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Executive Summary

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Background

The issue of care quality for social care delivered at home to older people (hereafter 'homecare quality') affects a substantial number of older people and those supporting them. The Office for National Statistics (ONS) estimates that in England in 2023, 307,000 older people/people with dementia were in receipt of homecare, with about 75% funded by local authorities and 25% self-funding.[1] There are currently around 12,800 registered homecare organisations, providing services to both local authorities and private clients.[2] They are subject to regulation by the Care Quality Commission (CQC). They are also regulated through the process of local authority commissioning of homecare, and in theory subject to the consumer market mechanisms of choice, voice and exit.

Current data show a system under stress. In August 2023, around 250,000 people were waiting for a care assessment or, having been assessed as qualifying for state supported care, waiting for care packages.[3] In the first three months of 2023, 564,000 hours of homecare could not be delivered because of insufficient workforce capacity.[4] The King's Fund and the Homecare Association have highlighted problems relating to low-rate, zero-hours commissioning and budget pressures.[5] Meanwhile, the number of family carers receiving support has fallen between 2022 and 2023 from 314,000 to 295,000 and respite care has fallen from 57,000 places in 2016 to 36,000 in 2023, indicating greater and growing pressures on family caregivers.[6]

Within this context, a shared understanding of homecare quality is important for older people, their families, care workers and service providers in setting expectations and standards, and in maintaining satisfaction, trust and respect. It informs minimum benchmarks in safeguarding and regulation as well as monitoring and improving provision. It is also an important factor in shaping the private market for consumers. Provision of high quality homecare has the potential to impact on health service utilisation.[7] In England, the integration of health and care services into Integrated Care Systems (ICSs) requires shared understandings of quality in social care across the NHS, local authorities and others in the system. In 2023, the CQC introduced a new single assessment framework for the holistic assessment of care quality including homecare providers.[8]

Determining how homecare quality is understood across the health and care ecosystem is therefore important for determining the focus for delivery, acceptability, regulation, service improvement and innovation, as well as how we should measure this concept.

Review aims and objectives

This scoping review[9] aimed to determine how homecare quality is conceptualised by key stakeholder groups.

The review objectives were to:

- Summarise the meanings of homecare quality for key stakeholders, reported in the published literature
- Highlight similarities and differences between different stakeholders' understanding of homecare quality
- Identify the measures of homecare quality (qualitative and quantitative) across this literature.

Methods: scoping review

Search strategy

We searched four databases (CINAHL, PsycINFO, ASSIA and Social Care Online) and websites of major UK organisations (e.g., Age UK, Alzheimer's Society, King's Fund, Homecare Association) for reports and briefing papers published between 2016 and 2023.

Review criteria

We used the Population, Concept and Context approach:

- Population: any stakeholder groups which expressed views on quality of homecare for people aged 65 and above, with dementia or Parkinson's disease, or described as 'older people' if the age was not explicitly defined.
- Concept: quality of care, however defined, considered across the entire spectrum of worst care (i.e., neglect/abuse) to best care.
- Context: homecare in Organisation for Economic Co-operation and Development (OECD) high-income countries (peer-reviewed literature); UK only (for grey literature).

Study selection

Records were screened in Rayyan, an online platform to support literature reviews. We adopted a two-stage screening process: (i) titles and abstracts were screened for relevance; (ii) full texts of selected records were assessed against the review criteria. Both stages involved a team approach with initial duplicate screening and discussion, followed by single-researcher screening.

Data extraction and synthesis

We extracted summary data from each paper, including descriptive information, and participant stakeholder views on what constitutes homecare quality. We used a descriptive qualitative analysis[10] to chart concepts of quality of homecare by each stakeholder.

Findings

We screened 5,168 records and included 93 articles (72 research papers, six comment papers and 15 grey reports) published in 16 countries. Most articles focused on homecare for older people with around a quarter focused on people with dementia (n=22). The views of older people were included in the highest number of papers (n=46), followed by care workers (n=27), family members (n=19) and senior staff/managers (n=17), with some reflecting views of experts and researchers. We did not find any reports of views of regulators, inspectors, assessors, lawyers, advocates or other policy actors, and only one article reflecting the views of commissioners.

Our analysis revealed four dimensions of homecare quality: (1) relationships and continuity of care; (2) bespoke care; (3) organisational and structural aspects of care; and (4) understanding of quality as a measurable construct. Most articles corresponded to more than one dimension. Most stakeholders (especially unpaid carers/family members) considered quality to comprise multiple dimensions: one in twenty articles covered all four dimensions, a third covered at least three dimensions, around a third covered two dimensions, leaving only a quarter that conceptualised quality within just one dimension.

Overall, there are very clear consistent and widely-held views about what high quality care looks like in homecare for older people across different stakeholder groups and countries. The four dimensions highlight an emphasis on relational and organisational aspects of care as being central to high quality:

High quality homecare is understood in relational terms (dimensions 1 and 2):

- High quality homecare includes the development and maintenance of good relationships between care staff, families and services users.
- This is often (although not always) seen as being linked to continuity of care staff to allow these relationships to develop.
- High quality homecare is bespoke:
    - the care meaningfully involves people in designing their care;
    - is compassionate and empathetic;
    - facilitates choice and control in how service user needs are met;
    - and is done in ways that maintain dignity and independence.

High quality homecare is also understood in organisational and structural terms (dimension 3):

- In terms of staffing, it requires
    - appropriate numbers and diversity of well-trained staff;
    - pay and working conditions that recognise the importance and complexities of their roles;
    - sufficient time and flexibility for staff to deliver the care that people want and that they want to deliver.
- It involves the homecare workforce being connected to the wider health and care infrastructure to facilitate support by other health and care professionals.
- It requires effective communication between organisations.

Although these views were largely consistent across stakeholders, there were some nuances:

- Maintenance of good relationships between care staff, families and services users can challenge care staff who may be accepted as ‘part of the family’ but who also may need to establish professional boundaries.
- While high quality care was broadly seen as care which meaningfully involves people in designing their own care, a minority of service users may not wish to be involved in decisions about their care.
- Organisational and structural challenges can restrict the ability of care staff to provide relational and bespoke care without ‘going the extra mile’; this may involve staff feeling obliged to work beyond their paid time. On the other hand, some service users may be discouraged from challenging perceived poor care quality, if they are aware of organisational and structural constraints that they believe preclude high quality care.

Our review also showed that there is value placed by some stakeholders, particularly service managers, researchers and expert commentators, on collecting data to measure or demonstrate homecare quality (dimension 4), but that there is uncertainty about which data or measures are appropriate, or how to do this.

Gaps

We found important gaps in this literature published between 2016 and 2023. These included how older people form and articulate their preferences for, and issues with, homecare. We found no literature relating to issues of older people’s mental capacity in understanding and evaluating homecare quality, a lack of consensus on care quality measurement, and no research that helped inform optimal models of care provision within existing budgets. The views of some stakeholders were absent from the literature. These included regulators, inspectors or assessors, lawyers, advocates or people who might be involved in challenging provision of care, and other policy actors. We found only one report

exploring the views of stakeholders who are involved in commissioning homecare services for older people. Most studies did not seek to assess homecare quality, or the prevalence of high quality homecare for older people. We did not find any comparative studies of homecare quality received by different socio-demographic groups or across geographies, systems, models or funding sources.

Conclusions

This scoping review identified clear and consistent views about how homecare quality is understood across stakeholders and countries. Research on this issue is predominantly focussed on understanding the views of four groups: older people, family carers, care workers and service providers. Homecare quality is understood as a multi-dimensional concept, with a focus on relationships and tailoring of services to individual needs. We identified four dimensions as important across stakeholder groups: (i) relationships and continuity of care; (ii) bespoke care; (iii) organisational and structural aspects of care; and (iv) understanding of quality as a measurable construct. We found general agreement across stakeholder groups on these issues although some nuances were identified around professional boundaries, involvement of people in decisions about care, and in staff 'going the extra mile' to deliver high quality care. There is an emphasis within the reviewed literature on meaningful relationships and relational aspects of care being critical for homecare quality.

There are implications of these findings for the new system of regulation of homecare by the CQC. Care England, Skills for Care and the Outstanding Society (a Community Interest Company (CIC) of adult social care providers who had achieved 'outstanding' ratings in 2014). All highlight that to achieve an 'outstanding' rating requires 'going the extra mile' to introduce innovative and exemplary practice that delivers bespoke care.[11-13] There are questions about how achievable this may be, given that our review identified that this 'extra mile' may require care staff to go beyond their resources and paid-for time, and perhaps beyond perceived professional boundaries.

Addressing potential organisational and structural barriers will require resources but may prove essential to the delivery of high quality care. Notably, we did not locate any research that would inform optimal models for high quality homecare for older people within existing budget constraints.

Some, but not all of the central messages of our review are reflected in the CQC's single assessment framework. Development of a consensus on homecare quality measurement in this setting, and how this relates to CQC requirements, is likely to be helpful. Our findings suggest that there is uncertainty among stakeholders about which data to collect to measure quality of homecare for older people. It will be important that adoption of a multi-dimensional approach to measuring homecare quality for older people does not lead to data collection that is overly burdensome for care providers, service users, or their families.

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