care inspectorate

Caring for people at home

How care at home services operate in Scotland
and how well they performed between 2010 and 2013

HAPPY TO TRANSLATE

10 key points for people involved in care at home services.

1. Get to know the person as an individual and understand how they like to live their life in order to provide the right care to meet their needs.

2. Deliver services to people using a human rights-based approach to care, supporting privacy, dignity and the right to confidentiality.

3. Give people the opportunity to be involved in their care; listen to their views and act upon them.

4. Establish a truly personalised care and support plan for each person, with trained staff undertaking an outcomes-focused assessment of need and risk.

5. Make sure that people have easy access to information about their service, before the service starts.

6. Have safe systems in place for the effective management of medicines, including appropriate staff training.

7. Ensure people are cared for by staff who have the skills, knowledge and training to provide high-quality, safe, and compassionate care.

8. Have clear service agreements, which establish a 'contract' between the individual using the service and the service itself, in place before the service starts and monitor and adapt them as needs change over time.

9. Ensure every person using a care at home service has a personalised care and support plan which details how health and wellbeing needs will be monitored and met in a way that meets the needs of the individual.

10. Make sure managers have robust systems for quality assurance in place to deliver the highest standard of care possible, within an inclusive and values-based culture.

Contents

Foreword

Almost everyone in Scotland will use a care service at some point in their life. More and more people will see that service delivered in their own home.

People are living longer and the number of us over 75 will increase dramatically in the next twenty years. That means there will be more demand for high quality, flexible health and social care.

There is a clear, and in many cases welcome, shift from more traditional institutional models of care towards care and support in the home or community setting. Often, that can allow care to be designed around the needs of the individual and help people who want to live in their own homes to do so for longer.

The number of care at home services is increasing. The types of service being offered are more diverse and creative, precisely to meet people's needs. Our challenge is to make sure that we encourage and support innovation, whist ensuring that vulnerable people are kept safe and receive the quality of care to which they are entitled. Supporting people to live longer lives in a way that suits them is welcome, but inspecting and assuring the the quality of a service provided in someone's home, rather than a service's building, presents particular challenges. I am determined that our inspection methodology stays current, robust and effective, which is why we are reviewing it at present.

This report draws out findings from our inspections of care at home services between 2010 and 2013. The findings show that many care at home services are provided at a good or very good level. This is welcome and shows that care at home services can and do achieve high quality of care. But, too many services are still not providing the level and quality of care that we, and people using services, expect. Services and people commissioning them must do more to ensure that truly individualised care becomes the norm. Care must be based on individual people's needs and be delivered by suitably skilled and experienced professionals. In particular, we need to see improvement in commissioning practices, better support for staff and more training. We also need to see clear progress on persistent quality of care issues that result from ineffective care planning, inconsistency of care and carers, and poor administration of medicines.

This report sets out our vision for how poorly-performing services must improve, and how services that perform well can stay at the cutting edge. We look forward to working closely with everyone involved so that every person receives high-quality, safe and compassionate care.

This report is based on inspection findings and issues arising from the investigation of complaints.

This evidence demonstrates that most services perform well. However service providers and local partnerships as commissioners of service must address the challenge of ensuring that service quality is delivered to a high standard in the context of diminishing resources. The needs of the individual must be at the heart of the commissioning and tendering process and the delivery of services. Maintaining a motivated and well trained workforce will be a challenge.

Self directed support now provides the opportunity for services to be tailored to suit the needs of the individual service user.

We have written this report for people using care at home services, their families and carers, service providers, commissioners of services, for people thinking about using support services and for the general public. We want to share the evidence from our inspection findings, explain what complaints about care at home services tell us, and show examples of really good care as well as care that needs to be improved.

We have included the voices of people using care at home, and others, to illustrate important points throughout this report. We have also made a series of specific recommendations and we expect those who provide services to take account of these.

Annette Bruton
Chief Executive

Terms we use in this report

Care at home service:	A care service provided to the individual in their own home.
Housing support service:	A service which provides support, assistance, advice or counselling to a person who has particular needs, with a view to enabling that person to occupy residential accommodation as a sole or main residence.
Inspection volunteer:	An individual with previous experience of receiving a care service, who voluntarily supports inspectors during inspection. Previously, we used the term "lay assessor".
National Care Standards:	A set of standards, created by Scottish Ministers, which help individuals understand what to expect from a wide range of care services.
Personal care:	Care related to the day-to-day physical tasks and needs of the person being cared for (for example, washing and eating).
Personal support:	Counselling, or other help, provided as part of a planned programme of care.
Telecare and telehealthcare:	Telecare and telehealthcare is the provision of care and health services at a distance using analogue, digital and mobile technologies.
Combined service:	A service which is combined with another type of service, usually a care at home service and a housing support service.
Stand-alone service:	A service (in this case a care at home service) which is not combined with a housing support service.

Background

A care service cannot operate in Scotland unless it is registered by the Care Inspectorate. We inspect all care services, for people of all ages, to ensure they are meeting the relevant standards and to help them improve where necessary. We regulate some 14,000 care services, including care at home, housing support, and combined services where a provider delivers both care at home and housing support.

There are many ways of delivering care at home. These depend on the specialism of the provider, what the person's needs are and their level of independence, and how the service is commissioned.

We inspect care at home services and combined services at least once every twelve months. During inspection we assess the standard and quality of care and outcomes for people who use services under four main themes – quality of care and support, quality of staffing, quality of environment and quality of leadership and management. We award grades for each theme, on a scale from unsatisfactory to excellent.

In March 2013, there were 814 care at home services, delivered by 403 different providers, supporting 63,000 people. This report describes some of our findings about these services from 2010 to 2013. The figures in the report come from all the inspections of all of these services. Where we have presented more qualitative information, this has come from a random sample of inspections drawn from services which performed poorly and those which performed well.

We analysed the complaints we received about care at home services in the year ending 31 March 2013 to identify common themes.

Registered services

- At 31 March 2013, there were 814 care at home services registered with us. This is an increase of 4.8% since 31 March 2010.
- These 814 services were delivered to almost 63 000 people.
- 584 (72%) of these 814 are combined with housing support services.
- Overall, most care at home services are operated by the voluntary sector (51%), but of stand-alone services the private sector is the largest provider group.

Service providers

- There were 403 registered providers of care at home.
- 310 providers (76.9%) operate 1 service only.
- 60 providers (20.8%) operate 2 - 5 services each.
- 33 providers (8.1%) operate 42.1% of all care at home services.

Grades

- Over 80% of services receive grades of good, very good or excellent for all themes.
- 50.1% of voluntary sector run services gained all very good or excellent grades.
- 29% of private sector run services gained all very good or excellent grades.
- 23.2% of local authority run services gained all very good or excellent grades.
- 0 services run by NHS gained all very good or excellent grades.
- 2.2% of all services gained all unsatisfactory or weak grades.
- 1% of services run by voluntary sector gained all unsatisfactory or weak grades.
- 5% of services run by private sector gained all unsatisfactory or weak grades.
- 0 services run by local authority or NHS gained all unsatisfactory or weak grades.

Complaints

- In the year ending 31 March 2013, overall 13% of services had complaints made about them that we had upheld or partially upheld (14.9% of combined services and 8.3% of stand-alone services).
- 22% of services run by private sector had at least one complaint upheld.
- 12.6% of services run by a local authority had at least one complaint upheld.
- 7.2% of services run by the voluntary sector had at least one complaint upheld.

A changing policy landscape

There is wide recognition that the current system of care will change significantly in the coming years. Scotland's older population is increasing: over the next ten years, the population aged over 75 years is projected to increase by around 28%, from 0.42 million in 2012 to 0.53 million in 2022. It is then projected to continue rising, reaching 0.78 million in 2037 – an increase of 86% over the 25 year period[1].

The impact of an ageing population is likely to mean that more people with multiple long-term conditions and complex needs, such as dementia, will live longer.

Reductions in public finances mean local authorities have to make difficult decisions on spending. The Scottish Government's Christie report of 2011 into the future delivery of public services suggests that as much as 40% of public spending was focussed on addressing problems that could have been avoided, had more been invested in a preventative approach[2]. Public services are therefore working together to develop a sustainable approach to care and support with an increasing emphasis on prevention and early intervention. There is growing emphasis too, on greater provision of care for individuals within their own home, or a homely setting, rather than in institutionalised or residential care.

Self-directed support

New self-directed support legislation will offer more choice and control to people who use care services. We estimate that over 60% of care at home services support people whose care package is funded, or partially funded, through self-directed support arrangements, primarily through direct payments[3].

Integrating health and social care

Recent legislation will create new health and social care partnerships, known as 'integration authorities', to deliver health and care seamlessly. Health boards and councils will need to work together, and with third sector partners, to achieve the best joint outcomes for people using services and their carers.

A programme to reshape older people's care

The policy goal for the Scottish Government's Reshaping Care programme is "to optimise the independence and wellbeing of older people at home or in a homely setting." This will require a "substantial shift in focus of care from institutional settings to care at home – because it is what people want and provides better value for money"[4]. Reshaping Care sets the agenda and supports the delivery of other national strategies for integration, self-directed support, dementia strategy, carers, and end of life care.

A strategy for quality healthcare

The Healthcare Quality Strategy aims to ensure that the work of the NHS in Scotland is integrated and aligned to deliver the highest quality health and care services. One of its six quality outcomes relates to people being able to live well at home or in the community so that the need for hospital admission is minimised.

Some overarching objectives run throughout public policy in these areas. There is wide consensus that there should be more choice and personalised approaches, more support and protection for vulnerable adults, more opportunities to live in the community, and more involvement of people who use services in planning and delivering them.

1 Projected Population of Scotland (2012 based). General Register Office for Scotland, 2013.
2 Commission on the Future Delivery of Public Services (2011), Public Services Commission, 2011
3 Care Inspectorate Annual Returns, December 2012
4 Reshaping Care for Older People: a programme for change 2001 – 2021. Scottish Government, 2011.

How care at home is provided in Scotland

Care at home services are delivered to people in their own homes. These services were traditional domiciliary care provided by a home help to people in their own homes, but now there are wide and diverse arrangements to meet people's care and support needs provided by private companies, the voluntary sector, and local authorities. Where a NHS trust delivers care at home (but not as part of part of continuing hospital care) then the trust is registered as the provider of the care service.

Around 14,000 care services are registered with us, of which some 800 are registered to provide care at home. Any organisation or person providing personal care and personal support to people in their own homes must register with us as a 'support service – care at home'. Personal care means care related to the day to day physical tasks and needs of the person being cared for, like washing and eating. Personal support means counselling, or other help, provided as part of a planned programme of care.

Where there is a personal and private arrangement (for example, personal assistants), or where the care is provided by a hospital as part of its continued healthcare service, this does not have to be registered with us. Throughout Scotland, different approaches are being taken to these arrangements.

In March 2012 there were 62,832 people using care at home and this number has been decreasing for the past five years. Approximately 57 out of every 1,000 people aged 65 and over in Scotland receive care at home, but these services are also provided to a wide range of people, including adults and young people with specific support needs.

At the same time, the number of hours of care at home is provided to clients has increased by around 4% to 712,894 hours. The average weekly hours per person has been increasing over the last 12 years from 5.6 in 2000 to 11.3 hours per week in 2012[5].

In addition to general domiciliary services, there are specialist care at home services provided to specific people. These include adults with learning disabilities living in their own single or shared tenancies, adults with mental health needs or physical disabilities, and children and young people with additional support needs. The support arrangements for people with specialist needs are contracted, funded and managed very differently from general domiciliary care services.

Combined services

Often, care at home is provided alongside housing support to the same group of people by the same group of staff. We call these 'combined services' and they include a wide range of support arrangements, provided to a diverse group of people. Most care at home services are combined with a housing support service (72%), while only 28% are stand-alone services.

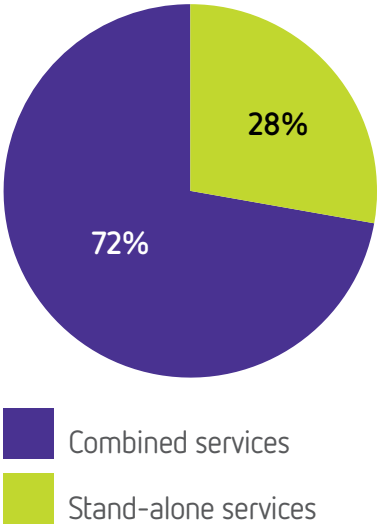
5 Home Care Services, Scotland, 2012, Scottish Government

The types of service we register as combined services include:

- supported accommodation for people with learning disabilities with 24/7 staff support (previously registered as care homes)
- supported accommodation for people with mental health needs with planned and on-call support
- high-dependency sheltered housing for older people with care staff also available
- residential schools for young people with additional support needs which offer outreach and housing support.

Sheltered housing for older people, domestic violence refuges, homeless and hostel accommodation with support, and visiting advice services to people in council tenancies to prevent eviction are all generally registered as housing support services but they are not the subject of this report.

Care at home services at 31 March 2013



The number of services and the provider type are summarised here.

Care at home services at 31 March 2013

Sector		stand-alone	combined	total
Health board	services	2	1	3
	%	0.9%	0.2%	0.4%
Local authority	services	21	98	119
	%	9.1%	16.8%	14.6%
Private	services	113	163	276
	%	49.1%	27.9%	33.9%
Voluntary or not for profit	services	94	322	416
	%	40.9%	55.1%	51.1%
Grand total	services	230	584	814
	%	100.0%	100.0%	100.0%

Source: Care Inspectorate service list 31 March 2013

Telecare and telehealthcare

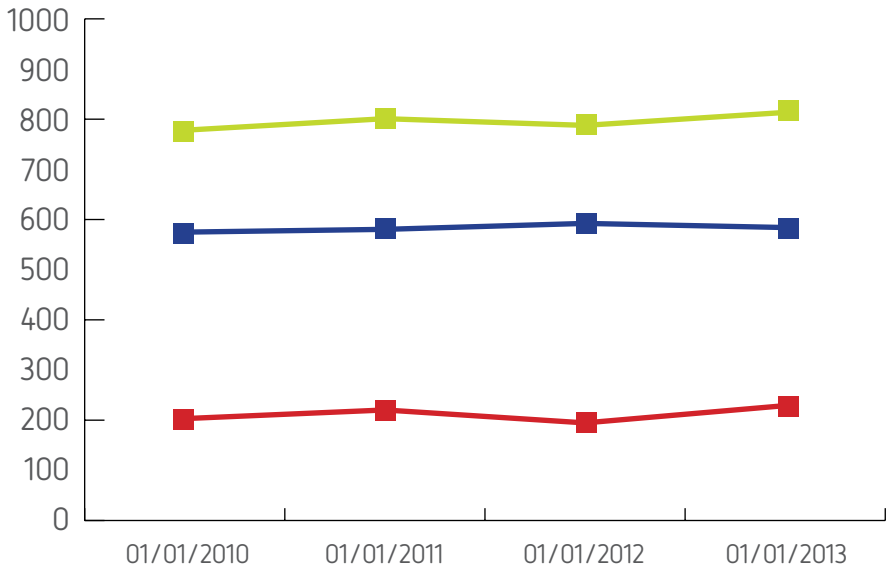
Many people receiving care at home services also use telecare or telehealthcare, either as stand-alone support or combined with care at home services. Telecare began as an electronic system of controls and monitors which a person could have installed in their own home or carry with them, such as a community alarm. Technology has become much more sophisticated and we are now seeing very innovative and creative methods of telecare being used to support more independent living arrangements. Over 110,000 people had a community alarm or another telecare service in March 2012. Over 54% of care at home clients had a community alarm or another telecare service[6].

Telecare arrangements are varied. Some operate alone, some are integrated within an existing care at home service and some only operate a call centre where the alarm response is provided by another care agency or the person's family or friends. There are different registration requirements depending on how the service is provided.

Has the number of care at home services changed over time?

The number of registered care at home services has increased overall by 4.8% over the past three years, from 777 services in March 2010 to 814 services in March 2013, but there is some fluctuation within this time period.

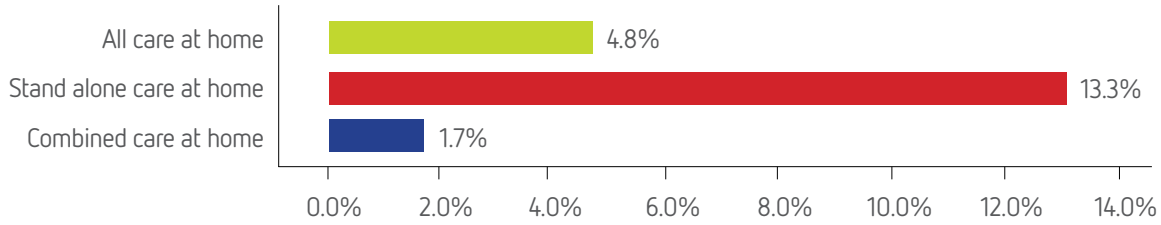
Registered care at home services over time



	01/01/2010	01/01/2011	01/01/2012	01/01/2013
Combined	574	580	593	584
Stand-alone	203	221	194	230
Overall	777	801	787	814

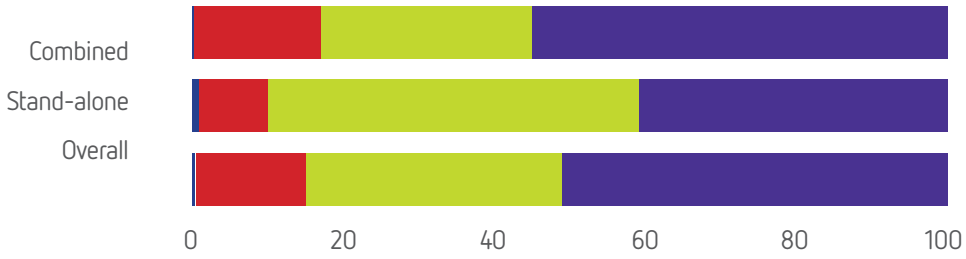
6 Home Care Services, Scotland, 2012, Scottish Government

% Change in number of care at home services 2010 to 2013



Who provides care at home services?

Care at home services at 31 March 2013, by sector



	Health Board	Local Authority	Private	Voluntary or Not for Profit
Combined	0.2%	16.8%	27.9%	55.1%
Stand-alone	0.9%	9.1%	49.1%	40.9%
Overall	0.4%	14.6%	33.9%	51.1%

Overall, 51% of care at home services are operated by the voluntary sector.

The private sector operates 34% of services overall, but it is the largest sector providing stand-alone services at 49%.

Local authorities and NHS boards can commission services to be provided by third party suppliers and they can themselves be direct providers of services.

Local authorities are direct providers of only 15% of services overall and most of their services are combined with housing support. NHS boards are direct providers of only three services overall.

This pattern has changed little in the past three years. Since March 2010, the not-for-profit sector has decreased slightly (from 54% to 51%) while the private sector has increased slightly (31% to 34%). This is mainly accounted for by an increase of thirty-two privately operated services; numbers in the other sectors have only changed very slightly.

Care at home services registered at 31 March 2013 by sector:

	Health board		Local authority		Private		Voluntary or not for profit		Total services	Total %
	services	%	services	%	services	%	services	%		
Combined	1	0.2%	98	16.8%	163	27.9%	322	55.1%	584	100.0%
Stand-alone	2	0.9%	21	9.1%	113	49.1%	94	40.9%	230	100.0%
Overall	3	0.4%	119	14.6%	276	33.9%	416	51.1%	814	100.0%

At 31 March 2010:

	Health Board		Local Authority		Private		Voluntary or Not for Profit		Total services	Total %
	services	%	services	%	services	%	services	%		
Combined	1	0.2%	99	17.2%	144	25.1%	330	57.5%	574	100.0%
Stand-alone		0.0%	16	7.9%	100	49.3%	87	42.9%	203	100.0%
Overall	1	0.1%	115	14.8%	244	31.4%	417	53.7%	777	100.0%

Providers delivering multiple services

Providers can operate more than one service. The 814 care at home services registered at March 2013 were operated by 403 different providers. However, over 75% of providers operated only one service, accounting for 38% of all services.

There were 60 providers operating between 2 and 5 services each – in total running 20.8% of all care at home services.

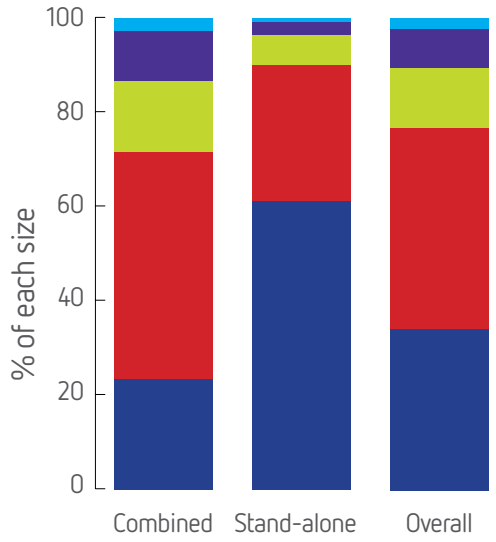
The remaining 33 providers (8.1% of the total number of providers) between them operate 42.1% of all care at home services.

number of services	number of providers	% of providers	total services	% of services
1	310	76.9%	310	38.1%
2-5	60	14.9%	169	20.8%
6-10	21	5.2%	157	19.3%
11-20	11	2.7%	152	18.7%
more than 20	1	0.2%	26	3.2%
Total	**403**	**100.0%**	**814**	**100.0%**

Staffing levels

We collect information about the number of staff care home services employ, based on whole-time equivalents (wte). Overall, 77% of care at home services employ 50 or fewer wte staff, with 34% employing 10 or fewer wte staff . There are some marked differences between combined services and stand-alone services in terms of their size. Combined services are more likely to have between 10 and 50 wte staff; stand-alone services are more likely to be smaller.

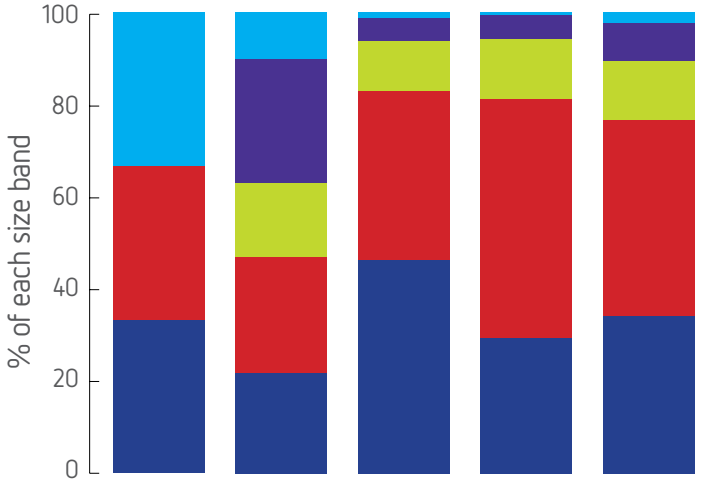
Care at home services at 31 March 2013, by size



	Combined	Stand-alone	Overall
>200	2.7%	0.9%	2.2%
>100-200	10.6%	2.6%	8.4%
>50-100	15.1%	6.5%	12.7%
>10-50	48.1%	28.7%	42.6%
0>10	23.5%	61.3%	34.2%

Looking at the size structure within each sector, local authorities tend to operate lower proportions of smaller services and the highest proportions of larger services – over half of local authority staff have more than 50 wte staff. Amongst private providers, 46.4% of services have 10 or fewer wte staff, and only 17% have more than 50 wte staff. Amongst the voluntary sector, 52% of services have between 10 and 50 wte staff, and 19% have more than 50 wte staff.

Care at home by size and sector

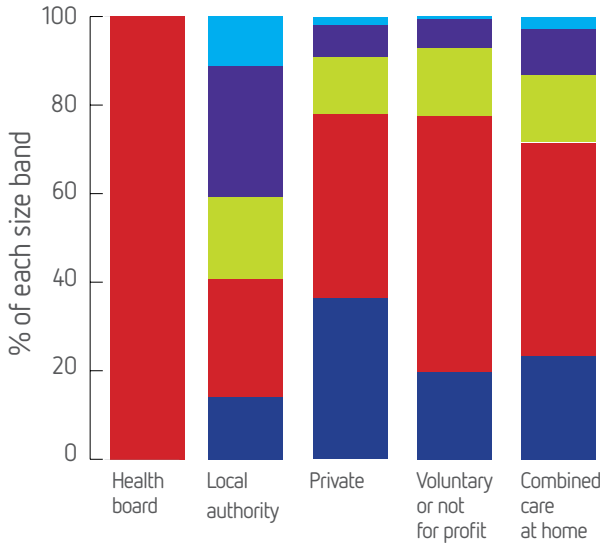


	Health board	Local authority	Private	Voluntary or not for profit	All care at home services
>200	33.3%	10.1%	1.1%	0.5%	2.2%
>100-200	0%	26.9%	5.1%	5.3%	8.4%
>50-100	0%	16.0%	10.9%	13.0%	12.7%
>10-50	33.3%	25.2%	36.6%	51.7%	42.6%
>0	33.3%	21.8%	46.4%	29.6%	43.2%

Local authorities, in particular, tend to have proportionately more large services than the voluntary or private sector: over 40% of the local authority services have more than 100 wte staff, compared with only 13% overall.

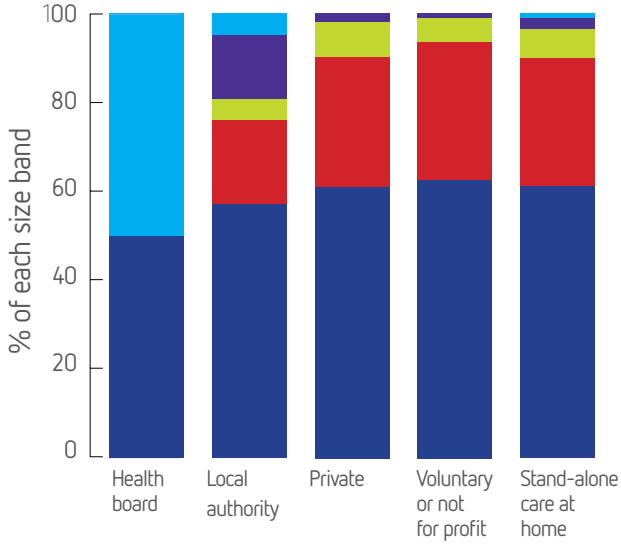
For stand-alone services, over 19% of local authority operated services have more than 100 wte workers, compared with only 3.5% overall.

Combined care at home services - by size



	Health board	Local authority	Private	Voluntary or not for profit	Combined care at home
>200	0.0%	11.2%	1.8%	0.6%	2.7%
>100-200	0.0%	29.6%	7.4%	6.5%	10.6%
>50-100	0.0%	18.4%	12.9%	15.2%	15.1%
>10-50	100%	26.5%	41.7%	57.8%	48.1%
>0	0.0%	14.3%	36.2%	19.9%	23.5%

Stand-alone care at home services - by size



	Health board	Local authority	Private	Voluntary or not for profit	Stand-alone care at home
>200	50%	4.8%	0%	0%	0.9%
>100-200	0.0%	14.3%	1.8%	1.1%	2.6%
>50-100	0.0%	4.8%	8.0%	5.3%	6.5%
>10-50	0.0%	19.0%	29.2%	30.9%	28.7%
>0	50%	57.1%	61.1%	62.8%	61.3%

Our inspection grades

We grade all care services using a six point scale:

1. Unsatisfactory
2. Weak
3. Adequate
4. Good
5. Very good
6. Excellent

Care at home services are inspected against three broad quality themes, and each one is graded:

- Quality of care and support
- Quality of staffing
- Quality of management and leadership.

This section sets out a summary of the grades given to all care at home services over the last four years.

Highly performing services

Between 2010 and 2013, there was a marked increase in services achieving very good or excellent grades for every theme. This now sits at just under 40% of all care at home services. A higher percentage of combined services meet these grades than stand-alone services.

Grades of very good and excellent (5 and 6) for every theme

	31-Mar-10		31-Mar-11		31-Mar-12		31-Mar-13	
Type	services	%	services	%	services	%	services	%
Combined	157	29.1%	176	31.9%	184	33.1%	233	41.2%
Stand-alone	42	29.4%	55	32.9%	45	29.4%	56	32.6%
Overall	199	29.2%	231	32.1%	229	32.3%	289	39.2%

Poorly performing services

At the other end of the quality spectrum, the percentage of care at home services with grades of unsatisfactory or weak for every theme increased from 1.3% in March 2010 to 2.2% at March 2013. There was a notable increase in the number of poorly performing services during 2012/13, especially in combined care at home services. Services achieving these very concerning grades generally improve, but these improvements are not always sustained.

None of the services with all grades of unsatisfactory or weak in 2010 have appeared in this category since. One of the services with all grades of unsatisfactory or weak in 2011 had improved by 2012, but by 2013 had slipped back. Four services with all unsatisfactory or weak grades in March 2012 still had these poor grades by 31 March 2013; three have since cancelled and the remaining one has improved.

Grades of unsatisfactory and weak (1 and 2) for every theme

	31-Mar-10		31-Mar-11		31-Mar-12		31-Mar-13	
Type	services	%	services	%	services	%	services	%
Combined	8	1.5%	4	0.7%	6	1.1%	13	2.3%
Stand-alone	1	0.7%	1	0.6%	3	2.0%	3	1.7%
Overall	9	1.3%	5	0.7%	9	1.3%	16	2.2%

Quality grades by sector

The number of poorly performing and highly performing services varies across different sectors. Half of services operated by the voluntary sector have grades of very good or excellent for every theme, while only 1% have all grades of unsatisfactory or weak.

In the private sector, 5% of services have grades of unsatisfactory or weak for every theme, while 29% have grades of very good or excellent for every theme.

Although no local authority or NHS run services had all grades of unsatisfactory or weak, local authorities had the fewest services with grades that were all very good or excellent (23.2%) and none of the three NHS care at home services achieved the top grades in all quality themes.

Services at 31 March 2013 with all low or high grades, by sector

	% of graded services with:			
	All unsatisfactory or weak		All very good or excellent	
Sector	number	%	number	%
Health board	0	0.0%	0	0.0%
Local authority	0	0.0%	26	23.2%
Private	12	5.0%	69	29.0%
Voluntary or not for profit	4	1.0%	194	50.1%
Total	16	2.2%	289	39.2%

For each theme, at least 80% of care at home services have good, very good or excellent grades. The quality of care and support, and the quality of staffing tends to be slightly better than the quality of management and leadership. Combined care at home services tend to have better grades than stand-alone services for every quality theme. A more detailed overview of grades for each theme at 31 March 2013 is presented here.

Summary of grades for care at home services at 31st March 2013

(Includes services with grades for each theme) -Source: Care Inspectorate service extract 2 April 2013.

Quality of care and support grade

Type	Data	Unsatisfactory	Weak	Adequate	Good	Very good	Excellent	All graded services
Combined	number	2	18	37	188	266	54	565
	%	0.4%	3.2%	6.5%	33.3%	47.1%	9.6%	100.0%
Stand alone	number		5	19	60	71	16	171
	%	0.0%	2.9%	11.1%	35.1%	41.5%	9.4%	100.0%
Total	number	2	23	56	248	337	70	736
	%	0.3%	3.1%	7.6%	33.7%	45.8%	9.5%	100.0%

Quality of staffing grade

Type	Data	Unsatisfactory	Weak	Adequate	Good	Very good	Excellent	All graded services
Combined	number	2	13	42	205	267	32	561
	%	0.4%	2.3%	7.5%	36.5%	47.6%	5.7%	100.0%
Stand alone	number		4	19	69	66	13	171
	%	0.0%	2.3%	11.1%	40.4%	38.6%	7.6%	100.0%
Total	number	2	17	61	274	333	45	732
	%	0.3%	2.3%	8,3%	37.4%	45.5%	6.1%	100.0%

Quality of management and leadership grade

Type	Data	Unsatisfactory	Weak	Adequate	Good	Very good	Excellent	All graded services
Combined	number	6	12	54	214	249	27	562
	%	1.1%	2.1%	9.6%	38.1%	44.3%	4.8%	100.0%
Stand alone	number	2	5	26	65	62	10	170
	%	1.2%	2.9%	15.3%	38.2%	36.5%	5.9%	100.0%
Total	number	8	17	80	279	311	37	732
	%	1.1%	2.3%	10.9%	38.1%	42.5%	5.1%	100.0%

Our inspection findings

We carried out 1,892 inspections of care at home services between March 2010 and March 2013. In order to understand themes and trends that emerge from the inspection reports, we have sampled reports with high grades and low grades.

Quality of care and support

Assessments of need and risk and individual care plans

In some services with low grades, we saw no evidence of individual risk assessments in place for individuals in their care. In some services where risk assessments were in place, there was no evidence of these being reviewed regularly. In other cases, staff undertaking the assessment were insufficiently trained or qualified to do so.

A small number of services had no personal support plans in place. Some services with low grades had no evidence of the individual using the service, or his/her carer, having been involved in the writing of the plan.

> "staff come in and talk to me and don't acknowledge my (relative)"
> (Person who uses a service)

Care plans in some services with low grades were not sufficiently detailed in terms of the health and wellbeing needs of the individual and how these should be met, or were unclear about which staff would support the individual and in what ways.

Some services with low grades had not reviewed care plans at least after six months and regularly thereafter. Where services had entered into 'contracts' with individuals, some services with low grades had no agreement in place detailing what the individual could expect of the service, what service would be delivered when, and lacked contingency planning.

All services with high grades had regular reviews of people's needs and care, involving all those relevant in supporting an individual's care. This often happened more regularly than the six monthly minimum requirement. Care and risk were clearly reviewed when required, when requested by an individual or professional, and in line with the needs of the individual using the service. We saw excellent evidence of regular and detailed communication with other relevant professionals and of a strong working relationship between professionals.

Recommendation
We expect that all staff undertaking a tailored and outcomes focused assessment of need and risk are appropriately qualified and trained to do so. This is needed to establish a truly personalised care and support plan for each person. This should set out how health and wellbeing needs will be met, outline the person's likes and dislikes and their personal goals and aspirations. It should describe how these will be met

and by whom. Plans should contain details of visits and times. People using services, and their carers, should be involved in writing their support plans. Care and support plans – and risk assessments – should be regularly reviewed in a way which involves everyone concerned. This should happen at least every six months, or more often if a person requests it or an aspect of care or need changes.

Recommendation
We expect that all care and support plans detail specific like and dislikes, including about food and diet. All staff must be trained in appropriate food preparation and food hygiene practice, and have the relevant qualifications. People using services should be encouraged to make informed choices about their health and wellbeing.

Care and support plans should adequately reflect the contact details for everyone involved in the individual's care. This should include other professionals and explain their role and contribution to care. It should also contain details of relevant family members and carers. It should be clear how to support a person's health and wellbeing in an emergency situation.

Participation

In some services with low grades, we saw insufficient evidence that those using the service were able to participate sufficiently in their care, or in service improvement, or in the recruitment and training of staff.

Some services with high grades had clearly evidenced that people using services, and their carers, were heavily involved and participated in various aspects of the service. These services demonstrated tailored and detailed involvement in care and support planning, staff recruitment and training, staff appraisals, service design, and improvement. In some services rated as excellent, people using services were part of organisational boards.

> "(Staff are) up for everything, they don't put obstacles in the way of what people want to do with them" (Person who uses a service)

Such services had very clear strategies for participation and involvement and evidently acted on these in their operations. Services actively and regularly sought the views of people using care.

> "I can speak at my review meeting and they listen to me" (Person who uses a service)

We saw a variety of person-centred methods used to gain feedback regularly, including social media, regular surveys, 'talking walls', pictorial methods, forums groups and advocates. The key element was that the views and opinions of those using services was clearly acted on and formed an action plan which was well communicated to individuals and their carers.

Recommendation
We expect that services support people using services to regularly communicate their views and opinions using a variety of methods to meet the communication needs of individuals. Services should regularly seek views and feedback from those using services and their carers, using methods appropriate to individuals' needs. Importantly, services should evidence that this feedback has informed decisions about the service, care provision or development.

Procedures and communication

In some services with low grades, we saw evidence that complaints procedures were not robust enough, not up-to-date, did not refer to the role of the Care Inspectorate, or were not communicated effectively to those using the service. Some services with low grades did not communicate information about the service widely enough to those using the service, their carers or families.

Services with high grades had excellent ways of communicating between the organisation, its staff, people who use services, other professionals and the wider community. There were clear communication strategies in place and this was followed through very well in practice.

"Communication is really good - we're always kept up to date with what's happening" (Person who uses a service)

"I've started writing for the newsletter - there's two pages of my own words in it" (Person who uses a service)

This included internal events such as regular team meetings involving all staff, forums for individuals (and a linking of the two through regular group feedback sessions) and external facing events such as open evenings, newsletters, and using local media to promote specific events.

In all services with high grades, those using services and their carers categorically stated they felt listened to and were able to make informed choices about their care, and that their care was delivered to a very high standard. In these services, the role of the Care Inspectorate was clear and those using the service, carers and staff knew about us and our role.

Recommendation
We expect that services have clear, detailed and accessible information about their service. They should dedicate time, before the service begins, to meet with the individual proposed to receive support, and their carers, to answer questions and allow them to meet the service.

Culture

Services with high grades demonstrated a values-based culture and one in which people using services were the clear focus of the organisation. Staff within these services delivered person-centred care to individuals and were aware of their role and impact on individuals. Senior managers and staff at all levels were visible in the service and were known to all those using the service and their carers. In many cases, senior managers met regularly with individuals using the service to monitor care and support.

"The carer works with compassion and gentleness" (Person who uses a service)

In services with high grades, the environment was inclusive, promoted individuals' best interests and was focused on personalised care. We saw staff enacting personal outcomes focused care plans and risk assessments, but also saw additional aspects of promoting an individual's wellbeing, like detail about people's likes and dislikes, supporting individuals to undertake new learning or activities, and supporting individuals towards personal goals.

"It's just something special - you just couldn't get better - it's very flexible and the staff are so understanding" (Person who uses a service)

Recommendation
We expect that providers deliver services to individuals using a human rights-based approach to care and support. People using services should be supported with dignity and have the right to privacy and confidentiality. Services should support individuals towards achieving their personal goals, as set out in their personalised, tailored and outcomes-focussed care and support plan.

Delivery of care

In some services with low grades, we saw no evidence of clarity about the times of visits to people in accordance with care plans (where this was specified), or in line with the individual's needs or agreement.

"The care is good but the timing is sometimes not very reliable" (person who uses a service)

In some services, guidance for staff travelling between visits was unclear.

'Several of the staff we spoke with described the problems they faced sometimes having to cut visits short to make up for the lack of travel time between visits. One member of staff commented that they frequently found themselves running over an hour late by the time they reached the end of their morning rota. This was also described as particularly problematic by staff working in rural areas'. (Inspector)

Recommendation
We expect that all services have a clear, detailed and accessible service agreement. This should establish a 'contract' between the person using the service and the service itself. This should describe the service being provided, the staff who will deliver it, roles and responsibilities, and set out a contingency plan. This should also outline how any changes to the service will be agreed.

Medicines management and administration

Services with low grades often had insufficiently robust systems and processes for managing medicines. Some practices around medicines management and administration were unsafe. Some services with low grades had medication errors which were poorly – if at all – recorded. Some staff were not trained sufficiently to support individuals with their medication. Some internal audit systems for medication management and processes were poor.

Recommendation

We expect that services have robust systems for administering, managing and auditing medicines. Clear systems for notifying errors in medicines management must be in place and complied with, and relevant organisations informed. Providers should ensure effective systems for medicines management are:

- person-centred
- based on a shared assessment of need (as part of the individual's whole assessment and care planning process)
- supported by clear policies, procedures, roles and responsibilities
- delivered by appropriately trained and supported staff
- subject to robust monitoring systems
- regularly reviewed
- in line with recent Royal Pharmaceutical Society guidance for best practice.

Quality of staffing

Staff culture, development and staffing levels

In services with high grades, carers, relatives and people using services spoke about staff "going the extra mile" and seeing their role as "not just a job". People recognised that staff were motivated and committed to improve the lives of those in their care.

"We are totally confident in the care team" (Family member)

In some services, there was clear evidence of the organisation making local and national links with other services to aid their development, and identifying opportunities for staff and those using the service to attend relevant national events.

Services with low grades often had staffing levels which were clearly insufficient to meet the needs of the individuals in their care, including contingency or emergency cover.

"I never know when staff are coming" (Person who uses a service)

Some services with low grades had a high turnover of staff or recruitment issues which had not been addressed by management.

"staff support is laughable" (Family member of someone who uses a service)

Recommendation
We expect that care at home services are provided by suitably qualified and trained staff who are subject to regular support, supervision and appraisals, and who receive on-going training. Staffing numbers should allow for contingency and emergency cover, and should be tailored to ensure consistency and continuity of care. Regular team and staff meetings should happen, and staff should feed back to people using services. Staff should be encouraged to make decisions, and their knowledge and experience respected. People using the service should be involved in staff recruitment, induction and ongoing training.

Delivering personalised support plans

In some services with low grades, we found that staff did not adhere to individuals' personal support plans or were insufficiently trained or qualified to undertake specific tasks outlined in support plans.

"Once (the service) got a regular carer in, I was more happy with the care I got" (Person who uses a service)

In services with high grades, staff delivered care to individuals which was outcomes-focussed, personal to the individual and with great attention paid to detail. Staff were able to demonstrate an excellent knowledge of those they supported and relationships between staff and individuals being supported were of a very high standard. In these services, we saw consistency and continuity of staff involved in supporting individuals.

"staff are a great support to me as well as my (relative)" (Family member)

Recommendation
We expect that services individually tailor care to meet the social, cultural and faith needs of every individual receiving care and support. The care and support plan should outline this from the point of assessment and this should be regularly reviewed.

Recruitment, training and supervision

Some services with low grades did not follow safer recruitment practices, including failing to request up-to-date references or disclosure checks. Some did not link properly with workforce regulators such as the Scottish Social Services Council or the Nursing and Midwifery Council.

Some services with low grades could not evidence robust induction for staff, or appropriate ongoing training relevant to an employee's role. We found evidence of poor monitoring of training. In some services with low grades, there was little or no evidence of regular and up-to-date staff supervision or appraisal systems in place and recording was sometimes found to be inconsistent.

In services with high grades, safer recruitment practices were used and comprehensive recruitment processes were in place, often including those using services and their carers to interview and meet with potential staff prior to a formal offer of employment. In some services, recruitment processes examined the characters of prospective employees, as well as their skills, knowledge and qualifications, in order to try to 'match' staff with people using the service. Such services had a clear and robust induction programme

which equipped staff to begin their role, and many were able to evidence appropriate ongoing training. In many of these services, a scheme was in place for more experienced staff to mentor newer staff. Many required that the manager was satisfied with a new employee's ability to carry out their role before were they confirmed in post.

In services with high grades, training was comprehensive and extended beyond mandatory training like adult support and protection or manual handling. Training involved both internal and external facilitators. Services ensured that the training was inclusive, meaning that even if a staff member was not specifically working with a person for whom a knowledge of, for example, the Adults With Incapacity Act was relevant, the staff member would still receive training in that area.

In some services, the organisation had gained, or was in the process of working towards, specific awards to support their staff. These included Healthy Working Lives, Investors In People, the EFQM Levels of Excellence Programme. Some were registered as an SQA assessment centre.

It was clear, in these services with high grades, that staff training was valued and valuable. Training calendars were used to prioritise sessions for all staff and individual employees' development plans were regularly updated. Staff demonstrated a good knowledge of relevant policies and procedures, including the National Care Standards.

"we're learning all the time" (Staff member)

"It's really smashing - supervision is regular and I always get backup or support when I need it, as I know I can contact the manager at any time" (Staff member)

Recommendation

We expect that all staff are appropriately trained in relevant aspects of the health needs of each individual using the service.

Quality of management and leadership

Quality assurance

Some services with low grades sometimes demonstrated no, or insufficiently robust, systems of internal auditing or quality assurance practices.

> "the management team seem to run on a very tight shoestring and if a carer goes off sick or on leave, the times of the carers' visits can be quite erratic."
> (Person who uses a service)

Some services did not regularly monitor staff practice. Some services failed to complete an annual return or self assessment in good time, or at all.

In some services with low grades, there was no evidence of organisational objectives linking through staff supervision and development. Some services with low grades did not store staff's confidential records securely. In some, staff did not adequately record their interaction with those using services.

Services with high grades demonstrated that they had robust systems for quality assurance and auditing. These included regular surveys, staff supervision and ongoing training programmes, internal and external audits such as for medicines management, and monitoring and addressing absence. There was often clear evidence of a strong governance framework across the organisations. Crucially, information was fed back to people using the service, their carers and staff.

There were often clear processes for identifying, addressing and reporting of poor practice, including reporting to the Care Inspectorate and the Scottish Social Services Council.

Organisational documents, such as annual reports and accounts were widely available. Meetings, such as services' annual general meetings, were communicated externally, with minutes clearly evident.

Recommendation
We expect that managers should encourage their staff to develop and be involved in all aspects of service design and delivery. Robust systems for quality assurance must be in place to ensure the highest standard of service delivery. Managers should ensure that staff are aware of organisational objectives and foster an inclusive and values-based culture.

Involvement

In services with high grades, staff were involved in the design and improvement of services. This meant they contributed to annual plans, target setting, mentoring less experienced staff and leading specific projects.

Staff were encouraged to develop and we saw clear internal promotion opportunities. Leadership was encouraged, particularly in key worker roles where staff were encouraged to make day-to-day decisions and were respected for their knowledge and skills.

Some of the services receiving high grades had focus groups for staff and particular groups of people, such as contributing to the annual report or the service's self assessment.

"As a staff member all my needs are met in all areas - training, support , appraisals - the manager and co-ordinator are always at hand if I need anything whether it should be advice, support or whatever" (Staff member)

Reporting

Some services with low grades also neglected to record accidents or incidents in line with their procedures, and some did not inform us of reportable incidents as required.

Registered manager

Some services received low grades where the registered manager was not fulfilling their role, for instance, if they had insufficient time to spend on management tasks and were expected to complete the staff complement, or where the registered manager was insufficiently qualified, or trained or fit to practice.

Policies and procedures

In services with high grades, relevant policies and procedures were in place and, more importantly, were acted on and accessible for all. For instance, people using services were aware of their right to make a complaint if they were unhappy with a particular aspect of the service and knew who to complain to. Information about the service was detailed, up to date, freely available and in a variety of formats.

Complaints about care at home services

During 2012–13, we completed investigations into 259 complaints which had been made about care at home services, of which 202 were upheld. Because each person making a complaint can raise one or more areas of complaint, the upheld complaints covered 356 separate issues.

The following tables show the percentage of services registered at 31 March each year which had at least one complaint upheld against them in the previous year. The number of services with complaints upheld has increased over time, and the percentage with complaints upheld has increased from 8.5% in March 2010 to 13% by March 2013. A complaint is upheld whether factual evidence exists to prove an allegation or complaint or, on the balance of probabilities, we believe that the allegation made was likely to have occurred.

The percentage of combined care at home services with complaints upheld is consistently higher than the percentage of stand alone care at home services.

Number of services with complaints upheld or partially upheld

Care service	At 31 Mar 2010	at 31 Mar 2011	at 31 Mar 2012	at 31 Mar 2013
Combined	55	74	80	87
Stand-alone	11	20	20	19
Overall	66	94	100	106

Percentage of services with complaints upheld or partially upheld

Care service	At 31 Mar 2010	at 31 Mar 2011	at 31 Mar 2012	at 31 Mar 2013
Combined	9.6%	12.8%	13.5%	14.9%
Stand-alone	5.4%	9.0%	10.3%	8.3%
Overall	8.5%	11.7%	12.7%	13.0%

At March 2013, 22% of services in the private sector had at least one complaint upheld during the year. This is considerably higher than for local authorities (12.6%) and the not for profit sector (7.2%).

Services with complaints upheld or partially upheld 2012/13

Sector	Number of services	Services at 31 March 2013 with complaints upheld or partially upheld in 2012/13	% services at 31 March 2013 with complaints upheld in 2012/13
Health board	3		0.0%
Local authority	119	15	12.6%
Private	276	61	22.1%
Voluntary or not for profit	416	30	7.2%
Total	814	106	13.0%

The table overleaf shows what these complaints were about. It shows that 259 complaints highlighted 356 separate issues. The largest group of complaints were about general health and welfare. A significant number of complaints about communication and staffing were also upheld.

Care at home complaints upheld 2012/13, by area of complaint

Note: each overall complaint can have several areas - this only includes those areas that were upheld or partially upheld.

Complaint area	Number	%
General health and welfare	**129**	**36.2%**
General health and welfare	129	36.2%
Communication	**65**	**18.3%**
Communication - between staff and service users/relatives/carers	35	9.8%
Communication - other	24	6.7%
Communication - information about the service	6	1.7%
Staff	**54**	**15.2%**
Staff - other	19	5.3%
Staff - training / qualifications	16	4.5%
Staff - recruitment procedures (including disclosure checks)	7	2.0%
Staff - levels	7	2.0%
Staff - other fitness issues	5	1.4%
Record keeping	**28**	**7.9%**
Record keeping - personal plans/ agreements	24	6.7%
Record keeping - other	4	1.1%
Healthcare	**28**	**7.9%**
Healthcare - medication issues	18	5.1%
Healthcare - infection control issues	4	1.1%
Healthcare - inadequate healthcare or healthcare treatment	3	0.8%
Healthcare - oral health	1	0.3%
Healthcare - tissue viability	1	0.3%
Healthcare - nutrition	1	0.3%
Policies and procedures	**26**	**7.3%**
Policies and procedures - complaints procedure	19	5.3%
Policies and procedures - other	7	2.0%
Protection of people	**7**	**2.0%**
Protection of people - adults	2	0.6%
Protection of people - restraint	2	0.6%
Protection of people - other	2	0.6%
Protection of people - policies and procedures	1	0.3%
Choice	**7**	**2.0%**
Choice - care and treatment	3	0.8%
Choice - other	2	0.6%
Choice - activities	1	0.3%
Choice - dignity and privacy	1	0.3%

Complaint area	Number	%
Privacy and dignity	**4**	**1.1%**
Privacy and Dignity	4	1.1%
Financial issues	**2**	**0.6%**
Financial Issues	2	0.6%
Property	**2**	**0.6%**
Property - loss of/missing	2	0.6%
Environment	**1**	**0.3%**
Environment - security	1	0.3%
Conditions of registration	**1**	**0.3%**
Conditions of registration - other	1	0.3%
Food	**1**	**0.3%**
Food - other	1	0.3%
Access	**1**	**0.3%**
Access - other	1	0.3%
Total	**356**	**100.0%**

Recommendation

We expect that providers of care at home services should involve people in the ongoing development of the service, encouraging active participation and sharing of ideas. They should encourage people who use their services to make complaints direct to them in the first instance, if they are not satisfied with the way the service is being delivered. Providers should carefully note our findings about complaints and use these to improve their service, especially in the areas of health and welfare, and communication between staff and people they are caring for.

Requiring improvements

Where we find services that are not meeting the National Care Standards, or where they are not providing good enough care and support, we make recommendations for improvement or requirements for change, within appropriate timescales. These requirements can be made as a result of an inspection or a complaint.

During 2012/13, we made at least one requirement in 252 (31%) of the 814 care at home services registered. Common issues are noted here, along with samples of the actual requirements made during inspections.

Staffing and training

- Staff should receive formal supervision, including annual appraisals.
- Staff should provide care in line with assessed need .
- Required staffing levels should be met at all times.
- Staff should receive regular training appropriate to the work they do – including induction and refresher training.
- Providers should implement training plans and records for staff.
- Providers should address specific training needs which include moving and handling, restraint, food hygiene, infection control and adult support and protection.
- Systems should be in place to monitor and assess staff competency and this should be linked to supervision, training and appraisal systems.
- Services should review the ways in which staff training needs are assessed.

Medication

- A clear medication policy should be in place and this should be regularly reviewed.
- Appropriate systems should be in place to support the medication policy.
- Administration of medication should be monitored – including written records kept.
- Staff should be appropriately trained and follow medicines management procedures.
- Medicines management in care plans should be regularly reviewed and regularly audited.
- Medication should be stocked in line with the needs of those using the service.

Planning

- The local authority has responsibility for assessing and sharing with the provider, a copy of each individual's personal plan (including risk assessment). This plan should accurately describe support and care needs, and how health, safety and welfare will be provided for by staff.
- Plans must be reviewed at least every six months, or sooner in response to changing care needs.
- Users of services and, where appropriate, their relative or representative, should be fully involved in developing and reviewing their personal plan.
- Providers must review how support is planned to ensure consistency in service.

Complaints

- Services should ensure that a complaints procedure is in place, and review it regularly.
- Complaints policy must be known to staff and those using the service and must make reference to the Care Inspectorate.
- Complaints made to the service should be recorded and fully investigated.

Safer recruitment

- Services should ensure they have robust policies in place for safer recruitment. This should include disclosure checks, references, PVG and so on.

Risk assessment

- Services should have a system of individual risk assessment in place.
- This should be recorded as part of care planning and regularly reviewed (at least every six months).
- Risk assessments should be completed with the involvement of the individual and/or, where appropriate, their relative or representative.

Incidents

- Develop and review procedures for managing and monitoring how accidents and incidents are reported and recorded, and what action is taken when reports are made.
- The Care Inspectorate must be notified of all significant incidents and accidents.

Quality assurance

- Providers must develop effective and robust quality assurance systems.
- Any issues of concern identified are appropriately recorded and followed-up with outcomes and improvements clearly identified.
- Staff fully trained in quality assurance and recording systems.
- Review and improve the level and frequency of monitoring service provision and ensure that accurate records are kept.

Management

- Service is managed appropriately, ensuring areas of responsibility and accountability are clear to all staff and the quality of care and staff performance is monitored effectively.

Communication

- Proper arrangements are in place to ensure effective communication between staff, service users and carers.
- Service users are notified of service schedule or staffing changes.
- Staff receive training around issues of confidentiality.

Conclusion

With over 80% of care at home services receiving grades of good, very good or excellent for all themes, and almost 40% of care at home services receiving grades of very good and excellent, it is clear that there is a lot of effective practice.

The sector is actively developing new ways of meeting people's needs, and is at the frontline of care innovations and developments such as telecare and telehealthcare.

Local partnerships are continuing to develop approaches to commissioning care at home services, as part of wider joint strategic commissioning. Some of these are now at a draft stage and have been the subject of wide consultation. Some take a long term view to develop sustainable services.

In recent years, we have seen improvements in the areas of involvement and participation of people using services, and their carers, although there is room for further improvement.

Where services are not performing at the levels we require, we will not hesitate to demand change or take enforcement action if necessary. We will continue to support and encourage improvements in this vital, valuable and ever-changing sector.

From our inspection findings and our professional expertise, it is clear that care at home services need to:

1. Get to know the person as an individual and understand how they like to live their life in order to provide the right care to meet their needs.
2. Deliver services to people using a human rights-based approach to care, supporting privacy, dignity and the right to confidentiality.
3. Give people the opportunity to be involved in their care; listen to their views and act upon them.
4. Establish a truly personalised care and support plan for each person, with trained staff undertaking an outcomes-focused assessment of need and risk.
5. Make sure that people have easy access to information about their service, before the service starts.
6. Have safe systems in place for the effective management of medicines, including appropriate staff training.
7. Ensure people are cared for by staff who have the skills, knowledge and training to provide high-quality, safe, and compassionate care.
8. Have clear service agreements, which establish a 'contract' between the individual using the service and the service itself, in place before the service starts and monitor and adapt them as needs change over time.

9. Ensure every person using a care at home service has a personalised care and support plan which details how health and wellbeing needs will be monitored and met in a way that meets the needs of the individual.

10. Make sure managers have robust systems for quality assurance in place to deliver the highest standard of care possible, within an inclusive and values-based culture.

We hope that all care at home providers, commissioners and others will learn from our inspection findings and make improvements – even the better performing services. Personalised care requires constant self-reflection, but is essential if people who use care services are to receive safe, compassionate and high quality care at home. Regular inspections, and our joint inspections of services for older people, will help make sure that happens.

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Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

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