Care Quality Commission

Not just a number

Home care inspection programme

National overview

February 2013

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

- Identifying risks to the quality and safety of people's care.
- Acting swiftly to help eliminate poor quality care.
- Making sure care is centred on people's needs and protects their rights.

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Foreword

Between April and November 2012, the Care Quality Commission (CQC) carried out a themed inspection programme of the quality of care provided to older people in their own homes. We inspected a sample of 250 home care services – of all different sizes – that were providing care to more than 26,000 people.

Home care is one of the most difficult areas of care to monitor in terms of gathering the views of people who use services. Often people are in vulnerable circumstances but the care provided is harder to observe than in a hospital ward or care home.

As recent events in the NHS have reinforced, it is of absolute importance that care providers gather and listen to what people receiving care, and their friends and families, are telling them about the quality of care. We canvassed the views of more than 4,600 people who were using home care services and their relatives and carers, and we tested a range of the methods for inspecting home care. We have published an evaluation of the methods we used on our website.

We received large amounts of positive comments from people about the regular care workers who support them to stay in their own homes. We have seen care delivered with compassion that respects the dignity of individuals, and underpinned by good management and support for care staff. In this report, we highlight what works well and we set out the characteristics of those services that provide a good quality of care.

There are a number of challenges for home care providers to contend with, including commissioning arrangements, increasing pressure on social care budgets and the rise in the number of people with complex care needs and dementia. But all home care providers should look to learn from these findings and incorporate them into their services where necessary.

For some, care has fallen below the standards that people have a right to expect. What is concerning is that our findings come as no surprise to people, their families and carers, care workers and providers themselves – not being kept informed about late arrivals, different care workers from one visit to another, not having their preferences clearly documented, a lack of support for care staff to carry out their work, and failure to address the ongoing issues around travel time.

In our State of Care report published in November 2012, we expressed our concerns about care providers where the unacceptable is allowed to become the norm. Many of the issues we report here happen when providers fail to listen to the views and experiences of people. This needs to be a top priority for every provider.

Summary

The number of people being cared for in their own homes is increasing and this trend is set to continue well into the future. As a consequence, the provision of home care services has grown significantly over the past few years.

The number of home care services registered with the Care Quality Commission (CQC) increased by 16% in 2011/12, and a further 6% in the first six months of 2012/13.

This themed inspection programme of home care services in England reports in detail on the quality of care delivered to people in their own homes by regulated providers.

This programme also gave us an important opportunity to test and develop different ways of capturing the views of people who use services, as well as those of their carers and relatives. The analysis and findings of the inspections, and the methods we used, will help to shape the way we carry out our future inspections of home care services, including those for people with mental health needs and learning disabilities.

We inspected 250 home care agencies, consisting of 208 privately owned agency services, 22 council owned and 20 owned by voluntary organisations. The number of people cared for in each of the services varied from the 'micro' providers providing services to fewer than five people to the large providers, caring for more than 200 people. The largest service was caring for 700 people.

Throughout the programme, we found many providers who were delivering a very good service. Overall, 74% (184 out of 250) of services met all the five standards we inspected.

What worked well

Our inspectors found a lot of good practice that could be reflected in all home care. Throughout this report we set out what CQC's inspectors saw that worked well, to help drive improvement. The following were many of the characteristics of good care:

- There is good written information about the services and choices available, and this is explained face-to-face.
- Relatives and carers are routinely involved in decisions about care.
- People are encouraged and supported to express their views. Detailed records document their preferences and choices, care plans in the home are kept up to date and care workers complete the daily logs accurately. There are regular reviews and risk assessments to adjust care plans and respond to changing needs and preferences.
- Care workers are properly introduced to people receiving services before the service starts. There is continuity of care workers, with any changes notified in advance.
- Care workers routinely knock and announce their arrival. Staff wear ID badges to confirm their identity and are aware of security requirements.
- Care workers show kindness, friendliness and gentleness, with respect for property and belongings.
- People's views are gathered in a variety of ways; survey results are acted on and they inform improvements, which are communicated back to people. Customer satisfaction surveys are supplemented by personal contact from the management team.
- Staff understand people's illnesses, so are better able to provide the right amount of support when needed. They have a good understanding of dementia.
- People using services are given written information about the types and signs of abuse and they are aware of who to contact at the agency if they have concerns.
- Inductions for care workers are monitored with supervision and include a period of 'shadowing' an experienced care worker. Training is included in induction and ongoing training is routinely updated, with attendance documented.
- Care workers have a clear understanding of what constitutes abuse, including failure to provide care in the right way.
- All staff undergo a Criminal Records Bureau (CRB) check before the provider offers a position and asks for references.
- Staff are not asked to undertake tasks unless they have the necessary knowledge and skills.
- There is good communication between workers, regular staff and team meetings, and regular information and updates for staff.
- Managers carry out systematic quality checking. They capture feedback from staff and use it to improve services. People are given information about how to complain, any learning from the complaint is fed back to the complainant, and action plans are developed to address any issues.

Two indicators of better performance stood out. We asked on every visit if people's preferred name was documented in the care provider's records. Where this was documented (in 90% of services), 98% of services met the standard on respecting and involving people. Where it was not, only 78% of services met the standard.

We also asked all services if information about the meaning of abuse and how to report concerns was provided to people receiving care. At services where this was provided (82%), 97% met the standard on safeguarding people from abuse. Where it was not, only 90% of services met the standard.

What needs to improve

Our concerns relating to **respecting and involving people who use services** included the lack of continuity of care workers, limited information to people about the choices available to them and failures to keep people informed about changes to their visits.

In respect of the **care and welfare of people who use services,** our main concerns related to:

- Missed or late calls and inconsistent weekend services
- Lack of staff knowledge and skill, particularly with regard to dementia
- Inadequate assessment of needs including reviews and updates
- Lack of detailed care plans including choices and preferences and complex care needs
- Lack of coordination of visits requiring two care workers
- Lack of involvement of family or carers.

The main concerns relating to **safeguarding people who use services from abuse** related to failures to report safeguarding concerns in line with local policy, out-of-date procedures and staff not understanding safeguarding or whistleblowing procedures.

In respect of **how providers support their staff**, our main concerns related to:

- Staff feeling unsupported by their management teams and not always being able to deliver care in the right way because they are too rushed, with no travel time and unscheduled visits added to their day.
- A lack of planned supervision and performance monitoring for staff.
- Training needs not being identified, or if they are identified, they are not met.
- Staff not being confident in using equipment.
- Induction not always being completed, or not following recognised standards and not monitored.

The main concerns relating to **how providers assess and monitor the quality of the services they deliver** focused on the lack of formal, documented quality monitoring processes. People were not asked for their views about the

service they received or if they were, no action was taken. Key areas of service provision were not monitored such as missed or late calls and there were no clear processes for managing incidents and complaints.

Other findings

In the programme, we also found that services providing a reablement service showed higher performance against the safeguarding standard. For agencies that provide intensive care (10hrs+ per week) the performance level was much higher against the standard for monitoring quality than for those that do not. Also, the provision of dementia care services was associated with notably higher performance against standards for safeguarding and supporting staff than for agencies that do not provide dementia care.

Conclusions

We have seen care delivered with compassion that respects the dignity and rights of individuals. We have received a significant number of positive comments from older people who use the services and their carers and relatives about the regular care workers who support them to stay in their own homes. We have also observed and noted that the care has been supported by some good processes and governance. There is much that the sector can take from these findings to continue to make further improvements in the quality and safety of home care.

However, where we have identified failings, a minority of people are affected by issues that are very familiar to both providers and people using services. In this report we are highlighting and making recommendations on the following:

1. Late and missed visits.

2. Lack of consistency of care workers.

3. Lack of support for staff to carry out their work, and failure to address the ongoing issues around travel time.

4. Poor care planning and a lack of regular review.

5. Staff understanding of their safeguarding and whistleblowing responsibilities.

We also found gaps in some agencies' quality monitoring processes, including not actively seeking the views of people using services and their carers and relatives. This is particularly important in an environment where people may be reluctant to complain for a number of reasons; some people are worried about getting their regular care workers into trouble, or are worried about reprisals if they complain about the service they receive.

Introduction to home care

Home care (also known as domiciliary care) is a term that is used to describe a range of care and support programmes that aim to help people live in their own homes and maintain their independence. It can take many forms, and can link with other services in the community, such as supported housing, community health services and voluntary sector services. Many older people need to have help with personal care, such as getting into and out of bed, washing and dressing, and eating.

Home care helps people to avoid the need to go into residential care or hospital and can also form part of a reablement package to help people to regain independence.

The number of people being cared for in their own homes is increasing and this trend is set to continue well into the future. As a consequence, the provision of home care services has grown significantly over the past few years. The number of home care services registered with the Care Quality Commission (CQC) increased by 16% in 2011/12, and a further 6% in the first six months of 2012/13.

Although home care is not just for older people, they form the majority of those who use home care. The needs of people aged 65 and over who receive care in their own home are becoming more complex, and in many cases include the provision of care for people with dementia.

Just over three-quarters of state-funded home care is provided to people aged 65 and over. The report *Where the heart is … a review of the older people's home care market in England*, published in October 2012 by the IPC Market Analysis Centre, part of the Institute of Public Care at Oxford Brookes University, looked at the numbers of people who receive privately-funded and state-funded care (excluding those in care homes). The numbers of older people who receive state-funded care (although this includes more than just home care) and who fund care themselves are similar (table 1).

Table 1: Private and state-funded help for older people by gender and age 2008/09

Gender and age group	Private paid help		State-funded help	
	%	Number	%	Number
Men 65-74	1.18	25,765	1.45	31,660
Women 65-74	3.33	79,527	1.29	30,807
Men 75 and over	4.23	39,749	4.38	41,158
Women 75 and over	9.69	240,622	9.09	225,722

Skills for Care found that there were more than 770,000 jobs in home care across all sectors in 2011 (*The size and structure of the adult social care sector and workforce in England 2011*). A high proportion of these jobs are filled by part-time workers. The IPC Market Analysis Centre reports that a survey of home care agencies in 2009 found that 22% of home care workers worked fewer than 20 hours a week, and less than half worked more than 30 hours a week.

It goes on to report that obtaining staff is problematic in some areas of the country, even given the current economic environment and the level of unemployment nationally. Providers have to compete with other low paid forms of employment that may be less personally demanding and offer more sociable, regular working hours and greater certainty of earnings. Home care workers are often employed on a zero hours contract, which offers little financial security.

Some recent national reports have pointed to problems with home care services. The Equality and Human Rights Commission (EHRC) published its report *Close to home* in November 2011, which reported the findings of an inquiry into older people and human rights in home care, and uncovered areas of concern in the treatment of some older people and significant shortcomings in the way that care is commissioned by local authorities. An investigation published by *Which?* in March 2012 also uncovered failings in many areas of home care, and the United Kingdom Homecare Association (UKHCA) reported on a survey about how home care services are commissioned by local councils and trusts in its report *Care is not a commodity* (July 2012). A further report published in summer 2012 by the trade union UNISON includes the results of a survey of home care workers. In the report, *Time to Care*, the responses showed "a committed but poorly paid and treated workforce which is doing its best to maintain good levels of quality care in a system that is in crisis". The report highlights how poor terms and conditions for workers can help contribute towards lower standards of care for people receiving home care services.

CQC announced in November 2011 that it would carry out a themed inspection programme of home care services in England. This programme by CQC reports in detail on the quality of care delivered to people in their own homes by regulated providers.

Regulation of the quality of home care

The Care Quality Commission (CQC) regulates the quality of care across a range of health and social care services under regulations set by Government. These describe the national standards of quality and safety that people who use services have a right to expect.

Regulation includes home care services that are registered with CQC to provide the regulated activity of 'personal care'. Personal care is defined by the regulations and includes physical assistance given to a person, for example with eating, washing, dressing, or supporting someone to carry out these tasks themselves.

Although other types of support, for example shopping and cleaning, also make a significant positive difference to people, CQC does not regulate the provision of these services.

In April 2012 when this programme started, 4,515 providers were registered with CQC to provide home care services. Some providers operate from more than one location, usually an office base, and CQC inspects at location level rather than at provider level. There were 6,830 locations registered with CQC to provide care to people in their own homes at the start of April 2012, an increase of 16% on the previous year. Throughout this report the individual locations are referred to as 'services' or 'agencies'.

CQC's inspectors carry out a mixture of scheduled inspections (conducted as part of CQC's ongoing programme), responsive inspections (conducted in response to a problem or concern) and themed inspections (looking at a particular issue or type of care). Almost all of these inspections are unannounced. Where a provider is not meeting a standard, we assess the impact of this on people who use the service and judge it to be either 'minor', 'moderate' or 'major'. The regulatory action we take depends on the level of this impact. An overview of how CQC inspects care services, and the national standards of quality and safety that it inspects against, and which people have a right to expect, are set out in appendix C.

Home care, like a number of other community-based services, presents a significant challenge in terms of gathering the views of people who use services. It is delivered in people's own homes behind closed doors to people who are often in vulnerable circumstances, but the care provided is harder to observe than in a hospital ward or care home.

We have made clear that a significant part of our approach to all our inspections is to give a central role to the voice of people who use services, their families and carers. This programme of themed inspections was therefore aimed at helping CQC to identify the most appropriate methods to gather and assess people's experiences and their views about the quality and safety of services provided and test new ways to check whether services meet the national standards.

We have published a separate report *Testing the methods* that evaluates the tools used in this programme. This will inform future inspections of home care services. It is available on our website.

However, the lessons we have learned from this programme have direct relevance for our future inspections of other community-based care services, including community health services such as district nursing care, and home care for groups of people with mental health needs and learning disabilities.

How we carried out this programme of inspections

The themed inspections ran from April to November 2012. They ran alongside CQC's ongoing inspections of home care services, but they focused on the regulated activity of 'personal care' provided to people aged 65 and over, as most home care is provided to these people.

Advisory Group

The programme was supported by an Advisory Group, with members drawn from a range of organisations including the Equality and Human Rights Commission, Age UK, the United Kingdom Homecare Association, the Association of Directors of Adult Social Services, Skills for Care, LINks and Shared Lives Plus (see appendix B).

The Advisory Group played a key role in helping us to develop the methodology and provide expertise and experience to inform the approach and scope of the inspection programme. The group provided comment and guidance on the nature of the inspections in terms of focus and desired outcomes. The group also helped to identify the key messages from the programme and action required to support improvements.

The sample

We identified an initial sample of 250 services. These were providing care to 26,419 people, which included a combination of those who paid for their own care and those who received state-funded care.

As we started the inspections, we found a number of services were in the process of de-registering, were dormant or had recently closed. We therefore identified an additional sample to ensure that we included 250 services. The end sample consisted of services spread across the four CQC regions: 63 in the Central region, 55 in London, 64 in the North and 68 in the South region.

The analysis in this report has been further divided regionally to reflect the local authority regional divisions. Table 1 in appendix A shows the distribution of sample services across the nine regions, which broadly reflects the distribution of agencies nationally. There are more agencies in the South East, London and the North West.

Our sample included a mix of providers: the majority (208) were privately-owned, 22 were council-owned and 20 were owned by voluntary organisations. However, there was considerable variation in the size of agencies, the number of staff they employed and the numbers of people using their services.

The standards

For this themed inspection programme, we checked to see if providers were meeting five of the national standards of quality and safety:

- Respecting and involving people who use services
- The care and welfare of people who use services
- Safeguarding people who use services from abuse
- How providers support their staff
- How providers assess and monitor the quality of the services they deliver.

The regulations relating to these standards are listed in appendix C.

Where a provider is not meeting the standards, we determine the impact or likely impact of this on people using the service. We decide the most appropriate action to take to ensure that the provider makes the necessary changes and we always follow up to check whether they have taken action to meet the standards. This inspection programme was undertaken using CQC's **judgement framework and enforcement policy**. Further information on how we make our judgements can be found in appendix C.

The inspections

We reviewed all the information we held about each provider and contacted relevant stakeholders such as local authorities, LINks and other healthcare professionals involved with the services being inspected.

All inspections to the offices of a service were unannounced (96%) unless we were aware that it was a small provider where there may not be anyone there. In this case, we gave the provider short notice that we would be visiting. Once at the office, we talked to staff and managers and looked at a variety of information and records. We also made home visits to people receiving care (see below).

A CQC inspector led each inspection, and the vast majority (212) were supported by an Expert by Experience. In addition, the inspection programme was supported by a small number of people recruited to our advisory bank. These advisers have experience in providing or managing home care services and have been available to provide specialist advice during the programme and to the national benchmarking panel. This national panel was set up to look at the majority of inspection reports that failed to meet standards as well as a sample of those judged to be meeting all standards inspected. This was to support the consistent collection of information and recording of evidence against the regulations.

Gathering experiences of people using home care services

People's experiences and views about their care are a vital part of our assessment of whether a care service is meeting the national standards. Our inspectors use a range of methods to listen to and gather people's views, and this inspection programme broadly followed our existing methods and systems. However, inspecting home care agencies presents a particular challenge, and so this programme gave us an important opportunity to test different ways of capturing the views of people who used services as well as those of their carers and relatives. We did this in a number of ways:

- **Questionnaires** – we needed to obtain contact details for people who receive home care while still maintaining the principle of unannounced inspections without alerting the provider. We therefore approached local authorities to provide lists of people who used the services of some of the 250 home care agencies in our sample. We sent out 4,794 questionnaires.[1] Of these, 2,397 were for people who used services and 2,397 were to pass on to their carers or relatives for their views.

  The contact details from local authorities were for people whose care was funded by the local authority. We used other methods to get the views of people who funded their own care or who used direct payments, such as home visits.

  We received a total of 1,003 completed questionnaires, which is a response rate of 21% (535 from people who used a service and 468 from a carer or relative). We put processes in place to identify and manage any safeguarding concerns as we received questionnaires.

- **Webforms** – to make it as easy as possible for people to provide feedback, we also developed a web-based form as an alternative to the paper questionnaire. We publicised this webform through LINks (local involvement networks). We received 130 webform responses (27 from people who used a service and 103 from a carer or relative).

  We have used the findings from the analysis of the questionnaires and webforms, together with other national findings from the inspection programme, to add a further user voice perspective.

- **Telephone interviews** – we carried out 2,742 telephone interviews with people who use services or their carers and relatives. Our inspectors worked with Experts by Experience – people with personal experience of using home care services or caring for somebody who uses this type of service. Experts by Experience were supported to help in the inspections by Age UK and Choice Support. Following training and briefing about the programme, the Experts by Experience undertook most of the telephone interviews on our behalf. Others were undertaken by our inspectors.

1 The number of questionnaires relates to the number of complete contact details received from local authorities for locations in our initial random sample.

Experts by Experience provided support to 212 of the inspections. On the day of the inspection, if we found that there were no, or very few, people over the age of 65, the inspector carried out the interviews themselves rather than requesting an Expert by Experience.

- **Home visits** – inspectors made home visits to people who were receiving care from the agency being inspected. Where possible, we tried to include home visits to people who were less able to complete a questionnaire or speak to us over the phone. Inspectors made home visits to 738 people who were receiving care from the agency being inspected.

Publication and follow-up

We publish all our inspection reports on our website, including those from the 250 home care services in this programme. These reports detail any action that services needed to take if they were either delivering poor care, or if they were at risk of delivering poor care if they did not make improvements.

We always follow up to check whether a provider has taken action to meet the standards. We have already carried out some of the follow-up activity needed for home care services that were inspected as part of the programme.

Evaluation

We evaluated all the methods we tested and have published a report on this evaluation on our website.

The analysis and findings of the inspections and the methods we used will help to shape the way we carry out our future inspections of home care services, including home care for people with mental health needs and learning disabilities. We will also take the learning from this work so that we can apply it to the way we sample and inspect other community-based services, such as community mental health services and general community health services such as district nursing care.

Our key findings

The analysis in this report took account of the 250 inspections of home care agencies undertaken between April and November 2012.

In total, we received the views of more than 4,600 people. Our inspectors visited some 738 people in their own homes; 2,742 people discussed their views with us over the telephone including 274 relatives who gave us their views during visits or through discussions with Experts by Experience. We also analysed over 1,000 responses to our questionnaires and 130 webform responses. We took into account all these contributions, together with information from our inspections, when making judgements about whether a provider was meeting the standards.

We carried out detailed analysis of the 250 inspection reports to identify the characteristics of those providers who were meeting the standards. We checked this information against the responses from people who spoke to the Experts by Experience and our inspectors.

Overall performance in meeting the standards

Of the 250 inspections, 184 (74%) provider services were meeting all five of the national standards that we checked. The four CQC regions (North, Central, London and South) were further divided into sub-regions to reflect the local authority regional divisions (see appendix A). Home care agencies in the East region were most likely to meet all national standards; those in the London region were least likely, with more than a third of all agencies requiring some action to meet the standards.

In addition to looking at overall performance by region, table 1 in appendix A shows the split of the ownership of the 250 services. Because of the small numbers of council and voluntary-owned services, no conclusions can be drawn.

Performance by the size of provider

The analysis included the size of each provider to identify whether their size influenced whether they met the standards. Providers were grouped according to the number people who were receiving their services at time of inspection:

Micro provider – 1 to 5 people receiving services

Small provider – 6 to 100 people receiving services

Medium provider – 101 to 200 people receiving services

Large provider – 201 or more people receiving services

The analysis also considered the number of locations that the provider managed.

Please see appendix A for tables showing performance by size of the service for each standard. Overall, the size of the service – in terms of the number of people using it – had little association with whether it met the standards. However, the medium and large agencies (that is, those providing a service to more than 100 people at the time of inspection) were more likely to need to take some action to ensure they met the standards than small agencies.

On the other hand, the services that were owned by providers managing more than 13 locations were less likely to need to take action, as more than three quarters of agencies with many locations met all the standards.

However, there was one area where the size of the service was more strongly associated with an element of one standard. Small agencies were more likely to involve people's carers in decisions about care, with 86% of carers reporting some level of involvement and only 3% stating they were not involved but wanted to be. This compares to 81% of medium-sized and 64% of large agencies.

Performance by the type of service provided

Our criteria for inclusion in this inspection programme included home care agencies providing personal care to older people in their own homes. This included agencies that provide more specific types of care such as reablement services (a short defined period of care for people who need help after a period of illness, or the onset of a disability), intensive home care services (10 hours or more a week) and dementia care.

We collected information about the types of care provided at each of the services in our sample. This information was available for 226 services but was not collected for the other 24. The proportions were:

- 53% of services provided intensive home care services
- 57% of services provided a reablement service
- 79% of services provided care for people with dementia.

We found that the agencies that provided a reablement service performed better in meeting the safeguarding standard. Those that provided 10 hours or more intensive care performed better in meeting the standard for monitoring quality than for those that did not. And agencies that provided dementia care had a better performance level for meeting standards on safeguarding and supporting staff than those that did not provide dementia care.

Overall, we saw many examples of agencies managing to address the challenges of providing a service to people with differing needs and meeting their expectations. We saw staff who were compassionate and professional and many older people using services who were very happy with the care they received.

We saw evidence in the daily records completed by care workers that care had been delivered in accordance with the care plans. Care workers told us they never felt rushed, and they always had time to complete all care tasks necessary. They always asked people if they needed any other assistance. They said they were introduced to new people before they visited for the first time and this meant that they were confident they had a very good understanding of each person's care needs, and how they wanted the tasks to be carried out.

Senior members of the agency staff team told us they good links with local health and social care professionals. They explained how they regularly sought advice and worked closely with professionals to ensure people received the care they needed. We saw evidence in the care plans that care workers had been instructed on how to maintain good hygiene and infection control when carrying out all personal care tasks. People told us that care workers always followed good hygiene procedures, for example, changing gloves before and after each task.

Inspection report, Harcombe Valley Care Limited, Devon

In three cases (1.2%), we found shortcomings that we judged to have a major impact, or that risked having a major impact, on people who use services. In these cases, CQC issued warning notices with timescales for the provider to make improvements. In a further 63 cases (25%) there were some examples of services not meeting standards where we judged that the impact was not sufficient to take enforcement action. These providers were required to submit a report detailing the actions that they intend to take so that they can meet the standards within the timeframe agreed with us. We will follow up with the provider to check that they have made the improvements.

The overall levels of providers that failed to meet the standards as part of this programme were slightly higher at 26% than comparable home care agency inspections undertaken outside of this programme, where 23% did not meet standards.

Findings by standards inspected

We have grouped the findings from the individual inspection reports under the five standards inspected. For each of the standards, we have identified and highlighted aspects of care that worked well. These sections include a list of the key characteristics that were present in services that were meeting the standard.

We also identify those areas where agencies failed to meet the standards.

Respecting and involving people who use services

There were 241 (97%) providers meeting this standard. As part of our assessment of this standard we focused on whether:

- Privacy and dignity was respected
- People were involved in making choices and decisions about their care.

What worked well

We received many very positive comments from people who use services about their care. People valued being encouraged to maintain their independence, and their needs and abilities were reviewed regularly to ensure they received the right level of assistance and care.

> **"I always know what's going on, because they say what they are doing."**

Characteristics of services meeting this standard

- Care workers are properly introduced to the person receiving the services before the service starts.
- People are encouraged and supported to express their views, and detailed records reflect people's preferences and choices.
- The tasks and timings have been agreed and are recorded clearly.
- People receive good written information about the services and choices available to them, and these are also explained face-to-face.
- There is continuity of support, and any changes are notified in advance.
- There is a flexible response to requests to change visit times for hospital appointments or other requirements.
- Care workers routinely knock and announce their arrival.
- Care workers show kindness, friendliness,and gentleness, with respect for property and belongings.
- There is a small and agreed number of known care workers.
- Support at weekends is consistent with weekdays.
- Managers routinely check the effectiveness of the methods they use to ensure that people are involved and respected, such as phone calls, questionnaires, and focus groups.
- Relatives and carers are routinely involved in decisions about care.

In some cases, senior care workers invited people to join in the care reviews and kept them informed of any changes if they had not attended the meetings. People were encouraged to comment directly into their care plans, which the agency then acted on.

“The [care workers] are professional in the way they do things; they get on with it but include me too.”

People also welcomed personal introductions to new staff who would be providing their care, particularly when they ‘shadowed’ a care worker that they knew well. Most providers had ensured that the care workers received training that included maintaining privacy and dignity for people being cared for in their own home. In most cases, this training was included in staff induction programmes. In some cases, there were ongoing updates and information was included in a staff handbook.

People appreciated care workers who showed a good understanding of their needs and routines. Those providers who were meeting this standard had drawn up comprehensive care plans, in partnership with the people using the service and their relatives, which detailed individual preferences and requirements. Our inspectors saw these care plans during home visits and in discussions between care workers and people using the service to support their choice and independence.

“Although I am not well I still feel am in control as they ask me what I would like them to do.”

For this programme of inspections we asked on every visit we asked if people’s preferred name was documented in their records. Where this was documented (in 90% of services), 98% of services met this standard. Where it was not, only 78% of services met the standard.

People commented positively when they felt that staff worked at each person’s preferred pace. They supported independence by helping people to do as much as they could for themselves. Care workers having good knowledge and understanding of people’s routines was something appreciated both by the people who received care and their relatives.

“They encourage me to be independent. That is important to me.”

We saw that many people had information packs about their home care agency, which set out how the agency would meet their needs, what they could expect and how they can raise concerns or make a complaint. In some instances there was evidence that these information packs had been fully explained to the person using the service, and regularly reviewed with them with regard to how they could request changes to their care package. People who used services from agencies that met this standard were more likely to receive enough information to inform their choice of care.

People told us their care workers always treated them with respect and called them by their preferred name. Without exception, everyone we spoke with felt they were treated with dignity and respect, one person said, "All the staff are so friendly; they put me at ease and always make me feel comfortable" and another said, "They are absolutely fantastic; they talk to me as a grown up".

People told us they felt they had sufficient choices in the care provided. They had been involved in the setting up of their care, and had been offered choices in having a male or female care worker, and in the times of the visits. One person using the service told us they were able to choose the times care workers called as they had numerous appointments at the hospital and [the care workers] were very happy to work around her. People who use the service told us they were given appropriate information regarding their care and support, and about the agency. Everyone we visited told us about the information folder in their homes. They knew who to contact if they were not happy with any part of their service. People said that all the staff were approachable, including office staff who were always very helpful.

Inspection report, Eboney Home Care Ltd, County Durham

Experts by Experience found that in 59% of agencies that met this standard everyone understood the choices available to them, compared to 13% of services that did not meet this standard.

What needs to improve

Privacy and dignity

As part of our assessment of this standard we expected to see that people's privacy and dignity was respected by:

- Staff treating people with dignity and respect.
- Staff who had received information and training to ensure that privacy and dignity were maintained when delivering care in people's own homes.
- The provider assessing and monitoring the above.

We found eight agencies were failing to meet this standard. We judged the impact of this to be moderate in three agencies and minor in five agencies.

Where providers were failing to meet this element of the standard, we found:

- People did not feel valued when visits were cancelled without notice or when care workers were frequently late. This was made worse if they were not kept informed if their care worker was going to be late. It sometimes appeared that people were resigned to accepting a level of unreliability within the service.

"I feel like I am just a number to them."

Where our inspectors saw that there were concerns about late or missed calls, they checked with senior staff to see what they were doing about it.

- We found some providers were failing to assess the problem. They were not monitoring late or missed calls and could provide no evidence of any action taken to improve.

> **"No shows can be an issue; they don't always let you know either."**

Managers attributed some of the problem to the way local authorities commissioned their services, which meant shorter visits without travel time in between.

> **"Telling the office things doesn't seem to make much difference. I can ring the office and tell them, I do if the girls don't come or if they are late but they just seem to fob you off or tell you any old thing."**

The report from the United Kingdom Homecare Association (UKHCA), *Care is not a commodity,* also commented on people's dignity being affected by having to deliver personal care in short visit times.

Involving people in making choices and decisions about their care

As part of this element of the standard we expected to see how providers ensured that:

- People were involved in making choices and decisions about their care and that where individual wishes are expressed, these were respected and implemented where possible.
- Providers responded to people's needs with regard to equality and diversity, and that the provider was able to assure itself that it acted on people's choices.

Where providers were failing to meet this element of the standard, we found:

- People were generally very positive about their regular care workers but many people felt that they lacked choice with regard to the number of new or unfamiliar care workers who arrived at their home. On many occasions they received no advance notice that they would be visited by someone they didn't know. Where people raised this with us, we checked the scale of the problem with the documentation. We found one instance where a person had received 13 different care workers for 35 calls. Another person told us:

> **"There is a lack of continuity and we have had 25-30 different [care workers] since they started coming."**

- A number of people told us that new care workers were often not aware of their needs and there were rare comments about poor attitude or failure to respect people's dignity, for example not announcing their arrival, or failing to cover people appropriately during care. One person told our inspector that some of the new staff were "rude" and "pushy".

People expressed high levels of frustration when they felt that they regularly had to explain to different care workers how they liked things to be done.

People's choice was often expressed as wanting the same care workers who know their preferences, needs and level of independence. This was a frequently recurring theme throughout the programme.

> **"The chopping and changing of hours and people is a real issue. I'm never sure who is coming. The girls may all be very nice but I feel more consistency would be so much better, I spend so much time explaining things. I would like to know who is coming, maybe not the same girl every time but several who come regularly. But I have all sorts coming. I don't seem to have much choice about that."**

- People told us that they had not been given any information about the support options available and therefore were unable to make an informed choice. Although providers often told us that people were involved in decisions and choices about their care, it was difficult to assess the extent to which this had occurred where this was not recorded. In the absence of any documentation recording discussions and decisions with people receiving care, we made a judgement that this was not occurring to an acceptable degree. This was backed up by what our inspectors saw in care plans in an agency's office that provided very little or no instruction or information about people's preferences, or how care workers should carry out personal care tasks.

The report from the Equality and Human Rights Commission, *Close to home,* also found that few older people had been actively involved in arranging their care. Many of those whose care was set up and managed by their local authority felt they had little say, and some were surprised to hear they had any choice at all.

- Overall, while people indicated that discrimination is a relatively rare occurrence, respondents to our questionnaire indicated that discrimination does occur in a few cases, with comments indicating that incidents of general rudeness, or poor performance, and lack of understanding regarding mental health issues (for example, dementia) made up the majority of these complaints.

The care and welfare of people who use services

A total of 212 (85%) providers were meeting this standard. As part of our assessment of this standard we focused on:

- Assessment of people's needs
- Care planning
- Delivery of care.

What worked well

People using services appreciated being kept informed about changes or delays to times of visits. People who received a weekly rota from the agency felt better informed than those that didn't, as long as there were not frequent changes to the rota or failure to inform them if the rota changed. Those people who routinely get the same care workers are most satisfied with the care provided. While we appreciate that this is not always possible, many agencies are ensuring that the care workers work in small teams so that people always get a visit from one of a small group of care workers they are familiar with.

> **"When I was ill the staff took into account that I would not be able to do the usual things for myself so they did it for me."**

We received positive comments from people receiving home care about the friendliness of care workers, being involved in planning their own care and involvement of their relatives or carers. People were very positive when they were regularly invited to take part in their own (or their relative's) care reviews and felt able to influence the care delivered

> **"They do things with me, not for me."**

Characteristics of services meeting this standard

- Detailed care plans in a person's home are kept up to date, and care workers accurately complete the daily logs.
- Care workers stay the full length of time with no sense of rushing.
- Staff are knowledgeable, friendly and cheerful, without discrimination, and respectful of cultural differences.
- Care workers are observant of changes in health conditions and are capable of responding quickly in emergencies.
- The service provides skilled help to regain independence.
- Care workers have a good understanding of dementia.
- There is good communication between workers.
- Managers systematically check the quality of care.
- Agencies make regular reviews and risk assessments, and adjust care plans to respond to people's changing needs and preferences.
- Families are involved in assessments of care needs.
- Records of people's satisfaction are kept on file.
- There is adequate detail about complex needs, and the use of equipment.
- Notes in care plans show the contribution and agreement with health professionals on procedures to be followed.
- The service delivered matches the care plan.
- Staff receive regular training to encourage best practice.
- The skills and knowledge of staff are matched to people's needs.
- Electronic call logging is used to help coordinate double-handed visits.
- If a care worker cannot get access into a person's home, the agency follows up quickly.

Most care plans included detailed information and guidance for care workers to ensure that they knew how people wanted care to be provided and the things people could do for themselves. The plans were personalised to suit individual preferences and choices. Some people had signed the plan and others had a relative's input into the planning. These were kept in both the person's home and a copy at the central office and were regularly updated. We could sometimes see clear evidence that changes had been made to care at the request of the person receiving care, including changes to the routine, visit time or care worker. We saw that people using services had documented comments in their own records about their satisfaction with the care they had received.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan…senior staff had visited people to complete an initial care assessment of their needs before they started using the service … risk assessments had been completed for each activity people needed support with, for example, moving and handling and medication…once risks had been identified interventions to reduce the risk had been recorded…One care worker said "If their needs changed I would talk to the manager and tell the office. I would document it if I felt someone was becoming unsafe. I watch and listen."

Inspection report, The Social Resource Centre Limited, County Durham

Assessment records clearly record key information such as religious and cultural needs and the name of an advocate for people, where necessary.

We saw a range of approaches taken by agencies to regularly monitor the content and quality of the care plans and people told us that their care plans were reviewed and revised every six months or as and when necessary. Managers could describe how they ensure that people using services and their relatives and carers are involved in that process.

Most people were very positive about the care they received and responses in questionnaires indicate that most or all care workers do turn up on time, deliver the service they are meant to, and have the right skills needed.

We heard from healthcare professionals who told us that one agency was good at offering more specialised care and working as part of a team with them. This was particularly the case when supporting people at the end stages of life and who were being cared for at home.

One relative told us that a thorough care plan had been drawn up involving the person and other family members. Another person said that they had "proper discussions about every aspect of what my needs were and this was concise and understood" … care plans … detailed the person's interests and the things that were important to them or worried them. The personal care required was described. There was an assessment of the person's ability to communicate, to move around, their sleep pattern and their eating and drinking preferences. In this way people's individual needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Inspection report, The Caring Company, Kent

What needs to improve

Thirty-eight providers were not meeting this standard, with just under a third of these located in London.

The key feature in the failure to meet this standard was the obvious lack of involvement of the person and their relatives in the assessment process and ongoing review of the effectiveness of their care.

The assessment of people's needs

When people start to use a home care service they may have had an assessment of their needs through the local authority that is commissioning their care package, or they may be funding their own care without a local authority assessment. When the home care service starts, the care agency should make its own assessment of a person's individual needs. As part of our inspection we expected to see documented evidence of an assessment of each person's needs; that this assessment was regularly updated and that changes to a person's needs were noted and managed appropriately.

Where providers were failing to meet this element of the standard we found:

- Assessments of care that had either not been completed or contained inadequate information. We found a number of occasions when risks associated with a person's care or medical conditions, such as diabetes or catheter care, had not been assessed, which meant staff may not know how to manage these risks.

Care planning

We expected to see that information gathered in the care needs assessments was used to develop individual support plans. We checked that the plans took into account the needs, choices and preferences of an individual and what arrangements are in place to ensure that planned care is in line with current guidance and best practice.

Of the 38 providers who were not meeting this standard, 28 failed in the area of care planning. Where agencies were failing to meet this element of the standard, we found:

- Care plans that did not contain enough detail for a new care worker to understand how specific tasks should be completed for a person, or how to manage specific care needs. This means that care may not be provided as required, people's needs are not met and changes to a person's needs or a deteriorating health condition may not be identified.
- Instances where people told us about their specific choices and preferences, but these were not recorded in any of the documentation, which meant that it would not be clear to anyone new. One of the things that people frequently raised with us was the frustration when they had to explain how they liked things done every time a new care worker attended.

- Some care plans referred to high risk care needs, such as the risk of pressure ulcers, or the need for catheter care, but with no indication of what care should be undertaken, how often and how to monitor for changes with appropriate action to follow.
- Care plans were poorly maintained, making it difficult to identify the most recent entries. We saw occasions when there was more than one care plan for an individual with conflicting information.
- Care plans had not been updated for several years and contained information that was no longer relevant or changing needs that had not been identified. For example, we saw a care plan that had last been updated in February 2009 and contained out-of-date care information and incorrect contact details for relatives.

> **"Her needs have changed; she was poorly and had to go to bed early. They noticed it but did nothing."**

- Managers did not have clear systems to monitor the quality and content of care plans. We saw instances of staff carrying out tasks that were not part of a documented care plan, such as administering medication. This means that there is no clear way of determining whether the care is appropriate, whether it is being delivered in the right way and whether it is effective.

> **"My needs varied, some care worker saw it, some didn't."**

Healthcare professionals gave us two examples of where they had carried out assessments and given instructions to senior care workers to amend people's plans but the agency had not updated the care plans.

Extract from inspection report

Delivery of care

We checked how agencies achieved and monitored continuity of care when delivering care to people in their own homes. We expected to see home care agencies involving and informing people about how care should be delivered, with particular focus on how they identify people's changing needs and how they communicate these.

Concerns about late or missed calls dominated this element of the standard. We found:

- Care not being delivered as planned and expected because of late or missed calls. The questionnaire responses also reported issues with the amount of time the care workers spent delivering care, with some respondents saying they did not have long enough to complete all the necessary tasks, including assistance with getting in or out of bed, washing and dressing and some people reported missed meals and medication. An extract from one report shows a manager that acknowledged and condoned the fact that care workers had to shave time off allocated visit times, which could mean people were not receiving care that they should.

The agency did not allow travel time between each visit. We saw that some travel time had been allowed for where care workers visited people in rural areas that may take more than 15 minutes to reach. We asked the manager how care workers were expected to reach people on time where no travel time was allocated. The manager said that some people did not require the full amount of time allocated, and this meant that care workers were usually able to leave a few minutes before the end of the allocated visit time. They also said that most care workers used their knowledge of people's needs and preferences to adjust their daily programmes to enable them to visit people close to the agreed times. This sometimes was achieved by care workers starting earlier than planned at the start of the day.

Extract from inspection report

The UKHCA's report *Care is not a commodity* found that "34% of providers reported concerns that their councils required them to undertake personal care in such short visit times that the dignity of service users was at risk, including 6% who were concerned that 'safety could also be compromised'". This suggests that providers, as well as people who use services, are concerned about the short length of visits being commissioned by local authorities.

- The reasons for late and missed calls often related to care workers being rushed or not staying for the allocated length of time. We saw examples of staff rotas where shifts for the current week were not covered; some staff told us that it wasn't unusual for them to be asked to cover an additional visit in their schedule for the day, which could mean that they had to cut short other visits. There were numerous examples of rotas that did not allow time for staff to travel between visits, meaning that this time was shaved off the time allocated to provide care to people in their home, for example where someone had a visit marked 'time specific' to give them their medication, we saw that the visit had been an hour late. One care worker gave an example of two consecutive calls being a 40 minute walk apart despite there being no travel time provided in their call schedule. We found that many care workers were frustrated with the way in which they had to work.

Some staff said they had been sent to people's homes with very little understanding of people's needs and how to meet them. They told us there was limited time to read the care plan and they had resorted to asking people how to meet their needs.

Extract from inspection report

The UKHCA report also highlighted issues around short visit times commissioned by local authorities, with 73% of home care visits in England lasting 30 minutes or shorter, with extensive use of 15-minute visits. The report cites this as a reason why home care services appear to be rushed. The report also comments that the majority of councils expect the provider to cover care workers' travel costs out of the hourly rate paid for the time spent in a person's home.

Similar concerns are raised in another report of a survey of home care workers conducted by UNISON between June and July of 2012. *Time to Care* showed that 79% of respondents reported that they had to rush their work due to the way their work schedule is arranged, or they have to leave a visit early to get to their next visit on time.

- Similarly, there was a negative impact on care when a person required two care workers, a double-handed visit, but one was either late or did not turn up at all. This means that the time allocated to a visit for specific two-person tasks can be significantly reduced, resulting in people not getting the care that they should. In one instance, we saw that both care workers were over an hour late, on other occasions a visit that was supposed to last an hour was cut by half an hour because of the late arrival of the second care worker. Some relatives of people receiving care told us that they had helped with some elements of their relative's care because the second care worker was late. We saw records that showed occasions where the second care worker had arrived after the first had to leave.
- There were isolated instances where the care recorded in a person's daily log did not reflect the care they actually received. For example, one person had managed to get to bed without support because the care worker had arrived very late and only stayed a short time. But the daily log stated that the care worker had spent the full amount of time and had delivered the care as planned.
- Weekends are a particular cause for concern with regard to missed or late calls; we were told about this by people who use services, care workers, relatives and carers. One person added that at weekends, a replacement was not always provided, which made it difficult for them.

> **"A couple of times, I've had to phone the agency to ask if I was going to get a [care worker] today."**

These issues all have an impact on people who use services. We considered that the impact was most significant when it was clear that agencies were not monitoring or taking action to reduce the number of missed or late calls and when they failed to inform people of changes to the expected or planned rota.

Safeguarding people who use services from abuse

There were 240 (96%) providers meeting this standard. As part of our assessment of this standard, we focused on:

- Preventing abuse and
- Raising concerns.

What worked well

We received few comments from people about this standard; generally the comments about safeguarding were very positive. The questionnaire responses from people who use services showed that 86% said they always felt safe when the care workers visit. A higher proportion of carers, friends or relatives (95%) thought that they did. This was the only question where a positive response was higher from relatives and carers than from people who use services.

Characteristics of services meeting this standard

- People using the service are aware of who to contact at the agency if they have concerns and they have received written information about this.
- There is evidence of a consistently applied process for reporting and responding to concerns.
- People are aware that they can contact social services if they are not satisfied with the agency's response.
- Staff wear ID badges to confirm their identity and are aware of security requirements.
- People are given information about the types and signs of abuse.
- Procedures are defined to show staff what action to take if they identify abuse.
- Training is given in induction and as part of routinely updated training. Attendance at training is documented.
- Staff have a clear understanding of what constitutes abuse, including failure to provide care in the right way.
- Information about access to people's homes is treated in a safe and secure manner.
- All staff undergo a Criminal Records Bureau (CRB) check before the provider offers a position and asks for references.

Many providers had processes that detailed the action that staff and managers had to take if they suspected any abuse. Some had the process set out in a clearly visible flow chart. All agencies had a whistleblowing procedure. Most staff had received training and understood their role in identifying and reporting suspected abuse. On the whole, agencies were able to show us records that monitored staff attendance at this training.

We asked if written information about the meaning of abuse and how to report concerns was provided to people receiving care. Some agencies had provided information for people that explained clearly how they should raise any concerns, and they had checked that people had received and understood it. Some had given people laminated cards with contact details to use if they had any concerns. At services where this was provided (82%), 97% met the standard on safeguarding people from abuse. Where it was not, only 90% of services met the standard.

… Safeguarding and adult abuse had been part of their induction training and the training was updated regularly … a plan of training confirmed that all staff who were due to receive an update were booked to attend training before the end of the year … Staff … told us they had received training in safeguarding. They all had a clear understanding of what constituted abuse, including the failure to provide care in the correct way, and were clear of the need to report any concerns to the manager. … The new manager had recently updated the whistle blowing policy which detailed staffs rights to confidentiality should they wish to raise concerns about colleagues conduct or the way they did their job. It also provided information about how concerns could be raised externally if necessary … All staff were checked using the Criminal Records Bureau (CRB) and references were sought from previous employers before a position was offered. The service had clear recruitment procedures in place.

Inspection report, Dial House Care Limited, Bedfordshire

Most agencies had clear processes for recording safeguarding concerns to allow these alerts to be tracked and monitored, which ensures the necessary actions had taken place. One care worker told us that they had raised a concern about a person who they suspected was being bullied by a family member. They told us that their concerns had been taken seriously, investigated and acted on. They were confident that the person had been protected.

What needs to improve

Ten provider services failed to meet this standard; they were located in London (4), North West (2), South West (2), South East (1) and East Midlands (1). We judged these failures to have a significant impact on people using services. One of the failures was judged to have a major impact on people who use services and we took enforcement action against the provider; five of the 10 were found to have a moderate impact or the risk of moderate impact on people.

Preventing abuse

For this element of the standard, we checked care workers' understanding of abuse and whether the agencies recognised that by meeting a person's individual needs, the potential for abuse is reduced.

We checked whether there were clear procedures to follow when abuse is suspected or allegations made and that staff were clear about their responsibilities.

Where we did find concerns, it was generally around the documented processes to ensure that signs of abuse are identified early or about the processes to report safeguarding concerns. In some instances, staff were not aware of their agency's whistleblowing policy, or they had not received safeguarding training in accordance with the providers' policy.

One care worker told us, "I do not understand what is safeguarding" and another care worker told us safeguarding is "protecting ourselves".

We saw some examples where adult protection reporting processes had not been followed and senior staff were not clear about reporting procedures.

Raising concerns

We saw a couple of isolated instances where people who use services or their relatives had raised concerns about suspected abuse due to poor care but had not been satisfied with the response from the agency's management. We found several instances where agency managers were not clear about the safeguarding reporting requirements.

In one instance we heard from staff who had raised concerns but did not feel that the management had listened and taken appropriate action. These concerns included missed visits where people were left without meals, medicines, or assistance to help them get in or out of bed safely. In this isolated instance we judged the issues to have a major impact on people receiving the service. As a result, we issued the provider with a warning notice, which included a timescale for improvement.

The recent Unison report about the survey of care workers, *Time to Care,* found that "whilst the vast majority of respondents had a clearly defined way of reporting concerns about their clients' wellbeing, 52.3% reported that these concerns were only sometimes acted on, highlighting a major potential safeguarding problem".

How providers support their staff

We found that 221 (88%) providers were meeting this standard. As part of our assessment of this standard, we focused on:

- Development, supervision and appraisal of staff
- Staff training.

What works well

People who receive care in their own home, and their relatives, value care workers who are knowledgeable and understand their or their relative's condition. People appreciate when new staff are accompanied and introduced by someone who is familiar to them. People comment positively about staff who are trained to use lifting and other equipment. We received a very large number of very positive comments from people about their regular care workers.

Characteristics of services meeting this standard

- Staff demonstrate compassion and build a rapport with people using services.
- Staff show knowledge and skill when meeting specific and complex needs.
- Staff understand the illnesses that people have, so are better able to provide the right amount of support when needed.
- Office-based staff are efficient and helpful.
- Staff supervision and appraisals are scheduled, monitored and documented.
- Staff report that managers make regular 'spot checks' and records show regular reports from these checks.
- Induction is monitored with supervision and includes a period of 'shadowing' an experienced care worker.
- Staff report regular training on a range of useful topics.
- Staff feel well supported by managers.
- Training needs are assessed following staff appraisals and supervision.
- Training records are complete for all staff, with indicators when updates are due.
- Staff are not asked to carry out tasks unless they have the necessary knowledge and skills.
- There are regular staff and team meetings, and staff receive regular information and updates.

For a number of agencies, people told us that they were happy with the knowledge and skill of their care workers and care workers told us that they were well supported and had regular planned supervision sessions with their manager. This was backed up by documentation showing that regular appraisals and supervision sessions were planned, undertaken and acted on in terms of staff development and performance management.

Regular staff meetings were referred to positively as a means of disseminating information and learning. Many staff told us that they were able to attend a range of training sessions and were supported to gain relevant qualifications.

People we spoke with said they felt fully supported by the care staff. Comments from people included "Staff are good to me and don't let me down", "Staff are reliable and I know they respect me for who I am", "I feel that staff all work very hard and if I have any problems I feel my support worker will help me", "They are a supportive team who are themselves supported by good managers". "This service enabled me to gain new skills and new interests. Staff have made me a functioning member of society". "I take part in interviews for new staff and training forums. This service really does empower the people who use it."

Inspection report, Creative Support – Manchester Services

What needs to improve

Of the 250 services inspected, 29 (11%) providers were failing to meet this standard.

In 26 of these services the impact of this was judged to be minor; three were judged to be moderate and in the remaining one service the impact was judged as major.

Development, supervision and appraisal

For this element of the standard we checked to see what arrangements were in place for supervising staff and monitoring their performance as well as identifying development needs. We also checked that agencies provided an induction programme for new staff that included information about privacy and dignity, providing choice and information about safeguarding.

Most of the failures to meet this standard were associated with a lack of support for staff through staff meetings, supervision and appraisal of their performance. Some agencies did not have any documented expectation for staff supervision or appraisal. Where there was a plan detailing the frequency of appraisal and formal supervision sessions, we often found that these were not taking place at the frequency set by the agencies' own policies. We saw records that showed care workers were not receiving supervision and appraisals in line with company policy. However, we were careful not to criticise a provider that was carrying out regular appraisal and supervision, but less frequently than the company policy stated. In a lot of cases this was better than the sporadic supervision and appraisal that was taking place without any documented plan or policy for frequency.

Sometimes staff and managers told us that supervision and appraisal meetings were taking place, but there were no records to support this. We saw many staff files that were incomplete and did not include records of supervision or performance appraisal meetings. Some care workers told us their managers provided good informal support by telephone, but in one agency care workers said they had not met or talked with other staff, apart from those they provided care with in the eight months they had worked for the particular agency. Other staff told us that they had to meet office staff in car parks to collect supplies due to the distance to the office. Many staff told us that they felt they could be better supported.

UNISON's November 2012 report of the survey of care workers reported that only 43.7% of respondents see fellow home care workers on a daily basis at work. The report states that "this isolation is not good for morale and impacts on the ability to learn and develop in the role". The report also states that over half the respondents reported that their terms and conditions had worsened over the last year.

Without formal appraisal of staff performance, it is difficult to identify what development or support staff need.

Generally there was a formal induction programme for new staff, which covered a range of relevant topics. However, we saw a theme emerging from the comments from the people who received home care, or their carers and relatives, that the new staff often didn't know what to do:

> **"When a new girl starts, they don't know what to do, the regular workers should tell new girls what to do."**

Training

We expected to see that staff were given information and training on issues and topics to help them deliver care to people in their homes. This includes ensuring that staff know how to support people to make choices about their care. We wanted to see how the training needs of care workers are identified, particularly with regard to using equipment that may be required as part of the care delivered.

Where providers failed to meet this standard we found that people using services commonly told us about a variation in the knowledge of staff. Some questionnaire respondents told us that they did not feel new care workers had received sufficient training and some raised concerns about particular workers (although generally, if they had complained, the staff member had not come again).

There were instances where necessary training was not provided, with some staff telling us that they had not received any recent training. We saw instances where staff had not been able to attend training due to schedules. We saw one note in the file of a field supervisor that they had been unable to complete training because of the long hours worked. In another agency, following a significant safeguarding case, they had an action to provide specific training to all care workers, but the training records showed many care workers had not received this training in line with the action plan. There were also some complaints about the lack of understanding regarding mental health issues (for example, dementia). Some people told us that care workers lacked proper understanding of old age and dementia and tasks are performed in a perfunctory manner.

Our findings are in line with those of the recent UNISON survey of home care workers, which found that: "41.1% are not given specialist training to deal with their clients' specific medical needs, such as dementia and stroke related conditions".

How providers assess and monitor the quality of the services they deliver

There were 212 (85%) providers meeting this standard. As part of our assessment of this standard we focused on the providers' arrangements for:

- Monitoring quality
- Managing risk
- Managing and monitoring complaints.

What works well

Some providers had good internal assurance processes for testing the efficiency and effectiveness of their services as part of a systematic quality assurance programme. Some have integrated the way they monitor quality and feedback from people into the daily business of running a home care agency.

We saw a range of effective methods including annual quality audits of a variety of records with evidence of analysis of results, action plans and resulting improvements made. We saw examples where senior staff monitored and checked the daily records and medication charts every week when they were brought into the office. Managers and team leaders often carried out 'spot checks' to ensure that care is being delivered as expected and according to care assessments and plans. We saw records of these checks in people's personal files and in offices where the use and effectiveness of these methods was monitored. Some providers also specifically targeted people who were either discharged from their service or left for other reasons to get feedback from them about the service they had received.

Characteristics of services meeting this standard

- People feel confident about contacting the agency if they have concerns.
- People's views are gathered in a variety of ways. Survey results are acted on and they inform improvements, which are communicated back to people.
- Customer satisfaction surveys are supplemented by personal contact from the management team.
- Forums are available for people using the service and their carers or relatives.
- Managers are aware of the need to follow up concerns and provide documentary evidence of any changes made.
- Quality assurance processes are scheduled and monitored.
- Feedback from staff is captured and used to improve services.
- Methods include a compatibility rating for the rapport/relationship between a care worker and the person receiving services.
- Quality surveys include the person receiving care, their family, and social workers.
- Systems are in place to record, collect and monitor risks and incidents. The agency learns from incidents, makes changes and feeds these back to care workers at staff meetings and supervisions.
- People have information about how to complain. There is a process for investigating, learning from the complaint, feeding back to the complainant, and implementing action plans to address any issues raised.

The people we spoke with were more positive when they had regular contact from the agency's managers or 'the office', when they asked about the care they were receiving. Some agencies made weekly phone calls to people using services to check that the care was meeting their needs. This may be easier in smaller agencies than those providing care for hundreds of people, but we still saw evidence of weekly calls to a given number of people on a regular basis. Even where people had cause to raise a concern with a home care manager, people still commented positively if they received a prompt response and saw that action was taken. Some managers were able to show clear records of concerns raised with the office and how they had been managed and addressed. There was evidence that the trends and themes of the concerns were monitored and audited to see whether there were any root causes and how best they could be avoided in the future.

The provider had appropriate quality assurance monitoring procedures. People who used the service and/or their representatives were asked for their views about their care and treatment and they were acted on. The agency sent out 60 quality monitoring surveys every month, comments from these were evaluated and presented in a report every three months. The service's quality monitoring officer also contacted people at the end of the four weekly programme of care and one of the questions they asked is ''how do you feel about the way your care workers treated you''. … reports were reviewed by a senior member of staff every month. The service monitored staff performance and provided regular discussions and training with regard to dignity and respect. We observed a person who used the service request a change of call time so that they could participate in an activity, this was immediately agreed to. The manager completed a monthly audit report which covered all areas of the service such as staff meetings, significant current issues, staffing and handover records.

Inspection report, West Berkshire Council Home Care Service

What needs to improve

We found 38 (15%) services to be failing to meet this standard. The impact of this for people using services was judged to be minor in 21 of these agencies; in 15 agencies it was of moderate impact, and in two agencies it was a major impact.

Monitoring quality

As part of our checks we expected to see how providers are protecting people using their service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the services. This is crucial in a service where all care is provided in isolation in a person's own home, to some of the most vulnerable people in society. It is up to the providers of home care to assure themselves, and us, that the care that their individual staff deliver is of a consistent, effective standard of quality. They must be able to identify when care dips below the standard of care that people have a right to expect as set out in the national standards of quality and safety. There are a number of ways this can be done ranging from audits and spot checks to surveys and meetings with people and their carers and relatives, to give a few examples. All these methods should be used to monitor activities and practice.

Where providers were failing to meet this element of the standard, we found the following contributing factors:

- Providers could sometimes show us examples of methods that they used to capture feedback from people using their service, but there was no evidence of any action taken. The findings did not seem to be used in any way to identify themes or trends, and there was often no feedback to people.

- Providers did not make the same efforts to capture the feedback of carers and relatives. The responses to our questionnaires showed that agencies are more likely to ask people who use the service for their views on the service rather than their friends or relatives (although about a third of people who used services said that they had never been asked for their views and nearly half of friends or relatives said they had not been asked for their views).
- On many occasions agencies told us about the processes that they used to monitor the quality of their service but they did not keep any records to support this, either in terms of frequency or in some cases there were no records of any quality monitoring.

"It's very awkward; the supervisor comes round every three months and asks me questions. It's difficult to answer because she does it with the carers there."

- Where we heard concerns from people who used services and staff about late or missed calls, or concerns about staff, we checked with the senior staff as to how they monitored these issues.

One person commented that whilst the care workers gave personalised care, she felt at times when she had contact with the office they treated her as just another statistic. One carer said he was having constant battles with the office about the timings for his relative and it was still not resolved.

Extract from inspection report

"No-one has asked us for any feedback, sadly this service has been gradually going downhill over the last eighteen months."

Many agencies had clear mechanisms for monitoring visits, including recording arrival and departure times and any missed calls, and processes to inform people of any unforeseen lateness, but it was not clear what they did with that information. Other agencies were unable to show us that they monitored visit times at all. On one occasion our inspector was with a person using services and the care worker did not arrive. Following the missed visit, the inspector checked and found that no notification had been made to advise the local authority funding the care about the missed visit. We referred this to the local authority responsible for funding the care.

We had already heard that many of the late or missed calls could be attributed to scheduling and lack of travel time built into care workers' daily allocation of visits. While some providers acknowledged that this was the case we saw no evidence of any action to address this issue.

The UKHCA report, *Care is not a commodity,* found that "the overwhelming majority of councils expect providers to cover care workers' travel time and travel costs out of the hourly rate paid for the time spent in the service users' home." This means that providers and commissioners need to manage this issue together.

Again our findings echo those of the EHRC report *Close to Home* where they found that "too much reliance is placed on self assessment of quality of care and more could be done to allow the unconstrained voices of older people to be heard by local authorities, regulators and providers so that any threats to human rights can be picked up and resolved as early as possible."

Risk assessment and management

We checked this element of the standard to make sure that providers had systems to identify risks to care delivery and how they manage those risks and incidents. We also checked how the learning from risks and incidents is disseminated to staff and others who need to know, such as district nurses, social workers or the local authority.

Many care workers told us that they would raise any identified risks with their managers and felt confident they would be acted on. A number of agencies used generic risk assessments, such as for staff safety and for lifting and handling. While these are useful for basic information, they must be tailored to ensure that they provide the right information for the particular risk and individual concerned. The assessment should include action that should be taken to mitigate that risk. Risk assessments should be reviewed regularly and any action taken as a result should be monitored for effectiveness. We found that many agencies had not developed mature risk management processes to assure us that risks to care delivery, people receiving care or staff would be quickly identified or managed. Similarly we were not always assured that if an incident did occur that this would be investigated and learning disseminated appropriately. We saw incidents that were recorded in people's records but no record of any investigation or follow-up taking place.

The agencies who had frequent missed calls were not able to show any monitoring of the trends and impact of these in terms of the risks to individuals and the actions that were being taken to mitigate the risks was not clear in a lot of cases.

> The provider had no records available of the number of missed calls occurring. They told us that there were never any missed calls.
>
> **Extract from inspection report**

Managing and monitoring complaints

We considered how the agencies captured and monitored complaints, and whether staff had received information or training on how to respond to complaints. We also checked how agencies collected comments or views on service delivery and how they used these to improve services, and the arrangements for seeking specialist advice (for example, safeguarding, infection control, equipment use).

The most common reasons for the complaints that we heard about included: staff arriving late, lack of consistency in care workers attending and the performance of particular individuals.

A number of providers could not show us how they recorded any complaints or acted on them to improve services. This included agencies whose clients had told us about specific complaints made to the managers.

> **"I raised my concerns about call timing and no key worker. I complained about this policy of changing workers so they don't become too friendly with service users. I had no response."**

We also found a number of people who had some concerns about the service but were reluctant to raise them because they liked their regular care workers and this stopped them complaining to the manager about other aspects of care delivery.

> **"I don't like to get people into bother."**

The EHRC report *Close to home* stated that "many difficulties older people are experiencing with their home care go undiscovered and unresolved. It was striking how reluctant older people are to make complaints. They did not want to get their care workers into trouble, feared being put into residential care and did not want to 'make a fuss'."

Concerns that related to other standards

In the course of checking the five planned standards, our inspectors occasionally identified concerns that related to other standards.

These included:

- Standards relating to effective recruitment procedures. We found three providers failing to meet this standard in terms of ensuring that Criminal Records Bureau (CRB) checks or references were received before commencing work. Where this was the case, the inspector found the provider to be failing this standard and issued them with a notice to take action to meet the standard.
- On two occasions as part of looking at daily care records, our inspectors identified issues with medicines and found the providers to be failing the standard on managing medicines. We found care workers helping a person with medication, which was not part of the care plan, and incomplete documentation about whether medication had been given or not. The inspectors checked records in the central offices for the two services where they had identified concerns about this standard. There were no clear processes or evidence that records for administering medications were monitored. In one case, there were unexplained gaps in the records. In these cases, the inspectors found the provider to be failing this standard and issued them with a notice to take action to meet the standard.

Conclusions and recommendations

Overall, our inspections have revealed that many agencies are providing a service to people in their own homes which they value and are content with.

Our inspections of 250 home care services involved talking with staff and managers. We checked care plans and training records, staff rotas and complaints records and a variety of other documentation. We talked to commissioners of services and healthcare professionals working with the home care agencies. Most importantly, we received the views of more than 4,600 people who use home care services and their carers and relatives – either directly or as respondents to our questionnaires.

But although we have seen many examples where providers are rising to the many challenges and succeeding in delivering good care, we have also seen that some areas need improvement and action from those who commission and provide home care. The need for good home care is only going to increase. The need for individualised plans for care is essential so that care delivered in people's own homes ensures their needs, wishes and independence are respected.

Most importantly, services that do not monitor the quality of the services delivered behind closed doors to people, often in vulnerable circumstances, can pose risks to individuals. There were too many instances of people reporting very late or missed calls, which were not adequately investigated or monitored by the provider. Commissioners and providers need to consider the issues around lack of travel time for staff and costs as one of the most frequently cited causes of late or missed calls.

Key themes

Late or missed calls

The most common theme that dominated all the standards we checked relates to late or missed calls. This has a significant impact on people using services, given their dependency on care workers. Being dependent and having to wait for a visit from their care workers leaves people feeling vulnerable and undervalued. Some providers are failing to assess the impact of late or missed calls, and failing to monitor and address this vital element of delivering care. All providers should learn from those delivering high quality care.

Recommendations

- Providers and local authority commissioners must continue to work together to understand why these challenges remain and work together to find solutions.
- Providers must develop their risk management processes to ensure that they have systems and processes in place to identify and monitor risks to delivering services, and act on trends and themes. For example, incidents such as missed calls should be investigated, their causes identified and action taken to reduce a recurrence. Providers should be learning from risks and incidents and using this knowledge to improve.
- Where two members of staff are required to attend a visit at a given time, staff rotas and management arrangements must be organised to ensure that this happens, apart from in exceptional circumstances. Where it is unavoidable, there must be a documented process for monitoring the impact on people who use services and others, such as relatives who step in to help with lifting or moving their relative as we saw in our inspections. These should be monitored and changes made to reduce the frequency of these incidents.
- Commissioners and providers of home care services must work together to address the issues of timings and length of visits and the travel times required for staff between visits, to ensure that people have the appropriate length of time needed for their care.

Continuity of care workers

Many people have real issues and concerns about consistency and continuity of their care, preferring their care to be delivered by the same care workers. It is extremely important for people in vulnerable circumstances to have their care provided by someone they know and not be faced with a series of strangers in their own home to carry out intimate personal care.

Recommendations

- Where new care workers need to be involved in someone's care, as will sometimes be the case, providers should ensure, wherever possible, that this person is personally introduced and that they attend at least one visit with someone who is familiar to the person receiving care. Care workers should not be expected to attend someone's home without a personal introduction and explicit detailed documented information about the person's expectations.
- Providers should try to ensure that there is a small team of care workers for each person receiving care, to reduce the risk of them having a visit from someone they don't know.
- The risks of missed or late calls or unfamiliar care workers are greater at weekends. The impact of this on people receiving services is significant and providers should ensure that weekend and holiday cover meets people's needs in the same way as at other times. If this is not possible, they must plan in advance, make other arrangements and communicate these clearly to people using services.

Supporting staff

The needs of people aged 65 and over who receive care in their own home are now known to be more complex, and in many cases will include people with dementia. Assessing the care needs of people in their own homes is highly specialised and requires distinctive approaches that recognise the unique nature of the setting where care is delivered. Staff meetings, development, appraisal and supervision are crucial, but they are not happening consistently across services. The increasing complexity of the needs of people receiving home care mean that ongoing staff development and training is more important than ever.

Recommendations

- New staff should not be placed in the position of starting work without being given a full induction according to national standards.
- A care worker's ability to build a rapport with people using services should be assessed at recruitment and monitored through the supervision and appraisal programmes. This should also take into account the language and culture of people using services. Providers should ask people, and their relatives or carers, to give feedback about their regular care workers to minimise the issues raised around attitude and 'compatibility'.
- Staff are working in some of the most isolated of positions and must be able to regularly see other care workers and meet with managers to discuss the needs and progress of the people they provide care for.
- Staff should receive the appropriate training to be able to support people in the best way possible; this is a particular issue for people with dementia. Staff caring for people with dementia should have access to relevant training and be able to develop their knowledge and expertise in this area.

Care planning

Assessing people's care needs and planning their care is fundamental to delivering services. It requires high priority in terms of regular reviews and updates to make sure that care plans reflect people's current needs and preferences. This allows any changes in needs to be quickly identified and monitored. The quality of care plans should be regularly assessed and form part of staff development plans.

Recommendations

- Providers must give staff enough information to allow them to identify and record people's preferences and choices about how they would like to receive care in their own home. People should be made aware of the choices available to them and have their expectations managed.

- Agencies must gather the views of carers much more proactively. We received 671 responses to our questionnaire from the relatives or carers of people receiving services, and nearly half said that they not been asked about their views about the service for their relative. Our findings show that larger organisations are less likely to involve carers in decisions about care (64%) than small agencies (86%). All services must seek and act on the views of carers but large services must make sure that they work to involve carers and not become remote from this source of information.

Safeguarding and safety

It is unacceptable to come across any staff providing intimate personal care to people in their own homes who do not fully understand their responsibilities with regard to safeguarding and whistleblowing.

Recommendations

- Providers must ensure that their staff have been trained and equipped with relevant information about local safeguarding procedures and processes, including how and where to raise concerns about quality and safety.
- Monitoring and managing complaints is an important aspect of quality monitoring. If a provider keeps records of all complaints and concerns raised by people using services and their carers/relatives, they can identify trends and act on them. Any changes made as a result of complaints should be recorded and communicated to people using services to show that they are being listened to and action is being taken as a result.

Appendix A: Tables of findings

Table 1: Number of services meeting the standards by region and type of ownership

	Number of services	Number of people using services at time of inspection	Number meeting all standards checked		Number needing to take action	
By region				**%**		**%**
East	**19**	**1,290**	**17**	89%	**2**	11%
East Midlands	**23**	**2,142**	**16**	70%	**8**	30%
London	**55**	**6,860**	**35**	64%	**20**	36%
North East	**13**	**2,723**	**10**	77%	**3**	23%
North West	**28**	**3,486**	**20**	71%	**8**	29%
South East	**34**	**2,937**	**27**	79%	**7**	21%
South West	**34**	**3,483**	**27**	79%	**7**	21%
West Midlands	**20**	**1,177**	**15**	75%	**5**	25%
Yorkshire & Humberside	**24**	**2,321**	**17**	71%	**7**	29%
By ownership type				**%**		**%**
Privately owned	**208**	**21,482**	**147**	71%	**64**	29%
Council owned	**22**	**1,865**	**19**	86%	**3**	14%
Voluntary owned	**20**	**3,072**	**18**	90%	**2**	10%

Performance in meeting the standards by size of provider

Table 2: Respecting and involving people who use services

	Number of services	Number of people using services at time of inspection	Number meeting standard		Number not meeting standard	
Size of provider, based on number of people using services at time of inspection						
Micro	**8**	**27**	**8**	100%	**0**	0%
Small	**101**	**4,661**	**99**	98%	**2**	2%
Medium	**48**	**7,072**	**46**	96%	**2**	4%
Large	**42**	**14,659**	**38**	90%	**4**	10%
Unknown	**51**	**0**	**51**	100%	**0**	0%
Size of provider, based on number of locations						
1	**129**	**11,234**	**125**	97%	**4**	3%
2 to 3	**42**	**6,676**	**39**	93%	**3**	7%
4 to 6	**16**	**1,431**	**15**	94%	**1**	6%
7 to 12	**13**	**821**	**13**	100%	**0**	0%
13 to 25	**17**	**2,504**	**17**	100%	**0**	0%
25+	**33**	**3,753**	**33**	100%	**0**	0%

Table 3: Care and welfare of people who use services

	Number of services	Number of people using services at time of inspection	Number meeting standard		Number not meeting standard	
Size of provider, based on number of people using services at time of inspection						
Micro	**8**	**27**	**7**	88%	**1**	13%
Small	**101**	**4,661**	**87**	86%	**14**	14%
Medium	**48**	**7,072**	**36**	75%	**12**	25%
Large	**42**	**14,659**	**34**	81%	**8**	19%
Unknown	**51**	**0**	**48**	94%	**3**	6%
Size of provider, based on number of locations						
1	**129**	**11,234**	**116**	90%	**13**	10%
2 to 3	**42**	**6,676**	**31**	74%	**11**	26%
4 to 6	**16**	**1,431**	**14**	88%	**2**	13%
7 to 12	**13**	**821**	**10**	77%	**3**	23%
13 to 25	**17**	**2,504**	**14**	82%	**3**	18%
25+	**33**	**3,753**	**27**	82%	**6**	18%

Table 4: Safeguarding people who use services from abuse

	Number of services	Number people using services at time of inspection	Number meeting standard		Number not meeting standard	
Size of provider, based on number of people using services at time of inspection						
Micro	**8**	**27**	**7**	88%	**1**	13%
Small	**101**	**4,661**	**96**	95%	**5**	5%
Medium	**48**	**7,072**	**46**	96%	**2**	4%
Large	**42**	**14,659**	**40**	95%	**2**	5%
Unknown	**51**	**0**	**51**	100%	**0**	0%
Size of provider, based on number of locations						
1	**129**	**11,234**	**122**	95%	**7**	5%
2 to 3	**42**	**6,676**	**39**	93%	**3**	7%
4 to 6	**16**	**1,431**	**16**	100%	**0**	0%
7 to 12	**13**	**821**	**13**	100%	**0**	0%
13 to 25	**17**	**2,504**	**17**	100%	**0**	0%
25+	**33**	**3,753**	**33**	100%	**0**	0%

Table 5: How providers support their staff

	Number of services	Number of people using services at time of inspection	Number meeting standard		Number not meeting standard	
Size of provider, based on number of people using services at time of inspection						
Micro	**8**	**27**	**6**	75%	**2**	25%
Small	**101**	**4,661**	**89**	88%	**12**	12%
Medium	**48**	**7,072**	**42**	88%	**6**	13%
Large	**42**	**14,659**	**34**	81%	**8**	19%
Unknown	**51**	**0**	**49**	96%	**2**	4%
Size of provider, based on number of locations						
1	**129**	**11,234**	**115**	89%	**14**	11%
2 to 3	**42**	**6,676**	**37**	88%	**5**	12%
4 to 6	**16**	**1,431**	**15**	94%	**1**	6%
7 to 12	**13**	**821**	**10**	77%	**3**	23%
13 to 25	**17**	**2,504**	**14**	82%	**3**	18%
25+	**33**	**3,753**	**29**	88%	**4**	12%

Table 6: How providers assess and monitor the quality of the services they deliver

	Number of services	Number of people using services at time of inspection	Number meeting standard		Number not meeting standard	
Size of provider, based on number of people using services at time of inspection						
Micro	**8**	**27**	**7**	88%	**1**	13%
Small	**101**	**4,661**	**85**	84%	**16**	16%
Medium	**48**	**7,072**	**40**	83%	**8**	17%
Large	**42**	**14,659**	**34**	81%	**8**	19%
Unknown	**51**	**0**	**46**	90%	**5**	10%
Size of provider, based on number of locations						
1	**129**	**11,234**	**109**	84%	**20**	16%
2 to 3	**42**	**6,676**	**37**	88%	**5**	12%
4 to 6	**16**	**1,431**	**12**	75%	**4**	25%
7 to 12	**13**	**821**	**12**	92%	**1**	8%
13 to 25	**17**	**2,504**	**14**	82%	**3**	18%
25+	**33**	**3,753**	**28**	85%	**5**	15%

Appendix B: Advisory Group

This themed inspection programme had the support of an Advisory Group to:

- Provide expertise and experience to inform the approach and scope of the programme.
- Comment and advise on the nature of the inspections in terms of focus (what should we be looking at)
- How to gather feedback from service users, and desired outcomes.
- Advise on the presentation of results from the inspection programme.
- Comment on emerging themes for this sector.
- Consider what actions need to be taken by the wider system, and the role of group members in taking these forward.

CQC is grateful for the time, support, advice and expertise given by the group.

The group has no decision making authority regarding CQC's regulatory activity.

As well as members of CQC staff, the group comprised:

Colin Angel	United Kingdom Homecare Association
Helen Charlesworth-May	London Borough of Lambeth
Victoria Fredericks	Mencap
Lilias Gillies	Expert by Experience
Sheila Grant	Carer
Bonnie Green	Richmond LINk
Richard Hartle	Expert by Experience
David Hogarth	Westminster LINk
Richard Jones	The Association of Directors of Adult Social Services
Des Kelly	National Care Forum
Joanna Lenham	Social Care Institute for Excellence
Stephen Lowe	Age UK
Joanna Owen	Equality and Human Rights Commission
David Richardson	Age UK
Doris Robson	Ealing LINk
Dame Philippa Russell, DBE	Standing Commission on Carers
Tracy Simpson	Community Options
Simon Taylor	Shared Lives Plus
Georgina Turner	Skills for Care
Miranda Wixon	CERETAS

Appendix C: How CQC checks whether national standards are being met

The Health and Social Care Act 2008 introduced for the first time a common set of standards – the essential standards of quality and safety – that apply across all regulated health care and adult social care services in England. Working to this new regime, CQC registered all NHS trusts and hospitals from April 2010 and independent healthcare and social care providers from October 2010 under the new regulation.

Once providers are registered, CQC inspectors check that the essential standards of quality and safety are being met. There are 28 standards in total but, of these, they focus on 16 standards that most directly relate to the quality and safety of care. CQC produces **guidance for providers** that helps them understand what meeting the essential standards looks like. The guidance sets out the outcomes that a person using the service can expect to experience if the provider is meeting the essential standards – with each essential standard having a corresponding outcome.

Providers must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.

As part of this themed inspection programme we inspected against the following regulations:

- **Regulation 17 Respecting and involving people who use services** (Outcome 1)
- **Regulation 9 Care and welfare of people who use services** (Outcome 4)
- **Regulation 11 Safeguarding people who use services from abuse** (Outcome 7)
- **Regulation 23 Supporting workers** (Outcome 14)
- **Regulation 10 Assessing and monitoring the quality of service provision** (Outcome 16)

If an inspector identified concerns relating to another outcome they would include the additional regulation as necessary.

All judgements are made using CQC's **judgement framework**. We will judge whether a provider is either meeting or not meeting the regulations. Where we judge that a provider is not meeting a regulation, we assess the impact of this on people who use the service, and judge it to be either minor, moderate or major. The level of impact determines the regulatory action we take.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant impact on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long-term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

As part of our consideration of impact, we also take into account who is using the service and what their circumstances are, as these factors may result in a greater impact. If we reach a judgement that the provider is not meeting one or more of the regulations, we use the **Enforcement policy** to help determine our regulatory response.

Appendix D: Definitions

Carer: a carer is a friend or relative of the person receiving home care who gives support to the person.

Care worker: a care worker is a member of staff employed by the home care provider to deliver care.

Personal care: personal care is defined by the regulations and includes physical assistance given to a person, for example with eating, washing, dressing, or supporting them to carry out these tasks themselves. It is delivered to people who, because of old age, illness or disability, are unable to provide it for themselves, and is provided in a place where they are living.

Reablement: a short defined period of care provided to people who need help after a period of illness, or the onset of a disability.

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