary to identify if technology options have been discussed with the individual. This would help determine whether there has been a sufficiently broad discussion about how the individual's needs would be met rather than relying on the default measure of activity, i.e. commencement of care/ quantity of care provided.
67	Sense	Statement 1	We welcome this statement's recognition of the importance of fully involving people in the planning of their care. We strongly welcome the mentions of sensory loss in this standard and the importance of identifying and responding to it. However, we consider that these mentions are somewhat lost in the detail and would be better represented as a standalone standard which could also reflect the importance of staff having appropriate training to support people with these needs. This is vitally important to ensuring that people's needs can be appropriately met and that their sensory loss is identified and staff have the necessary skills to respond. The EHRC report into Home Care noted that there are, "only a minority of older people not experiencing some degree of hearing or sight loss." Over seven out of ten people over the age of 70 have some form of hearing loss and one in five people aged 75 and over are living with sight loss. We were told by organisations supporting older people that it was quite common for older people's impairments not to be taken into account in home care. Questions were also raised about the skills of home care workers in relation to issues such as communicating effectively with older people with sensory impairments. It is vital that home care workers are trained in basic communication skills such as clear speech, since some level of hearing and sight loss should be assumed amongst the client base of any provider of home care for older people.
68	North Lincolnshire Council	Statement 1	It is already an existing requirement for our commissioned providers to develop with service users a home care plan that is focussed on their personal priorities and outcomes.
69	North East Lincolnshire Clinical Commissioning Group	Statement 1	Good overview of need. Clear rationale. Process a) and b) clear.
70	NHS Sheffield CCG	Statement 1	Person-centred planning is achievable and many home care providers are currently involving people and their carers

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			in developing their home care plans focused on personal priorities and outcomes.
71	NHS Sheffield CCG	Statement 1	This data is already held by care providers and samples of care plans are audited as part of the Contract Monitoring and Quality Assurance work currently being undertaken by the Local Authority and CCG in Sheffield.
72	AGILE	Statement 1	Developing a home care plan with the older person should, with their permission, be conducted jointly with other health services currently involved in the management of that patient. This will prevent overlapping or duplicating plans and will ensure that all teams are working towards to the same agreed goal with the client. When home care is begun often community rehabilitation teams are involved and it is important everyone is working to the same goals. There may need to be an organisational standard which relates to the requirement for commissioners and local health and social care providers to work together to ensure there is a mechanism for shared goal setting, communication and documentation as well as this being measured on a case by case basis. Home care plans should link clearly to other Anticipatory or Urgent Care Plans that are in place.
73	United Kingdom Homecare Association (UKHCA)	Statement 1	UKHCA considers that under the Care Act the responsibility for person centred planning of homecare services falls to the commissioners of care with homecare providers adhering to that initial assessment. Local authorities currently commission over seventy-percent of domiciliary care within the meaning of the Care Act and the experience of our members is that 'packages' of care at the outset are overly prescriptive and are too often seen to be the proprietary property of the local authority and therefore not open to amendment
74	Home Instead Senior Care	Statement 1	Comment about "involvement" The statement recommends that people starting to use the service and their carers (in this instance family carers?) are involved in developing a home care plan. Involvement could be sought but their needs ignored at the point of delivery if their needs cannot be facilitated within the providers operational model and practices. E.g. A client wants to be accompanied to a regular social engagement. Who has the final say about the elements covered in the plan, the client or the provider? How will commissioners ensure that their contracted providers are able to meet the needs of the clients.
75	Kirklees Council	Statement 1	We support this statement.
76	Kirklees Council	Statement 1	Quality measures Process a In Kirklees we have a Person Led Assessment document that records the outcomes of assessment and these should all reflect personal priorities and outcomes. We query as to whether this is a useful measure, though in respect of practicalities around collecting the data.
77	Kirklees Council	Statement 1	Quality Process measures b The Person Lead Assessment is translated in to a support plan and this is refined by providers in the independent sector. It would be difficult to measure this. Currently our Contracts Unit undertake a sample of monitoring visits so it could only be measured via a very small annual sample.

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78	Action on Hearing Loss	Statement 1	a) *Proportion of older people starting to use home care who have a record of a discussion about their personal priorities and outcomes for their home care plan.* It would be good explicitly to reference here, and in other similar places, the importance of discussing information and communication preferences, as the Accessible Information Standard[25] requires, to ensure this is not overlooked by providers and care staff. [25] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
79	Action on Hearing Loss	Statement 1	We welcome the inclusion of social care practitioners needing to identify and agree how to meet needs arising from "physical problems, mental health conditions or sensory loss". However, we think this paragraph should be strengthened and include the requirement for social care practitioners to develop and agree on clear methods of communication with the person receiving home care and their families/ carers, as part of the process of developing a person-centered home care plan.
80	Action on Hearing Loss	Statement 1	We agree that commissioners should "commission services that ensure older people starting to use home care, and their carers, are involved in developing a home care plan that is focussed on their personal priorities and outcomes and meets any needs arising from physical problems, mental health conditions or sensory loss". However, to ensure this is put into practice for each person receiving home care, we think this section should include that commissioners should place this requirement on providers and ensure it is enforced.
81	Action on Hearing Loss	Statement 1	*"Older people starting to use home care services and their carers should be involved in planning their care. This is so that the care they get reflects what is important to them, what they feel they can do, and what they want to be able to do…*" We think that this list should include 'what support they need' as a way of making reference to practical things such as information and communication support.
82	Action on Hearing Loss	Statement 1	*"A discussion about personal priorities and outcomes should address the full range of support needed to help the person to live how they choose, including practical support as well as personal care needs"* Communication and information support is important to add to this list, as it is key to enabling people to make informed decisions and retain independence, and could get missed if it's assumed to be part of discussions about practical support.
83	Action on Hearing Loss	Statement 1	*"People with communication difficulties or sensory loss should be offered appropriate support to enable them to identify their personal priorities and outcomes for home care."* Given the importance of appropriate information and good communication in ensuring informed decisions can be

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			made, we think this consideration should be expanded to ensure the best outcomes for people with communication difficulties or sensory loss, adding the following: "…*offered appropriate support to enable them to understand information, identify their personal priorities and outcomes for home care and participate in discussions designing their home care plan."*
84	Royal college of General Practitioners (RCGP)	Statement 1	The care package should also consider softer areas like entertainment-books, films and pets.
85	West Sussex County Council	Statement 1	Whilst it is useful to have a standard about development of person centred plans and the need for a 6 weekly review, there is no mention of the need for different agencies to work together to support the development / review / delivery of the plan, and this could lead to ambiguity about who is 'leading' the plan with the danger that no-one does. With the increasing complexity of need being seen, it is likely that a person will need to receive support from a number of agencies to ensure they are able to remain independent in their own home. If the delivery of these services is not coordinated in a single plan then this could create quality issues for the person as well as lead creating inefficiencies in the system. The need for joint planning / reviewing / delivery should at least be acknowledged in the standards if not explicitly mentioned, including, possibly, the need for a clear care coordinating organisation / person, like, for example, all people over 75 should now have a named GP.
86	West Sussex County Council	Statement 1	Quality Standard 1 The data revolves around the number of people who have a record of a discussion. The query is where this discussion should be recorded by the provider or by the local authorities, as generally, without a trusted assessment and with the need for a slightly different assessment, it is likely that both the provider and local authority will have this discussion. Also a question on this quality statement is the quality of the evidence. E.g. the numerator does not distinguish how involved the customer was in the discussion or the quality of the discussion and the number of people who have priorities included doesn't reflect the quality of the input or the relevance to the customer. A suggestion in the paper is that the Personal Social Services Survey of Adult Carers and adult social care surveys includes questions about how involved carers feel and health related quality of life. However, it is not clear as to whether this survey is able to differentiate between the type of service that the customer or the cared for is receiving. E.g. is it possible to differentiate between a domiciliary care service compared to a day service from these survey results?
87	College of Occupational Therapists – Specialist Section Older People	Statement 1	We welcome the acknowledgment that care plans must be person centred – tailored to the person's priorities and outcomes, rather than using a generic "one size fits all" approach. Although this will require more time to plan and monitor, in order to ensure that the package is right for the individual, in the long term this will be more successful as people using the service, families and home carers will be happier. Will clients have the opportunity to record in

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			written format, or otherwise, that they agree with the care plans? Will NICE provide tools/guidance on training to homecare providers in order to enable staff to communicate with people who have communication difficulties?
88	London Fire and Emergency Planning Authority	Statement 1	LFB welcome the opportunity to comment on the draft quality standard covering Home Care For Older People. This is of interest to LFB due to the prevalence of people receiving home care in the occurrence of fatal fires and fires where injuries were serious enough to require lengthy hospitalisation. Our published evidence[31] shows that people with care and support needs are significantly at risk from fire. As such, we have worked with Skills for Care, the UK Home Care Association (UKHCA), the Care Quality Commission and the Prime Minister's Dementia Challenge Group to raise awareness of these fire risk factors and the means to reduce them. Our work with Skills For Care lead to knowing how to identify and reduce fire risk for people receiving care and support being a requirement of the Care Certificate for care staff. However, our evidence[32] shows that opportunities to identify and reduce the risk of fire are sometimes still missed. We would therefore ask that the Home Care For Older People quality standard includes a requirement for an assessment of fire risk to be carried out as part of the home care planning process and contains a prompt to contact the local fire and rescue service for advice on reducing fire risk tailored to the person's individual need and circumstances. This will not only help reduce the number of fires and fire deaths and injuries involving older people receiving home care, but will help older people to maintain their independence for as long as possible and reduce the likelihood of them going on to need more intensive nursing care or hospital admission/readmission. [31] Fire Safety of People in receipt of Domiciliary Care – FEP 1952 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=920 [32] Review Of Accidental Dwelling Fires and Fatalities – FEP 2484 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384
89	North Lincolnshire Council	Statement 2	We already monitor service providers annually to check how frequently service plans are reviewed.
90	North East Lincolnshire Clinical Commissioning Group	Statement 2	6 week review and annual requirement is clear. As per Care Home requirements. Data collection relatively simple. Question – who instigates and leads/co-ordinates the review? The Care Practitioner or the Service Provider? As the standard states the same for both.
91	NHS Sheffield CCG	Statement 2	Reviewing home care plans is achievable and many home care providers currently undertake reviews of home care plans with people within 6 weeks of starting to use their service.
92	NHS Sheffield CCG	Statement 2	This data is already held by care providers and evidence of reviews undertaken is gathered as part of the Contract Monitoring and Quality Assurance work currently being undertaken by the Local Authority and CCG in Sheffield.

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93	NHS England	Statement 2	For most people, reviewing the home care plan within 6 weeks of starting the service is reasonable, but there needs to be a caveat (perhaps within the rationale) that for people with rapidly changing needs, this initial review period needs to be sooner than that. This is particularly so if the care plan was put together whilst the person was still in hospital – once discharged home, the reality may be different in that the person, carers and professionals may have underestimated or overestimated needs. Also, for those with changing needs, a review annually after that first 6 weeks may be too long. I appreciate the quality statement has been written in a way that's measurable and achievable, but this could be strengthened in the rationale. Could the Committee consider whether having the first review within 6 weeks of starting to use the service, or within 6 weeks of the care plan being changed.
94	AGILE	Statement 2	Regular reviews are key in a care package focussed on reablement to enable care to be reduced as the individual gets better.
95	United Kingdom Homecare Association (UKHCA)	Statement 2	We have some doubts that the process statement identifying the Numerator and Denominator factors will produce the required results because this appears to be an administrative function rather than a quality measure and could easily be obscured by the pace of the care programme.
96	Kirklees Council	Statement 2	We support this statement.
97	Kirklees Council	Statement 2	Quality Measures - We feel all these can be measured.
98	Age UK	Statement 2	This standard and the previous one both assume that a care package does not need to change between reviews. In reality the needs of many older people who need care change constantly, and commissioners increasingly expect providers to be able to respond to change without the local authority needing to be involved in a formal review. Clients might also be referred to a provider with the expectation that the provider will complete the assessment, especially if it is impossible to obtain a full picture of the person's needs until they have been discharged from hospital and are living at home. A professional in contact with Age UK noted that 'Whereas in the old days we would hold on until the patient was medically 100%, then look at getting them home, with pressure on acute hospital beds the discharge is at the point that the patient is medically stable. The other change, certainly in my geographical area is an increase in good quality services within the community. These services are skilled at resolving home-based issues in-situ'. The implication of this comment is that there is a growing expectation that good home care services ought to be able to respond to changes in the client's needs on a week to week basis. One way that the standards could address this need for flexibility of approach could be by rewording Statement 1 (on involving older people and carers in 'developing a home care plan') to refer not just to 'people starting to use care' but also to the need for review and development of the plan as a continuous process.
99	Action on Hearing Loss	Statement 2	We agree that home care plans should be regularly reviewed in order to ensure people's needs are met as best as possible, particularly as many physical and mental health conditions, including hearing loss, are progressive and needs will change, often requiring an increasing amount of support.

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			Under the Accessible Information Standard[26], from July 31st 2016 it will be mandatory for health and social care providers to identify, record, flag, share and meet communication needs of people in their care, and this quality statement should reference this legislation regarding reviewing home care plans to make clear the need for plans to contain up to date records of communication and information needs of people receiving home care. This point could fit well into one or both of the *What the quality statement means for people using home care services and carers or Equality and diversity considerations* sections. [26] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
100	West Sussex County Council	Statement 2	Quality Standard 2 As with monitoring of Quality standard 1 it is unclear as to whose responsibility it is to collect data about whether there has been a review of the plan after 6 weeks and whether this reflects a local authority review or a provider review - this will impact on where the data is held and how available it is. In addition the local authority may review customers after 6 weeks but this may be limited to those funded by the Council, whereas providers may also be delivering services to private funders, Continuing healthcare customers, and Direct payment customers for example. It is therefore not clear at what unit of accountability the denominator, 'the number of people starting to use home care' refers to – a provider level (including private as well as public funded people) or Local Authority level (which will only include public funded people). It is also not clear whether this should be a whole plan review – i.e. potentially by a number of different organisations if the plan covers a number of different providers – or a review by just the home care provider. The standards mention 'have a discussion with a member of their care team' – who is this referring to as if no responsibility is given to a lead agency then this review could get missed.
101	College of Occupational Therapists – Specialist Section Older People	Statement 2	Reviewing a new care package at 6 weeks and then annual intervals is too long a gap. People, especially where a reablement approach is used, may continue to make significant improvement within the first 3 months of a package starting. Peoples' needs can drastically change within the course of a year. It is not appropriate to leave it up to clients or family to be responsible for requesting a more regular review – some people will not want to make a fuss. Intervals between review dates should also be person centred rather than a generic annual review.
102	The relatives and residents association	Statement 2	Statements 1 and 2 are already provided for in the Regulations. Putting timescales into Statement 2 does provide a framework for reviews, which can be useful and can be monitored, but the danger is that these become a minimum standard for a provider to meet and again do not reflect the individual needs of the person receiving the service. Although the rationale explains the need to hold a review following a change of circumstances, the Statement by itself

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			may give the impression that the timescales are the standard to be met.
103	Sense	Statement 3	We welcome this statement and its emphasis on providing a consistent staff team who are aware of the individual's needs and preferences. This is particularly important for those with sensory loss for whom an ever changing staff team can be particularly confusing due to difficulties in accessing information, issues with safely identifying new workers and the importance of staff teams being aware of their specific sensory needs and the impact this may have on the way individuals receive care.
104	North Lincolnshire Council	Statement 3	As part of annual monitoring, we undertake checks to ascertain staffing levels in relation to service users, however, we do not check on the consistency of staff with individual service users. Standard 3, Not convinced that a the PSS Survey asking service users how safe they feel, really gives service users opportunity to comment on how many care workers are providing their support and the level of continuity they experience.
105	North East Lincolnshire Clinical Commissioning Group	Statement 3	Valid standard, however has multiple external factors out of Provider or Care Practitioners control. E.g. staff turnover, absences, capacity issues.
106	NHS Sheffield CCG	Statement 3	Continuity of care is harder for home care providers to achieve and their current inability to consistently achieve this at the moment is often symptomatic of the wider challenges the sector faces. A contributory factor in achieving this is their ability to recruit and then crucially retain sufficient staff of the right calibre. A high turnover of staff, unplanned absences and low staffing levels severely impact on continuity of care. Current moves to address the issue of pay in the sector may go some way to address this problem but consideration also needs to be given to improving the conditions for Home Carers. Job design for Home Carers, in terms of moving away from task and time, allowing carers more flexibility to deliver person-centred care, and developing team working in localities may also help to address this, as well as developing clearer career pathways for carers who wish to progress.
107	NHS Sheffield CCG	Statement 3	Home care providers electronic call monitoring call systems will capture this information but it would require a large data analysis exercise to monitor this for all service users over time.
108	British Geriatrics Society	Statement 3	Older people consistently tell us that they want their care to be delivered by a person they can get to know, and the relationship they develop with their carer is an important part of the experience of care for them. Knowing the care giver is especially important for intimate tasks such as help with washing and dressing. We completely agree with the statement that people with dementia or learning disability find inconsistency in care giver especially distressing. Clearly it also allows the care giver to find their work more rewarding and to operate more effectively if they know the person they are caring for and are familiar with their environment.
109	Kirklees Council	Statement 3	We support this statement.
110	Kirklees Council	Statement 3	Quality Process Measure b) - This data is not currently collated but this could be explored via Electronic Call Monitoring.
111	Kirklees Council	Statement 3	Quality Outcome Measure a - This data is not currently collated. This data could only be collated via quality

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			monitoring via Kirklees Council Contracts Unit and would only be a very small sample and unlikely to be representative.
112	Kirklees Council	Statement 3	Quality Outcome (general) - Would staff turnover be a better and more realistic measure of this standard? Providers with good employment practices will tend to retain staff and be more likely to deliver more consistent provision.
113	Kirklees Council	Statement 3	(p19) What the Quality measure means for service providers - For generic home care providers, we do not feel that it is practically possible for all new home care workers to be introduced to the older person by someone they know before they visit them. Whilst we recognise that this would be the ideal good practice, due to the current pressures in home care provision - volumes, complicated rostering, high staff turnover it is not feasible in many cases, especially where a short term substitution is made due to staff sickness, for example. It may be more realistic to suggest that the older person is alerted where appropriate as this could include also a telephone call to the servicer user or their carer/ relative.
114	Action on Hearing Loss	Statement 3	Rationale - We think it is important to highlight the advantages continuity of care can have on communication, referencing this explicitly in this paragraph, for example: *"They can communicate well with the person they are caring for, deliver care in the way the person wants…*"
115	Action on Hearing Loss	Statement 3	*"It is a priority to keep the number of home care workers to a minimum for some people using home care such as those with dementia, learning disabilities or sensory loss."* We support the inclusion of sensory loss in this list of priority groups for whom care workers should be kept consistent, however for people with sensory loss, particularly hearing loss, this is best practice often due to familiarity with communication styles rather than confusion and feeling unsettled, and we think the last sentence in this paragraph should be amended to reflect this: "*This is because it can be very confusing and unsettling for these groups to receive care from people that they do not know, and for ease of communication."*
116	West Sussex County Council	Statement 3	Quality Standard 3 Quality statement 3 talks of 'local arrangements' to ensure older people have a consistent team of home care workers. Again are these local arrangements expected to be from providers or from the local authority? In addition, how is it anticipated to be evidenced – e.g. xxx% of customer feedback is that 'I feel that my care is consistent' or by a number 'e.g. customers receive visits from no more than x care workers in a given week/month'. Either way how will these percentages be agreed and/or how will they be evidenced / audited? Electronic Call Monitoring Systems (ECMS) could be used but not all providers have this or else you could be relying upon provider paper / electronic rotas or other mechanisms that may be difficult to audit. This statement mentions the 'number of home care visits per homecare worker per older person using home care'

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			This feels unclear. Does this mean an average number of care workers per individual, or actual numbers of care workers per individual. In addition, for both data recommendations, there is no indication of the time frame? It is also not clear why having a consistent number of people supporting them should make people feel safer (under 'b) service user perception of safety') and also where having consistent care supporters ranks amongst other issues that people may feel contribute to their safety, for example the home environment. Therefore it is not clear how responses to the national service user questionnaire on safety will be able to be directly attributable to the number of care supporters a person has.
117	North Lincolnshire Council	Statement 3 - Question 4	We would suggest a three month period. The period needs to be as short as possible, yet long enough for there to be the likelihood of care workers being ill or on not at work for other unplanned reasons. This way we will see how a care provider responds to an unplanned absence of a care worker. A three month period is also likely to provide enough time for a providers rota/scheduling system to cycle through all its variations.
118	North East Lincolnshire Clinical Commissioning Group	Statement 3 - Question 4	Over 3 months and quarterly thereafter. 3 months is long enough a time for any short term staff planned or unplanned absence to be taken into account and mitigated against. It is long enough to establish a pattern and for rota's to be embedded, but short enough to identify issues and action as required.
119	NHS Sheffield CCG	Statement 3 - Question 4	I would suggest that monitoring of the consistency of the home care team should not begin until the care has been delivered for 6 months, to allow any adjustments to the care package to be made and enable a settling in period. Care providers are best placed to answer this question though.
120	Parkinson's UK	Statement 3 - Question 4	We recommend 12 months as a meaningful period of time for monitoring the consistency of the home care team. This is of particular importance for people with advanced Parkinson's, which is both degenerative and fluctuating, and therefore presents complexities for care workers in both the short and longer-term. The fluctuating nature of Parkinson's means that symptoms, such as fatigue, pain, tremors and freezing can change over the course of a week, day or even an hour. A person with the condition explains: "There are periods every day when my inability to carry out simple tasks and the feeling of my body and mind shutting down, together with pain, weakness and fatigue and breathlessness to mention a few of the symptoms, give me a feeling of despair as to how something like this could happen to me". Given the unpredictability of the fluctuating nature of Parkinson's, the consistency of care workers should be evaluated over the course of a year, as this should provide a sufficient timeframe for them to understand the way in which a person's condition fluctuates as well as recognising and adapting to changes in their symptoms, particularly when they are at their most severe.

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			Parkinson's is a degenerative condition, which means that, in addition to these unpredictable fluctuations, the severity of person's condition and its impact on their daily life will always increase over time, although the speed with which this occurs is different for each individual. Research commissioned by Parkinson's UK has found that people with Parkinson's were often unaware of social care until they reached crisis point. The research therefore emphasised the importance of an 'anticipatory approach' to social care planning for people with Parkinson's, which increases in step with a person's growing needs, to prevent these 'crisis points' from occurring*. For people with advanced Parkinson's who have need for home care services, monitoring the consistency of care provided to them over twelve months will enable home care providers to understand the extent to which care teams are adapting to the gradual increase in an individual's needs. If the degenerative aspect of a person's condition is not being accounted for, and the level of care is not increasing in-step with a person's needs, this must be urgently addressed. * Tod, Angela Mary et al. "Good-Quality Social Care For People With Parkinson's Disease: A Qualitative Study". BMJ Open 6.2 (2016) available at: http://bmjopen.bmj.com/content/6/2/e006813.full?keytype=ref&ijkey=CuaBWbzDxtyfN3z
121	Rotherham Met Borough Council	Statement 3 - Question 4	Difficult to set a time limit – many variables including, recruitment and retention issues, change in needs may require two carers from one carer and due to real world logistics providers generally have "single" and "double" rounds. Also pressures to facilitate hospital discharge may result in carer workers being assigned to a package initially that then may change as the package develops and needs/cultural requirements etc are better assessed. How would it be monitored?
122	Skills for Care	Statement 3 - Question 4	It would seem reasonable to monitor this based on rota systems. We'd guess that most rota's will run month by month – so if this is the case, monthly monitoring. This way consistency can be easily monitored (relatively small amount of data) and issues quickly recognised (without inconsistencies continuing indefinitely), and amendments made promptly. A shorter timeframe may lead to the creation of more issues than it solves – e.g. looking for inconsistencies week by week could at times pick up annual leave and sickness, which if left for a few days will revert back to 'normal' and consistent care whereas if action is taken it could increase inconsistency. However, without being on the front line, this is just our opinion.
123	National Community Hearing Association (NCHA)	Statement 3 - Question 4	Hearing loss is mainly age-related and increase exponentially with age. For older people receiving home care, it is advisable that a sensory check, including hearing, is a part of setting up and updating the personal care plan. Care staff should be aware of the prevalence of hearing loss in older people to increase the chance of recognising

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			symptoms and getting the appropriate support. Any changes to a service user's hearing, either detected through a visit to a hearing care professional, GP or any other health or social care professional should be noted and the care plan subsequently updated. This would also serve as a useful point to monitor the consistency and skill set of the care team to safeguard that this matches the demands of the older person receiving home care.
124	AGILE	Statement 3 - Question 4	Over the first 6 weeks which ties in with the initial review period and thereafter over each subsequent 6 month period balancing reality with ideal care.
125	British Geriatrics Society	Statement 3 - Question 4	We are not aware of any data which can help here. We would suggest a monitoring period of 8 weeks should be sufficiently long to ensure consistency and a period over which one could reasonably expect stability from the care givers employing organisation.
126	United Kingdom Homecare Association (UKHCA)	Statement 3 - Question 4	After due consideration we are concerned that any prescribed time scale would be somewhat arbitrary. Current staff churn rates within the sector are in the region of thirty-percent per annum and our membership frequently report that this rate of turnover affects all sizes of providers in all localities. This level of turnover has always generated difficulties over consistency and continuity and is well recognised within the sector. This places homecare services at a disadvantage, almost by definition, in terms of performance indicators that focus of team consistency. The commissioning of homecare services rarely appear to take into account the qualitative impact of staff churn and typical local authority fee rates across the UK do not offer any comfort that there are likely to be improvements in remuneration in a way that will address this long term issue. It has often proved elusive for care providers to ensure that there is a static workforce that can be assigned to a specific client for the duration of their care. This is not a preference on the part of providers, but is more a structural facet of the sector that is a product of the low wage social care economy and the commissioning disposition of the majority of local authorities providing state funded care. Whilst there is a hesitation to suggest a timeframe because of the exigencies of very different services in different locales, we accept the principle but would suggest a variable period dependent upon what is achievable for providers, but with a floor rather than a ceiling. We would therefore suggest a period of not less than one month. It may be helpful to consolidate the terms adopted in the guidelines and consultation documentation: consistency is used in this question, whilst Quality Statement 3, to which this question applies, uses continuity of care, which could have quite different connotations and Section 1.1 of the guidelines refers to "the same care workers": continuity, consistency and stability of the workforce could usefully be clarified or even consolidated. Continuity of care is not necessarily dependent on workforce consistency or stability.
127	Home Instead Senior Care	Statement 3 - Question 4	It will be very difficult to set a standardised period of time for consistency of the care team, as there are many varied external influences which can have an impact, including care workers leaving the organisation and absenteeism. However each organisation should themselves prepare a written policy statement, outlining their intentions in relation

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			to consistency. Our experience is that "consistency" is built around a number of elements, including appropriate and timely communication of any changes to the client and their family, introductions to clients prior to the carer giver working a shift, and matching of care giver to client based on mutual interests and experiences. The most important factor is that the client is aware of who is delivering their care on a daily basis and is comfortable in their presence.
128	Age UK	Statement 3 - Question 4	This depends on whether consistency is evaluated on the basis of users' subjective perceptions or on the basis of an objective indicator such as the number of different carers visiting the person. The former might be best monitored as a 'snapshot' of perceptions at a particular time in order to enable changes in perceptions to be tracked.
129	Elizabeth Homecare	Statement 3 - Question 4	The timescale would alter for the different measures mainly for efficiencies in gathering the data. If this was a longer period then it might cover higher deviation periods eg main holiday periods. If too short then short term changes would affect the result and might not show the norm. Measuring at different times of the year would also have an effect.
130	Alzheimer's Society	Statement 3 - Question 4	People with dementia should be receiving care from home care workers familiar to them, ideally with as little change in workers as possible. As dementia is a progressive condition which impacts people differently it is difficult to state a meaningful timeframe to monitor consistency. However, a period of 3 months would enable home care agencies or commissioners to pick up a lack of consistency, if present, and address the issue before it becomes a serious issue. The issue should also be picked up if a person with dementia or their family members and carers express concern about the consistency of home care workers as each person will interpret consistency differently and will be impacted in different ways.
131	College of Occupational Therapists – Specialist Section Older People	Statement 3 - Question 4	Continuity of care is essential in order to build rapport and trust. Consistency should be monitored over 3-6 monthly period to allow the person to get used to the team of carers and for rotas and teams to become settled – allowing for holiday cover, school holidays etc. This also allows time to gain meaningful feedback/views from clients and family and to allow time for this to be acted upon and any issues resolved.
132	The relatives and residents association	Statement 3 - Question 4	We would suggest that, initially, three months after a person commences the service would be sufficient time to monitor the information in Statements 1 to 6. This would allow for the initial assessment/production of the care plan, the first (and any further reviews if circumstances have changed). The consistency of staff could be measured by information which should be available from the provider. However, in some cases a person's care package may consist of several calls a day, possibly needing two care workers at each call, so there may be good reasons for a high number. Also, a person's changing needs or preferences may also necessitate more changes than appear desirable. However, the need for providers to work in a way which minimises changes e.g. small patch teams, needs to be monitored. While the introduction of new care worker to a person is highly desirable, in reality there are cost implications to the agency, e.g. paying two staff for the same call, which it will probably need to pass on. With the hourly rates paid by local authorities, it is unlikely they would absorb the cost.
133	West Sussex County	Statement 3 -	Consistency can be affected by staff sickness and holiday in the short term as well as staff retention in the longer

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	Council	Question 4	term sense. To measure in any given week may mean that a week where usual carers are on holiday may impact on the outcome. It would therefore be suggested that a month is a more appropriate timescale to enable a larger time frame to consider how consistent the team of care workers are.
134	Sense	Statement 4	This standard has huge potential to make a difference to the care received by older people in their homes - visits shorter than 30mins can lead to rushed and compromised care. This is particularly important for those with sensory loss, where time is needed to establish and maintain good communication and to ensure the individual can be fully included in their care.
135	North Lincolnshire Council	Statement 4	Standard 4, Again not convinced the PSS Survey would provide a response to the length of visits.
136	North East Lincolnshire Clinical Commissioning Group	Statement 4	Agree that this is relevant and should be included. Need clear and open dialogue between Social Workers and Providers from the outset and when a change is required. Often a cause of conflict which needs addressing. (who knows best)
137	NHS Sheffield CCG	Statement 4	Length of Home Care visits is a key improvement and very important for people who use the services but will have an impact on the Local Authority in terms of increased costs for packages and increased workload for assessors to determine which short calls are appropriate to continue and which may need to be increased. CCG commissioned home care packages tend to be bigger and take longer due to complexity of need, so the impact of this standard should be minimal. .
138	NHS Sheffield CCG	Statement 4	This data is captured and easily retrievable from Home Care provider's electronic call monitoring systems.
139	AGILE	Statement 4	Visits of less than 30 minutes are not acceptable in any circumstance. Simply introducing oneself, making an initial assessment of the person to check their condition hasn't changed and introducing the purpose of the visit is likely to take 10 minutes. All visits should be 30 minutes or longer. This will reduce the number of late or missed visits which are often caused by not allowing sufficient time for apparently 'short' tasks. This includes pop in visits to check the person is alright / hasn't fallen etc. If these visits are 15 minutes they are not long enough to respond if a problem is found. Equally short visits to assist with medication are also inappropriate if the person is going to be properly supported with medication compliance.
140	British Geriatrics Society	Statement 4	The BGS agree that these standards are appropriate. With regard to quality statement 4 we suggest that this needs to be monitored carefully and it might be appropriate to specify tasks which should never be allocated less than 30 minutes such as help with washing and dressing or undressing, or help with meals.
141	Home Instead Senior Care	Statement 4	General comment about the wording of this statement There needs to be more clarity around the definition of "part of their home care package". Is a visit shorter than 30 minutes permissible once a day or more frequently, or only in conjunction with an agreed number of longer visits? The current wording could be read that a care package where all visits are shorter than 30 minutes is appropriate if agreed with the stakeholders.

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			Our view at Home Instead Senior care is that visits should be a minimum of one hour. Visits of less than 30 minutes should only be agreed as part of an overall home care package where the majority of visits are 30 minutes or longer. These visits should be for a limited range of specific tasks e.g. medication checks.
142	Kirklees Council	Statement 4	We feel that this statement may conflict with the person centred planning approach we are all encouraged to use. We feel that specifying times isn't helpful. We feel it would better if it was a statement about call times adequately reflecting the time needed to deliver the task rather that specifying lengths of call. Although it is appreciated that specifying times has the aim of reducing rushed calls, this could have a knock on impact on assessors who could feel that calls less than 30 minutes should be discouraged. This could lead to unnecessary increased charges for service users who may be unwilling to pay for longer calls. There could also be a knock on impact on workforce availability to deliver this in the short term. Shorter calls for specific tasks are appropriate for some service users.
143	Age UK	Statement 4	The NICE Homecare guidelines state that any homecare visits of fewer than 30 minutes are only acceptable if they meet the following criteria; They are part of a larger package The specified task can properly be done in the time allocated The older person already knows the homecare worker, and (in the next paragraph of the Guidance) The time allowed does not compromise dignity or safety These requirements should be referred to in the standard. The section on 'what the quality standard means for people using home care services and their carers' states that people should only have visits of less than 30 minutes if they have agreed in advance that some specific shorter visits are acceptable'. Guidance to providers, practitioners and commissioners takes the same approach, which Age UK strongly supports. Quality Statement 1 includes definitions of terms used in the standard. The same approach would be useful in this standard in order to better define the concept of 'specific tasks' which might be carried out during a visit of less than 30 minutes. .
144	West Sussex County Council	Statement 4	Quality Standard 4 Quality statement 4 asks for 'local data collection' to ensure visits of less than 30 minutes are for specific tasks or checks agreed as part of a package. Some service providers will have information on the times of visits through ECMS (if they have these) but others may rely on rotas to provide this, which could make it quite resource intensive to collect. In addition, through either method, it might be difficult to audit what visits for under 30 minutes are for, and in particular where there is a clear, unambiguous agreement between the provider and the person as to what a sub

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			30 minute call may be used for. Whilst sub 30 minute calls should be infrequent, they can be provided for 'legitimate' purposes, for example for medical or other checks. Although they should be infrequent there will still be a fair number per day and collecting this data for each visit will create a need for a high volume of recording and monitoring data if done over a longer period.
145	College of Occupational Therapists – Specialist Section Older People	Statement 4	To enable people using the service to have choice, an opportunity to actively engage and to be treated with dignity takes time – 30 minutes is the minimum time required for most tasks – allowing time to assist, communicate and document appropriately. If a person is confused/ cognitively impaired and not allowed enough time for staff to reassure and communicate effectively with them, this could result in unnecessary extra anxiety and a person becoming more confused and distressed – ultimately requiring more time to help them to settle. There is a temptation that the term "specific tasks" may be misused – people may become "processed" with care done to them rather than enabling them to actively participate in their care routine. If less than 30 minutes allocated, what happens if the person unexpectedly has a problem which takes longer to resolve? This will result In extra stress for the person and homecarer. This may then impact on the next visit.
146	Social Care Institute for Excellence	Statement 4	Concern that this does not capture all 3 criteria in recommendation 1.4.2 plus the emphasis on dignity and respect in 1.4.4. Concern that the current wording does not discourage some of the current poor practice related to limited and inflexible visits that the Guideline Committee wanted the recommendation to address. Concern that the statement as it stands will not drive quality improvement in this area.
147	Parkinson's UK	Statement 4 - Question 5	We are unable to estimate the impact on home care services if a minimum of 30 minute care appointments were implemented. However, we feel this would have a significant, beneficial impact on people with Parkinson's and their carers. Given the progressive nature of the condition, people with Parkinson's require increasing social care support in order to prevent or mitigate the impact of their condition as it develops. As Parkinson's is such an unpredictable condition, we feel that slots of 15 minutes or less are never appropriate in the case of personal care for someone with Parkinson's. For example, the research referenced above identified particular problems with the fluctuating nature of Parkinson's, which makes issues around At times the fluctuating nature of the condition made issues around timing more pronounced, for example if a carer only had 15 minutes allocated and the person with Parkinson's had frozen. A Parkinson's nurse specialist explains: *"I went to see a lady yesterday…She'd actually she'd come downstairs that*

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			morning and she'd forgot to bring her dispersible Madopar with her, which she needs as a rescue dose and she realised this too late and by the time she got back up to the bedroom she was rigid, she was absolutely solid and everything was going off, you know, breakfast and everything and this lady couldn't do anything, she couldn't even speak. For myself and the occupational therapist that understood that it wasn't an issue, but for other people around, carers, they really, really struggled with the fact that this person could be faking this, could be putting this on, you know.' Fixed appointments of at least 30 minutes would give people with Parkinson's the confidence that their home care workers have time to address their needs, fully understand how their condition is impacting them day-to-day, and when these needs are no-longer being met.
148	North Lincolnshire Council	Statement 4 - Question 5	It is reported by home care providers that 15 minute visits are not long enough and have a negative impact on a provider's ability to either remunerate staff adequately or make a viable profit. Implementation of this quality measure would serve as a useful reminder that visits of less than 30 minute duration are not desirable unless agreed as part of the home care package. Yet is does give the service user scope for shorter visits if this is of their choosing.
149	North East Lincolnshire Clinical Commissioning Group	Statement 4 - Question 5	NEL currently only use less than 30 minute calls for non-personal care specific tasks, such as wellbeing checks, medication checks etc. These are discussed and agreed at the time of assessment with the practitioner; however this standard would be useful for regular audits.
150	Elizabeth Homecare	Statement 4 - Question 5	Calls of less than 30 minutes can only be outcome based tasks, where little or no interaction takes place. Check medication has been taken, fill a coal bucket. There would need to be a more detailed limit of the tasks undertaken. There should be little proportional cost saving as the length of the call would not alter the "off costs" (recruitment, training, paperwork/diary, supervision and travel time) of the call. It would be difficult to achieve 3 x15 minute call into 60 minutes unless all three call were within a close proximity to each other. Does not help with rural calls. These calls may be more time of day sensitive due to the task based side of the call and be more difficult to fit in a rota.
151	NHS Sheffield CCG	Statement 4 - Question 5	Implementing statement 4, Length of home care visits, would be welcomed by Home care providers, I imagine, but initially would require them to invest a lot of time re-rostering staff and may require them to recruit more Home carers, which is currently proving to be challenging in Sheffield. Again, providers of home care services are best placed to answer this. For older people, this change is likely to be welcomed and will no doubt enhance the care experience for individuals and lead to greater satisfaction for service users and carers. This may also assist Home care providers to retain staff, who may previously have become disillusioned.
152	Rotherham Met Borough	Statement 4 -	Statement 4 is very vague – all care packages are agreed with the service user's input and in RMBC a weekly total

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	Council	Question 5	hours is agreed with the service user and the Provider then agrees with the service user how outcomes in the support plan will be achieved utilising the weekly hours agreed. Task and time support plans are not used in Rotherham. However in agreeing the weekly hours for a package it may result in some visits being less than 30 mins. Data on the number of visits less than 30 minutes would not be collectable. Packages are also often amended implementation Eg moving and handling assessment in a hospital setting can be very different to what actually will be required in the home environment and lead to changes in the number of weekly hours required. 30 minute calls would obviously allow for a better quality service and for care plans/daily logs to be completed fully and meaningfully (including your proposed care diary), however this is probably unachievable due to the budget savings that Councils are having to make year on year combined with the increased pressures that will be placed on existing service provision with the implementation of the National living Wage. In an ideal world all care visits would be at least half an hour but in reality this is unlikely to happen.
153	Skills for Care	Statement 4 - Question 5	Crucial to identify what task would require less than 30minutes and for any visits under 30mins to be clearly agreed. But pragmatic in some cases. Longer visits would enable meaningful care and support could be provided more in line with someone's needs and more likely to promote dignity and independence
154	National Community Hearing Association (NCHA)	Statement 4 - Question 5	Communication is key to good outcomes for any health and social care intervention. Therefore without specifically taking in to account older peoples' communication needs, i.e. including hearing, it is unlikely the quality statement will be successful.
155	Home Instead Senior Care	Statement 4 - Question 5	At Home Instead our calls are typically one hour or longer. We find that clients benefit from having a longer duration call which provides time for the client and care giver to build a relationship, and time for the care giver to carry out their work without rushing the client or feeling rushed themselves. Building a relationship over time has additional benefits including providing companionship which helps reduce loneliness, and provides an opportunity for the care giver to identify any deterioration or improvement in the clients' condition and needs. For those not currently operating this model there may be additional costs necessary to make the transition, including costs of recruitment, training and rationalising the number of clients each care giver visits. Given the current backdrop of underfunding within the social care sector, this will necessitate many providers communicating and renegotiating with Local Authority commissioning bodies.
156	Age UK	Statement 4 - Question 5	Improvements in outcomes set out in the ASCOF domains, including enhanced quality of life, delayed or reduced needs for support, safeguarding, and having a positive experience of care and support should all be demonstrable.

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			There could potentially be a cost benefit in that home carers could play a broader role than just carrying out tasks, for example by monitoring the client's wellbeing, agreeing minor changes to the care package with the client and supporting clients to be as independent as possible. We would expect an increase in job satisfaction amongst home care staff, who would be able to provide care to a much higher standard and to develop better relationships with clients. Very short care visits are, in our view, dehumanising both for older people and for care workers.
157	Action on Hearing Loss	Statement 4 - Question 5	We think this would be a positive measure for older people, enabling better communication and more time for person-centered holistic care. Spending more time with care professionals and building better relationships can also help combat social isolation, which is very prevalent in over 65s and can contribute to the development of other conditions that place added burdens on the health and social care system, such as depression and dementia[24]. We know that hearing loss at any level can mean communication takes more time, and given the overlap in the demographic between people accessing home care and people with age-related hearing loss (over 71.1% of over 70 year olds have some form of hearing loss), longer appointments would be beneficial for ensuring needs are met in line with personal preferences. [24] Action on Hearing Loss (2015) Hearing Matters (available at: www.actiononhearingloss.org.uk/hearingmatters)
158	West Sussex County Council	Statement 4 - Question 5	There are opportunities and risks with this. Ensuring that the quality standard on calls shorter than 30 minutes is implemented could lead to less rushing from care workers, less evidence of call cramming, and more quality time with individuals. It will benefit care workers as they feel better able to meet the needs of their customers, and will be able to spend more time conversing with customers thus reducing their loneliness. It may mean a reduction in accidents and safeguarding's as care workers are ensuring that more complex tasks such as hoisting have appropriate lengths of times to complete the tasks. It may also mean a reduction in travel costs as visits are longer, which may support viability of businesses, and attractiveness of the role for staff. In addition, it may enable greater consideration of alternatives to be fully explored. For example, assistive technology opportunities for medical prompts and for check calls. However, there are also some risks. The costs of packages of care may increase if more calls are 30mins or longer or less calls may be commissioned as a result. Private customers may go without care if they feel they have to pay for a 30 min call as a minimum due to the expense. Customers who are reluctant recipients of care may feel more reluctant if care workers are in their home for longer periods. The focus on the timeslots may also take away the emphasis on the importance of meeting peoples outcomes as the focus becomes more on how long a care worker was there for, and not on what did they support the customer with during that time, and how did they enable the

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			customer to meet their agreed outcomes.
159	Alzheimer's Society	Statement 4 - Question 5	It is important to recognise that people with dementia may have different needs compared to other people who use home care services. As such visits of less than 30 minutes may not be appropriate for a person with dementia under any circumstance. Symptoms of dementia include forgetfulness and confusion so a home care worker, who may be unfamiliar to the person with dementia, visiting for a short amount of time may cause agitation and distress. The person with dementia needs time to familiarise themselves with the home care worker and may need to be reminded of the purpose of the visit and at no point should this be rushed through because the time allocated is less than thirty minutes. Alzheimer's Society is encouraged by the Equality and diversity considerations mentioned at the end of Quality Standard 4. In particular the point that 'individual needs should be carefully considered before it is agreed that home care visits of less than 30 minutes are acceptable'. This must be emphasised with providers to ensure there is recognition of the specific needs of a person with dementia.
160	The relatives and residents association	Statement 4 - Question 5	At times, calls of less than 30 minutes may be acceptable. However, it needs to be shown that these are assessed, agreed and reviewed soon after implementation, with both the person receiving the service and the care workers. In some cases, e.g. giving medication, the task may only take a few minutes and unless combined with, say, providing a meal or snack, be all that is required. The provision of meals or personal care in a very short call, which can be current practice, is far less acceptable and again the task needs to be reviewed to ensure that the task is being carried out satisfactorily. In some cases, it will be because the receiving the service may be paying the full or part cost of the service, even if commissioned by the Local Authority, and therefore does not want to pay for a care worker who is not productively employed with them. It may also be a personal preference that the person only wants a care worker in their home for the time it takes to carry out the task and not for 'company'. These choices have to be part of a person centred approach to care planning. Asking a care worker to do less than their allocated time may impact on their pay, therefore there are further implications in allocating time for a task. Many agency workers are paid for the time actually spent with their client so allocation needs to be carefully planned if care workers are not to lose further pay.
161	United Kingdom Homecare Association (UKHCA)	Statement 4 - Queston 5	UKHCA are concerned that Quality Statement 4 is too brief and does not reflect the three criteria listed at Section 1.4.2 of NG21. This states that: "Homecare visists shorter than half an hour should be made only if: the homecare 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"

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			UKHCA considers that the responsibility for delivering this quality statement falls to the commissioners of homecare services, and is a quality issue that providers would find universally appealing. UKHCA holds the position that short visits, for any reason, have a very limited role in the delivery of homecare services, to the extent that we have significant doubts of the validity of the examples cited in Section 1.4.2 of NG21, particularly when working with people who are cognitively impaired where short interventions can often further exacerbate or distort emotional disequilibrium. We consider that the elimination of short visits would significantly enhance the standards of care as described in Section 1.1 of NG21 and as outlined in Question 4 (above) of this consultation. For homecare providers such a measure could introduce the potential for improved continuity of service delivery for the simple expedient that staff could spend more time with each service-user. There would also be potential benefits in recruitment and retention, rota planning and logistical simplification in scheduling visits.
162	North Lincolnshire Council	Statement 5	Standard 5, Not convinced that looking at the number of safety incidents and service user perception of safety will provide an accurate picture of the number of late visits. Service users may instead see this as more of an annoyance or poor service but may not report as a safety incident.
163	North East Lincolnshire Clinical Commissioning Group	Statement 5	Already measured locally. Would suggest prioritise calls labelling those that are urgent/critical against those that could wait
164	Disabled Living Foundation (DLF)	Statement 5	This quality statement is focused on the process to be followed following notification of a missed or late visit. This depends on reporting by the individual which is often not realistic if they are disoriented, do not have the contact details to hand or do not wish to 'be a nuisance'. A preferable service model would be for care providers to implement simple, cost effective visit logging using sensors, which would provide a log of visits and visit lengths and provide early warning of missed visits/ the need for follow up visits. The process for measurement could then be based on the number of clients for whom automatic notification is in place with missed or late visits logged automatically providing data for analysis. While this is not current practice it is the logical direction of travel in relation to management of risk for vulnerable clients. Although this is a development standard, some reference within the Quality Standard would be useful.
165	NHS Sheffield CCG	Statement 5	Planning for missed or late calls is achievable and many home care providers currently involve people in their plans for how the provider will address these. However, many providers fail in this area due to the same reasons mentioned for Standard 3 above, Continuity of care. With a stable workforce standard 5 is easily achievable but when a provider is under extreme pressure due to staff shortages, particularly when this is in the office as well as the home care workforce, then agreed plans do not always get followed.

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166	NHS Sheffield CCG	Statement 5	These plans should be incorporated in the care plan and so achievement of this can be measured when these are audited as part of the Contract Monitoring and Quality Assurance work currently being undertaken by Local Authority and CCG in Sheffield.
167	NHS England	Statement 5	How will a provider know a visit is late or missed? There's a danger that someone will be overlooked without a robust notification process in place.
168	Skills for Care	Statement 5	Is there something that can be added around the service user not allowing access and what to do in this event (as they may be hurt/unconscious etc). Many people will have access by key safes etc, but if there is an incident where the person didn't open the door, it does need to be reported in case the older person is laying on the floor hurt.
169	AGILE	Statement 5	The aim behind this standard is appropriate but the standard itself is not helpful. Older people do not want an individualised plan for how to respond to late or missed visits. They will all say the same that they want to be informed, if they lack capacity or are likely to need urgent support in the event of late or missed visits, then their initial care plan should outline what this support is (e.g. could a neighbour / family member help, how are they contacted etc). What is needed is a minimum standard for care providers to aim for in terms of % of late / missed visits in the same way that rail providers have standards for punctuality.
170	Kirklees Council	Statement 5	We feel that this statement is slightly unclear as the response to missed calls would be different to that of a late call. We would suggest separating missed call and late calls out. Missed calls are always unacceptable and would be dealt with via the complaints or safeguarding route if necessary. In Kirklees, we do not specify exact call times. Instead we have time bandings so that service users are given clear expectations. The statement in relation to late calls could be reworded to read '… inappropriate call times that impact on meeting the service user needs'. A later call may have no impact on one service user or for another service user it could have more serious implications. Where there is little flexibility in time to meet a service user needs this could be documented on the support plan. For example, a specific call time may be needed to meet medical needs.
171	Kirklees Council	Statement 5	Measures (general) - As stated above we feel that this measure should be separated out. The number of missed calls could be measured but we would query how appropriate it would be to measure individual plans for missed calls as all would be responded to as urgent. Safeguarding incidents and complaints are recorded. It would be difficult to measure where plans for late calls had been documented on individual support plans (in aggregate) other than via quality monitoring visits via the Contracts Unit and this would only represent a very small, non-representative sample.
172	Age UK	Statement 5	This standard is welcome, but as the standard is intended to influence commissioners as well as providers it is essential that it also refers to the statutory responsibilities of commissioners, who ultimately retain responsibility for ensuring that the service users' needs are met. Commissioners should seek to meet this responsibility by ensuring that providers have a contingency plan, but it should be clear to service users who are receiving care arranged by the local authority that if this plan breaks down they can contact the local authority. The statement should refer to there being a plan for how the 'home care provider and if necessary the commissioner' will respond to missed or late visits.

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			The NICE guidelines include a specific statement about what commissioners should do, including ensuring that service contracts allow home care workers enough time to provide a good quality service, including time to talk to the person and their carer, to have sufficient travel time between appointments, and to ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.
173	Action on Hearing Loss	Statement 5	In the Plan for responding to missed or late visits definition, we think that it's important to ensure appropriate action by home workers is taken and not just assessed if a visit is late or missed. Therefore, the "assessment of risk and action needed if a visit is late or missed" bullet point should be strengthened and could echo more closely the corresponding point in the NICE Home Care Recommendations, which requires providers/ home care workers to "set out clearly in the person's risk assessment what should happen if a visit is missed."
174	Royal college of General Practitioners (RCGP)	Statement 5	Where possible the elderly person/carer should be in contact via smart phone or alarm for notice of visits, changes in care and provision of medication.
175	West Sussex County Council	Statement 5	Quality Standard 5 Quality statement 5 asks for local data on how the provider responds to missed calls. Each individual provider should have a policy on missed calls which dictates how they respond. This will be 'local' to the provider. The number of missed calls may only be recorded if a provider has an ECMS For both monitoring suggestions it is not entirely clear what is meant by the numerators and denominators. Particularly for process B it would seem to be difficult to identify, if starting from the missed visits, the number of those missed visit people who had a plan. This would mean that for each missed visit there would need to be a 'backwards' check to see if the person had a plan. Also, surely the first process to look at quality of provision will be to identify the number of missed calls full stop. Then there may be a need to review which of those missed calls had a pan as set out? Also there will be times when, through no fault of the service provider (including serious weather conditions etc) when despite the best efforts of providers, a call may simply not be able to be made and be missed. Should these times be included within the recording as set out in the draft standard? If so what constitutes such an event? This quality statement states that the Safeguarding adults' annual report would include information on referrals made as a result of neglect. As with Quality Standard 3 comments above, it is not clear however, that the 'neglect' would relate specifically to missed calls, as neglect could encompass other aspects. In addition, the service user perception of safety may not translate to whether they have had missed calls or whether the provider responded as per a plan.
176	College of Occupational Therapists – Specialist Section Older People	Statement 5	Contingency arrangements will need to be extremely clear, robust and not left open to misinterpretation. P26 – it would be better to refer to clients who "have cognitive impairment" as "capacity" is very specific to a particular decision/ choice.

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177	The relatives and residents association	Statement 5	Statement 5 – Missed and late calls are two very different events. Late calls may sometimes be unavoidable for the care worker due to traffic, emergencies with other clients, for instance. Although probably distressing for the person, their care is ultimately being provided. Missed calls, particularly as the majority of home care clients nowadays are those with high needs, are potentially life threatening and should be treated as a 'never' incident. Many home care clients will not be able to let anyone know that their call is missed, so having plans in place will not always be enough. The use of technology e.g. telephone log-ins, can lessen the risks but it needs to be shown that the provider has the staff to monitor any systems which may be in place. The employment of sufficient staff is again enshrined in legalisation and many late calls may be because of staff shortages and this need to be part of the data collection.
178	Social Care Institute for Excellence	Statement 5	This does not currently emphasise enough the need to avoid missed or late visits. Suggested that we should focus the statement explicitly on avoiding missed or late visits as per rec 1.4.10, as well as having a plan for dealing with them
179	NHS England	Statement 6	I agree the care diary is a very good idea and I have seen this used with great effect in palliative care. The care diary should include a record of the care plan that has been agreed, as a point of reference for everybody involved in the care, and to help early recognition if there has been an unplanned drift away from a plan agreed with the individual.
180	Disabled Living Foundation (DLF)	Statement 6	It is now possible for very simple online care diaries to be deployed, either based on simple sensor networks (see Jointly/ CanaryCare) or supplemented with digital pens to allow input of data. This enables communication across the formal and family care network. A paper based 'silo' of information in the client's home is of limited value. While this is not current practice it is the logical direction of travel in relation to paperless services in the NHS and to maximise the capacity of the informal care network. Although this is a development standard, some reference within the Quality Standard would be useful.
181	North Lincolnshire Council	Statement 6	We do not currently require providers to make use of a care diary, so would welcome this to ensure that an accurate and transparent record of care is accessible to all care and support providers who visit an individual service user.
182	North East Lincolnshire Clinical Commissioning Group	Statement 6	Single care diary. Good in principle if all use. Whose responsibility to ensure all parties input? Will there be a national template?
183	NHS Sheffield CCG	Statement 6	The single care diary is achievable and has been used in Sheffield before, with mixed success. The problems with its use in Sheffield were around who "owned" it and supplied it – the care provider, the Local Authority or the person? Each organisation has their own records to complete and this was seen as duplication if they didn't own it. Visiting professionals were also reluctant to use it, for the same reasons, and often they would go missing in people homes. With integrated working more advanced these days, a single care diary may be more successful,
184	NHS Sheffield CCG	Statement 6	Data around the successful use of these can only be captured through auditing them once completed. .
185	Rotherham Met Borough Council	Statement 6	Comment on statement 6 – in practical terms it would be difficult to agree one diary that different providers/agencies/professionals would complete as each provider/agency/professional will have to complete their

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			own paperwork and would this then be a duplication/additional task that would take time.
186	NHS England	Statement 6	Is there a template for a care diary? Should there be one?
187	Elizabeth Homecare	Statement 6	The “diary” that is proposed, who “owns” who checks where is it kept what format is it? Is it paperless who transfers data?
188	Skills for Care	Statement 6	Care Diary important, but it’s probably unlikely that it will remove ‘duplication’. Individual services will want a record of their own notes on their own systems -unless they all have access to a shared online system, which is still unlikely for most services. Although with further input of technology this may well improve in the future.
189	Kirklees Council	Statement 6	We support this standard and have this in place. Kirklees are trying to ensure that this is fully implemented across Kirklees.
190	Kirklees Council	Statement 6	Quality Standard (Measures) - The measures are clear but would need to set up a process for collating this in Kirklees.
191	Action on Hearing Loss	Statement 6	What the quality statement means for service providers, social care practitioners and commissioners - This section should stress the important of recording communication and information needs and any changes to these, in line with the Accessible Information Standard[27], which will be mandatory from 31st July 2016. [27] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
192	Royal college of General Practitioners (RCGP)	Statement 6	The information base should be held as a “live” register with updates added manually in the home but also via direct access to the central register from a handheld device which each carer should have and use at the end of the visit.
193	Royal college of General Practitioners (RCGP)	Statement 6	This record would be essential to the process of regular review in matching services, quality of care and carer to changing needs.
194	West Sussex County Council	Statement 6	Quality Standard 6 The quality measured in quality statement 6 include the evidence that ‘everyone providing care and support to them at home contributes’ to the care diary. Given the rationale is that this improves coordination for multi-disciplinary teams, this could suggest that the home care diary should enable community nurses, GPs, physios etc to input into a providers records. This may prove difficult to implement at least initially as agencies have their own set of requirements for recording and reporting information, and each provider will have a different format for recording their diary. The quality measure would require consistent paperwork to be implemented across local areas. Also, to actually physically audit this standard would mean that someone would have to attend people’s home to check there is a home care diary. It is not clear how and when this would need to be done or who would do it.
195	College of Occupational Therapists – Specialist Section Older People	Statement 6	A single care diary will aid communication, enable transparency and encourage best practice.
196	Alzheimer’s Society	Statement 7	Alzheimer’s Society recognises the importance of supervision meetings at least every three months but would

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			recommend that they were flexible. We would recommend the supervision meetings were held as soon as concerns become apparent so that they can be addressed as soon as possible.
197	North Lincolnshire Council	Statement 7	Currently as part of the annual performance review we ascertain the level of staff supervision with each provider.
198	North East Lincolnshire Clinical Commissioning Group	Statement 7	Supervision every 3 months, clear and already monitored.
199	NHS Sheffield CCG	Statement 7	Supervision of home care workers is achievable and is already undertaken by the majority of Home Care Providers.
200	NHS Sheffield CCG	Statement 7	This data is already held by care providers and evidence of supervisions undertaken is gathered as part of the Contract Monitoring and Quality Assurance work currently being undertaken by the Local Authority and CCG in Sheffield.
201	NHS England	Statement 7	I strongly support this quality statement.
202	Skills for Care	Statement 7	However 3 monthly must be an absolute minimum. Skills for Care's understanding of the value of supervision for identifying learning and development needs and for problem solving etc would suggest monthly pattern is better to aim at for lone workers.
203	Skills for Care	Statement 7	Learning & Development is a key part of this standard to ensure a high level of knowledge and skill to support a successful and quality implementation. Statement 7 should include the promotion of L&D opportunities, communication and recording skills.
204	Kirklees Council	Statement 7	We support this statement.
205	Kirklees Council	Statement 7	(Measures) General - This information would need to be collected directly from providers. There is potential to look at whether this could be included in Electronic Call Monitoring system that is being developed in Kirklees.
206	Action on Hearing Loss	Statement 7	What the quality statement means for service providers, social care practitioners and commissioners - We agree it's important for social care practitioners to have supervisions and be well supported in their role, and think this section should be expanded to include the areas that should be included in these supervisions. For example, in order for home care to provided in line with national guidance and best practice, it is important that social care workers are well supported to identify development needs, which should include communication and delivering person-centered care and wider aspects of their role. In terms of hearing loss, we know there is a high proportion of unaddressed hearing loss in care homes[28], and this has adverse effects on physical and mental health, including decreasing cognitive functioning and the development of depression and dementia. It is very important that service providers and social care practitioners are aware of this and are trained in how to identify and address hearing loss, and are more generally aware of the link between conditions and new research and guidance. Being as these Quality Standards, aimed at those over 65, will impact on many people that will have comorbidities and need a variety of health and social care support, it is important to

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			ensure that practitioners are regularly updated and reminded of the link between conditions and new research and guidance, and that these supervisions offer a good opportunity for this. [28] 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
207	Action on Hearing Loss	Statement 7	In the *Supervision of home care workers* definition, we agree that an observation of practice is a key element of the supervision, and think the need for supervisions to "update professionals on developments in best practice and relevant policy changes and legislation" should also be included.
208	Action on Hearing Loss	Statement 7	Diversity, equality and language This section should make reference to the requirements of the NHS England Accessible Information Standard[29], which will become mandatory from July 31st 2016 and will require health and social care staff to identify, record, flag, share and meet communication needs of people in their care, be able to set up an environment that facilitates good communication and carry out any necessary training to be able to do this. Also the following sentence from this section needs amending: Older people using home should have access to an interpreter or advocate if needed. [29] NHS England Accessible Information Standard (2015), available at: https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/#standard
209	College of Occupational Therapists – Specialist Section Older People	Statement 7	Will staff have the opportunity for more frequent supervision if an incident occurs or if they are assisting people with very complex needs? If carers require extra support to improve their skills or approach (p31) there must be sufficient staffing levels to underpin this, otherwise an increased case load shared by remaining staff will result in sickness, short cuts etc. To ensure that staff development needs are addressed and an opportunity to gain new skills, enough time must be provided for this extra training. It should occur in paid work time and not in carer's own time. The development of certain skills should be mandatory e.g. moving and handling, infection control, baseline obs, pressure trauma awareness etc.…
210	West Sussex County Council	Statement 7	Quality Standard 7 Whilst regular supervision is important it is not clear how or why a 3 month level has been suggested – that is not to say that 3 months is not reasonable but if this is to be monitored, and with the ensuing resource requirements, then there should be a clear rationale as to how often. Again, as with other standards, it is not clear how this figure will be audited as this would mean a check (not sure at what regularity) of every providers (or a proportion of then which could still be considerable considering the size of the home care market) individual staff member records to check when the last review was held.
211	The relatives and residents association	Statement 7	Statement 7, on staff supervision, cannot really be separated from staff training. Part of the purpose of supervision to monitor the training needs of staff and to check the effectiveness of their training. It is also important in checking the care and support of the people on their caseload, so the argument for more supervision, office based and observed,

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			is compelling. We would argue that home care workers, because of their isolation, need more supervision that those who work in care homes and four times a year should be considered too infrequent to be effective.
212	Social Care Institute for Excellence	Statement 7	Concern that this will not tackle some of the poor practice the Committee wanted this recommendation to address. Suggested instead that this should capture more about ongoing, regular supervision rather than just the supervision meeting every 3 months e.g. observations of practice and getting feedback from service users and their carers.

Registered stakeholders who submitted comments at consultation

- Action on Hearing Loss
- Age UK
- AGILE
- Alzheimer's Society
- Baxter Healthcare Ltd
- British Geriatrics Society
- College of Occupational Therapists – Specialist Section Older People
- Disabled Living Foundation
- Elizabeth Homecare
- Home Instead Senior Care
- Kirklees Council
- London Fire and Emergency Planning Authority
- National Community Hearing Association

- NHS England
- NHS Sheffield CCG
- North East Lincolnshire Clinical Commissioning Group
- North Lincolnshire Council
- Optical Confederation and Local Optical Committee Support Unit
- Parkinson’s UK
- Rotherham Borough Council
- Royal College of General Practitioners (RCGP)
- Social Care Institute for Excellence (SCIE)
- Sense
- Skills for Care
- The Relatives & Residents Association
- United Kingdom Homecare Association (UKHCA)
- West Sussex County Council