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Introduction

In this scoping review we examine what is known from existing literature and prior research about what ‘quality of care’ means to different stakeholders in the domain of paid-for social care at home for older people.

The issue of care quality for social care delivered at home to older people affects a substantial number of older people and those supporting them. While estimating the population in receipt of homecare has proven difficult, the most recent Office for National Statistics (ONS; experimental) estimate of the older population/population with dementia suggests 307,000 older people in receipt of homecare, with about 25% of those self-funding.[1]

The current formal sector for social care in England is large and highly fragmented. It comprises about 18,000 organisations across 39,000 locations, with about 1.5 million people working in the sector (cf. 1.4 million working in the NHS).[14] Of these, around 12,800 are registered homecare providers.[2] Formal providers in England often service both local authorities and private clients and are subject to regulation (registration, inspection, monitoring and enforcement) by the Care Quality Commission (CQC). They are also regulated through the process of local authority commissioning of homecare, and in theory (if not always in practice) by the consumer market mechanisms of choice, voice and exit. Some providers exclusively support self-funders and organise their services in a way which they suggest ensures ‘quality’ for the higher price that this allows. However, evidence suggests that most self-funders lack sufficient information to make informed choices, in a market “characterised by complexity, plurality, and imperfect information” and thus likely exert weak influence on quality through consumer market mechanisms.[15] In the publicly funded domain, local authority commissioned care is argued by many to be at prices that preclude the structural conditions that would permit high quality care.

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, up from 223,000 in March 2023.[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 highlight problems relating to low wages, low-rate, zero-hours commissioning and budget pressures.[5] The highest vacancy rate in adult social care is in homecare. Meanwhile, the number of family carers receiving support has fallen in the last year 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 at home.[6]

Within this context, a shared understanding of quality in homecare is important for older people, their families, care workers and service providers in setting expectations and standards, and in maintaining satisfaction, trust, respect and understanding. It informs minimum benchmarks and scales for providers, commissioners and regulators in safeguarding as well as monitoring and improving provision; and is an important factor in shaping the private market for consumers, which is also of interest to policymakers and providers. Furthermore, provision of high quality homecare has the potential to impact 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, and in 2023, the regulator for health and social care in England, the Care Quality Commission (CQC), introduced a new single assessment framework for the holistic assessment of care quality including homecare providers.[8]

Determining how quality of homecare for older people 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 might or should measure this concept. In this report we first briefly set out the background and context for this review, before describing our review objectives and scoping review methodology. We then present our findings, and close with a discussion.

Background and context

Formal homecare for older people in England

Adult social care includes a wide range of activities that help people in need of support for optimal daily living. It comprises self-care, unpaid care mostly by family but also friends, neighbours and communities, and a paid-for system of residential and homecare (previously called domiciliary care) providers. In this report we focus on the quality of paid homecare for older people (hereafter 'homecare quality') in the formal sector. In England, this is funded either by local authorities via a state-funded system, or individuals and families in the private market. Homecare in this sense can include support for washing, dressing, getting up and going to bed, toileting, cleaning, shopping, cooking and eating, and other everyday individual or household activities essential to being able to live at home, as well as wider support for engaging in leisure activities and family and community life. Formal homecare is also vital for the support of family and other unpaid caregivers, and can help to sustain critical unpaid caregiving. It can be short or long term and can mean anything from a 15 minute support visit to 24 hour care at home.

Since care commissioners, regulators and consumers all have important roles in ensuring care quality, how homecare is commissioned and funded is important for understanding how social care is provided and how care quality is understood. While in 1993, 95% of homecare was provided by local authorities, by 2018, 98% of council funded homecare hours in England were outsourced to independent sector providers.[16] As well as commissioning functions, Local authorities also have a statutory duty to make markets for themselves and self-funders, ensuring that markets provide sufficient choice and capacity across the full range of social care provision.[17]

The costs of care of older people are mostly borne by individuals and families in the unpaid and paid-for systems. The King's Fund estimate the contribution of family care as the equivalent of four million paid care workers, and LaingBuisson, which produces (paywalled) market sector reports, estimate about £12.4 billion spent in the private market for homecare and supported living.[18] Publicly funded care expenditure is also substantial. About half of net local authority public expenditure of £20.4 billion on adult social care in 2022/23 is on those over 65, making local authority commissioners important stakeholders in ensuring homecare quality,[19] and in considering minimum acceptable standards for homecare and equity of homecare quality across the population.

Local authority funded homecare is currently restricted to those with low means and high needs. For the means test (as of October 2024), broadly speaking, people with more than £23,250 in savings and property (including the home they live in) are not eligible for any local authority funding for residential care, while the value of the home people live in is disregarded for homecare. Even if the means test is fulfilled, only those assessed as having the highest levels of social care needs are eligible for funding. This is determined through a ‘needs assessment’, with the local authority determining the services that it decides will meet eligible needs (the ‘care package’). There are limited opportunities to challenge local authority decisions in practice. For publicly funded clients, the local authority largely determines homecare quality through its commissioning practices.

In 2012 the CQC conducted a major themed inspection programme of homecare.[20] This highlighted difficulties in monitoring homecare and raised concerns about continuity of care workers, staff knowledge and training, poor working conditions and lack of support for staff. A lack of formal documented processes for quality monitoring and managing complaints was also noted. Many of these challenges endure. Research by the King’s Fund and the University of York conducted between 2016 – 2018 highlighted three major issues: recruitment and retention of staff (described as a ‘relentless’ challenge); the driving down of prices by local authority commissioners (with disagreement between commissioners and providers as to whether this influences quality); and commissioning on a ‘time and task’ basis rather than on outcomes.[21] The latter was frustrating for commissioners who highlighted the lack of infrastructure among providers to collect and monitor outcome data.

About two million people a year request adult social care support from local authorities, of whom 1.4 million are over 65, an increasing trend.[6] Of these, 53% receive no services or only information, advice and signposting to others. The last decade has seen publicly funded care delivering more intensive care to fewer people, despite needs growing across the (ageing) population. For the older population this has fallen from 6% of the population over 65 in 2016 to just over 5% in 2023.[6] Our understanding of care quality for this report therefore emerges from a context in which the sector is perceived to be struggling.

Within this highly strained and constrained environment, delivering high quality care is likely to be challenging, especially to local authority funded clients who are the most socio-economically disadvantaged.

Regulation and the regulator’s concept of care quality

Care Quality Commission

England has a mature long term care system. The CQC, formed in 2009, is a single regulator across health and social care and regulates local authority duties relating to social care and providers. The Care Act 2014 mandates local authorities to provide or arrange services that prevent people’s needs from worsening, provide comprehensive information and advice about available care and funding options, and help develop a market of sustainable, high-quality care and support services.[22] Across the sector it is argued that funding is insufficient to achieve these aims, but the regulator is nevertheless tasked with ensuring that homecare services provide high-quality, safe, and person-centred care, and holding providers accountable for maintaining these standards.

Homecare of older people provides significant challenges for regulators.[23] Regulator resources and time are limited, enforcement is challenging, and the market is fragmented and fluid. Homecare is delivered across all geographies, with quality, staff, training, management and the use of technology varying widely. Needs of clients are constantly changing, experiences are subjective, and recruitment and retention of staff is problematic. Obtaining honest feedback from service users and families is extremely challenging because of the potential consequences for care, and complex health problems amongst people needing care.[24-26]

The CQC initially focused on a compliance-based approach, but following a period of review and consultation, introduced major changes in 2016 towards a more holistic framework, resulting in four summative quality ratings [outstanding, good, requires improvement, inadequate] based on five key questions set out below. In the wake of the Covid-19 pandemic, The Health and Care Act 2022 created Integrated Care Systems (ICSs) and gave the CQC new regulatory powers. In this light and following a further lengthy and detailed consultation process, in 2023 the CQC introduced a new ‘single assessment framework’ for health and social care, aiming to provide a single vision of ‘quality’ for the whole health and care system.[8] While the quality ratings and five key questions remain, the new regime relies on a new series of 34 quality statements or ‘We’ statements, where the CQC sets out its expectations of commitments that providers, commissioners and system leaders should live up to, and 16 ‘I’ statements, which are part of the assessment framework reflecting what people have said matters to them. The 50 ‘We’ and ‘I’ statements are set out in Appendix A. Although it has had a very bumpy start,[27] the idea is that each quality statement will draw on six associated evidence categories: people’s experiences, feedback from staff and leaders, observations of care, feedback from partners, processes, and outcomes of care. While this framework is argued by the CQC to be simpler, focused on what really matters to people, and reflects how care is actually delivered by different types of services as well as across a local area, it potentially leads to an overwhelming plethora of varying evidence across a very large number of domains. The process by which ratings are calculated is clear – a review of quality statements based on evidence leading to a score for each of the five inspection categories, aggregated to give a global rating. However, the evidence required to achieve scores that would differentiate between ‘good’ and ‘outstanding’ is not made explicit.[28]

The five key questions are:

1. Are they safe? Safe: you are protected from abuse and avoidable harm.
2. Are they effective? Effective: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
3. Are they caring? Caring: staff involve and treat you with compassion, kindness, dignity and respect.
4. Are they responsive to people's needs? Responsive: services are organised so that they meet your needs.
5. Are they well-led? Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

In 2023, the CQC rated 4% of homecare services in England as ‘outstanding’, 81% as ‘good’, 14% as ‘requires improvement’, and 1% as ‘inadequate’.[29] The new Framework is now in force for all health and social care providers across England. However, a recent report (August 2024) by the Homecare Association is extremely critical of the CQC, arguing that systemic problems with resources, infrastructure and leadership mean that 60% of homecare providers either have no rating or very outdated ratings.[30]

Other bodies

In addition to the regulatory framework, other bodies have also produced guidance. The National Institute for Health and Care Excellence (NICE) have published quality standards in homecare for older people,[31] and the Homecare Association (the trade body for homecare providers) has published a Code of Practice for its members.[32] The Adult Social Care Quality Matters initiative from the Department of Health and Social Care aimed to achieve ‘a shared understanding of what high-quality care is' (but it is not clear what has happened to this programme of work after 2019).[33] The current Nuffield Trust/Health Foundation 'Quality Watch' programme monitors more than 200 quality indicators across health and social care; 13 of these indicators focus on social care, but none of them are explicitly about homecare.[34]

Commissioning and quality

In the UK, local authority social services departments are required to develop management systems to optimize available resources and produce the best results in each area.[35] That includes planning for future and current homecare needs, purchasing homecare and providing support to homecare providers. Much of this activity falls within the remit of 'commissioning', defined by the European Social Network as 'the process through which public authorities specify, guarantee and monitor services... a process that involves a broad range of activities from social planning… to the authorisation, accreditation and contracting of providers, as well as quality monitoring and assurance.'[36]

While in the UK accreditation is performed by the regulator (the CQC), local authorities still occupy a key role in quality control. Commissioning has been framed as a multi-dimensional link between local authorities (the buyers) and care services (the providers).[37] It involves active or strategic planning ('strategic commissioning'), market shaping, search for suppliers ('procurement'), and contract management.[35] Numerous studies and recommendations on local authority commissioning emphasise its centrality to improving homecare quality in the UK.[38-42] This will become increasingly important in light of the new CQC power regulating local authority market-shaping behaviour.

Who are the stakeholders?

As the above reveals, there are many different groups of people with perspectives and interests in understanding homecare quality. Accordingly, for this review we considered meanings of 'quality' in the provision of formal social care across all those involved in the provision or receipt of care by older people: older people themselves, their unpaid caregivers, front-line staff and service providers, commissioners of services, policymakers, regulators, advocates and researchers.

Review objectives

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

We conducted a scoping review, which is recommended for reviews that aim to clarify concepts and definitions within the literature.[9] Our review follows Joanna Briggs Institute guidance and is reported below in line with the PRISMA-ScR checklist.[43] A protocol was registered on Open Science Framework.[44]

Search strategy

Targeted search strategies were designed and tested for the following databases: CINAHL, PsycINFO, ASSIA and Social Care Online.[a] These strategies were developed between July and October 2023. The full strategy applied to CINAHL is provided in Appendix B. For grey literature, we also searched websites of major UK organisations (Association of Directors of Adult Social Services, Age UK, Alzheimer's Society, Carers UK, Homecare Association, King's Fund, Local Government Association, Nuffield Trust) for relevant reports and briefing papers.

Databases were searched from January 2016 until October 2023. This period covers two major strategic periods of the CQC: the 2016 – 2021 strategy (which consolidated earlier strategies) and the current, post-2021 strategy.[45, 46] The period 2016 – 2023 therefore covers the transition from the old regime to the new, and captures how homecare quality was being conceptualised in the literature during that period.

Review criteria

The review criteria are summarised here and shown in full in Table A1 (Appendix C). We used the Population, Concept and Context approach to develop the criteria:

- Population: any stakeholder groups which expressed views on quality of homecare for people aged 65 and above, with a mean age of 65, 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. In the first stage, 50 records were screened by the whole team, followed by discussion and clarification of review criteria. In the second stage, three records were screened by the whole team, with further discussion and clarification of criteria. The remaining records were screened by individual researchers. The size of the team allowed for differential allocation of records across both stages, so that any individual researcher screened different records at stage two to those they had screened at stage one. The team met weekly during screening to discuss any challenges. Additional grey literature reports from website searches were screened by one researcher and checked by a second.

Data extraction and analysis

We extracted summary data from each article including:

- Author
- Year of publication and country

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[a] Social Care Online closed down in March 2024 and was last updated in early 2023: https://www.scie.org.uk/social-care-online/

- Publication type
- Article aim
- Description of care provided
- Care recipient group (i.e. general older adults or those with specific conditions)
- Quality definition: research framing (i.e., the meaning of quality that the authors have used to frame the work and to articulate the aim of the article)
- Study design and methods, study participant type (i.e., stakeholder group(s))
- Study participant demographic details
- Quality definition: participant views (i.e., how does the stakeholder group understand quality)
- Details of any quantitative measures or data deemed by stakeholders to be important in the concept of quality
- Any research outcome, author assessment or comment about whether good quality care was achieved

We extracted the data into an MS Excel form, which we piloted with three articles and refined by team discussion.

In keeping with our aim to clarify conceptualisations of ‘quality’, we undertook a qualitative content analysis of the data,[10] using a second MS Excel document to establish a framework in which to chart understandings of quality according to our stakeholder groups. One researcher used the data extracted from 10 articles (selected to provide variation in methodology and stakeholder group) to develop an initial framework of sub-dimensions relating to quality. Three different researchers checked this analysis using the same 10 articles and refined the framework via discussion. We then applied the revised framework to the remaining articles, dividing them equally between four researchers. Once the extracted data had been charted in the analytical framework, we discussed grouping the sub-dimensions into higher-order dimensions.

Public and community involvement and engagement

This review builds on our recent Care Act easements project,[47] which concluded with a focus group with four participants aged 70 and above whose spouses were or had been in receipt of homecare services. The group endorsed the aims and focus of the present review. We also discussed the work with our public and community involvement and engagement partners (the Elders Council of Newcastle and the Greater Manchester Older People’s Network), who endorsed the aims and objectives of the review.

Findings

Included articles and characteristics

We identified 93 articles (Figure 1): 72 research papers,[48-119] six academic comment papers[120-125] and 15 reports from the grey literature (which were either comment or research),[126-140] published in 16 countries (Table 1). Most of the articles focused on homecare for older people as a general population, but around a quarter were specifically about homecare for people with dementia (n=22).

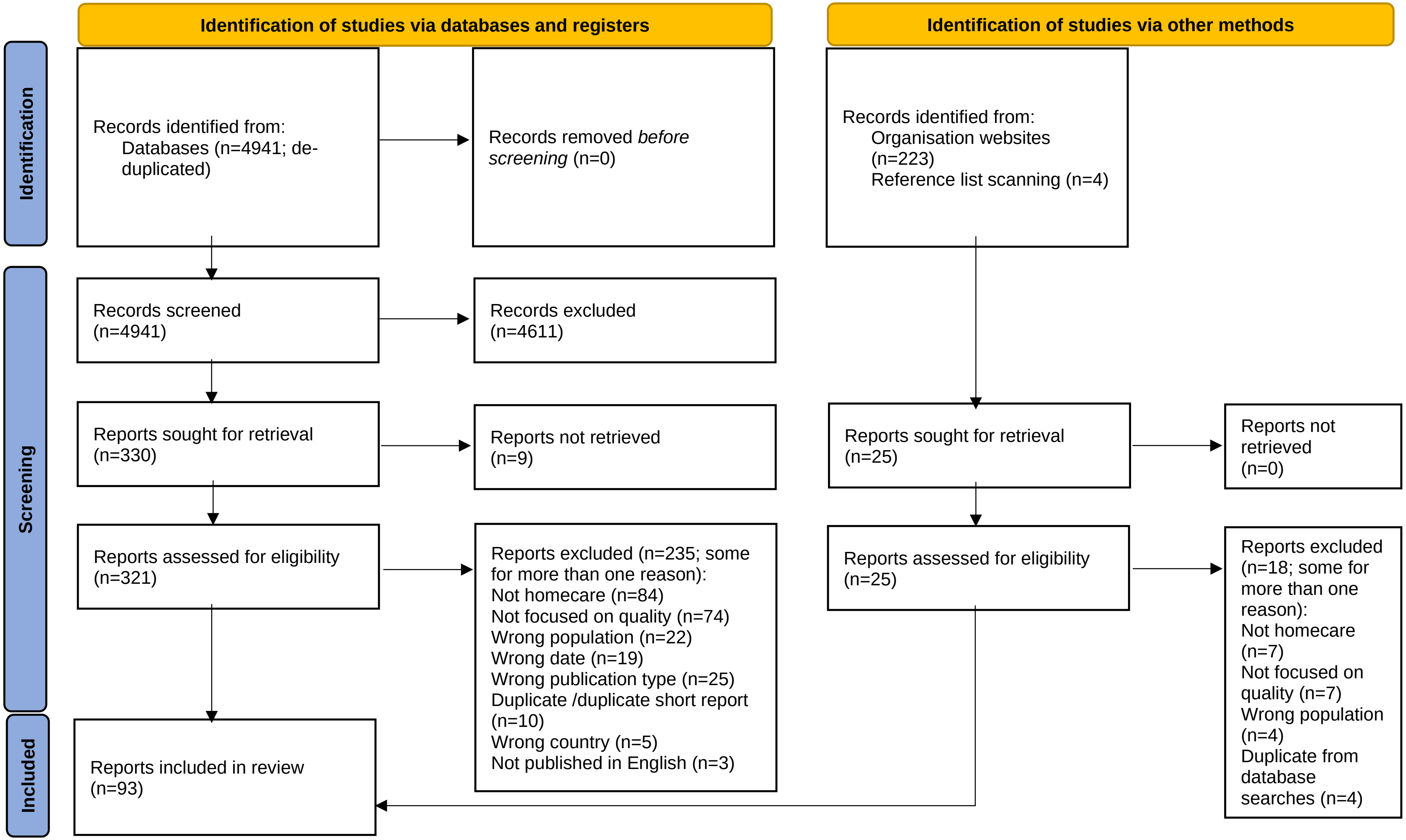


Figure 1. Flow diagram of articles

Table 1. Included articles according to country and method

	Total	Qualitative	Quantitative	Mixed Methods	Comment
Total	**93**	**55**	**16**	**11**	**11**
UK	**25**	10	5	6	4
Nordic (Denmark, Faroe Islands, Finland, Iceland, Norway, Sweden)	**35**	27	6	2	
Australia	**8**	6		2	
USA	**8**	2	2		4
Canada	**7**	4	1		2
Others (Czech Rep, Germany, Japan Ireland, Israel, Netherlands, Europe-wide	**10**	6	2	1	1

We developed four broad dimensions, three of which capture core aspects of quality [(1) to (3) below], and a fourth [(4) below] relating to measurability:

(1) relationships and continuity of care

(2) bespoke care

(3) organisational and structural aspects of care

(4) the extent to which quality is understood as a measurable construct.

Table A2 (Appendix D) summarises the characteristics of the 93 included articles, including the mapping of the four broad dimensions. We present these four dimensions in a narrative summary below, discuss similarities and differences in views among stakeholders, and consider the relationships between the different ways that stakeholders conceptualised care quality. Figure 2 shows the four main dimensions and underlying sub-dimensions. Most articles encompassed multiple dimensions and sub-dimensions. A minority (around 5%) covered all four dimensions, a third covered at least three, around a third covered two, leaving only a quarter that conceptualised quality within just one of the dimensions. Most reports therefore demonstrated that all stakeholders consider quality to comprise multiple dimensions. This was strongest for unpaid carers/ family members.

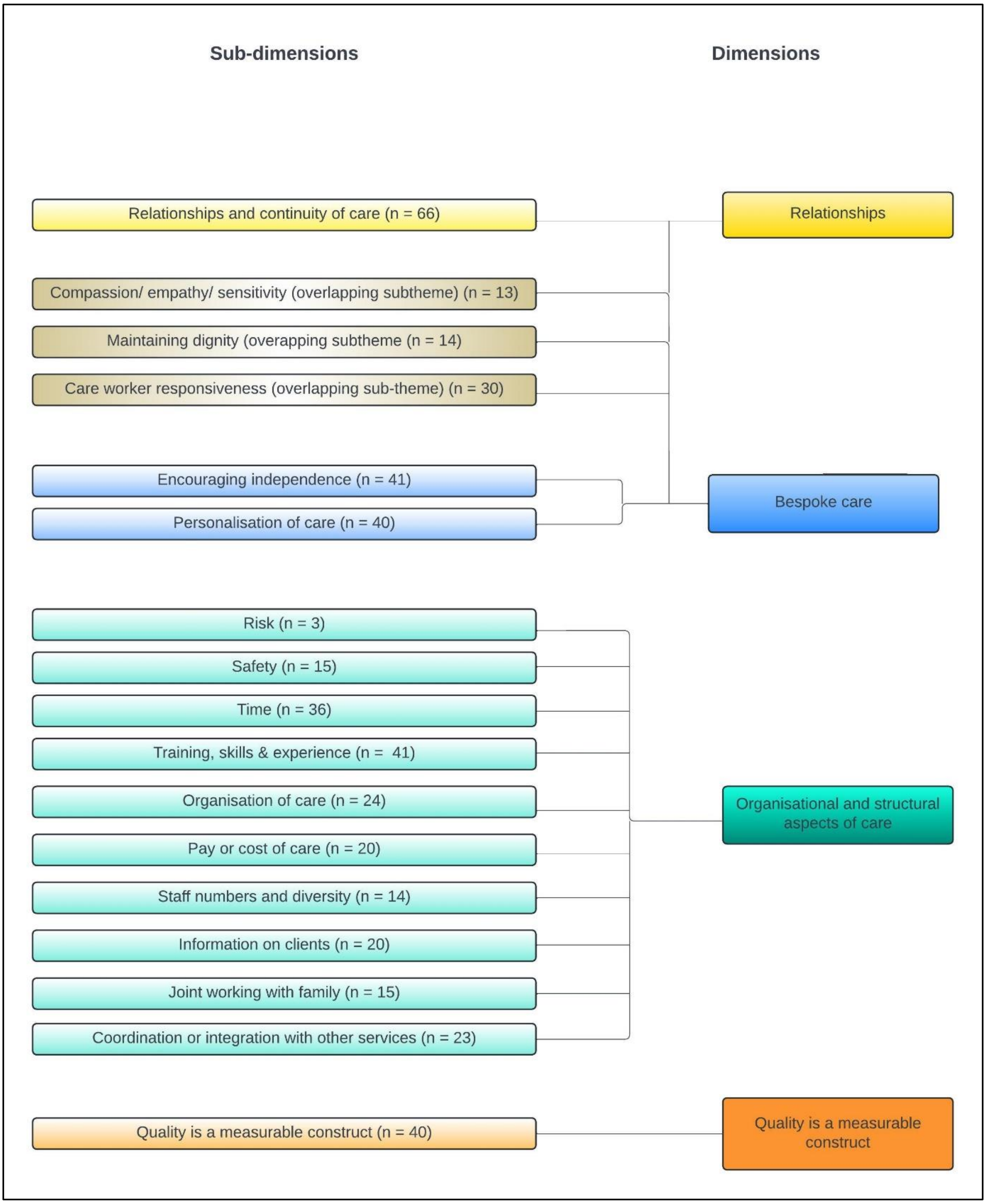
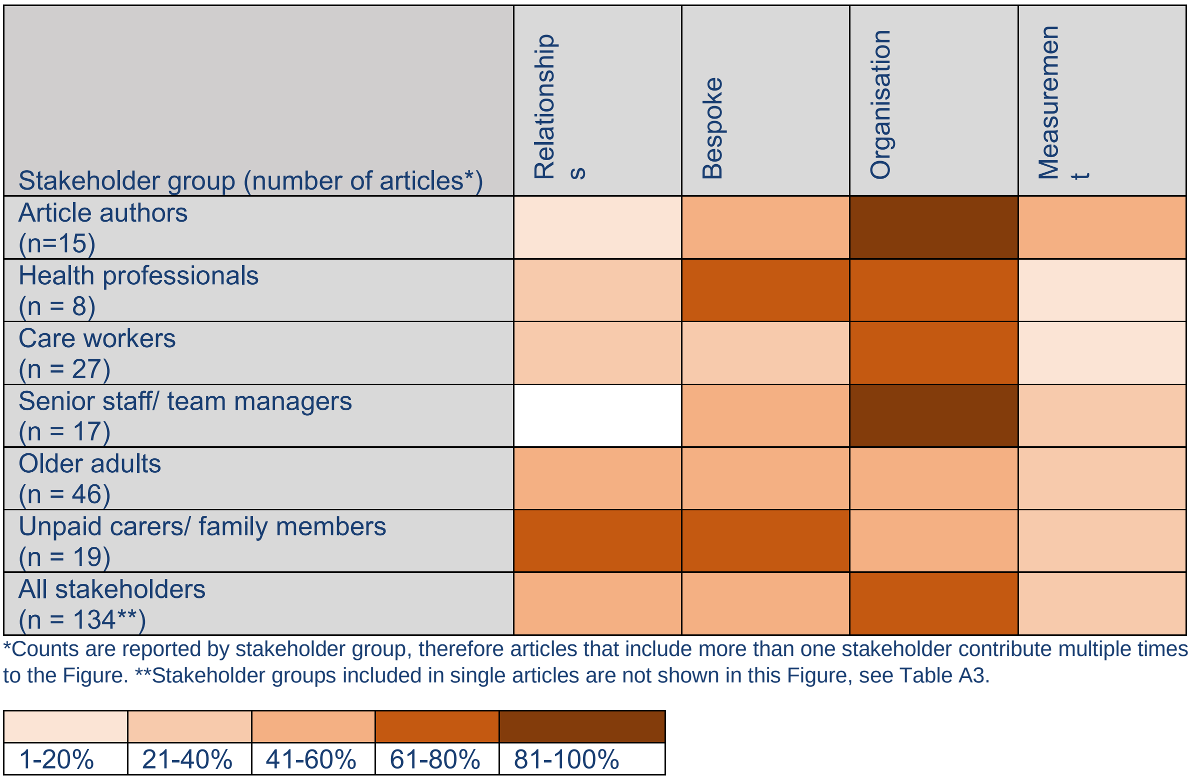


Figure 2. Dimensions and sub-dimensions observed in the included articles (n = frequency)

Dimensional and national variation by stakeholder group

There were some variations in the frequency of dimensions reported by stakeholder groups (Figure 3, Table A3 Appendix E). Organisational and structural aspects of care were reported more frequently by staff working in homecare and as reflections by the authors of articles, while bespoke care, relationships and continuity of care were slightly more prevalent among reports from unpaid carers and family members. However, given that these differences were slight and likely influenced by the nature of studies aimed at different stakeholders (including research framing), the overriding message is that there is a great deal of consensus on what is important for homecare quality.



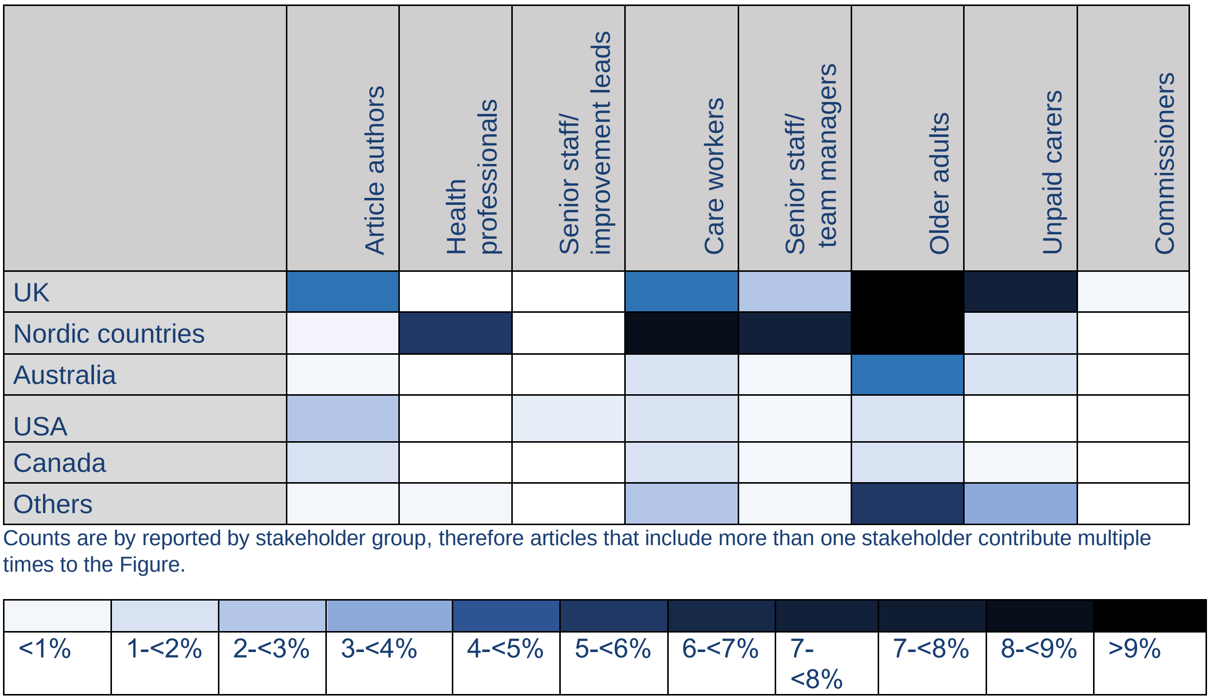
Stakeholder group (number of articles*)	Relationships	Bespoke	Organisation	Measurement
Article authors (n=15)	░	▓	🟫	▓
Health professionals (n = 8)	▒	🟧	🟧	░
Care workers (n = 27)	▒	▒	🟧	░
Senior staff/ team managers (n = 17)		▓	🟫	▒
Older adults (n = 46)	▓	▓	▓	▒
Unpaid carers/ family members (n = 19)	🟧	🟧	▓	▒
All stakeholders (n = 134**)	▓	▓	🟧	▒

*Counts are reported by stakeholder group, therefore articles that include more than one stakeholder contribute multiple times to the Figure. **Stakeholder groups included in single articles are not shown in this Figure, see Table A3.

░	▒	▓	🟧	🟫
1-20%	21-40%	41-60%	61-80%	81-100%

Figure 3. Heat map of dimensions reported by stakeholder groups

There were also some subtle international variations in the reporting of different stakeholder group views (Figure 4), although they need to be interpreted with caution since the underlying numbers of articles by country and stakeholder group are very small (Table A4, Appendix E). Most countries had produced articles on how quality is conceptualised by older adults (13/16 countries) followed by care workers (12 countries). Articles from the UK comprised a quarter of the included studies and captured the greatest range of stakeholder groups (six), with emphasis on the views of older adults and unpaid carers, followed by Australia, the USA and Canada (five). There was also a clear cluster of views of care workers, senior staff and health professionals from the Nordic countries (the presence of the latter group reflects the organisation of homecare and team composition in these countries, where qualified health professionals are involved in social care delivery). Despite articles from Norway accounting for nearly a fifth of the total body of literature (second to the UK), they only represented three of the stakeholder groups, with views from unpaid carers/family members absent.



Counts are by reported by stakeholder group, therefore articles that include more than one stakeholder contribute multiple times to the Figure.

Figure 4. Heat map of perspectives by stakeholder group and country

We now turn to discuss each of the four dimensions in detail.

Quality is about relationships and continuity of care

Summary

The analysis of this dimension revealed that the development and maintenance of relationships between older people and care workers, and continuity of care (i.e., having the same care worker), are seen as important determinants of quality. Relationships and continuity of care were explored in 43 studies across 12 countries (plus one European-wide report). The majority of articles were Scandinavian (n=15) or UK-based (n=12). Most (n=32) were qualitative, with four quantitative studies, four mixed methods studies, and three comment pieces. Conceptualisation of quality as a function of relationships and continuity was encountered in two-thirds of articles where unpaid/family carers views were included, over half of articles involving older people and almost half of articles where care workers views where included (Table A3, Appendix D). It also appeared in approximately half of articles from senior staff/managers and health professionals.

The studies highlight that both relationships and continuity of care are vital for enhancing the quality of life and care experiences for older adults. Challenges such as high staff turnover, communication difficulties, and over-familiarity can complicate these relationships. The findings also suggest that while relationships and continuity of care are often discussed separately, they are interrelated and can significantly influence each other, impacting on the overall quality of care.

Evidence

Older people and unpaid/family carers viewed high quality care as being dependent on the relationship between the older person and the carer, with emphasis placed on trust, communication, and the ability of the carer to know and understand them beyond their surface level care needs.[63, 74, 90, 93, 95, 102, 111] Relationships were also a recurring issue for care workers/health professionals, who viewed good care as being characterised by open communication and mutual understanding.[49, 74, 84, 111, 112, 133] Care workers also highlighted potential challenges around forming relationships with the older people they cared for. Staff sometimes felt they were 'too close' and were seen as members of the family, which could result in the older person not listening to them.[59] Another study found that care workers/health professionals who had a desire to be seen as a 'good' person were at risk of overstepping their boundaries or responsibilities.[108] Everyday racism towards care workers could also prove challenging, causing elements of the care relationship to be rejected.[98] Furthermore, communication difficulties may arise due to cognitive impairment or dementia, with some care workers feeling they do not possess the necessary skills to ensure effective interactions.[86]

Only one study reported the views of senior care staff/managers regarding relationships. A mixed sample of senior homecare staff and health professionals felt that good carers should have a close relationship with those they care for, much like family or friends, but acknowledged that this is not always possible for various reasons (e.g., high staff turnover; communication difficulties due to high volumes of foreign care workers).[114] The same study reported ambivalence amongst some managers towards carers becoming too close to the older person.

The importance of the care relationship was also highlighted in the grey literature. The Global Coalition on Aging gave particular weight to this, stating that relationship-based homecare 'will empower countries to deliver on the promise of high-quality care' for older people.[135] Researchers in the field argued that high quality care is characterised by mutual care between care workers and those they care for, but this can be undermined by organisational level structures such as low pay, high turnover, few benefits, little control over working hours and care recipients, and inadequate training.[125]

The perceived essential nature of the care relationship for high quality care overlapped with the conceptualisation of quality as hinging on 'continuity of care.' Continuity of care, whereby a small number of care workers visit the same person regularly, was seen by many older people, unpaid/family carers, and care workers as important to high quality care.[62, 74, 97, 106, 107, 110, 117, 126, 128, 132, 133, 139] Only one study suggested that continuity was important to some older people and not others.[96] Healthwatch England highlighted that lack of continuity was a problem for older people, with as many as a quarter of service users almost never seeing the same care worker.[136] It was acknowledged that this could cause particular anxiety for people with dementia. There were only two studies examining continuity of care from the perspectives of senior staff and management, both suggesting that continuity is an important aspect of high quality care. In one study, senior homecare staff suggested that continuity of *care managers* promotes better decisions and more efficient decision-making.[70] In another study, providers of homecare services suggested that high turnover of staff impacts continuity of care.[138]

Although often discussed independently, relationships and continuity of care can be viewed as interrelated concepts that may influence each other. Older people, unpaid/family carers and care workers felt a relationship built on knowledge and understanding depends on continuity of care, as these relationships take time to develop.[50, 65, 67, 82, 83, 94, 100, 102, 107, 127] One study found that patients were more likely to rate the number of carers as suitable when they reported that they were familiar with them.[71] In a study of older people receiving homecare, interpersonal factors, such as relationships, were found to have a greater impact on quality of life than organisational factors, such as continuity of care, although both aspects were found to be significant.[92] Similarly, a study of older people with dementia found they experienced a trusting relationship as more important than the same staff visiting them regularly, but the authors note that continuity of care and trusting relationships are factors that may influence each other.[79]

Table 2 summarises the nuanced variations in how different stakeholders conceptualise the importance of relationships and continuity of care for high quality care. This reveals a great degree of congruence between care workers, older people and unpaid carers/family members both in the importance they place on this dimension and in the ways that they think about it. Trust was an important component for older people and unpaid carers. Communication and understanding were important components for older people, unpaid carers and care workers. Managers and senior staff also value a close relationship between carers and recipients of care, but the components of this relationship were not specified. All stakeholders valued continuity of care.

Table 2. Stakeholder conceptualisations of the importance of relationships and continuity of care for high quality care

Relationships and Continuity of Care			
Older People	Unpaid carers/Family Members	Care Workers	Managers/Senior Staff
Trust	Trust		A close relationship between carers and recipients of care
Open communication and collaboration	Open communication and collaboration	Open communication	
Ability for care worker to understand them beyond 'surface' care needs	Ability for care worker to understand them beyond 'surface' care needs	Mutual understanding	
Seeing the same care workers regularly	Seeing the same care workers regularly	Seeing the same care recipients regularly	Continuity of staff and management

Quality is about bespoke care

Summary

In this dimension we use the term 'bespoke' care to mean care centred on individual needs, personalities, histories and circumstances; that meaningfully involves people in designing their care; is compassionate and empathetic; and facilitates choice and control in how service user and caregiver needs are met, in ways that maintain dignity and independence. We have avoided incorporating the phrase 'person-centred care' because this has become a ubiquitous term that has a large number of meanings in the field. The importance of bespoke care was strongly recurring for all stakeholder groups, except senior staff/ quality improvement leads and local authorities or their equivalents for which there were only two included studies (Figure 3). It comprised five sub-dimensions, three of which overlapped with the relationships dimension (Figure 2). The bespoke care dimension was explored in 57 articles from 14 countries, particularly prominently in Scandinavian work (n=25) and in the

UK literature (n=13), with smaller contributions (n=1 – 4) from the other countries. Most of the work (n=41) was qualitative, with seven quantitative studies, four mixed methods studies and five comment pieces.

The studies, mostly qualitative, highlighted that older adults value having control and choice, maintaining dignity and independence, and having care that is responsive to their needs and histories. This perspective was shared by family members, who stressed the importance of routines aligned with the care recipient's lifestyle and respect for emotional, social, and cultural needs. Care workers and health professionals also recognised the importance of adapting care to individual needs and ensuring respect for dignity. The literature acknowledged potential challenges, such as difficulties in identifying psychosocial needs, especially in dementia care. There were also differences in views, with some older people not expressing their desires or being reluctant to participate in care decisions. Organisational challenges, such as time constraints and balancing unmet needs with wants, were also noted as potential barriers to providing bespoke care. Overall, the dimension underscores the importance of personalised care in enhancing the quality of life and care for older individuals.

Evidence

Most of the literature reporting older people’s views and preferences on what makes good quality care highlighted that older people felt it was important to ensure personalisation, choice and control and to maintain their dignity and independence, often through having a say in the care that they receive.[67, 82, 83, 94, 97, 109, 113] This was similarly central in comment pieces and grey literature.[122, 124, 128, 139] Older people also highlighted the importance of care that engaged with them and listened to their needs and those of their families.[60, 96, 106] There was acknowledgement by older people and by authors of research and grey literature that it is important for care to be responsive to changing needs.[83, 90, 96, 111, 115, 131, 135] This was echoed in quantitative work showing that older people and families emphasised the need for carers to respect and to know the person.[63] Conversely, older people felt that a lack of involvement in planning care reduced the extent to which they felt their care was attuned to their needs.[104] Fostering a sense of independence was seen to be an important marker of quality care by older people as it could influence their acceptance of the inherent dependency upon care.[93] Other work showed older people’s preferences for acknowledgement of their complex, life histories, personal identities and relationship histories that went beyond immediate care needs.[57, 120]

Similar perspectives were held by family members, who believed that older people should have opportunity to participate and influence their own care,[107] and that care should be delivered according to routines that align with the care recipient’s way of living,[74] respectful of their emotional, social and cultural needs,[65] and compatible with their broader family context.[72] Some work reported that families favoured consultation with care services to help identify how care may be personalised for the older care recipient.[102] Two related quantitative studies from the UK found that unpaid carers of people with dementia, at both early and late stage, valued emotional support.[61, 87]

Care workers also saw the importance of choice and control for older people, and for care to align with their needs, requirement and preferences, way of living and family contexts.[56, 59, 68, 72, 74] In the context of homecare for older people with intellectual disabilities, the importance of flexibility of staff to adapt to changing needs of clients, facilitate their involvement and to focus on clients’ perspectives to understand their wishes, needs and behaviours has been identified by care workers and other professionals as a key component of Integrated Emotion-Oriented Care (IEOC).[112] Health professionals were also aware of needs for tailored, person-centred care that respects dignity, delivered by people knowledgeable about the person's family life and situation.[49, 99, 114] In the context of dementia care, quantitative work suggested that maintaining independence or upholding dignity may be more challenging for service users, e.g., if care workers ignore the older person or treat them like a child, but was no less important to the service user or to their family.[75, 78, 103, 130]

Some senior care staff, including CEOs, recognise that compassion, sensitivity, respect for dignity and a focus on ethics of care are important drivers of care quality.[51, 52, 55] Empathy was seen as important by care workers, particularly when experiencing challenges in delivering personal care and in dementia care.[50, 116, 118]

Although this literature was largely uniform in emphasising bespoke care as being key to quality, there was some recognition of potential divergent views. One study from Norway highlighted that some older people may not voice their own desires out of politeness, or that some would not want to be involved in decisions about their care and may find it odd to be asked.[96] Another Norwegian study with people with dementia found that homecare services could be difficult for them to understand clearly, but that they accepted the support they were offered as they did not want to cause difficulties for the care workers.[79] Other work found that some older people may dismiss any dissatisfaction with non-bespoke care by citing perceived organisational challenges as barriers to its provision, e.g., they could see the staff operating under time constraints.[117] One study in Canada found that senior care staff and managers attempted to consider service user wishes and ability to make their own decisions about their care, but recognised the need to balance and differentiate between meeting their unmet healthcare needs with their wants, as they felt that homecare may be unable to meet the latter.[70] However, it was unclear from the study how the differentiation between 'needs' and 'wants' is made, or who is making the distinction. We discuss organisational and structural aspects of care and their relationship with quality in the following dimension.

Table 3 summarises the extent to which there was almost no variation in how different stakeholders conceptualise the importance of bespoke care for high quality care. This reveals a great degree of congruence between all stakeholders included in the articles in this review both in the importance they place on this dimension and in the ways that they think about it.

Table 3. Stakeholder conceptualisations of the importance of bespoke care for high quality care

Bespoke Care			
Older People	Unpaid carers/Family Members	Care Workers	Managers/Senior Staff
Compassion/empathy/sensitivity	Compassion/empathy/sensitivity	Compassion/empathy/sensitivity	Compassion/empathy/sensitivity
Care should be personalised to align with recipient's way of living and individual needs, and older people should be involved in care planning.	Care should be personalised to align with recipient's way of living and individual needs, and older people should be involved in care planning.	Care should be personalised to align with recipient's way of living and individual needs, and older people should be involved in care planning.	Care should be personalised to align with recipient's way of living and individual needs, and older people should be involved in care planning.

Care that is responsive to changing needs	Care that is responsive to changing needs	Care that is responsive to changing needs (in the context of recipients with intellectual disability)	Care that is responsive to changing needs
Maintaining dignity	Maintaining dignity	Maintaining dignity	Maintaining dignity
Supporting independence			

Quality is about the organisational and structural aspects of care

Summary

This dimension captures the extent to which quality is understood according to organisational and structural aspects of care and care systems. It includes work highlighting aspects relating to the homecare workforce (e.g., the need for sufficient numbers of well-trained, suitably skilled staff who are remunerated appropriately), the organisation of care (e.g., considerations of time taken to deliver care) and wider structural aspects (e.g., the co-ordination or integration of homecare with other aspects of health and care systems). It has some overlaps with the first two dimensions, as the ability to deliver relational and/or bespoke care may at least be partly contingent on organisational and structural factors. However, it is also partly distinct from the two earlier dimensions, as there are some understandings of quality based on organisational and structural factors that may not align clearly with understandings that emphasise relational and/or personalised care.

This dimension was the most populated and complex of all four main dimensions, covering 10 sub-dimensions (Figure 2). It was explored in more articles (n=72) than any other dimension and across the greatest range of countries (n=14, plus one European-wide report). Most were conducted in Scandinavian countries (n=27) and in the UK (n=21). The importance of organisational and structural aspects of care recurred across all stakeholder groups but was more frequently encountered in articles which reported the views of senior staff and team managers, care workers and health professionals (Figure 3). Most articles were qualitative (n=46), with five quantitative studies, 10 mixed methods studies and 11 comment pieces.

Key points

1. Older People and Families: Valued choice, control, and flexibility in care. They expressed concerns about lack of choice, inadequate information, and difficulty navigating the system. Costs were linked to perceived care quality, and effective communication between services was crucial. They stressed the importance of trained and reliable care workers, especially in dementia care.

2. Care Workers: Emphasised the need for organisational support, fair wages, adequate staffing, and training. Time pressure and poor working conditions were major concerns, affecting care quality and safety. Effective communication and collaboration were vital for high-quality care.

3. Senior Staff and Managers: Recognised the need for information, communication, and a supportive work environment. They highlighted issues like recruitment challenges, funding, and market competition. They also noted the importance of understanding and addressing structural issues to improve care quality.

4. Experts and Researchers: Echoed concerns about equitable access to services, the impact of financial models on care quality, and the need for coordinated, team-based services. They emphasised the importance of adequate funding, training in mental health and dementia care, and clear mechanisms for feedback and complaints.

Overall, the dimension underscores the complex interplay between organisational and structural factors and their impact on homecare quality. It highlights the need for a well-supported workforce, effective communication, and appropriate funding to achieve high-quality care.

Evidence

Older people, families, and the organisation of care

Similar issues were raised by older people and family members in relation to organisation of care. Both groups placed importance on choice and control, information, access, and coordination in relation to care. Older people valued choice and flexibility in their care, in the form of self-managed care or the use of micro-providers (small businesses that provide care and support in diverse ways), as this allowed them to have more control over the care they received.[91, 106, 133] Older people and their family members were concerned about a perceived lack of choice regarding homecare services, which can result in people feeling unable to question the care they are receiving as no alternative options are available to them.[136] This may be exacerbated by inadequate or misleading information on the care options available to them.[60, 94, 96, 106, 113, 127] Both older people and their family members reported finding it very difficult to navigate the system to arrange care for themselves or a loved one.[127]

Care costs were seen in some studies as related to quality. One study reporting high variation in hourly rates among homecare recipients.[106] Other studies examined the relationship between costs and perceived quality of care. A Swedish study reported that the perceptions of older people regarding quality of care remained level, despite steadily increasing costs,[89] whereas another UK-based study suggested that older people and their families' experience of care at the point of use was inadequate and they had to pay more to receive care that in their terms met a high standard.[127]

Well-coordinated care is important for both older people and their family members, with emphasis being placed on communication between organisations/services.[60, 94, 96, 107, 126, 136] Communication between services and older people/families is also viewed as important, as both groups reported uncertainty about how services were organised and a lack of involvement in planning and scheduling.[72, 79, 104, 127] For people with dementia in particular, there can be a great deal of uncertainty about how the service is organised, experiencing the service as being predetermined, which limited opportunities to participate in decision-making.[79] Case managers, or a key person assigned to co-ordinate care were viewed as integral to high quality care.[97, 106] Unpaid carers/family members felt that collaboration between families and care organisations is vital if high quality care is to be achieved.[65]

Older people expressed fear that raising a complaint might negatively affect the care they were receiving. For those who did complain, many felt their concerns were not taken seriously, and those who proposed service improvements felt their suggestions were not acknowledged or acted upon.[136] Other issues important to older people and family members, and linked to organisation of care, related to the homecare workforce, particularly their level of training and experience. Older people valued homecare workers who were seen as appropriately trained, knowledgeable, reliable, and trustworthy, with good communication skills.[106, 107, 109, 117, 126, 128, 130] Older people and family members emphasised the need for appropriate training in relation to dementia.[60, 62, 72, 87, 102] They also placed importance on punctuality and sufficient time being allocated to carers to complete required tasks.[74, 83, 96, 106]

Time was seen as a key indicator of quality care, with longer visits viewed as integral to building a trusting relationship,[65, 94, 107, 109, 127] and short visits causing carers to seem ‘hurried and stressed’ from the perspective of older people.[117] One Norwegian study (the only study that reported descriptive quantitative findings in relation to time) noted that 83% of patients and 80% of unpaid carers reported that homecare workers had enough time during care.[71] Numbers and diversity of staff and safety issues were a concern for older people in particular. Rapid staff turnover and a lack of racial and ethnic diversity was viewed as resulting in a depersonalised service that lacked continuity of care.[60, 128] This may lead to older people feeling unsafe and insecure as they are unable to develop strong relationships with their carers.[94, 96, 106, 109, 111]

Care workers, organisational structures and time

Care workers identified quality issues related to organisational and structural aspects of care that echoed those of older people and family members, although their perspectives placed greater emphasis on system-level challenges. They highlighted the need for organisational support, such as ongoing education, fair wages and sufficient staffing to improve care quality and promote relationships characterised by continuity, integrity and respect, as well as the need for policies reflecting experiences and knowledge of frontline workers.[51, 54] Collaborative practices such as teamwork and effective communication between older people/families, care workers and management, as well as between services, were seen as important to high quality care.[54, 68, 72, 105, 108, 112, 118, 119] In some contexts, care staff reported they did not experience integration and collaboration across services and this reduced opportunities for continuity, dialogue and interdisciplinary support.[73] Inadequate pay, working conditions and training were also viewed as hindering high quality care. Care workers saw a need for training to better understand dementia and its progression in order to provide high quality care and include the family in the planning and provision of care.[54, 72, 86, 118, 130] In the UK, workers reported feeling overworked and undervalued, with pay not reflecting level of responsibility and a general lack of recognition from the government compared to NHS staff.[130, 140] Similarly, a mixed sample of care workers and health professionals felt additional training is required to improve safety,[108] but there is also a need for more organisational support, with care workers reporting lack of a formal mandate to deal with safety issues as they arise (e.g., whether a client should be sent to hospital; how to report abuse).[64, 76]

Time pressure was a strongly recurring issue for care workers and health professionals and was seen as negatively impacting quality, as it is viewed as incompatible with personalised care and threatening to safe care.[74, 80, 108, 114, 118] Care workers reported not having enough time to complete scheduled tasks and often ‘going the extra mile’ and working additional time unpaid to ensure good quality care.[116, 140] Insufficient staffing levels may be a contributing factor to time pressure.[54, 80] Health professionals reported that time pressures may also exacerbate safety issues, with task completion being prioritised over the health of clients.[99] Care workers felt their duties were often unclear and undefined, particular with regard to medical tasks,[64] and working conditions often resulted in stress and exhaustion due to time pressure.[50, 59, 105]

Perspectives of senior homecare staff, managers and providers

Senior homecare staff and managers/providers recognise and echo many of the concerns highlighted by older people, their families, and care workers, particularly regarding the need for thorough information about providers and effective communication within and between services and families,[68, 72, 73] the necessity of case managers to coordinate care,[70] and the importance of a supportive work environment if high quality care is to be achieved.[52, 72] Perceived benefits of integrated working (e.g., improved flow of tasks, connection, trust, knowledge and mutual understanding) were much clearer for managers than for care workers due to shared office space and working hours.[73] Some of the organisational challenges facing management included regulations and practices that were seen to favour larger companies,[55] recruitment and retention problems due to low pay and lack of experienced applicants,[51, 70, 114, 129, 132] poor communication between health and homecare services (e.g., lack of detail regarding medication),[132] and problems funding the service (e.g., low pricing in order to remain competitive), implicitly linked to lower quality care.[138] Pressure to compete locally and provide services commissioned by local authorities means employers had limited capacity to improve pay for their staff.[129]

A survey of local authorities in the UK found that the way in which older people contribute to costs of their care varies greatly, and for many people care is unaffordable, with access to support for paying for care unevenly distributed across the country.[134] A report by the CQC addressed issues around access and continuity of care, noting that some local authorities were paying retainers to care providers to keep packages of care open if a person they cared for was admitted to hospital, meaning the same care provider would still be available when the person was ready to be discharged. This approach also provided greater stability to the homecare market, enabling providers to recruit and retain staff at reduced risk.[132] The same report stated that local authorities recognised the challenges providers face in relation to recruitment and retention of staff, and some were increasing rates of pay to providers to enable them to offer better working conditions. A number of local authorities were also reforming their homecare markets to increase quality and capacity by reducing the number of providers on the commissioning framework to support more stable and high-quality provision.[132]

With regard to care workers, management often viewed homecare quality as being dependent on the attributes of the carer, rather than an organisation. For some managers, good care involves staff who ‘love their work’ and are not just doing it for the money,[114, 116, 119] which may be used as a justification to avoid changing working conditions.[119] Managers highlighted how contractual obligations determined the use of clock time for care workers,[58] and acknowledged how this can challenge the provision of personalised care and create time pressure for care workers.[55] Some managers expressed empathy for care workers having to rush, but were also distrusting of staff and suspected them of cutting visits short.[114] With regard to safety, care managers have to accept client choice about the level of risk they choose to live with, while also being aware of any changes to the client’s support system to help mitigate risk.[70]

Research framing and expert consensus: the importance of structural issues for high quality care

The organisation of care is a widely researched area, and the views of experts largely echo the challenges to high quality care highlighted by older people, their families, those working in the field, and managers. In terms of access to services, researchers have argued that quality involves equitable access, and strategic planning is required to better understand supply and demand issues as well as funding models to enable equality of access.[124, 134] Researchers also widely agreed that people’s needs are best met by coordinated, team-based services.[120, 122, 124, 130, 135] There has been substantial research on working conditions for care workers, particularly in North America, and these issues have been linked to financial models of care provision. Low wages, inconsistent hours, few benefits, and lack of regulation, can lead to lower quality care and result in workers leaving the field.[121-125] An expectation is placed on care workers to overcome difficult working conditions in a ‘heroic’ manner, with little organisational support.[114] Research has shown that services are struggling to maintain or improve quality standards within tight financial margins imposed by municipalities or councils,[89, 131] and that the marketisation of adult social care compromises care quality due to problems with staff recruitment and retention, and low pay.[137] In the UK, funding is seen to be at the core of the care crisis, and recommendations for councils to improve homecare services include examination of the impact of reductions in hourly rates, incentivising outcome based commissioning, and utilising open book accounting arrangements (a transparent approach to procurement) with providers.[138]

Links between structural issues and the dimensions of relational and bespoke care discussed above were made by researchers and experts. An emphasis on efficiency coupled with financial constraints made it challenging for the carer to focus on the individual beyond their immediate physical needs.[77] Relational care was seen as undermined by homecare structures that impose strict time limits,[125] whereas structures that allow flexibility in work practice (e.g., the Danish care system) allowed care workers to act according to the particular care demands they encounter on any given day.[115] Care plans could facilitate person-centred care and should be regularly reviewed and updated to align with clients' needs and preferences.[56, 136] Experts argued that if local authorities want to commission care that meets people's needs, there should be a clear understanding of the price of the care to be offered, the choice of services that may be required, and the outcomes to be sought and measured, as well as an assessment by both care managers and providers to ensure that people are getting the right help.[131]

Experts and researchers identified that in order to improve homecare quality, care workers should be trained in both mental health and dementia care, and lobby groups have argued that governments must find the resources to ensure all local authorities offer a high-quality, dementia-specific training programme.[120, 122, 130] There is also a perceived need for increased data collection to assess abuse, neglect, or adverse events in the context of homecare as this will impact on both care worker and client safety.[123] Providers and carers were seen as needing to make it clear to their clients how they can give feedback, both positive and negative, and how complaints or allegations of abuse would be handled, as this would impact on safety.[123, 136]

Table 4 summarises the extent to which, although as the analysis above shows these were sometimes differently expressed, there was a very high degree of congruence across these stakeholders in how they conceptualise the importance of organisational and structural factors for high quality care. Some subtle distinctions are that older people perceived rapid turnover of staff as being linked to lack of continuity of care and a depersonalisation of care, whereas care workers linked insufficient staffing with time pressures, while managers were concerned with issues around recruitment and retention. For older people, safety issues were associated with a lack of continuity of care workers. Care workers linked safety to appropriate training and reduced time pressures, whereas managers were concerned with helping their clients mitigate risk in their homes. All stakeholders viewed time as an essential issue for high quality care, as well as well-coordinated care and good communication between organisations, services, and older people and their families

Table 4. Stakeholder conceptualisations of the importance of organisational and structural factors for high quality care

Organisation of Care			
Older People	Unpaid carers/Family Members	Care Workers	Managers/Senior Staff
Organisational support –	Organisational support –	Organisational support –	Organisational support –

appropriately trained and knowledgeable care workers	appropriately trained and knowledgeable care workers	appropriate training, pay, staffing	appropriate training, pay, staffing
Well-coordinated care/good communication between organisations, services, and older people and their families	Well-coordinated care/good communication between organisations, services, and older people and their families	Well-coordinated care/good communication between organisations, services, and older people and their families	Well-coordinated care/good communication between organisations, services, and older people and their families
Sufficient time to complete tasks	Sufficient time to complete tasks	Sufficient time to complete tasks	Sufficient time to complete tasks
Number and diversity of staff – rapid turnover and lack of ethnic diversity impacts continuity and personalisation of care		Sufficient staffing linked to reduced time pressure	Sufficient staffing – issues around recruitment and retention
Cost of care seen by some as related to quality	Cost of care seen by some as related to quality		
Safety – linked with a lack of continuity of care workers		Safety – linked with appropriate training and sufficient time to complete tasks	Safety – help clients mitigate risk
Easily available information	Easily available information		Easily available information

Quality is a measurable construct

Summary

This dimension overlaps with the other three dimensions, as it has implications for the extent to which relational care, bespoke care, and specific organisational and structural aspects, deemed to be important in understandings of quality, might be measured (Figure 2). The measurement of quality was represented in fewer articles (n=33, spanning 11 countries) than the other dimensions. Of these articles, 11 used a quantitative methodology, 11 were qualitative, six were mixed methods, and three were commentaries. There was relatively little data for analysis, and what there was mostly came from studies involving care workers in Sweden and the UK, unpaid carers and family members in the UK and older adults in the UK, Sweden, Israel, Australia and Canada. With the exception of one study involving senior staff and quality improvement leads which focused entirely on quality as a measurable construct, and some commentaries, the importance of measuring quality was reported alongside other dimensions. Nevertheless, it appeared significantly less often than the other dimensions in studies involving the main stakeholders (Figure 3, Table A3 Appendix E). There were no clear differences in views between people that receive care and support and those that provide it.

Thirteen instruments were identified across the reviewed articles for measuring homecare quality from the perspectives of older people, unpaid carers, care workers, and managers (Table A5; Appendix E). These instruments assessed quality through common aspects such as satisfaction, carer responsiveness, personalisation, relationships, communication, dignity, safety, and organisation of care. Many measures adopted a person-centred approach, some explicitly, like the Person-Centered Care Assessment Tool (P-CAT) and the Person Directed Care measure (PDC), and others implicitly, focusing on care experience and quality of life. The literature underscores the value of collecting quality data in homecare, though there is uncertainty about what data to collect. Continuous quality monitoring was advocated in some studies and commentaries, though challenges in identifying appropriate measures were noted. Studies called for a person-centred approach to evaluating homecare, suggesting further development of quality measures, especially for older people with cognitive and functional impairments. Interpersonal care processes and the care relationship were deemed crucial for quality evaluations, with some recommending observational data collection over self-report measures to reduce bias. There are calls for performance metrics focused on user satisfaction and outcomes for older people. While there is consensus on the importance of measuring homecare quality, uncertainty remains about the best methods. Nevertheless, a person-centred approach, considering the carer-client relationship, is largely seen as essential for effective quality measurement.

Evidence

We identified 13 instruments that had been developed or were described as possibly being used to measure the concept of homecare quality from the perspectives of older people, unpaid carers and family members, care workers, and/or managers (Table A5; Appendix E). For all measures, homecare quality was operationalised using a number of common aspects of care, including general satisfaction with care, carer responsiveness to needs, personalisation of care (in the sense of bespoke care, as we have discussed it above), relationships and communication, dignity, safety, and organisation of care (including psychosocial aspects of the work environment for carers). All measures view quality through a person-centred lens, although to varying degrees. Two measures, the Person-Centered Care Assessment Tool (P-CAT) and the Person Directed Care measure (PDC), view person-centred care as being synonymous with high-quality care, and only included items with a person-centred focus.[88] Similarly, the Quality of Care Questionnaire and the Life Through My Eyes questionnaire were developed using a person-centred framework and explicitly seek to measure quality in terms of support for the preferences of the older person and knowledge and understanding of their individual needs.[63, 95] Others are more indirect, with a focus on the care experience and quality of life, which can implicitly be viewed as related to person-centred care. For instance, the National Board of Health and Welfare in Sweden administers an annual national state survey to evaluate user experience of homecare services.[53, 75, 85, 117] Many questions are structured to capture views and preferences of the older person regarding their care. Similarly, the ASCOT measures social care related quality of life (SCRQoL) with a focus on the outcomes of care for care recipients and carers, many of which take into account the individual needs and preferences of the older person.[103] The Homecare Quality Indicators (HCQIs) derived from the RAI-HC similarly focus on health outcomes implicitly considered to be associated with the quality of care provided.[66]

From the literature, it is clear that there is great value placed on collecting data in relation to homecare quality, but there is also uncertainty about the most appropriate data to collect. Due to the nature of the dimension, views regarding measurement are predominantly from the perspective of researchers and senior care home staff/managers. In a study of older people receiving homecare, the authors argued that continuous quality monitoring of homecare services should be undertaken,[60] a view also emphasised in commentaries by long-term care experts and geriatricians,[122] and public health experts who highlighted a lack of standardised data collection.[123] A study in a sample of senior homecare staff echoed the sentiment that measuring quality should be a top priority for homecare organisations, but acknowledged that some organisations struggle to identify appropriate quality measures, and did not provide detail relating to appropriate measures.[48] They also highlighted that organisations working with older people were less experienced in identifying quality areas than those working with younger people.[48]

In studies that included mixed samples of older people, unpaid carers/family members, and care workers, it was suggested that more work needs to be done to develop a measurement of experienced quality of care in homecare.[74, 107] There was emphasis on the need to take a person-centred approach to the evaluation of homecare services, with quality of care being viewed as ‘a great deal more than meeting perceived care outcomes’.[74] In a study on older adults with complex needs, the authors argued that there is a need to further develop existing quality measures for use with older people with greater levels of cognitive and functional impairment (e.g., modified easy read versions or pictorial versions).[101] They suggest that given this group are the primary target audience for homecare, these types of measures should be mandatory in the evaluation of homecare.

A study with a mixed sample of care workers and senior homecare staff (managers) concluded that the interpersonal care process (how care workers behave towards their clients) is crucial for quality evaluations, and data pertaining to this should be gathered via observations as opposed to self-report measures which are more susceptible to bias.[84] Similarly, a study in a mixed sample of older people and homecare workers highlighted the importance of the care relationship in achieving good care.[111]

In the UK, the CQC is tasked with ensuring high quality adult social care and CQC inspections have been used to highlight the state of care.[137] However, a 2018 CQC report focussing on joined-up care (particularly the interface between health and social care) was critical of performance measurement of individual organisations, as it does not incentivise collaborative working across organisations, and argued that the focus of measurement should be on outcomes for older people.[132] Similarly, Healthwatch England suggest that specific performance metrics around user satisfaction should be considered to enable local scrutiny mechanisms and ensure quality care is being delivered.[136]

In summary, a number of measures have been identified in the literature that purport to measure at least some aspects of the concept of homecare quality, and there is agreement between senior homecare staff and researchers that the measurement of quality should be a priority for homecare organisations. However, there is still uncertainty surrounding the appropriate measurement of quality. The need for a person-centred approach to measurement that also considers the relationship between the older person and the carer was highlighted.

Discussion

In this section we first present a summary of the findings from this review and a reflection on its strengths and limitations, followed by a discussion of measurement issues, the relevance of these findings to the question of achieving high quality homecare for older people; and the relevance of these findings for the new regulatory framework from the CQC, set out in the Background and Appendix A. We close by discussing research gaps observed through this review.

Summary of findings

Understanding what high quality care means, and to whom, is important in improving the circumstances of older people in society. This scoping review has examined what is known from existing research literature about what 'quality of care' means to different stakeholders in the domain of paid-for social care at home (homecare, or domiciliary care) for older people. We included 93 research papers, comment pieces and reports from 16 high-income countries, published since 2016. This body of research conveys the perspectives of older people, unpaid caregivers, paid care staff and care service managers/senior staff on the issue of homecare quality. A number of perspectives were notably absent from this literature despite being in scope for this review, and they are discussed below in the section on research gaps.

Overall, there are very clear, largely consistent and widely-held views about what high quality care looks like in homecare for older people across different stakeholder groups and countries. We highlighted 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. These dimensions highlight a particular 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.

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, but that there is uncertainty about which data or measures are appropriate, or how to do this (dimension 4). The results of this review suggest some key aspects that may be important to measure to relate homecare quality to the perspectives and understandings of older people, unpaid caregivers, paid caregivers and service managers.

Strengths and limitations

Our review includes international literature with a date limitation (2016 onwards) that specifically reflects changes in the UK policy context. However, we screened over 5000 records and have reviewed close to 100 articles. Much of this literature is influenced by earlier work that informs understandings of quality. Our review required articles to focus on homecare for older adults and, therefore, those about homecare quality that do not clarify older adults as care recipients would not be included. We analysed understanding of quality according to broad stakeholder groups and did not focus on granular analysis of more specific groups. Our review is also not a review of the development of quality measurement instruments in homecare. Our use of a relatively small number of generic terms for quality may mean that we have not captured some articles. However, we considered that it would be very difficult to write about quality of care without using one of these terms. More importantly, we felt that the use of multiple specific terms for different concepts such as ‘person-centred care’ that are associated with quality presented too much risk of influencing the search and of missing potential understandings of quality that would not have been included in such a search strategy.

A final challenge is the inconsistency in international terminology to refer to homecare, which reflects different health and care systems and service provision. The UK financing model creates a striking divide between healthcare provided within the home (such as community nursing) and homecare as a specific, social care service. This is important for understanding the occupational structure and necessary qualifications for care work in the UK, where trained nurses are largely absent from the workforce and care workers may be assessed to perform ‘delegated healthcare tasks’ to meet the needs of clients.[141] In many other countries where homecare serves similar populations, it includes support delivered by trained nursing staff and other health professionals working alongside assistant nurses (akin to care workers in the UK) and encompasses a much wider range of services delivered alongside support than is typically available in UK homecare settings.[142] This is likely to affect the experience of providing and receiving care and with it, perceptions of quality. Despite this difference, the similarities of views held by different stakeholder groups about high quality care found within the included articles in our review are striking. Our findings closely reflect those of Cleland et al.’s 2021 review on defining quality of older people’s care, which applied narrower search terms, mainly included articles about residential care, and only those reporting older people’s or proxies’ perspectives.[143]

Homecare quality indicators

Many stakeholders valued collecting data to measure or demonstrate quality of homecare, but there was uncertainty about which data or measures are appropriate, and no consensus emerges from these studies. Two recent reviews appraising international homecare quality indicator sets, one by Foong et al.[144] (two interRAI sets and the ASCOT) and the other by Wagner et al. (three interRAI sets),[145] raise three points that are worth noting. First, Foong et al. found that the interRAI sets focus predominantly on clinical and functional outcomes, whilst ASCOT includes a focus on person-centred care. These are all designed to be used within services, rather than compare across settings, and all three lack coverage of structural aspects of care quality. Our review found a substantial amount of literature that included stakeholder views on organisational and structural aspects of care as being essential to quality and highlighting their influence on the relational and bespoke nature of care. It is therefore not clear how far these quality indicator sets, particularly the interRAI sets, align with our findings. Second, Foong et al. and Wagner et al. both reported methodological shortcomings with the interRAI sets leading to concerns over validity and reliability, despite their widespread use in practice. Third, Foong et al. also noted that use of routine data alone is unlikely to capture social aspects of care quality. Therefore, there is likely to be a burden of additional data collection placed upon providers if they, or researchers, want to measure quality in ways that meet the dimensions found in our review. As our findings suggest that there is uncertainty among stakeholders about which data to collect, it seems reasonable to suggest that this burden should not be underestimated. In England, current work exploring the information that homecare providers routinely collect about their service users shows that it is highly variable, and influenced by funding source, as providers who have more self-funders place more emphasis on data that reflects personalised care.[146] This work also suggests that standardised data collection would entail resource implications for providers and training for staff.

CQC and Healthwatch England argue that measurement should focus on outcomes for older people and metrics around user satisfaction. However as this review has shown, outcomes are important but not synonymous with ‘care quality.’ Many people articulate their understanding of care quality by relationships, the nature and manner of the care delivered, and organisational factors, rather than outcomes. Good outcomes may correlate with high quality care, but will also depend on many other things. Similarly, it is possible that users may be satisfied with a service, when poor quality care is delivered across domains that are perceived as less important or salient to the care recipient.

Relevance for understanding what can be done to achieve high quality care

Our review highlights the publication of almost 100 international articles between 2016 and 2023 containing very similar messages about what high quality homecare should look like for older people in high income countries. One implication of this is that across a wide range of countries, with significant variation in the funding and organisation of homecare and the composition of its teams,[142] more often than not, care is deemed lacking in aspects which stakeholders understand to be fundamental components of high quality. This raises the question of what can be done to achieve high quality homecare. Our review did not aim to explore this question, but it is telling that we found consistent and clear emphasis on various organisational and structural factors that underpin what is understood by quality. This means that research on homecare quality can read like something of a wish list.

In the context of the UK, to a large extent, this is epitomised in guidance by bodies like NICE, whose reports are designed to provide evidence-based recommendations for health and care prepared by independent committees (including professionals, citizens and interested parties).[31, 147] As highlighted in the introduction to the present review, over a decade of work since the CQC’s large-scale homecare inspection in 2012 shows that the same organisational and structural problems that stakeholders believe preclude the delivery of high quality care, persist. It is therefore not clear how, within the current system and current budget constraints, to achieve care that fully aligns with understandings of what is meant by high quality care, with recommendations made by organisations such as NICE, or with the CQC rating of ‘outstanding’ care. The extent to which innovation by individual homecare organisations within this context can genuinely improve quality of care within current funding constraints remains unclear, and researchers have shown at times that attempts at innovation may have negative consequences for care quality.[148, 149] None of the research that we reviewed assisted with informing models for the delivery of high, or higher, quality care on the budgets available. While the research has informed what good quality care is believed to be, it has been less informative on the question of how to achieve it in the real world.

We did not find many studies that sought to assess homecare quality, or that sought to find out whether people felt they were receiving good enough, good, outstanding, or indeed unsatisfactory or even neglectful or abusive care. As noted below, we also did not find studies comparing homecare quality for different groups, of any type. This was an unexpected lacuna in the analysis.

Relevance for CQC framework

As noted in the introduction and set out in Appendix A, the regulator has identified five key questions, with 50 domains of care quality in the form of 'We' and 'I' statements. Each is each effectively a YES/NO metric. For each statement, evidence is sought from six possible sources, with no specific measurement guidance or common metrics. Although the process by which ratings are calculated is clear (a review of quality statements based on evidence leading to a score for each of the five inspection categories, then aggregated to give a global rating), the evidence required that would lead to scores that would ultimately differentiate between the ratings, e.g., 'good' and 'outstanding' is not.[28]

The CQC statements are all-encompassing so at a generic level, the issues raised through this review are all reflected somewhere in the CQC framework. For example, the CQC asks, as one of its key questions, whether the management and governance of the organisation make sure it is providing high quality care based around individual needs, and as another, whether services are organised so that they meet individual needs. They include that organisations should care about and promote the wellbeing of their staff, and that staff should be supported to provide person-centred care. These are very high-level generic statements and so can be interpreted to cover all aspects of high quality care. However, the 50 sub-domains have much more specificity, and so it is worth noting what, from this review, is clearly reflected there, and which specific things emerging from this review, are not easy to discern across any of those CQC domains.

Findings reflected in CQC domains

Many of the 'We' and 'I' statements of the CQC Framework (Appendix A) reflect the central messages found in this review about what high quality homecare looks like. However, some of the central messages from this review are not clearly among the statements across the CQC Framework. In particular:

- There is no mention of care staff, families and service users forming and then being able to maintain meaningful relationships, seen as central to high quality homecare for older people in the research reviewed here;
- Provision of continuity of care staff for individuals, also seen by stakeholders as central to high quality homecare for older people, is not among the 'We' or 'I' statements;
- While appropriate numbers of staff are mentioned, diversity is only mentioned in terms that 'We value diversity in the workforce' (Statement 30), not to employ a diverse workforce that meets the needs of service users;
- Whether staff feel that their pay and working conditions reflect the importance and complexity of their roles emerged as important from this review, but is not featured in the CQC statements;
- Staff having time and flexibility to deliver the care that people want and that they want to deliver is not a clear CQC requirement, yet was seen as fundamental to high quality care across this review.

These important elements of high quality care are not being reflected across the CQC framework, and the framework also gives no indication of salience or weighting. Matters that might be very important to stakeholders, and might be done extremely well by a particular service provider, would not necessarily lead to a summative rating that would convey that information clearly to older people or their unpaid carers, or indeed reflect that excellence back to staff and service providers.

Because the process of evaluating evidence by the CQC to determine their summative ratings is opaque, this review raises another question. This is whether the ways that older people, their caregivers, and indeed care workers and care providers, conceptualise high quality care in the literature reviewed here maps to 'good' or 'outstanding' care in CQC terms, on the relevant domains (or indeed to something more akin to 'satisfactory' or 'ok' or 'good enough', which is not a summative outcome on the CQC scale). This question has been articulated previously by various groups including Care England (the largest representative body for independent providers of adult social care) and Skills for Care (the strategic workforce development and planning body for adult social care in England).[11, 12] It is also reflected in the existence of the Outstanding Society, a Community Interest Company of adult social care providers who had achieved 'outstanding' ratings in 2014 and who formed in order to share best practice and improve standards across the sector.[13] All these organisations highlight that to achieve an outstanding rating requires 'going the extra mile' to introduce innovative and exemplary practice that delivers bespoke care. This is potentially problematic, since some of the findings in our review suggest that in order to 'go the extra mile', care staff may feel they need to work beyond their paid hours, as they attempt to deliver bespoke care in a context where resource pressures mean that they rarely have time to do so.

The above discussion highlights a number of risks for the CQC inspection regime in the context of homecare for older people: that they are not necessarily asking the questions that really matter to people, that they are not reflecting the salience of certain aspects over others for key stakeholders in the system, including older people and their families; and that there is a potential mismatch between regulatory requirements and the expectations of people using or purchasing homecare services.

Who and what are missing from the research?

Some important research gaps have been identified in the discussion above:

1. We did not find any studies or how older people in receipt of homecare formulate and articulate their preferences and issues with care; nor of issues of capacity, the raising of complaints, or cognitive dissonance in understanding satisfaction with homecare quality.
2. We also found few studies that sought to assess homecare quality, or explore people's perceptions of whether their care was good enough, good, outstanding, unsatisfactory or even neglectful or abusive.
3. We also found no consensus on what measurement is optimal in this realm of homecare quality for older people.
4. None of the research in this review served to evaluate models for the delivery of high quality care on the budgets available.
5. We found no UK studies that compared local authority to privately funded homecare in terms of care quality. There were also no comparisons of homecare quality across different commissioners, geographical areas, or using different types of provider or organisational models of care. There were no studies included in our scope that explicitly aimed to determine whether there was equity of access to good or excellent quality homecare for older people across socio-demographic groups, or protected or other characteristics.

6. The articles included in this review contain views of diverse groups including older people in receipt of homecare, family members/unpaid carers, frontline care workers, staff in more senior or leadership roles of homecare organisations, and expert commentators from academic and professional communities. However many crucial perspectives were absent. Owners of homecare organisations especially larger corporate organisations were barely represented in this literature. We found only one article exploring the views of stakeholders who are involved in commissioning services for older people, and no research about the views of regulators, or inspectors/assessors involved in regulation, nor of people within the legal or advocacy professions who might be involved in challenging provision of care.

Our focus on homecare for older adults is likely to have influenced the capture of views from commissioners. Reports on commissioners' conceptualisations of quality in homecare cover tend to be generic to all care recipient groups and therefore were not captured by the search strategy.[150] Equally, much of the literature on commissioning is not explicitly linked to quality,[38-40] instead referring to concepts such as outcomes and sustainability.[151, 152] Broadly speaking, the literature on commissioning argues that much of what drives (or does not drive) quality is tied to market conditions, dynamics in the system of providing and contracting care services including how providers are reimbursed for care. There is a limited body of literature on outcomes-based commissioning that attempts to leverage quality in homecare by commissioning mechanisms,[41, 153, 154] which fell outside the scope of our search but is nevertheless weak as an evidence base. The absence of research on commissioner conceptualisations of quality means it is not possible to examine, e.g., the tensions that might exist between a prevalent view across stakeholders that was revealed in our study, that time and task commissioning is not conducive to the provision of good quality care to older people, and how commissioners view this issue. We also could not consider potential tensions between providers, commissioners and regulators as to what excellent care looks like when it is delivered, that might be suggested by our findings. Moreover, excellent care in terms of the development of caring relationships, relational care, compassionate care, care with dignity, empathy and understanding, and care delivered with time, that is revealed across the studies reviewed here, might be enough for care recipients and their families to consider the care outstanding, but would not be enough for the regulator if evidence on the regulators' other domains is weak.

Conclusion

This scoping review identified clear and consistent views about how quality in homecare for older people 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, with the views of regulators, assessors/inspectors and advocates absent from the literature, and we found only one account of commissioners' views. We found very little research that sought to understand how older people form and articulate their preferences for, and issues with, homecare, nor how they or others in the system respond when homecare is perceived as not being of good or sufficient quality. We found no literature relating to issues of capacity in understanding and evaluating homecare quality for older people.

This review revealed that 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. 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 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. This aligns with concerns identified in our review that high quality care 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 helped inform optimal models for high quality homecare provision for older people within existing budgets.

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 homecare quality 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.

References

1. Office for National Statistics. Estimating the size of the self-funding population in the community, England: 2022 to 2023, https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/bulletins/estimatingthesizeoftheselffunderpopulationinthecommunityengland/2022to2023 (2023, accessed 25 June 2024).
2. Homecare Association. *An Overview of the UK Homecare Market*. 2024. London: Homecare Association. https://www.homecareassociation.org.uk/asset/2A51F1FC-A86D-4DDB-8470982FF17E8B2D/
3. Association of Directors of Adult Social Services. *Autumn Survey 2023: Part 2*. 2023. London: ADASS. https://www.adass.org.uk/wp-content/uploads/2024/06/autumn-survey-report-2023-adult-social-care-budgets-waiting-times-2.pdf
4. Association of Directors of Adult Social Services. *Spring Survey 2023*. 2023. London: ADASS. https://www.adass.org.uk/documents/adass-spring-survey-2023/
5. Houghton A. *The Homecare Deficit 2023*. 2023. London: Homecare Association. https://www.homecareassociation.org.uk/resource/the-homecare-deficit-2023-pdf.html
6. Bottery S and Mallorie S. *Social care 360*. 2024. London: The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360
7. Spiers G, Matthews FE, Moffatt S, et al. Impact of social care supply on healthcare utilisation by older adults: a systematic review and meta-analysis. *Age Ageing* 2019;48(1):57-66. DOI: 10.1093/ageing/afy147.
8. Care Quality Commission. Single assessment framework, https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework (2024, accessed 28 October 2024).
9. Peters MDJ, Marnie C, Tricco AC, et al. Updated methodological guidance for the conduct of scoping reviews. *JBI Evid Synth* 2020;18(10):2119-2126. DOI: 10.11124/JBIES-20-00167.
10. Pollock D, Peters MDJ, Khalil H, et al. Recommendations for the extraction, analysis, and presentation of results in scoping reviews. *JBI Evid Synth* 2023;21(3):520-532. DOI: 10.11124/JBIES-22-00123.
11. Care England. A Brief Guide to Outstanding, https://www.careengland.org.uk/brief-guide-outstanding/ (2024, accessed 21 June 2024).
12. Skills for Care. Good and Outstanding care (GO), https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Good-and-outstanding-care/Good-and-Outstanding-Care-GO.aspx (2024, accessed 21 June 2024).
13. The Outstanding Society. Our Story, https://theoutstandingsociety.co.uk/about/ (2024, accessed 21 June 2024).
14. The King's Fund. Key facts and figures about adult social care, https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-adult-social-care (2023, accessed 25 June 2024).
15. Jasper R, Wright S, Rogers S, et al. A Discrete Choice Experiment of Older Self-Funders' Preferences When Navigating Community Social Care. *Health Soc Care Community* 2023:6642636. DOI: 10.1155/2023/6642636.
16. Scourfield P. The hidden, human costs of the UK's failing 'market' for home care. *Critial and Radical Social Work* 2024;12(3–4):1-9. DOI: 10.1332/20498608Y2023D000000017
17. The King's Fund. What is commissioning and how is it changing?, https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-commissioning-and-how-it-changing (2023, accessed 21 June 2024).
18. LaingBuisson. *Homecare and Supported Living UK Market Report 6ed*. 2024. London: LaingBuisson. https://www.laingbuisson.com/shop/homecare-and-supported-living-uk-market-report-6ed/
19. NHS Digital. *Adult Social Care Activity and Finance Report, England, 2022-23*. 2023. London: NHS. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2022-23
20. Care Quality Commission. *Not just a number: home care inspection programme - national overview*. 2013. Newcastle upon Tyne: Care Quality Commission. https://www.cqc.org.uk/sites/default/files/documents/9331-cqc-home_care_report-web_0.pdf

21. Bottery S. *Home care in England: Views from commissioners and providers*. 2018. London: The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/reports/home-care-england
22. Department of Health and Social Care. Care Act factsheets, https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets (2016, accessed 21 June 2024).
23. Rayner M. The Care Quality Commission: A Regulatory Evolution. *Judicial Review* 2022;27(2):126-131. DOI: 10.1080/10854681.2022.2111965.
24. Aronson J. Silenced Complaints, Suppressed Expectations: The Cumulative Effects of Home Care Rationing. *Int J Health Serv* 2006;36(3):535-56. DOI: 10.2190/CGPJ-PRWN-B1H6-YVJB.
25. Byrne K, Sims-Gould J, Frazee K and Martin-Matthews A. “I'm Satisfied … But”: Clients' and Families' Contingent Responses About Home Care. *Home Health Care Serv Q* 2011;30(4):161-77. DOI: 10.1080/01621424.2011.622242.
26. Vamstad J. Exit, voice and indifference – older people as consumers of Swedish home care services. *Ageing Soc* 2016;36(10):2163-2181: DOI: 10.1017/S0144686X15000987.
27. Dash P. *Review into the operational effectiveness of the Care Quality Commission*. 2024. London: Department of Health and Social Care. https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission
28. Care Quality Commission. How we reach a rating, https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessing-quality-and-performance/reach-rating (2024, accessed 21 June 2024).
29. Care Quality Commission. *State of Care 2022/23*. 2023. Newcastle upon Tyne: Care Quality Commission. https://www.cqc.org.uk/publications/major-report/state-care/2022-2023
30. Townson J. *Care Quality Commission: regulatory performance in homecare*. 2024. London: Homecare Association. https://www.homecareassociation.org.uk/asset/84CE8F42%2D2C4B%2D4D73%2DA1A62EAC26758704/
31. National Institute for Health and Care Excellence [NICE]. *Homecare for older people. NICE Guideline QS123*. 2016. Leeds: NICE
32. Homecare Association. *Code of Practice for homecare provider members of the Homecare Association*. 2022. London: Homecare Association. https://www.homecareassociation.org.uk/resource/j0423-homecareassociationcodeofpracticepre-aw-pdf.html
33. Department of Health and Social Care. *Adult Social Care: Quality Matters*. 2019. London: Department of Health and Social Care. https://www.gov.uk/government/publications/adult-social-care-quality-matters-overview
34. Nuffield Trust. QualityWatch, https://www.nuffieldtrust.org.uk/qualitywatch/indicators (2024).
35. Davey V. *Estudios de caso de innovaciones en al servicio de ayuda a domicilio. [Case studies of innovation in home care services]* 2022. Barcelon: Diputacio de Barcelone
36. European Social Network. *Putting Quality First. Contracting for Long-Term Care*. 2021. Brussels: European Social Network. https://www.esn-eu.org/publications/putting-quality-first-contracting-long-term-care
37. Knapp M, Hardy B and Forder J. Commissioning for Quality: Ten Years of Social Care Markets in England. *J Soc Policy* 2001;30(2):283-306. DOI: 10.1017/s0047279401006225.
38. Davies K, Dalgarno E, Angel C, et al. Home-care providers as collaborators in commissioning arrangements for older people. *Health Soc Care Community* 2022;30(2):644-655. DOI: 10.1111/hsc.13169.
39. Davies K, Dalgarno E, Davies S, et al. The challenges of commissioning home care for older people in England: commissioners’ perspectives. *Ageing Soc* 2021;41(8):1858-1877. DOI: 10.1017/s0144686x20000021.
40. Davies S, Hughes J, Ahmed S, et al. Commissioning social care for people with dementia living at home: Findings from a national survey. *Int J Geriatr Psychiatry* 2020;35(1):53-59. DOI: 10.1002/gps.5214.
41. Glasby J, Newbigging K, Mangan C, et al. *Commissioning for better outcomes: a route map*. 2015. London: Local Government Association. http://pure-oai.bham.ac.uk/ws/files/24079361/Commissioning_for_Better_Outcomes_Final_Oct2014_.pdf
42. Needham C, Allen K, Burn E, et al. How do you Shape a Market? Explaining Local State Practices in Adult Social Care. *J Soc Policy* 2023;52(3):640-660. DOI: 10.1017/s0047279421000805.

43. Tricco AC, Lillie E, Zarin W, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med* 2018;169(7):467-473. DOI: 10.7326/M18-0850.
44. Hall A, Price D, Astbury J, et al. The meaning of ‘quality’ of homecare for older people: a scoping review, https://osf.io/khxj5 (2024).
45. Care Quality Commission. *Shaping the future: CQC’s strategy for 2016 to 2021*. 2016. Newcastle upon Tyne: Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20160523_strategy_16-21_strategy_final_web_01.pdf
46. Care Quality Commission. *A new strategy for the changing world of health and social care: Our strategy from 2021*. 2021. Newcastle upon Tyne: Care Quality Commission. https://www.cqc.org.uk/sites/default/files/Our_strategy_from_2021.pdf
47. Price D, Drake P, Allen N and Astbury J. *The impact of Care Act Easements under the Coronavirus Act 2020 on older carers supporting family members living with dementia at home*. 2022. Manchester: NIHR Older People & Frailty Policy Research Unit / University of Manchester. https://documents.manchester.ac.uk/display.aspx?DocID=64273
48. Abrahamson K, Myers J, Arling G, et al. Capacity and readiness for quality improvement among home and community-based service providers. *Home Health Care Serv Q* 2016;35(3-4):182-196. DOI: 10.1080/01621424.2016.1264343.
49. Alnes RE, Malmedal W, Nordtug B, et al. Improving everyday life of people with dementia living at home: Health care professionals' experiences. *J Nurs Manag* 2022;30(7):3628-3636. DOI: 10.1111/jonm.13819.
50. Andersson K, Lövgren V, Ahnlund P and Kalman H. Empathetic Attuning: 'How Would I Feel If I Had to Expose Myself All the Time?'—Strategies for Managing Personal and Intimate Care in Swedish Formal Home Care. *Br J Soc Work* 2023;53(2):921-938. DOI: 10.1093/bjsw/bcac164.
51. Andersson K and Sjölund M. Nighttime Home Care in Sweden: "A Constant Struggle to Manage Unforeseen Events"—Operations Managers' Perceptions of Organization and Provision of Care for Older People. *Health Soc Care Community* 2023:4101574. DOI: 10.1155/2023/4101574.
52. Blomqvist H, Bergdahl E and Hemberg J. Ethical sensitivity and compassion in home care: Leaders' views. *Nurs Ethics* 2023;30(2):180-196. DOI: 10.1177/09697330221122965.
53. Bostrom A-M, Lundgren D, Kabir ZN and Kareholt I. Factors in the psychosocial work environment of staff are associated with satisfaction with care among older persons receiving home care services. *Health Soc Care Community* 2022;30(6):e6080-e6090. DOI: 10.1111/hsc.14045.
54. Breen R, Savundranayagam MY, Orange JB and Kothari A. Quality home care for persons living with dementia: Personal support workers' perspectives in Ontario, Canada. *Health Soc Care Community* 2022;30(5):e2497-e2506. DOI: 10.1111/hsc.13692.
55. Brodin H and Peterson E. Doing business or leading care work? Intersections of gender, ethnicity and profession in home care entrepreneurship in sweden. *Gend Work Organ* 2019;26(11):1640-1657. DOI: 10.1111/gwao.12402.
56. Brown P, Leverton M, Burton A, et al. How does the delivery of paid home care compare to the care plan for clients living with dementia? *Health Soc Care Community* 2022;30(5):e3158-e3170. DOI: 10.1111/hsc.13761.
57. Browne-Yung K, O'Neil D, Walker R, et al. 'I'd rather die in the middle of a street': Perceptions and expectations of aged care among Forgotten Australians. *Australas J Ageing* 2021;40(2):168-176. DOI: 10.1111/ajag.12851.
58. Burns D, Hamblin K, Fisher DU and Goodlad C. Is it time for job quality? Conceptualising temporal arrangements in new models of homecare. *Sociol Health Illn* 2023 Sep;45(7):1541-1559. DOI: 10.1111/1467-9566.13650.
59. Cederbom S, Thunborg C, Denison E, et al. Home Help Service Staffs’ Descriptions of Their Role in Promoting Everyday Activities Among Older People in Sweden Who Are Dependent on Formal Care. *J Appl Gerontol* 2017;36(8):971-992. DOI: 10.1177/0733464815595511.
60. Chapman A. Person-centred care in Northern Ireland: learning from the experiences of adult social care users. *J Integr Care* 2021;29(3):242-253. DOI: 10.1108/JICA-06-2020-0036.
61. Chester H, Clarkson P, Davies L, et al. People with dementia and carer preferences for home support services in early-stage dementia. *Aging Ment Health* 2018;22(2):270-279. DOI: 10.1080/13607863.2016.1247424.
62. Chester H, Clarkson P, Davies L, et al. A discrete choice experiment to explore carer preferences. *Qual Ageing Older Adults* 2017;18(1):33-43. DOI: doi:10.1108/QAOA-10-2015-0047.

63. Cohen-Mansfield J, Sela AH, Iecovich E and Golander H. Quality of care for frail older persons in a homecare setting: what is it and how can it be measured? *Int Psychogeriatr* 2018;30(9):1259-1267. DOI: 10.1017/S1041610217002228.
64. Craftman ÅG, Grundberg Å and Westerbotn M. Experiences of home care assistants providing social care to older people: A context in transition. *Int J Older People Nurs* 2018;13(4):e12207. DOI: 10.1111/opn.12207.
65. Dalgarno EL, Gillan V, Roberts A, et al. Home care in dementia: The views of informal carers from a co-designed consultation. *Dementia* 2021;20(7):2261-2277. DOI: 10.1177/1471301221990504.
66. Davidson JGS and Guthrie DM. Older Adults With a Combination of Vision and Hearing Impairment Experience Higher Rates of Cognitive Impairment, Functional Dependence, and Worse Outcomes Across a Set of Quality Indicators. *J Aging Health* 2019;31(1):85-108. DOI: 10.1177/0898264317723407.
67. Dostálová V, Bártová A, Bláhová H and Holmerová I. The experiences and needs of frail older people receiving home health care: A qualitative study. *Int J Older People Nurs* 2022;17(1):e12418. DOI: 10.1111/opn.12418.
68. Duner A, Bjalkebring P and Johansson B. Autonomy, choice and control for older users of home care services: Current developments in Swedish eldercare. *J Soc Serv Res* 2019;45(1):129-141. DOI: 10.1080/01488376.2018.1479677.
69. Eltaybani S, Kitamura S, Fukui C, et al. Toward developing care outcome quality indicators for home care for older people: A prospective cohort study in Japan. *Geriatr Gerontol Internat* 2023;23(5):383-394. DOI: 10.1111/ggi.14578.
70. Fraser K, Lisa GB, Laing D, et al. Case Manager Resource Allocation Decision-Making for Adult Home Care Clients: With Comparisons to a High Needs Pediatric Home Care Clients. *Home Health Care Manag Pract* 2018;30(4):164-174. DOI: 10.1177/1084822318779371.
71. Gjevjon ER, Romøren TI, Bragstad LK and Hellesø R. Older Patients’ and Next of Kin’s Perspectives on Continuity in Long-Term Home Health Care. *Home Health Care Manag Pract* 2016;28(3):142-149. DOI: 10.1177/1084822315626001.
72. Goh AMY, Polacsek M, Malta S, et al. What constitutes 'good' home care for people with dementia? An investigation of the views of home care service recipients and providers. *BMC Geriatr* 2022;22(1):42. DOI:10.1186/s12877-021-02727-4.
73. Gudnadottir M, Bjornsdottir K and Jonsdottir S. Perception of integrated practice in home care services. *J Integr Care* 2019;27(1):73-82. DOI: 10.1108/JICA-07-2018-0050.
74. Haex R, Thoma-Lürken T, Beurskens AJHM and Zwakhalen SMG. How do clients and (In)formal caregivers experience quality of home care? A qualitative approach. *J Adv Nurs* 2020;76(1):264-274. DOI: 10.1111/jan.14234.
75. Hammar LM, Alam M, Olsen M, et al. Being Treated With Respect and Dignity?—Perceptions of Home Care Service Among Persons With Dementia. *J Am Med Dir Assoc* 2021;22(3):656-662. DOI: 10.1016/j.jamda.2020.07.002.
76. Hanberger A and Lindgren L. Evaluation systems in local eldercare governance. *J Soc Work* 2019;19(2):233-252. DOI: 10.1177/1468017318760788.
77. Hansen A, Hauge S and Bergland Å. Meeting psychosocial needs for persons with dementia in home care services - a qualitative study of different perceptions and practices among health care providers. *BMC Geriatr* 2017;17(1):211. DOI: 10.1186/s12877-017-0612-3.
78. Hansen A, Hauge S, Hellesø R and Bergland Å. Purchasers' deliberations on psychosocial needs within the process of allocating healthcare services for older home-dwelling persons with dementia: a qualitative study. *BMC Health Serv Res* 2018;18(1):746. DOI: 10.1186/s12913-018-3550-7.
79. Hoel K-A, Rokstad AMM, Feiring IH, et al. Person-centered dementia care in home care services - highly recommended but still challenging to obtain: a qualitative interview study. *BMC Health Serv Res* 2021;21(1):723. DOI: 10.1186/s12913-021-06722-8.
80. Hoel KA, Rokstad AMM, Feiring IH, et al. Staff's perspectives on the organization of homecare services to people with dementia—A qualitative study. *Nurs Open* 2021;8(4):1797-1804. DOI: 10.1002/nop2.822.
81. Hsieh C-M. A client satisfaction measure of homecare services for older adults. *J Soc Serv Res* 2017;43(4):487-497. DOI: 10.1080/01488376.2017.1307308.
82. Hughes S and Burch S. 'I'm not just a number on a sheet, I'm a person': Domiciliary care, self and getting older. *Health Soc Care Community* 2020;28(3):903-912. DOI: 10.1111/hsc.12921.
83. Jakobsen LM and Lind R. ´You are not yourself anymore´: The place of the ethical demand in a practical home care context. *Scand J Caring Sci* 2023;37(1):79-87. DOI: 10.1111/scs.13076.

84. Kajonius P and Kazemi A. Advancing the Big Five of user-oriented care and accounting for its variations. *Int J Health Care Qual Assur* 2016;29(2):162-76. DOI: 10.1108/IJHCQA-03-2015-0040.
85. Kajonius PJ and Kazemi A. Structure and process quality as predictors of satisfaction with elderly care. *Health Soc Care Community* 2016;24(6):699-707. DOI: 10.1111/hsc.12230.
86. Kamalraj P, Savundranayagam MY, Orange JB and Kloseck M. Communication in home care: Understanding the lived experiences of formal caregivers communicating with persons living with dementia. *Int J Older People Nurs* 2021;16(6):e12401. DOI: 10.1111/opn.12401.
87. Kampanellou E, Chester H, Davies L, et al. Carer preferences for home support services in later stage dementia. *Aging Ment Health* 2019;23(1):60-68. DOI: 10.1080/13607863.2017.1394441.
88. Kazemi A and Kajonius P. Assessing person-centred care: An item response theory approach. *International Journal of Older People Nursing* 2021; 16. DOI: 10.1111/opn.12352.
89. Kazemi A and Kajonius PJ. Cost and Satisfaction Trends in Swedish Elderly Home Care. *Home Health Care Manag Pract* 2016;28(4):250-255. DOI:10.1177/1084822316646353.
90. Kristensen DV, Sundler AJ, Eide H, et al. Characteristics of communication with older people in home care: A qualitative analysis of audio recordings of home care visits. *J Clin Nurs* 2017;26(23-24):4613-4621. DOI: 10.1111/jocn.13807.
91. Laragy C and Vasiliadis SD. Self-managed aged home care in Australia – Insights from older people, family carers and service providers. *Health Soc Care Community* 2022;30(5):e2518-e2529. DOI: 10.1111/hsc.13695.
92. Malley J, D'Amico F and Fernandez J-L. What is the relationship between the quality of care experience and quality of life outcomes? Some evidence from long-term home care in England. *Soc Sci Med* 2019:243:112635. DOI: 10.1016/j.socscimed.2019.112635.
93. Martinsen B, Norlyk A and Gramstad A. What Makes Dependency on Homecare Bearable? A Phenomenological Study. *West J Nurs Res* 2023;45(5):388-394. DOI: 10.1177/01939459221135325.
94. McDonald A, Lolich L, Timonen V and Warters A. “Time is more important than anything else”: tensions of time in the home care of older adults in Ireland. *Int J Care Caring* 2019;3(4):501-515. DOI: 10.1332/239788219X15622468259858.
95. Miller P, Gill C, Mazza K, et al. Learning What is Important: A Quality Improvement Initiative to Enhance Patient-Centred Care in Home Care. *Phys Occup Ther Geriatr* 2019;37(1):3-15. DOI: 10.1080/02703181.2019.1567643.
96. Nilsen ER, Hollister B, Söderhamn U and Dale B. What matters to older adults? Exploring person-centred care during and after transitions between hospital and home. *J Clin Nurs* 2022;31(5-6):569-581. DOI: 10.1111/jocn.15914.
97. Olaison A, Cedersund E, Marcusson J, et al. Maneuvering the care puzzle: Experiences of participation in care by frail older persons with significant care needs living at home. *Int J Qual Stud Health Well-Being* 2021;16(1):1937896. DOI: 10.1080/17482631.2021.1937896.
98. Olasunkanmi-Alimi T, Natalier K and Mulholland M. Everyday racism and the denial of migrant African women's good caring in aged care work. *Gend Work Organ* 2022;29(4):1082-1094. DOI: 10.1111/gwao.12802.
99. Olsen CF, Bergland A, Bye A, et al. Crossing knowledge boundaries: health care providers' perceptions and experiences of what is important to achieve more person-centered patient pathways for older people. *BMC Health Serv Res* 2021;21(1):310. DOI: 10.1186/s12913-021-06312-8.
100. Olsen M, Udo C, Boström A-M and Hammar LM. Important aspects of home care service: An interview study of persons with dementia. *Dementia* 2021;20(5):1649-1663. DOI: 10.1177/1471301220964393.
101. Phillipson L, Towers AM, Caiels J and Smith L. Supporting the involvement of older adults with complex needs in evaluation of outcomes in long-term care at home programmes. *Health Expect* 2022;25(4):1453-1463. DOI: 10.1111/hex.13484.
102. Polacsek M, Goh A, Malta S, et al. 'I know they are not trained in dementia': Addressing the need for specialist dementia training for home care workers. *Health Soc Care Community* 2020;28(2):475-484. DOI: 10.1111/hsc.12880.
103. Rand SE, Silarova B, Towers AM and Jones K. Social care-related quality of life of people with dementia and their carers in England. *Health Soc Care Community* 2022;30(5):e2406-e2418. DOI: 10.1111/hsc.13681.

104. Róin Á. Person-centredness in elder care: A secondary analysis of data from a study among home-dwelling men and women in the Faroe Islands. *J Clin Nurs* 2018;27(11-12):2416-2424. DOI: 10.1111/jocn.14161.
105. Ruotsalainen S, Jantunen S and Sinervo T. Which factors are related to Finnish home care workers' job satisfaction, stress, psychological distress and perceived quality of care? - a mixed method study. *BMC Health Serv Res* 2020;20(1):896. DOI: 10.1186/s12913-020-05733-1.
106. Russell SJ, Siostrom K, Edwards I and Srikanth V. Consumer experiences of home care packages. *Australas J Ageing* 2020;39(3):e402-e409. DOI: 10.1111/ajag.12771.
107. Sanerma P, Paavilainen E and Åstedt-Kurki P. Home care services for older persons. The views of older persons and family members: A realistic evaluation. *Int J Older People Nurs* 2020;15(1):e12281. DOI: 10.1111/opn.12281.
108. Silverglow A, Johansson L, Liden E and Wijk H. Perceptions of providing safe care for frail older people at home: A qualitative study based on focus group interviews with home care staff. *Scand J Caring Sci* 2022;36(3):852-862. DOI: 10.1111/scs.13027.
109. Silverglow A, Lidèn E, Berglund H, et al. What constitutes feeling safe at home? A qualitative interview study with frail older people receiving home care. *Nurs Open* 2021;8:191-199. DOI: 10.1002/nop2.618.
110. Teshuva K, Borowski A and Wells Y. Holocaust survivors' perspectives on using community aged care and support services. *Ageing Soc* 2021;41(2):231-246. DOI: 10.1017/S0144686X1900093X.
111. Teshuva K, Cohen-Mansfield J, Iecovich E and Golander H. Like one of the family? Understanding relationships between migrant live-in care workers and older care recipients in Israel. *Ageing Soc* 2019;39(7):1387-1408. DOI: 10.1017/S0144686X1800003X.
112. Thalen M, Oorsouw WMWJ, Volkers KM, et al. Integrated emotion-oriented care for older people with ID: Defining and understanding intervention components of a person-centered approach. *J Policy Pract Intel* 2021;18(3):178-186. DOI: 10.1111/jppi.12370.
113. Tiilikainen E, Hujala A, Kannasoja S, et al. "They're always in a hurry" - Older people's perceptions of access and recognition in health and social care services. *Health Soc Care Community* 2019;27(4):1011-1018. DOI: 10.1111/hsc.12718.
114. Timonen V and Lolich L. "The Poor Carer": Ambivalent Social Construction of the Home Care Worker in Elder Care Services. *J Gerontol Soc Work* 2019;62(7):728-748. DOI: 10.1080/01634372.2019.1640334.
115. Tufte P and Dahl HM. Navigating the field of temporally framed care in the Danish home care sector. *Sociol Health Illn* 2016;38(1):109-22. DOI: 10.1111/1467-9566.12343.
116. Turner N, Schneider J, Pollock K, et al. 'Going the extra mile' for older people with dementia: Exploring the voluntary labour of homecare workers. *Dementia* 2020;19(7):2220-2233. DOI: 10.1177/1471301218817616.
117. Westerberg K, Hjelte J and Josefsson S. Understanding eldercare users' views on quality of care and strategies for dealing with problems in Swedish home help services. *Health Soc Care Community* 2017;25(2):621-629. DOI: 10.1111/hsc.12351.
118. Wilfling D, Flägel K, Steinhäuser J and Balzer K. Specifics of and training needs in the inter-professional home care of people with dementia: A qualitative study. *Pflege* 2023;36(2):67-76. DOI: 10.1024/1012-5302/a000878.
119. Zoeckler JM. Occupational Stress Among Home Healthcare Workers: Integrating Worker and Agency-Level Factors. *New Solut* 2018;27(4):524-542. DOI: 10.1177/1048291117742678.
120. Adelman M. Overcoming Barriers to Care for LGBT Elders with Alzheimer's. *Generations* 2016; 40(2):38-40.
121. Butler S. Maine's bold initiative: homecare for all. *J Gerontol Soc Work* 2019;62(3):255-260. DOI: 10.1080/01634372.2019.1575137.
122. Golden RL, Emery-Tiburcio EE, Post S, et al. Connecting Social, Clinical, and Home Care Services for Persons with Serious Illness in the Community. *J Am Geriatr Soc* 2019;67(S2):S412-S418. DOI: 10.1111/jgs.15900.
123. Hopwood P and MacEachen E. Policy and practice note: Policy, safety, and regulation with regard to Ontario home care clients and personal support workers. *Can J Aging* 2022;41(3):490-498. DOI: 10.1017/S0714980821000209.
124. Seeman N. Toward an Integrated Strategy for Care in the Home for Frail Elders. *Healthc Q* 2022;25(3):14-17. DOI: 10.12927/hcq.2022.26947.
125. Solis C, Mintz KT, Wasserman D, et al. Home Care in America: The Urgent Challenge of Putting Ethical Care into Practice. *Hastings Cent Rep* 2023;53(3):25-34. DOI: 10.1002/hast.1487.

126. Age UK. *The failing safety net*. 2018. London: Age UK. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/rb_2018_sept18_-failing_safety_net_for_older_people.pdf
127. Age UK. *Why call it care when nobody cares?* 2018. London: Age UK. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/RB_mar18_social_care_campaignreport.pdf
128. Age UK. *Why can't I get care? Older people's experiences of care and support*. 2022. London: Age UK. https://www.ageuk.org.uk/globalassets/age-uk/documents/campaigns/care-in-crisis/why-cant-i-get-care-report.pdf
129. Age UK and Homecare Association. *What if you need care at home and there's no one to provide it?* 2021. London: Age UK. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/homecare/homecare-report-age-uk-homecare-association.pdf
130. Alzheimer's Society. *Fix Dementia Care: Homecare*. 2016. London: Alzheimer's Society. https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/fix_dementia_care_homecare_report.pdf
131. Bolton J and Townson J. *Messages on the future of domiciliary care services*. 2018. Oxford: Institute of Public Care. https://ipc.brookes.ac.uk/files/publications/The_Future_of_Domiciliary_Care.pdf
132. Care Quality Commission. *Beyond Barriers: How older people move between health and social care in England*. 2018. Newcastle-upon-Tyne: Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf
133. Community Catalysts. *Releasing Somerset's capacity to care: community micro-providers in Somerset. The impact and outcomes of the Community Catalysts project*. 2017. https://www.communitycatalysts.co.uk/wp-content/uploads/2019/09/Somerset-Year-3-report-final-public.pdf
134. Cottell J and Harding C. *Older people's care survey 2018*. 2018. London: Coram Family and Childcare. https://www.familyandchildcaretrust.org/file/4596/download?token=Ri6cFGrq
135. Global Coalition On Aging. *Relationship-based home care: a sustainable solution for Europe's elder care crisis*. 2018. New York: Global Coalition on Aging. https://globalcoalitiononaging.com/wp-content/uploads/2018/06/RHBC_Report_DIGITAL.pdf
136. Healthwatch England. *Home care: what people told Healthwatch about their experiences*. 2017. London: Healthwatch England. https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20171002-_home_care_-_what_people_told_local_healthwatch.pdf
137. Hudson B. *The failure of privatised adult social care in England: what is to be done?* 2016. London: Centre for Health and the Public Interest. https://chpi.org.uk/wp-content/uploads/2016/11/CHPI-SocialCare-Oct16-Proof01a.pdf
138. Koehler I. *Paying for it*. 2017. London: London Government Information Unit. https://lgiu.org/publication/paying-for-it-the-human-cost-of-cut-price-care/
139. Pursch B and Isden R. *Behind the headlines: the battle to get care at home*. 2018. London: Age UK. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/rb_jun18_-the_struggle_to_get_care_at_home.pdf
140. Unison. *The damage: care in crisis*. 2016. London: Unison. https://www.unison.org.uk/content/uploads/2016/11/24149_The_Damage_care_in_crisis_web.pdf
141. Skills for Care. Delegated healthcare activities, https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities.aspx (2024, accessed 21 June 2024).
142. Davey V, Healy J, Liddle J, et al. Defining home care: An exploration of its roles, challenges, and purpose (preprint). *SocArXiv* 2024. DOI: 10.31235/osf.io/9ej8k.
143. Cleland J, Hutchinson C, Khadka J, et al. What defines quality of care for older people in aged care? A comprehensive literature review. *Geriatr Gerontol Int* 2021;21(9):765-778. DOI: 10.1111/ggi.14231.
144. Foong HY, Siette J and Jorgensen M. Quality indicators for home- and community-based aged care: A critical literature review to inform policy directions. *Australas J Ageing* 2022;41(3):383-395. DOI: 10.1111/ajag.13103.
145. Wagner A, Schaffert R, Möckli N, et al. Home care quality indicators based on the Resident Assessment Instrument-Home Care (RAI-HC): a systematic review. *BMC Health Serv Res* 2020;20(1):366. DOI: 10.1186/s12913-020-05238-x.

146. Davey V, Healey J, Liddle J, et al. Routine data collection in homecare: A national survey of homecare providers in England (preprint). *medRxiv* 2024. DOI: 10.1101/2024.06.10.24308698.
147. National Institute for Health and Care Excellence [NICE]. *Home care: delivering personal care and practical support to older people living in their own homes. NICE guideline [NG21]*. 2015. Leeds: NICE. https://www.nice.org.uk/guidance/ng21
148. Bensliman R, Casini A and Mahieu C. "Squeezed like a lemon": A participatory approach on the effects of innovation on the well-being of homecare workers in Belgium. *Health Soc Care Community* 2022;30(4):e1013-e1024. DOI: 10.1111/hsc.13506.
149. Burns D, Goodlad C, Hamblin K and Zimpel-Leal K. Innovation in UK independent homecare services: A thematic narrative review. *Health Soc Care Community* 2022;30(6):e3447-e3458. DOI: 10.1111/hsc.13954.
150. Loeffler E and Bovaird T. Co-commissioning of public services and outcomes in the UK: Bringing co-production into the strategic commissioning cycle. *Public Money Manag* 2019;39(4):241-252. DOI: 10.1080/09540962.2019.1592905.
151. Government Outcomes Lab. *Better Commissioning for Older People's Services*. 2017. Oxford: GO Lab. https://golab.bsg.ox.ac.uk/documents/108/GO_Lab_Better_Commissioning_for_Older_Peoples_Services_Symposium_-_Final_v3mfTDE.pdf
152. Local Government Information Unit (LGiU). *Achieving outcomes-based commissioning in homecare*. 2016. London: Local Government Information Unit. https://lgiu.org/publication/achieving-outcomes-based-commissioning-in-home-care/
153. Bolton J. *New Developments in Adult Social Care*. 2019. Oxford: Institute of Public Care. https://ipc.brookes.ac.uk/wp-content/uploads/2024/07/New_Developments_in_Adult_Social_Care.pdf
154. Whalley R. *Why not home, why not today?* 2017. Oxfordshire: Newton Europe. https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf

Appendix A: CQC statements

Taken from: https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework

CQC ‘We’ statements

1. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
2. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
3. We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
4. We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
5. We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
6. We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.
7. We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
8. We make sure that medicines and treatments are safe and meet people’s needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.
9. We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
10. We plan and deliver people’s care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
11. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
12. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
13. We routinely monitor people’s care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
14. We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

15. We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
16. We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
17. We promote people’s independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
18. We listen to and understand people’s needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
19. We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.
20. We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
21. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
22. We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
23. We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what’s changed as a result.
24. We make sure that everyone can access the care, support and treatment they need when they need it.
25. We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
26. We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.
27. We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
28. We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
29. We foster a positive culture where people feel that they can speak up and that their voice will be heard.
30. We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
31. We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
32. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
33. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

34. We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

CQC ‘I’ statements

1. When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.
2. I feel safe and am supported to understand and manage any risks.
3. I know what to do and who I can contact when I realise that things might be at risk of going wrong or my health condition may be worsening.
4. If my treatment, including medication, has to change, I know why and am involved in the decision.
5. I have considerate support delivered by competent people.
6. I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.
7. I have care and support that is co-ordinated, and everyone works well together and with me.
8. I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.
9. I am treated with respect and dignity.
10. I am supported to manage my health in a way that makes sense to me.
11. I am in control of planning my care and support. If I need help with this, people who know and care about me are involved.
12. I can keep in touch and meet up with people who are important to me, including family, friends and people who share my interests, identity and culture.
13. I am supported to plan ahead for important changes in my life that I can anticipate.
14. I know how to access my health and care records and decide which personal information can be shared with other people, including my family, care staff, school or college.
15. I can get information and advice that is accurate, up to date and provided in a way that I can understand.
16. I am encouraged and enabled to feedback about my care in ways that work for me and I know how it was acted on.

Appendix B: Search strategy applied to CINAHL

S23 S22 AND S11 AND S17

S22 S21 AND S11 AND S17

S21 S5 NOT S20

S20 S19 NOT (S1 OR S2)

S19 (MH "Nursing Homes") OR (MH "Skilled Nursing Facilities") OR (MH "Nursing Home Patients")

S18 S12 AND S17

S17 S13 OR S14 OR S15 OR S16

S16 TI(“quality standard*”) OR AB(“quality standard*”)

S15 TI(quality N2 (monitor* OR assurance OR assure*)) OR AB(quality N2 (monitor* OR assurance OR assure*))

S14 TX (quality OR good OR “high-quality” OR “low-quality” OR "good quality" OR "bad quality" OR "poor quality" OR fail* OR “gold standard*” OR “best practice” OR abuse* OR safeguard* OR neglect* OR complain*)

S13 MH "Quality of Health Care"

S12 S5 AND S11

S11 S6 OR S7 OR S8 OR S9 OR S10

S10 TI(older OR geriatric* OR elder* OR aging OR ageing OR parkinson* OR dementia* OR alzheimer*) OR AB(older OR geriatric* OR elder* OR aging OR ageing OR parkinson* OR dementia* OR alzheimer*)

S9 (MH "Dementia+")

S8 (MH "Parkinson Disease")

S7 (MH "Aged+")

S6 (ZG "aged, 80 & over") or (ZG "aged: 65+ years")

S5 S1 OR S2 OR S3 OR S4

S4 TI(domicil* N3 care) OR AB(domicil* N3 care)

S3 TI("home care" OR homecare OR "home health care") OR AB("home care" OR homecare OR "home health care")

S2 (MH "Home Health Aides") OR (MH "Home Health Agencies")

S1 (MH "Home Health Care") OR (MH "Home Health Nursing") OR (MH "Home Rehabilitation") OR (MH "Home Occupational Therapy") OR (MH "Home Physical Therapy") OR (MH "Home Visits") OR (MH "Homemaker Services")

Appendix C: Review criteria

Table A1. Review criteria

	Include	Exclude
Population	Articles that report perspectives of stakeholders on quality of homecare for older people: • Older homecare recipients (aged 65+) • Unpaid family carers • Homecare providers, workers, managers or agency owners • Social workers • Local authority and healthcare commissioners • Government and other policymakers • Non-governmental organisations (NGOs; including statutory and non-statutory advocates/advocacy services) • Legal representatives • Regulators • Researchers	Articles reporting perspectives of stakeholders on forms of care other than professionally provided homecare. For example, records reporting unpaid family carers' perspectives on professional homecare would be included, but records reporting unpaid family carers' perspectives on their own experiences of providing unpaid care would be excluded
Concept	Articles providing a definition of quality or indicating how quality is characterised, conceptualised or operationalised. 'Quality' is considered across an entire spectrum from neglect/abuse to excellent care	Articles with no indication of what quality means
Context	Care recipients aged 65+; or with mean age of 65+; or with dementia or Parkinson's; or described as 'older people' --- Homecare provided to older people in their own homes If an article refers to multiple setting of care, e.g., nursing homes and homecare, the evidence regarding homecare must be clearly identifiable	Articles with mixed populations where it is not possible to determine relevance to over-65s/older people --------------------------------- Care provided in hospital settings, assisted living, supported/extra care housing or care/nursing home facilities, unless there is also a homecare component and reference to its quality (e.g., transition from homecare to nursing home, with clear discussion about the implications of quality of homecare for this transition) Palliative/end-of-life care, including hospice care (as defined by study authors; may or may not specify a

	-- Homecare provided by care professionals -- Qualitative, quantitative or mixed methods papers Opinion/comment pieces Published in English language since 2016 Peer-reviewed literature: care provided in OECD high-income countries: Australia, Austria, Belgium, Canada, Chile, Czech Rep, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Rep, Slovenia, Spain, Sweden, Switzerland, UK, USA Grey literature: UK only	time frame, e.g., last 12 months of life) Reablement or other specific short-term interventions --------------------------------- - Solely medical care provided by registered health professionals Unpaid care provided by family, friends or volunteers with no professional involvement --------------------------------- Review papers (potentially relevant primary studies within review papers will be assessed)

Appendix D: Characteristics of included articles

Table A2. Summary of included articles

Authors, date and country	Publication type	Homecare recipient group	Aim of study/article	Design	Study participants (i.e. stakeholder views reported)*	Dimensions highlighted**
Abrahamson et al. 2016 USA[48]	Empirical research	Older adults	To explore home and community-based service providers' perspectives of organizational readiness for quality improvement	Quantitative	Senior staff/quality improvement leads (n=56)	M
Alnes et al. 2022 Norway[49]	Empirical research	Older adults with dementia	To investigate healthcare professionals' perspectives on improving the everyday lives of people with dementia at home.	Qualitative	Health professionals (n=14)	R B O
Andersson et al. 2023 Sweden[50]	Empirical research	Older adults	To describe and analyse care workers' and personal assistants' strategies in managing situations and challenges relating to personal and intimate care in formal homecare settings	Qualitative	Care workers (n=25)	M B O
Andersson & Sjolund 2023 Sweden[51]	Empirical research	Older adults	To explore how community homecare is provided and organised at nighttime	Qualitative	Senior staff/managers (n=41)	B O
Blomqvist et al. 2023 Finland[52]	Empirical research	Older adults	To explore homecare leaders' perceptions of ethical sensitivity and compassion associated with care quality in homecare	Qualitative	Senior staff/managers (n=10)	M B O
Bostrom et al. 2022 Sweden[53]	Empirical research	Older adults	To examine associations between psychosocial work environment of homecare staff and satisfaction with care among older persons receiving homecare services in Sweden	Quantitative	Older adults (n=723) Care workers (n=219)	M B O
Breen et al. 2022 Canada[54]	Empirical research	Older adults with dementia	To explore perceptions of personal support workers regarding quality homecare for persons with dementia in Ontario, Canada	Qualitative	Care workers (n=15)	B O
Brodin & Peterson 2019 Sweden[55]	Empirical research	Older adults	To critically examine assumptions underlying Swedish elder care policies. Specifically, to assess belief that market practices in publicly funded	Mixed Methods	Senior staff/managers (n=24)	M B O

			eldercare services will promote women’s entrepreneurship			
Brown et al. 2022 UK (England)[56]	Empirical research	Older adults with dementia	To explore alignment between actual delivery of paid homecare and care plans for clients living with dementia, in order to understand effectiveness of care plans in ensuring person-centred care in homecare setting for individuals with dementia	Qualitative	Care workers (n=16) Older adults (n=17) Authors (ethnographic observations of delivery of care)	B O
Browne-Yung et al. 2021 Australia[57]	Empirical research	Older adults: 'Forgotten Australians' (care-leavers)	To explore perceptions and expectations of aged care among older Forgotten Australians, in order to identify ways to deliver aged care services in safe and inclusive ways	Qualitative	Older adults (n=16)	B
Burns et al. 2023 UK[58]	Empirical research	Older adults	To examine how service delivery models and job quality are temporally connected through homecare work	Qualitative	Senior staff/managers Care workers Older adults (n=70 total)	M O
Cederbom et al. 2017 Sweden[59]	Empirical research	Older women with chronic pain	To explore how homecare staff described their role in improving their abilities of older people, particularly older women with chronic pain who are dependent on formal care, to perform everyday activities	Qualitative	Care workers Senior staff/managers (n=12 total)	R B O
Chapman 2021 UK (Northern Ireland)[60]	Empirical research	Older adults	To examine the views and experiences of adult social care users who receive care at home, to explore if and how a person-centred approach might work for older adults in Northern Ireland	Qualitative	Older adults (n=12)	M B O
Chester et al. 2018 UK[61]	Empirical research	Older adults with dementia	To examine people with dementia and carer preferences for home support attributes in early-stage dementia	Quantitative	Older adults (n=44) Unpaid carers/family (n=103)	B
Chester et al. 2017 UK[62]	Empirical research	Older adults with dementia	To explore unpaid carers' preferences for different attributes of homecare for older people with dementia	Quantitative	Unpaid carers/family (n=28)	R B O
Cohen-Mansfield et al. 2018 Israel[63]	Empirical research	Older adults	To establish the components of quality of care as provided by migrant live-in caregivers	Quantitative	Older adults (n=72) Unpaid carers/family (n=117)	M R B

Craftman et al. 2018 Sweden[64]	Empirical research	Older adults	To describe homecare assistants' (HCA) experiences of providing social care in older people's own homes	Qualitative	Care workers (n=19)	O
Dalgarno et al. 2021 UK[65]	Empirical research	Older adults with dementia	To explore the views of unpaid carers of those with dementia concerning homecare	Qualitative	Unpaid carers/family (n=52)	R B O
Davidson & Guthrie 2019 Canada[66]	Empirical research	Older adults with Dual Sensory Impairment (hearing and vision)	To describe homecare clients, aged 65+, with Dual Sensory Impairment (DSI) on demographic characteristics, items related to functional and cognitive status, health-related outcomes, and rates across a set of quality indicators	Quantitative	Older adults (n=72,188 with DSI)	M
Dostalova et al. 2022 Czech Republic[67]	Empirical research	Older adults	To explore the experiences and needs of frail older people receiving home health care	Qualitative	Older adults (n=15)	R B O
Duner et al. 2019 Sweden[68]	Empirical research	Older adults	To analyse the processes and practices of individualized eldercare, focusing on preconditions for older peoples' choice and control	Qualitative	Senior staff/managers Care workers (n=12 total) Older adults (n=12)	B O
Eltaybani et al. 2023 Japan[69]	Empirical research	Older adults	To describe the development of quality indicators for long-term care (QIs-LTC) in Japan	Quantitative	Senior staff/managers (n=699) Older adults (n=1450) Unpaid carers/family (n=808)	M
Fraser et al. 2018 Canada[70]	Empirical research	Older adults	To extend what is known about resource allocation decision-making factors identified in a previous systematic literature review and ethnographic study	Qualitative	Senior staff/managers (n=17)	R B O
Gjevjon et al. 2016 Norway[71]	Empirical research	Older adults	To explore how patients and next of kin experience and assess continuity when patients receive daily and long-term home health care from multiple health personnel	Quantitative	Older adults (n=125) Unpaid carers/family (n=92)	R O

Goh et al. 2022 Australia[72]	Empirical research	Older adults with dementia	To explore what people receiving and providing care consider to be ‘good’ in-homecare for people living with dementia	Qualitative	Senior staff/managers (n=14) Care workers (n=10) Older adults (n=4) Unpaid carers/family (n=15)	B O
Gudnadottir et al. 2019 Iceland[73]	Empirical research	Older adults	To explore the benefits and barriers of collaboration between the nursing and social service teams in a homecare ostensibly fully integrated but divided into separate nursing and social service teams	Qualitative	Senior staff/managers Health professionals Care workers (n=42 total)	O
Haex et al. 2020 Netherlands[74]	Empirical research	Older adults	To explore and understand the views of clients and formal and unpaid caregivers about the experienced quality of homecare for older people	Qualitative	Care workers Older adults Unpaid carer/family (n=9 total; n=3 ‘care triads’)	M R B O
Hammar et al. 2021 Sweden[75]	Empirical research	Older adults with dementia	To enhance knowledge of the perceptions of people with dementia regarding their treatment with dignity and respect in homecare services over time	Quantitative	Older adults (n=271,915; 8.1% of which with dementia)	M B
Hanberger & Lindgren 2019 USA[76]	Empirical research	Older adults	To identify home health aides’ experiences and perceptions around detecting and reporting elder abuse	Qualitative	Care workers (n=17)	O
Hansen et al. 2017 Norway[77]	Empirical research	Older adults with dementia	To explore how the psychosocial needs of home-dwelling, older people living with dementia were perceived, emphasized and met by homecare services	Qualitative	Health professionals Care workers (n=24 total)	O
Hansen et al. 2018 Norway[78]	Empirical research	Older adults with dementia	To explore purchasers’ deliberations on psychosocial needs during the process of allocating healthcare services to older home-dwelling persons with dementia	Qualitative	Health professionals (n=19)	B
Hoel et al. 2021 Norway[79]	Empirical research	Older adults with dementia	To explore the experience of homecare services among people with dementia, to understand the continuity in services, how the service was adapted to people with dementia, and how the patient experienced person-centred care and shared decision-making	Qualitative	Older adults (n=12)	R B O

Hoel et al. 2021 Norway[80]	Empirical research	Older adults with dementia	To explore the experiences of homecare staff about the impact of the organization of homecare services for people with dementia	Qualitative	Care workers (n=14)	B O
Hsieh 2017 USA[81]	Empirical research	Older adults	To describe the development and psychometric testing of the Client Satisfaction: Homecare (CSAT-HC) measure, which uses a client-centred perspective to measure client satisfaction for homecare services for older adults	Quantitative	Older adults (n=156)	M
Hughes & Burch 2020 UK (England)[82]	Empirical research	Older adults	To understand the individual's lived experience of care and how it interacts with sense of self	Qualitative	Older adults (n=17)	R B
Jakobsen & Lind 2023 Norway[83]	Empirical research	Older adults	To express the phenomenon of lived experience as presented by an elderly woman, more specifically her experience of care in home nursing run according to the principles of new public management	Qualitative	Older adults (n=1)	R B O
Kajonius & Kazemi 2016 Sweden[84]	Empirical research	Older adults, some with dementia	To describe the basic elements of care process quality as user-oriented care. Specifically, the questions of how and why quality in user-oriented care varies were investigated in the context of elderly care	Qualitative	Senior staff/managers Care workers (n=30 total)	M R
Kajonius & Kazemi 2016 Sweden[85]	Empirical research	Older adults	To investigate the empirical validity of the structure versus process approach to quality of care presented by Donabedian, specifically concerning the relative effects of structure and process on satisfaction with elderly care as perceived by the older persons themselves	Quantitative	Older adults (n=61,600 using homecare)	M
Kamalraj et al. 2021 Canada[86]	Empirical research	Older adults with dementia	To understand the lived experiences of personal support workers regarding their communication with people living with dementia who live in their own homes	Qualitative	Care workers (n=15)	R O
Kampanellou et al. 2017 UK[87]	Empirical research	Older adults with dementia	To examine the relative importance of different home support attributes from the perspective of carers of people with later-stage dementia	Quantitative	Unpaid carers/family (n=100)	B O
Kazemi & Kajonius 2021 Sweden[88]	Empirical research	Older adults	To examine whether selected items from commonly used instruments of person-centred care were able to differentiate between	Quantitative	Care workers (n=1342; 23% of	M

			respondents with a reasonably even level of measurement precision across different regions of the construct range using item response theory (IRT)		which working in homecare)	
Kazemi & Kajonius 2016 Sweden[89]	Empirical research	Older adults	To analyse the longitudinal trends in costs and perceived quality of care across three years using nationwide data in Swedish elderly homecare	Quantitative	Older adults (2012: n=61,573; 2013: n=99,469; 2014: n=92,945)	O
Kristensen et al. 2017 Norway[90]	Empirical research	Older adults	To describe the characteristics of communication practice in homecare visits between older people and nurse assistants and to discuss the findings from a person-centred perspective	Qualitative	Care workers (n=12) Older adults (n=15)	R B
Laragy & Vasiliadis 2022 Australia[91]	Empirical research	Older adults	To examine whether self-management improved consumers' perceptions of their choice, control, and wellbeing; to examine whether provider prior experience with self-managed packages significantly influenced consumers' perceptions of choice, control and wellbeing	Mixed Methods	Older adults (n=60) Unpaid carers/family (n=41 supporting or proxy responders) Senior staff/managers (n=14)	O
Malley et al. 2019 UK (England)[92]	Empirical research	Older adults	To assess the relationship, synergies and trade-offs between 'quality of care' dimensions in long term homecare, including safety, experience and effectiveness, and how these impact on quality of life	Quantitative	Older adults (n=14,172)	M R
Martinsen et al. 2023 Denmark and Norway[93]	Empirical research	Older adults	To explore the existential dimension of being dependent on homecare with a particular focus on what makes dependency bearable	Qualitative	Older adults (n=15)	R
McDonald et al. 2019 Ireland[94]	Empirical research	Older adults	To consider time in the delivery of homecare for older adults in Ireland from the perspective of multiple stakeholders, bringing visibility and clarity to the subject while providing suggestions as to how the more effective use of time could improve the care experience for all stakeholders	Qualitative	Older adults (n=46) Senior staff/managers (n=29) Care workers (n=18) Other professionals not specified (n=11)	R B O
Miller et al. 2019 Canada[95]	Empirical research (quality	Older adults	Quality improvement initiative to increase the utilization of a new tool designed by/for CBI	Qualitative	Older adults (n=10) Unpaid carers/family (n=9)	M R B

	improvement initiative)		Homecare to facilitate the provision of patient-centred care in the homecare setting			
Nilsen et al. 2022 Norway[96]	Empirical research	Older adults transitioning between hospital and home	To explore person-centred care provided to a group of older adults by understanding their experiences of care received, their participation in care and what matters to them during and after the transition process between hospital and home	Qualitative	Older adults (n=8; n=4 follow-up interviews)	R B O
Olaison et al. 2021 Sweden[97]	Empirical research	Older adults	To investigate the experiences of participation in care by older people following their involvement in an intervention of a health care model called Focused Primary Care (FPC)	Qualitative	Older adults (n=20)	R B O
Olasunkanmi-Alimi et al. 2022 Australia[98]	Empirical research	Older adults	To interrogate the implications of the tension between positioning migrant care workers as a solution to the care capacity crisis, and the widespread racism that questions or denies their commitment and skills	Qualitative	Care workers (n=30)	R
Olsen et al. 2021 Norway[99]	Empirical research	Older adults transitioning between hospital and home	To explore health care providers' perceptions and experiences of what is important to achieve more person-centred patient pathways for older people	Qualitative	Health professionals (n=20)	B O
Olsen et al. 2021 Sweden[100]	Empirical research	Older adults with dementia	To described the views of people living with dementia on the important aspects of receiving a homecare service	Qualitative	Older adults (n=14)	R B O
Phillipson et al. 2022 Australia[101]	Empirical research	Older adults	To understand what support older service users with varying degrees of cognitive and physical impairments needed to participate in reporting their own care-related outcomes, and the value of this reporting to illuminate the service use experiences of this cohort	Mixed Methods	Older adults (n=43) Authors	M
Polacsek et al. 2020 Australia[102]	Empirical research	Older adults with dementia	To explore older people living with dementia's experiences of receiving homecare services and to invite suggestions for improvement of community support for older people living with dementia	Qualitative	Older adults (n=4) Unpaid carers/family (n=15)	R B O
Rand et al. 2022 UK (England)[103]	Empirical research	Older adults with dementia	To establish factors relating to social care-related quality of life of people living with dementia and their carers	Quantitative	Unpaid carers/family (n=313)	M B

Roin 2018 Denmark (Faroe Islands)[104]	Empirical research	Older adults	To investigate how older people's experiences with homecare reflect a person-centred approach to care	Qualitative	Older adults (n=15) Unpaid carers/family (n=2)	B O
Ruotsalainen et al. 2020 Finland[105]	Empirical research	Older adults	To explore the challenges, stressors, teamwork and management factors that are associated with homecare staff members' well-being, job satisfaction and experienced care quality, and how staff members experience their work	Mixed Methods	Care workers (n121 survey; n=15 interviews)	M O
Russell et al. 2020 Australia[106]	Empirical research	Older adults	To explore consumers' experiences of receiving a homecare package	Qualitative	Older adults (n=37)	R B O
Sanerma et al. 2020 Finland[107]	Empirical research	Older adults	To evaluate client-centred care in older persons' homecare services from the perspective of older persons and family members using a realist evaluation approach	Qualitative	Older adults (n=6) Unpaid carers/family (n=7)	M R B O
Silverglow et al. 2022 Sweden[108]	Empirical research	Older adults	To describe care providers' perceptions of providing safe care for frail older persons living at home	Qualitative	Health and care professionals (n=30; including n=10 care workers)	R O
Silverglow et al. 2021 Sweden[109]	Empirical research	Older adults	To highlight experiences of what constitutes feeling safe at home among frail older people receiving homecare	Qualitative	Older adults (n=12)	B O
Teshuva et al. 2021 Australia[110]	Empirical research	Older adults	To investigate Jewish Holocaust survivors' lived experience of using community aged care services	Qualitative	Older adults (n=13)	R
Teshuva et al. 2019 Israel[111]	Empirical research	Older adults	To explore the quality and the nature of care relationships between full-time, live-in migrant care workers and older people in Israel	Mixed Methods	Older adults (n=73) Care workers (n=116)	M R B O
Thalen et al. 2021 Netherlands[112]	Empirical research	Older adults with intellectual disabilities	To identify the intervention components of Integrated Emotion-Orientated Care and to obtain an in-depth understanding and illustration of the use of these components in the day to day support of older people with intellectual disability	Qualitative	Health and care professionals, subject experts, care workers (n=47 total)	R B O
Tiilikainen et al. 2019 Finland[113]	Empirical research	Older adults	To examine older people's perceptions of quality of life from the perspective of access and use of health and social care services	Qualitative	Older adults (n=19)	B O

Timonen & Lolich 2019 Ireland[114]	Empirical research	Older adults	To examine the social construction of the formal homecare worker from the perspective of various professionals in the elder care sector in Ireland	Qualitative	Health and care professionals, senior staff/managers (n=31 total)	R B O
Tufte & Dahl 2016 Denmark[115]	Empirical research	Older adults	To investigate the performance of homecare work within the frame of the purchaser-provider model: how the daily work schedules (rotas), which indicate predefined work tasks and provide strict time frames, are translated into practice by the care workers.	Qualitative	Care workers (n=8, observations of c. 100 home visits, focus groups) Researchers (analysis draws heavily on ethnographic work)	M B O
Turner et al. 2020 UK (England)[116]	Empirical research	Older adults with dementia	To explore manifestations of, and motivations for, homecare workers going the extra mile in their everyday work	Qualitative	Care workers (n=14) Senior staff/managers (n=6)	B O
Westerberg et al. 2017 Sweden[117]	Empirical research	Older adults	To gain a deeper understanding of eldercare users' strategies for dealing with problems in the quality of care and care satisfaction in relation to home help services	Qualitative	Older adults (n=35)	M R B O
Wilfling et al. 2023 Germany[118]	Empirical research	Older adults with dementia	To identify specifics of inter-professional care for people living with dementia and training needs of homecare nurses and general practitioners involved in care	Qualitative	Care workers (n=10) GPs (n=3) Unpaid carers/family (n=9)	B O
Zoeckler et al. 2018 USA[119]	Empirical research	Older adults	To explore stressors that impact the occupational health of home health aides taking into account agency-level factors and eliciting policy recommendations to mitigate stressors	Qualitative	Care workers (n=25) Senior staff/managers (n=20)	O
Adelman 2016 USA[120]	Comment piece	LGBT older adults with dementia	To highlight barriers to care for LGBT elders with Alzheimer's, including double stigma, lack of legal recognition, and fear of discrimination	Comment	Authors	B O
Butler 2019 USA[121]	Comment piece	Older adults	To review the problems addressed by the Homecare for All initiative, what was proposed, the campaign process and anticipated next steps, and implications for gerontological social workers	Comment	Authors	O
Golden et al. 2019 USA[122]	Comment piece	Older adults with serious and/or long-term illnesses	To outline elements of home-based care that are key to best meeting the needs of older adults with serious illness and their families; To review models that provide the key elements effectively and cost	Comment	Authors	M B O

			efficiently; To propose an Essential Care Model that defines best practice and comprises all the aforementioned key elements of care			
Hopwood & MacEachen 2022 Canada[123]	Comment piece	Older adults	To explore the confluence of the current homecare policy landscape and the organisation of personal support worker (PSW) work (which is currently unregulated), and highlight the need to consider governance of PSW work generally, and in-home and community care especially	Comment	Authors	M O
Seeman 2022 Canada[124]	Comment piece	Older adults	To introduce ethical, technological and stakeholder engagement considerations that may help Canada move forward with a strategy that offers the capacity to better understand the perspectives of different stakeholders and champions high-quality homecare services	Comment	Authors	B O
Solis et al. 2023 USA[125]	Comment piece	Older adults	To make the case that, as the industry is currently structured, homecare workers and clients who form caring relationships are going above and beyond what can reasonably be expected of them. To argue that care—of a deep sort—should be the standard and that significant changes are urgently needed to make that care a reasonable expectation	Comment	Authors	O
Age UK 2018 UK[126]	Grey report	Older adults	To highlight how people's realities of receiving care do not match policy rhetoric about the care they should receive. The report presents personal stories of challenges with care to demonstrate how people 'fall of the health and care radar' so that they only receive help at crisis point. This help may be inadequate.	Qualitative	Older adults Unpaid carers/family (n=14 stories total)	R O
Age UK 2018 UK (England)[127]	Grey report	Older adults	To ask older people and their families what they think about problems in the social care system	Qualitative	Older adults Unpaid carers/family (n=127 total)	R O
Age UK 2022 UK (England)[128]	Grey report	Older adults	To highlight challenges in getting care	Mixed Methods	Older adults (n=unclear)	R B O
Age UK & Homecare	Grey report	Older adults	To highlight the experiences from providers on the front line who are being forced to pull out the stops	Comment	Senior staff/managers	O

Association 2021 UK[129]			to find and keep hold of staff to make sure they can provide care, and the impact that a dwindling homecare workforce is having on older people, their carers and loved ones		(n=unspecified; authors' commentary)	
Alzheimer's Society 2016 UK (England)[130]	Grey report	Older adults with dementia	To highlight challenges associated with a lack of dementia-specific training among the homecare workforce, and make recommendations for change	Mixed Methods	Older adults Unpaid carers/family (n=1227 total) Care workers (n=739) Authors	B O
Bolton & Townson 2018 UK[131]	Grey report	Older adults	To bring together two different perspectives with a strong focus on how might we continue to help people to remain in their own homes and what might care look like in tomorrow's world	Comment	Authors	B O
Care Quality Commission 2018 UK (England)[132]	Grey report	Older adults	To review 20 local health and care systems in order to understand how services are working together to meet the needs of people who move between health and care services	Mixed Methods	Broad range of stakeholders across the care spectrum; details unclear	M R O
Community Catalysts 2017 UK (England)[133]	Grey report	Older adults	To evaluate the Community Catalysts project in Somerset	Qualitative	Older adults Unpaid carers/family (n=45 families total)	R O
Cottell & Harding 2018 UK[134]	Grey report	Older adults	To survey all local authorities and health and social care trusts to find out about care across the UK; key focus is cost and availability of care	Mixed Methods	Local authorities (n=166)	O
Global Coalition On Aging 2018 Europe (authors inc. UK experts)[135]	Grey report	Older adults	To demonstrate how relationship-based homecare can enable ongoing delivery of high-quality, person-centred, and outcomes-based care to older adults	Comment	Authors	R B O
Healthwatch 2017 UK (England)[136]	Grey report	Older adults	To provide a snapshot of what life is like for those who rely on homecare services	Qualitative	Draws on experiences of older adults, unpaid carers/family and care workers (n=3,415 total); n=20	M R O

					focused reports on local services	
Hudson 2016 UK (England)[137]	Grey report	Older adults	To explore the growth in the market in adult social care in England and the problems which have resulted from this; to provide recommendations to address the worst aspects of privatised provision	Comment	Authors	M O
Koehler 2017 UK (England & Wales)[138]	Grey report	Older adults	To examine the human side of a care market on the brink of failure with stories from across the care system; to examine why care is priced so low and how people in the system end up paying for cut-price care	Comment	Authors	R O
Pursch & Isden (Age UK) 2018 UK[139]	Grey report	Older adults	To highlight challenges in accessing and receiving homecare for older people and their families in the UK	Mixed Methods	Older adults (n=unclear)	R B O
Unison 2016 UK[140]	Grey report	Older adults	To expose the scale of spending cuts to social care and the impact on care workers, older people needing care and their families	Mixed Methods	Care workers (n=1075 survey) Older adults Unpaid carers/family (n=unclear qualitative accounts)	O

* International differences in care systems and terminology makes succinct, consistent labelling of health and care professional stakeholders challenging. We adopted three broad groups: ‘care workers’ if they were indicated to be providing frontline homecare (this could include nurses/nurse assistants); ‘senior staff/managers’ if they were described as occupying some kind of leadership or more senior role within homecare organisations (this includes company owners/directors); ‘health professionals’ if they were described as other kinds of registered health professionals (e.g., psychologists, occupational therapists, general practitioners) who may be involved in homecare.

** R = relationships and continuity of care; B = bespoke care; O = organisational and structural aspects of care; M = measurable construct

Appendix E: Additional tables

Table A3. Number of articles reporting dimensions by stakeholder groups*

	All (n)	Relationships (n)	Bespoke (n)	Organisation (n)	Measurement (n)
Article authors	15	1	9	13	8
Senior staff/ quality improvement leads	1	-	-	-	1
Health professionals	8	4	5	6	1
Care workers	27	13	14	21	8
Senior staff/ team managers	17	7	9	14	6
Older adults	46	26	27	28	16
Unpaid carers/ family members	19	12	13	11	5
Local authorities (or equivalent)	1	-	-	1	-
All stakeholders	134	63	77	94	45

*Counts are reported by stakeholder group, therefore articles that include more than one stakeholder contribute multiple times to the Table.

Table A4. Number of articles reporting stakeholder views by country*

	Article authors		Health professionals		Senior staff/ improvement leads		Care workers		Senior staff/ team managers		Older adults		Unpaid carers		Commissioners		All	
	n	%	n	%	n	%	n	%	n	%	N	%	n	%	n	%	n	%
UK	6	4.48	-	-	-	-	6	4.48	3	2.24	13	9.70	10	7.46	1	0.75	39	**29.10**
Denmark	*1*	*0.75*	-	-	-	-	*1*	*0.75*	-	-	*1*	*0.75*	*1*	*0.75*	-	-	*4*	***2.99***
Norway	-	-	*4*	*2.99*	-	-	*3*	*2.24*	-	-	*5*	*3.73*	-	-	-	-	*12*	***8.95***
Iceland	-	--	*2*	*1.49*	-	-	*1*	*0.75*	*3*	*2.24*	-	-	-	-	-	-	*6*	***4.48***
Sweden	-	-	*1*	*0.75*	-	-	*5*	*3.73*	*6*	*4.48*	*8*	*5.97*	-	-	-	-	*20*	***14.93***
Finland	-	-	-	-	-	-	*1*	*0.75*	*1*	*0.75*	*2*	*1.49*	*1*	*0.75*	-	-	*5*	***3.73***
Nordic	1	0.75	7	5.22	-	-	11	8.20	10	7.46	16	11.94	2	1.49			47	**35.07**
Australia	1	0.75	-	-	-	-	2	1.49	1	0.75	6	4.48	2	1.49	-	-	12	**8.95**
USA	4	2.99	-	-	1	0.75	2	1.49	1	0.75	2	1.49	-	-	-	-	10	**7.46**
Canada	2	1.49	-	-	-	-	2	1.49	1	0.75	2	1.49	1	0.75	-	-	8	**5.97**
Netherlands	-	-	*1*	*0.75*	-	-	*2*	*1.49*	-	-	*1*	*0.75*	*1*	*0.75*	-	-	*5*	***3.73***
Israel	-	-	-	-	-	-	*1*	*0.75*	-	-	*2*	*1.49*	*1*	*0.75*	-	-	*4*	***2.99***
Germany	-	-	-	-	-	-	*1*	*0.75*	-	-	-	-	*1*	*0.75*	-	-	*2*	***1.49***
Japan	-	-	-	-	-	-	-	-	*1*	*0.75*	*1*	*0.75*	*1*	*0.75*	-	-	*3*	***2.24***
Czech Rep	-	-	-	-	-	-	-	-	-	-	*1*	*0.75*	-	-	-	-	*1*	***0.75***
Ireland	-	-	-	-	-	-	-	-	-	-	*2*	*1.49*	-	-	-	-	*2*	***1.49***
Europe	*1*	*0.75*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	*1*	***0.75***
Others	1	0.75	1	0.75	-	-	4	2.99	1	0.75	8	5.97	5	3.73	-	-	18	**13.43**
All	**15**	**11.19**	**8**	**5.97**	**1**	**0.75**	**27**	**19.85**	**17**	**12.69**	**47**	**35.07**	**20**	**14.92**	**1**	**0.75**	**134**	**100.00**

* Counts are reported by stakeholder group, therefore articles that include more than one stakeholder contribute multiple times to the Table.

Table A5. Measures and operationalisation of homecare quality

Authors, date and country	Measure	Operationalisation	Target user
Bostrom et al. 2022[53] Hammar et al. 2021[75] Kajonius & Kazemi 2016[85] Westerberg et al. 2017[117] Sweden	National Board of Health and Welfare annual national state survey	Users' experiences of homecare services: 25 questions about overall satisfaction with care, treatment by staff, performance of services, contact with staff and sense of security	Older people
Rand et al. 2022[103] UK	ASCOT- Proxy; ASCOT-Carer	Social care related quality of life (SCRQoL): occupation (being occupied in a range of activities); control over daily life; social participation; personal safety; food and drink; accommodation comfort and cleanliness; personal comfort and cleanliness; dignity; self-care; space and time to be yourself; feeling supported and encouraged.	Older people, unpaid carers/family
Hsieh 2017[81] USA	Client Satisfaction-Homecare (CSAT-HC)	Client satisfaction: attitude of homecare workers; personal care services; homemakers services; dependability of homecare staff; communication between client and homecare staff; job skills of homecare worker	Older people
Davidson & Guthrie 2019[66] Canada	Resident Assessment Instrument for Homecare (RAI-HC)	Homecare quality: Standardized assessment tool that contains approximately 300 items across multiple domains such as physical functioning, cognitive and behavioural status, sensory function and communication, chronic disease diagnoses, social support, and service use. A set of 22 Homecare Quality Indicators (HCQIs) can be generated directly from specific items measuring health-related outcomes within the RAI-HC	Older people
Cohen-Mansfield et al. 2018[63] Israel	Quality of Care Questionnaire (QuCQ)	Person-centred care: quality of care given by out-of-home physicians (knowing the older person/knowing their main concern); support from	Older people

		caregivers in needed areas; caregiver responsiveness; treatment (respect); communication (extent to which older person and caregiver understand each other); general quality of care provided	
Eltaybani et al. 2023[69] Japan	Quality Indicators for Long Term Care (VENUS QI-LTC)	Care quality domains: maintaining dignity (including social interaction; realising desired way of life; realising desired care); minimizing symptoms and disease deterioration; maintaining nutritional status; maintaining bladder/bowel control; encouraging physical activities; experiencing sound sleep; maintaining serenity and contentedness; maintaining family's well-being	Older people, unpaid carers/family, care workers, managers
Miller et al. 2019[95] Canada	Life Through My Eyes (LTME)	Person-centred care: five questions/items intended to gather important personal information from the patient used to direct individualised care. Aims to help care providers 'know and value' care recipients.	Older people, unpaid carers/family, care workers
Malley et al. 2019[92] UK	National User Experience Survey (UES)	User experience: continuity of care workers; fluid communication of changes in care; flexibility of the service to meet needs and preferences; reliability of care workers; good relationship with care workers and feeling that they are caring, trustworthy, ensure privacy and dignity; responsiveness of care workers	Older people
Kazemi & Kajonius 2021[88] Sweden	Person-entered Care Assessment Tool (P-CAT)	Person-centred care: 13 items measuring personalised care, organisational support, and environmental accessibility	Care workers
Kazemi & Kajonius 2021[88] Sweden	Person Directed Care measure (PDC)	Person-centred care: 63 items measuring personhood, knowing the person, autonomy and choice, nurturing relationships, and comfort care.	Care workers

Ruotsalainen et al. 2020[105] Finland	Quality of (home) care measure	Care quality domains: Care workers’ perceptions of their co-workers professional competence; way of treating clients; friendliness; ability to consider clients' requests for assistance; ability to consider clients' self-determination; knowledge of issues related to the client; and ability to consider the clients next of kin	Care workers
Bostrom et al. 2022[53] Sweden	Strain in Dementia Care Scale (SDCS)	Perceived level of job strain among care staff: frustrated empathy (7 items), difficulty understanding and interpreting (7 items), balancing competing needs (5 items), balancing emotional involvement (4 items) and lack of recognition (4 items)	Care workers
Bostrom et al. 2022[53] Sweden	General Nordic Questionnaire for Psychological and Social Factors at Work (QPSNordic 34+)	Psychosocial aspects of the work environment related to health and productivity: support from manager, group work climate, sense of mastery, job control, social work environment and positive challenges	Care workers

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