National Institute for Health and Care Excellence

NICE Quality Standards Consultation – Home care

Closing date: Please send this electronically by 5pm on **Monday 22 February 2016** to QSconsultations@nice.org.uk

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Please note: comments submitted on the draft quality standard are published on the NICE website.	
Would your organisation like to express an interest in formally supporting this quality standard? ☐ **Yes** ☐ No For information about supporting quality standards please visit http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards	

The Institute is unable to accept

- Comments received after the consultation deadline
- Comments submitted not on this proforma
- More than one response per stakeholder organisation
- Confidential information or other material that you would not wish to be made public
- Personal medical information about yourself or another person from which your or the person's identity could be ascertained

The personal data submitted on this form will be used by the National Institute for Health and Care Excellence (NICE) for the purpose specified. The information will not be passed to any other third party and will be held in accordance with the Data Protection Act 1998.

Please provide comments on the draft quality standard on the form below, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, section 1 Introduction). If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor). If your comment relates to the standard as a whole then please put 'general'.

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the quality standard.

Please add rows as necessary.

Section	Comments
Q1 does this draft quality standard accurately reflect the key areas for quality improvement	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. 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.
Q2 if the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?	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.
Q3 do you have an example from practice of implementing the NICE guideline that underpins this quality standard?	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.

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Q4 for draft quality statement 3: over what period of time would it be meaningful to monitor the consistency of the homecare team for older people using homecare?	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.
Q5 for draft quality statement 4: what impact would there be on home care services and older people if this statement were implemented?	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" 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.

Section	Comments
	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.
Overall View	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. 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 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. .
Quality 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

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	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
Quality 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.

Section	Comments

What will happen to your comments
A summary of the consultation comments, prepared by the NICE quality standards team, and the full set of consultation comments will be shared with the Quality Standards Advisory Committee (QSAC). The QSAC will then meet to review the comments and the quality standard will refined with input from the QSAC chair and members.

Please note that NICE does not respond to consultation comments submitted on NICE quality standards. Instead, following the publication of the quality standard, NICE will provide stakeholders who submitted comments with a link to the minutes of the meeting that will summarise the committee discussions and decisions.

The summary of consultation comments and full set of comments received from registered stakeholders will be published on the NICE website alongside the quality standard. Comments received from individuals and non-registered stakeholders will be considered by the QSAC but will not be published on the website.

NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Comments received in the course of consultations carried out by the Institute are published in the interests of openness and transparency. The comments are published as a record of the submissions that the Institute has received, and are not endorsed by the Institute, its officers or advisory committees.