



**Health and Social Care
Change Agent Team**

**London & South East
Capacity Development Programme**

Collection of Papers on Domiciliary Care

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London & the South East Capacity Development Programme

Domiciliary Care Papers

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INTRODUCTION

When the Change Agent Team was first set up by the Department of Health to explore the reasons why patients often got 'stuck' in hospital systems, it rapidly became apparent that their transfers to other forms of care were often delayed because of the absence in the community of a suitable range of alternative services, or the inability of partners in health and social care to make appropriate arrangements to broaden the variety and scope of available services.

This gave the work programme of the Change Agent Team an additional focus and, during 2003/04, specific pieces of work were commissioned to try to understand why a greater range of services in the community was not more readily available or why some of the services that were available failed to meet the needs of the people whose quality of life and independence depended upon them.

This programme, which was led by Fran McCabe, was especially concerned about the immediacy of acute problems in London and the South East, and the South West, and various strands of work were put in place to particularly ameliorate the worst effects of rapid reduction in independent provision of residential, nursing and – to a lesser extent - home-based care. An account of these various work streams is appended, with a note on where to find out more. Some of them had a wider application than geographical areas and the following chapters are devoted to papers on various aspects of home-based service provision.

These have been undertaken by Lucianne Sawyer, who is a member of the Change Agent Team panel of experts, and they draw upon her personal experience of domiciliary care services as well as some targeted investigation which she took into specific elements of the arrangement and provision of such care services. From the work undertaken by Lucianne and others within the various pieces of work commissioned by the London & South East Capacity Development Programme, it becomes clear that there are several key messages that need to be addressed around service commissioning for home care and all the other services that support people in their own homes.

- Responding flexibly to demand needs to be underpinned by better and more closely integrated commissioning across and within health and social care systems
- That in meeting the challenges of a changing regulatory environment, service commissioners need to work with partners in provision
- Resources devoted to home care services need to be directed towards services and contact time rather than in transaction costs, and that true service costs are better understood by those holding purchasing budgets
- Practices in commissioning that lead to poor practices in service delivery need to be reviewed
- There is an emerging role for health on service provision, its relationship to social care and to the challenges of change

These papers, which have been brought together as chapters in one document, should be read in conjunction with other CAT material which can be found on the CAT website (www.changeagentteam.org) and on the website of the United Kingdom Home Care Association (www.ukhca.co.uk).

Chapter One

THE POTENTIAL AND THE MARKET

Domiciliary care has enormous potential

- To promote and assist re-ablement
- To help maintain maximum independence
- To provide early warning of deterioration which may respond to rapid intervention
- To respond rapidly to emergencies
- To prevent hospital admission through providing intensive short term care and support
- To facilitate earlier discharge from hospital
- To improve quality of life by:
 - supporting health maintenance
 - ~ ensuring adequate nutrition and fluid intake
 - ~ promoting and supporting appropriate exercise
 - supporting continued involvement in community and family life
 - supporting participation in meaningful activity such as
 - ~ paid work
 - ~ voluntary work
 - ~ leisure pursuits
 - assisting in ensuring that there is a satisfactory environment
 - ~ that the home is clean and comfortable
 - ~ and well maintained

Introduction

Lack of capacity in long-term care homes has been cited as one of the main reasons for delayed discharge of older people from hospital. Where there was little in the way of alternatives, this was inevitable. The emphasis now on rehabilitation and re-enablement may give more people a chance of remaining at home. Older people responding to a recent Mori

poll were unequivocal in their preference for remaining at home¹. Supporting people adequately and effectively in their own homes through a range of flexible domiciliary care services may be a much better solution for most people and the government is now emphasizing this as the service of choice.

Home care, especially intensive home care, is the main alternative to care homes and the introduction of Reimbursement earlier this year has intensified demand pressures. The government's target for local authorities, that 30% of all older people supported in either care homes or through domiciliary care should be receiving domiciliary support by 2006, is a tough one and will require a massive change in investment over the next two years since domiciliary care is expanding only slowly and does not yet have the capacity to fill the gap.

The purpose of this series of briefing documents is to assist authorities or agencies wishing to establish or expand the home care option by bringing together various strands of work, experience and learning as a key resource. The potential and the market will be discussed in this paper. Further papers will discuss workforce and training, the costing of domiciliary care, older people's views about domiciliary care services and quality issues, and an outcome approach to providing services.

Potential

Domiciliary care has long since moved away from the old 'home help' image. Even before the 1990 NHS & Community Care Act the policy thrust was towards supporting the most dependent through more intensive services providing mainly personal care. Home care now embraces many of the tasks which were formerly undertaken by district nurses. The level of dependency of those supported at home has also increased markedly and domiciliary care is now critical in enabling very vulnerable people to remain longer in their own homes.

The last decade has seen a dramatic expansion in publicly funded home care from around 1.6m to nearly 3m hours per week. Independent providers' share of that market has increased over the same timescale from 2.3% to 64% as a result of government policy. Yet despite the growth and importance of this service, which supports more than twice as many people in the community than are supported in care homes and employs over 200,000 care staff, home care still has a remarkably low profile and its potential is often forgotten or ignored. Some of the reasons for this may be:

- Its invisibility – it happens behind closed doors in people's own homes
- Little or no media interest – independent home care providers have been non-confrontational, focus has mainly been on care home industry
- New providers over-dependent on local authorities for work and lacked the self confidence and resources to market or publicise their services more widely
- Home care services have only very recently started to be registered and regulated
- Although the image has changed this has not been widely recognized

Pressures on social services budgets make it difficult to shift the balance from residential to community based expenditure. Eligibility criteria for domiciliary provision are now drawn so

¹ *When I Get Older: What people want from social care services and inspections as they get older* (2004) Mori poll undertaken for the Commission for Social Care Inspection

tightly that admission to a care home may be regarded as the only viable option for a very frail individual. Local authorities are entitled to choose on the basis of cost and financial and other factors can often make a care home seem a more attractive option.

- The local authority may recoup most or all of care home costs, whereas there may be only partial recoup of domiciliary costs
- Effect of housing benefit component in care home costs makes more than low level domiciliary provision comparatively unattractive from cost point of view
- Continued demand on care management resources from those supported at home
- Capacity problems in home care services and the potential for breakdown in service
- Failure to appreciate the range and type of home care provision

Range of home care services

Home care can be both flexible and versatile and it has considerable unexploited potential:

Mainstream services

All local authorities provide and/or purchase mainstream domiciliary care services which have the potential to be provided 24 hours, 7 days a week, although staffing problems may restrict providers' ability to provide round-the-clock cover. Night cover can be either 'sleep-in' or 'waking night duty'. Mainstream services can come in a variety of guises depending on the format and commissioning strategy adopted by local authorities. This may include:

- Standard generic services
- Services for specific user groups, for example:
 - For people with dementia
 - For adults (under 65) with physical disabilities
 - For people with learning difficulties

Specialist services

In some areas a wider range of services will be available, often as a result of independent voluntary or private innovation. Some examples of these are:

- Respite care, specifically to support informal carers
- A scheme to support people in rural areas*
- For people from a specific ethnic community
- A scheme which aims to rehabilitate over a specific period*
- A palliative care service*

** for contact details see end of chapter*

Live-in services

Live-in services are available from specific independent agencies*. Some local authorities purchase live-in services, usually for younger physically disabled people. Live-in can be a very cost effective means of providing intensive short term care during a period of illness which

might otherwise necessitate hospital admission. It is often a much less disruptive solution for respite care if the family carer intends going away for a break. It can also provide very satisfactory longer term home based support. There are also some specialist live in services, such as one for people with acquired brain injury where the individual would otherwise have to stay in intensive hospital care but, with this service, is able to have a greatly improved quality of life at home*.

Intermediate Care

Many of the new short-term Intermediate Care services now being developed in response to both the Health Act Flexibilities and to Reimbursement are likely to involve home care:

- Intermediate care schemes which centre on home care can be more effective because they equip the individual with the skills to manage in their own home, rather than in a simulated environment. Some Intermediate Care schemes with a residential component involve care workers who then transfer with the service user to their own home towards the end of the period of service.
- Hospital discharge schemes in which multidisciplinary teams include domiciliary staff who are trained to promote independence. Input is tapered on the basis of frequent monitoring after short term intensive support.
- Rapid response teams can provide almost immediate support to prevent hospital admission or to support someone returning home from hospital. Rapid response teams often include care staff or may be linked into the mainstream home care service.
- Rehabilitation schemes with staff trained specifically to promote independence and working closely with occupational and physiotherapists
- Integrated teams trained in both social care and health skills and able to provide a wider range of services including rehabilitation to older people at the interface between hospital admission and remaining at, or returning, home.

Assisted Living

Home care will be a critical component of the many forms of assisted living or housing with care. The older person retains the independence and choice of their own self contained accommodation, but gains the benefits of lower cost, very flexible and adjustable, home care service either on site 24-hours (as in extra care schemes) or during specific hours. Care services will be resourced at differing levels in order to cope with the peaks and troughs in demand which occur throughout the day. These advantages are possible because the housing will be clustered, either around a nursing home (as in close care), or in groups or within a complex of flats (extra care or very sheltered housing), or within a retirement community so that care workers' travel time and costs are eliminated.

Hospital at Home

Hospital at Home schemes will primarily use qualified nurses but may include a home care element. A range of services and procedures can now be provided for people in their homes, often involving technology. Included are chemotherapy, intravenous therapies, intravenous feeding, blood transfusions, kidney dialysis and other procedures.

Prevention

A wider strategy for older people which involves a more proactive approach is also likely to draw on domiciliary care services, for example:

- Supporting carers early in their caring career with flexible home care services, possibly provided through a voucher system so that they can call on help when they need it.
- Providing practical support which may guard against poor nutrition and deteriorating home conditions. The former leads to poor health among older people and the latter to depression and 'giving up' on independence. Lack of domestic support often means that intervention only occurs at crisis point – when hospital admission is the only option.

Direct Payments

Money, rather than direct service provision, should now be offered to older people as well as younger people. It can be used to purchase care and support from organizations, other than local authorities' in-house service, or to recruit personal assistants directly, or to pay relatives. A ministerial announcement recently has suggested that even cohabiting relatives could be paid to provide care under some circumstances. Although there are concerns about the ability of older people to undertake the role of employer, many did this satisfactorily when eligible for the first phase ILF payments and were mostly very satisfied with the services they were able to arrange for themselves. Evidence from similar schemes both in Europe and the US indicates that the ability to choose the personal assistant(s) is one of the key reasons for their popularity². As yet the take up of direct payments by older people is very slow.

Home care is the basis for a wide range of support services enabling even very vulnerable people to continue living in their own homes. Mainstream services are important but authorities need also to consider the potential of specialist and other services

Many of the above are examples of the changing role of home care – influential in both getting people home early from hospital and, more important, in keeping them out of hospital altogether. Most involve a multidisciplinary approach but home care is an essential component. A key point is that domiciliary care is likely to be more effective when it is linked with other services and disciplines, for example:

- Home care staff are frequently responsible for assisting with medication. Close links with Community Pharmacists will help to ensure proper management of medication in the community. Between 5-17% of people end up in hospital because of inappropriate medication or adverse reactions between different medications. A quarter of readmissions arise from non-compliance with medication regimes³.
- Domiciliary care providers need to have access to a resource for carrying out small maintenance tasks where this is available.

² Weiner JM, Tilly J, Evans Cuellar A., *Consumer Directed Home Care in the Netherlands, England and Germany* (2003) AARP Public Policy Institute, Washington

³ Burke S, Neilsen E, (2002) *Pharmacists and the new Intermediate Care Agenda* Royal Pharmaceutical Society

- Often District Nursing services will provide additional specific training and support for home care workers who are required to take responsibility for complex procedures such as PEG feeding or catheter care.
- Combining domiciliary care with assistive technology, of which various types are now available, will help to minimize risk for vulnerable people living alone.

Domiciliary care is likely to be more effective where it is linked with other services and disciplines. A major challenge for commissioners (and for the Change Agent Team) is how to work with providers to help ensure that even small agencies are more aware of, and included in, the whole system. Where there is a confrontational approach to commissioning and purchasing, independent domiciliary organisations are likely to work in isolation. Where providers and purchasers are equal partners and there is trust between them effective links with other services are more likely to be in place

The market – constituent parts

- **Over 4 million hours of home care are provided each week**
- **Over 700,000 people are supported by home care services in a year**
- **Over 200,000 staff are involved in providing home care services**
- **The home care market is worth more than xxx per annum**

Service Providers

Until the 1990 NHS and Community Care Act local authorities had no funding for domiciliary services other than their own Home Help teams. The Act gave local authorities the responsibility of assessing needs and the means to meet those needs, either through direct provision or by purchasing from independent suppliers. Notably this was to include more flexible services to support people at home.

Government attempts to persuade care home owners to diversify to supply this new market were initially unsuccessful. Local authority in-house services, historically provided 9 to 5 on weekdays, found it difficult to respond to the demand for flexibility. The existing private domiciliary sector was already providing very flexible services. Established providers and new agencies entering the market were quick to respond to the new opportunities.

Under the legislation local authorities were initially required to spend 85% of new resources in the independent sector. Social services, on the other hand, were not necessarily keen to engage in the mixed economy of care. Many councils were strongly committed to public sector services and had both political and ethical objections to allowing private (for profit) organizations to care for vulnerable people. Purchasing initially tended to be on a 'spot' basis and of non-social weekend and evening hours which the in-house found difficult to provide. It is also fair to say that there has been a very considerable learning curve on both sides, with initial suspicion and confrontation only gradually being replaced by trust and progress towards partnership working.

Service provision is exceptionally fragmented. Although there has been some consolidation through acquisition, business failures and through a reduction in the number of providers local authorities are willing to contract with, this remains the case⁴. There also continue to be new entrants to the market⁵. There have been relatively few barriers to entry with no requirement for large scale capital investment and, until 2003, no regulation of the industry. There were also no major acquisitions in the period prior to 2004, possibly due to uncertainty about the impact of regulation, PCT commissioning and of other legislation and reflecting growing anxieties about the availability of staff. There are also many very small agencies⁶.

There is considerable diversity in ownership:

- Local authority social services in-house home care teams
 - may include joint health/social services funded teams
- Voluntary or not-for-profit organizations
 - may be small, often local and specialist, providers
 - or larger organizations often providing a range of different services nationwide
- Sole proprietors or partnerships
 - usually small to medium size (between 1 and 5 branches)
- Franchises
 - operating as sole proprietors usually with a single branch, but linked with a national franchisor
- Limited companies or PLCs
 - may be any size from small single branches, to more than a hundred branches
 - large national organizations with a range of other services or products
- Individual paid care workers recruited by service users
 - either funded by Direct Payment or self funded
(individual workers are not required to be checked by the CRB nor are they subject to any kind of inspection or regulation)

Small providers (single proprietors, partnerships and franchisors) and larger providers (limited companies and PLCs) hold equal amounts of the independent market (41% each), although the larger organizations are gradually gaining market share whilst the voluntary sector's share is diminishing⁷.

Within the whole of the publicly funded market, as stated in the introduction to this paper, the last decade has seen a remarkable change in balance. In-house teams in 2002 provided only 46% of domiciliary care compared with 98% in 1992 (although the growth in volume overall

⁴ There were 3,100 outlets (sole provider's offices or branches) in 2000, a fall from 3,900 branches over the previous three years. These figures were from England, Scotland and Wales. In England alone the figure was 2,500 (Laing & Buisson, *Domiciliary Care Markets 2000*). Since April 2003 all organizations in England supplying personal care have been required to apply for registration and the current total applying is 4,750. Either there were many unknown and uncounted providers previously or there have been a lot of new entrants to the market.

⁵ Mathew D, *Commissioning home care: Changing practice: delivering quality (2004)* Report from DH Change Agent Team and UKHCA reported 19% of independent respondents said that they entered the market within the last four years, although some may be diversifying from related businesses. CSCI reported 820 applications from new providers between April – November 2004, verbal report November 2004

⁶ Mathew D, (2004) *Ibid.* reported that of 675 independent provider respondents 39% were small organizations providing fewer than 500 contact hours per week. Only 35% provided more than 1000 hours per week. This compares with in-house providers where only 17% did fewer than 2000 and 27% did more than 10,000 contact hours per week.

⁷ Laing & Buisson (2002) Reports that there has been some growth in the number of larger organizations, limited companies and PLCs (to 41% from 36%) but this still accounts for well under half the independent market, whilst the voluntary sector has a diminishing share of the market, at 18% of all providers, having fallen from 22%.

means that their volume of care was only reduced by 35%). Independent providers, on the other hand, have achieved huge growth, going from 2% of the market in 1992 to 64% in 2002.

Size of market

Department of Health annual returns for 2003 indicate that in a sample week 3.1 million hours of care were provided. In addition the privately funded market was estimated in 2000 to be nearly a further million hours a week⁸. Without allowing for growth in the private market or further growth in publicly funded home care the volume of service being provided must be in the region of 4,100,000 hours a week, or over 2 billion hours per annum.

Future growth in demand for home care will result from the increasing older population and particularly the projected growth of the very old⁹. Demand on home care increases from 70 years upwards, with by far the highest demand from the 80+ population.

Numerous surveys tell us that most people's preference is to remain in their own homes where they can exercise control and choice over their own lives. Increasing consumerism will reinforce these aspirations. Governments are likely to respond, particularly where the evidence shows that caring for people at home is cheaper than caring for them in residential or nursing homes¹⁰.

Although there have been reports that changes in women's working lives and divorce mean fewer able or willing to take on the role of informal family care givers, the evidence is that the proportion of the population taking on this role has been, and is predicted to be, stable¹¹. It will, however, be very important to support informal carers adequately especially since many are elderly themselves and admission to long term care can result from carers' deterioration in health and the emotional consequences of unremitting caring responsibilities^{12,13}.

Demographic changes and attitudes both point to a growing market for formal domiciliary care services but need only translates into demand (and a market) if funding is available. Policy, both nationally and locally, exerts considerable influence on demand. Although policy has advocated intensive home care as a means of avoiding admission to care homes for over a decade now, there have been inbuilt disincentives which meant that home care was often the last, rather than the first, resort. The current policy thrust, reimbursement pressures, performance targets and the loss of care home beds are all combining to put domiciliary care centre stage at present. Nevertheless, unless local authorities are able to shift the balance of expenditure from care homes to home care the initiative will be lost.

⁸ Mathew D (2000) *Who Cares? A Profile of the Independent Sector Home Care Workforce in England* UKHCA

⁹ The Census 2001 reports 3.9 million people aged 75+. The number of people aged 65 and over has increased faster than the general population over the last 10 years. Over the next 20 years this growth will speed up even more, with the over-85 year olds being the fastest growing group, projected to rise from 1.1 million (1.9% of the population) in 1999 to 3.3 million (5.2% of the population) at the peak in 2056.

¹⁰ With individual care packages averaging 8.1 hrs in 2002 and the average cost per hour (taking both in-house and independent provision into account) was £12.10 per hour in 2002-03, the average cost of domiciliary support is around £90-£100 per week whereas the average care home cost is £315. Laing & Buisson *Domiciliary Care Markets* 2003, Department of Health *Social Services Performance Assessment Framework Indicators 2002-2003*

¹¹ Royal Commission on Long Term Care (1999) *With Respect to Old Age: long-term care – rights and responsibilities*

¹² Wade B, Sawyer L, Bell J, (1983) *Dependency with Dignity* Occasional Papers on social Administration 68

¹³ Sale AU (2004) *Caring but not Coping* Community Care 29 April-5 May

The private market is also set to grow. Self-funders, who were able to access free local authority funded home care at the outset of Care in the Community, virtually decimating the private market, are (or their successors are) gradually returning as local authorities have introduced charges (sometimes equivalent to, or greater than, the cost of purchasing the service privately), tightened eligibility criteria and imposed prescriptive task regimes. Growth will be restricted only by lack of capacity. The extension of Direct Payments will reinforce this growth although those using this source of funding are likely to recruit their own staff or pay family members rather than using formal home care organizations.

Although demographic change and a growth in consumerism point to growing demand for home care, unless local authorities are able to shift the balance of expenditure from care homes to home care, opportunities to expand the home care market will be lost

Capacity

Undoubtedly the key problem facing the market is the availability of care staff. This has been getting increasingly difficult over the last four or five years and has now reached crisis proportions in some areas. At least three-quarters of independent providers report difficulties in recruiting and retaining care workers¹⁴. Pay and terms and conditions are a main part of the problem and, as such, the situation is likely to deteriorate even further for independent providers next year when single status leads to considerable gains in pay for local authority in-house home care staff.

Pay, however, is not the only reason for the difficulties – the increasing requirement to undertake very short visits (15 minutes is not unusual), rigid prescription of tasks, increase in time spent travelling (often unpaid) and inability to develop relationships with those they care for and the perceived low status of care work, all tend to make the job unattractive.

The vast majority of home care workers are women. Along with growth in the older population there is a continuing decline in the numbers of women of working age and this is likely to continue¹⁵. It is a matter for concern that a large proportion of the workforce are older women, nearly one-third in a fairly recent survey being 50 or over, with relatively few coming up behind them¹⁶. There are also reports of large numbers of experienced older care workers taking early retirement because of their concern at being required to obtain NVQ competencies¹⁷.

Although demographic factors are important, economic prosperity and high employment probably have greater impact. Home care is competing with opportunities in retail, call centres etc. where work will be guaranteed and there are fewer responsibilities. Another current concern is that good applicants may not be prepared to wait whilst CRB clearance is obtained.

¹⁴ Reported turnover rates vary but for the independent sector they are said to range between 26% to 35% and 12% to 15% in local authorities.

¹⁵ Association of Directors of Social Services, Local Government Association (2004) *All Our Tomorrows – Inverting the Triangle of Care*

¹⁶ Mathew D, (2000) Ibid.

¹⁷ George M, (2004) When I'm 65, *Care and Health*, Nov 9-Nov 15

Capacity is severely restricted at present by the availability of suitable care staff. Unless there is adequate investment in better terms and conditions and changes in commissioning which lead to making the work more satisfying, the domiciliary care market will fail to expand to meet increasing demand.

*Workforce issues are discussed in more detail in **Chapter Two – Workforce and Training**.*

A brief summary of legislation which is currently affecting domiciliary care provision is given on the next page

Legislation currently impacting on the market

COMPETITION ACT

This Act seeks to ensure that business 'undertakings', either purchasers or providers of a commodity or service, cannot act in a concerted way in order to agree prices. Penalties for infringing the rules include hefty fines, enforced closure of businesses and being barred from taking part in a business of this nature again. This is likely to cause problems for local care associations if members are known to have acted in relation to their own charges as a result of comparing charges with colleagues. It may also prevent such an association from seeking to represent providers' views on purchasers' proposed rates, or from jointly undertaking any cost analysis etc. Nationally there may be a problem in, for example, using data resulting from a resource such as the UKHCA's Costing Model to negotiate increases in price. Case law at present indicates that there is likely to be no corresponding problem for local authority purchasers from the Competition Act since they are said not to be 'undertakings' within the meaning of the Act.

EMPLOYMENT AGENCIES REGULATIONS

Regulations introduced in April 2004 affect Employment Businesses (introducing temporary workers to be under the control of the hirer) and Employment Agencies (recruiting and supplying workers to potential employers). Fully managed domiciliary services should not be affected, although providers need to review all their documentation and practise to ensure that they are not inadvertently included (UKHCA produce guidance for members). The regulations impose cumbersome and onerous requirements on EBs in relation to workers and hirers which are inappropriate for a domiciliary care service. They are also in conflict with the National Minimum Standards in some respects. One consequence of the regulations would be, for a provider considered to be an EB, that they could no longer provide a managed domiciliary service to a local authority or health authority purchaser, but could only supply workers to be under the control of the purchaser.

CARE STANDARDS ACT

All organisations providing personal social care in people's homes have been regulated since April 2003. As with other services coming new into regulation many providers were not sure what was expected of them and did not have minimum standards in place. The NCSC adopted the approach of registering conditionally with timescales for achieving the necessary improvements. Its successor, CSCI has continued with this approach. Many inspectors were not familiar with domiciliary care operations and there were initially some problems with interpretation of the standards, for example the definition of 'specialist' services, what is meant by 'adequate staff' in a domiciliary care context, and inappropriate imposition of standards on offices as if users were receiving the service there. CSCI has developed a new methodology specifically for domiciliary care inspections which relies to a much greater extent on the views of service users. Its process is also now more proportionate to risk. Early feedback from a small number of care organisations is very positive. There are some standards which are compromised by the way services are commissioned and purchased, for example the requirement for providers to be able to respond flexibly to users' needs and preferences on a day to day basis. The independent sector has welcomed regulation and look forward to much more consistent standards for domiciliary care. There are, however, major concerns at the training target of 50% of service delivered by NVQ2 staff by 2008 because of the current recruitment and retention crisis, the high turnover of staff and especially the reluctance towards training of older workers, who constitute a major part of the workforce.

There are also concerns about the regulation of some assisted living schemes since the NCSC's intention was to register as a care home, which it was anticipated would deter potential providers, rather than registering the domiciliary care element. It is early days to understand what CSCI's approach will be. The NCSC's criteria were to register as a care home if:

- the individual resident does not have a choice over which organisation provides his or her care
- the individual enters the scheme specifically in order to access a care service
- both the housing and the care service is provided by the same organisation .

Managing the market

Pressures on local authorities

A key requirement of the 1990 Act was that services would be carefully targeted and intensive. Despite the substantial increase in total contact hours and increasing numbers of older people 31% fewer households are now receiving home care than were doing so in 2002¹⁸. The average intensity of provision for those that do receive a service reached 8.1 hours per week in 2002¹⁹. This has been at the expense of preventative 'lower level' services. There is a tendency for local authorities to contract out more intensive packages to the independent sector, possibly because they can provide better flexibility.

Another responsibility of social services was that they should 'manage the market'. Initially this was seen as attracting sufficient providers to ensure competition and thus, lower prices. Independent providers, who were anxious to 'get a foot in the door' and who often had little idea of the additional costs of working for local authorities, priced their services at the level at which they had been supplying to private purchasers, and sometimes even lower because authorities argued that they should be able to gain economies of scale. In this way, many would argue, a price level was set which was too low and which has bedeviled the industry ever since. The influential King's Fund report argues the continued effect of expenditure constraints which cause authorities to drive down costs to the extent that quality is inevitably compromised²⁰

Care managers have to manage within a finite budget and budgetary pressures have led to reducing the length of service visits, frequently to half an hour and even to quarter hours²¹. Short visits are much disliked by users who complain that care workers are rushed, by care workers who feel that they cannot do the job properly and have no time to build a relationship with the person they are caring for or to promote independence, by managers who have great difficulty in planning and persuading staff to undertake the visits. In addition, there are additional pressures to pay for increased travel time and costs.

Price and costs

2002-03 data on the Unit cost of home care for adults and older people, suggest that the provisional figure, taking both in-house and independent provision into account, averages at £12.10 per hour²². Prices for independent home care quoted in the recent commissioning survey ranged from £5 to £16, although the higher price related to a specialist service. In-house services reported a range from £7 to £29 per hour. The calculation of in-house costs is not straight-forward and there is no standard method established.

Historically, independent agencies have supplied home care at lower cost than local authorities' own services but the differential is now reducing as independent providers take on the costs of regulation and also have to pay care staff for more non-contact time as a result of the Working Time Regulations and simply in order to retain good staff. The introduction of Single Status for local authority staff and consequent pay increases for care workers, will increase the cost of in-

¹⁸ Laing & Buisson *Domiciliary Care Markets 2003*, reported services provided to 367,000 households in 2002 compared with 529,000 in 1992

¹⁹ *Community Care Market News*, (2004) Vol.11 Issue 2.

²⁰ Henwood M, *Future Imperfect?* Report of the King's Fund Care and Support Inquiry (2001) King's Fund Publishing

²¹ Mathew D (2004) *Ibid.* reported 58% of independent and 43% of in-house providers said that more than half their visits were for half an hour or less, 11% of independent and 16% of in-house providers said that more than a quarter of their visits were for quarter of an hour or less

²² Department of Health PSS X1 2002-2003

house services and result in huge cost pressures in the independent sector as they compete for scarce staff.

Costs are discussed in more detail in Chapter 3

Types of contracts

Very few authorities purchased on the basis of block or cost and volume contracts initially. More frequent were spot purchases of a few hours of care for an individual, sometimes for a short period while the in-house service organized its own provision, or sometimes of the evening and weekend care which the in-house found difficult to provide. This was resented by independent providers who found the fluctuation in demand and insecurity of income very difficult to manage. The situation has now changed but the majority of home care is still spot purchased²³. Where there is high and consistent demand, providers may see no advantage to moving to a more structured contractual situation²⁴.

There is considerable diversity in local authorities' contracting arrangements. Providers are thought to prefer cost and volume or block contracts because of security of income and the ability to offer guaranteed work. There are, however, considerable risks with large contracts, and especially with those that extend over several years, that either initial calculations or unforeseen changes in legislation or unprecedented labour cost increases will result in catastrophic losses. Small organizations are often reluctant to participate, lacking the expertise and resources for tendering and also fearing the consequences of failing to deliver. In the past contracts were often written in such a way that all the risks were borne by the provider and contained draconian penalty clauses. Where councils have moved towards working in partnership with providers there is much more willingness to discuss difficulties and to share risks.

The majority of social services now commission at least some of their home care through block or cost and volume contracts²⁵. There are also developments of 'locality' or 'zone' contracts in which the expectation is that the provider will accept all referrals within the area (often with a secondary provider selected to back them up). There are major advantages for authorities in moving to more formal contracts, in that they can:

- reduce transaction costs
- have a more reliable and stable source of supply
- reduce monitoring costs
- obtain economies of scale

Tendering processes vary and some authorities are more experienced and efficient than others but independent providers complain at the resource intensity, the lack of information provided, and their view that decisions are made primarily on the basis of lowest cost, rather than on quality.

²³ Mathew D (2004) *Ibid.* 61% of providers responding reported being dependent on spot purchasing

²⁴ A survey of 155 independent providers found the preference for block contracts had fallen from 60% in 1995 to 32% in 1999. Matosevica T, Knapp M, Kendall J, Forder J, Ware P, Hardy B (2001) *Domiciliary Care Providers in the Independent Sector* Discussion Paper 1605 from Mixed Economy Programme (PSSRU and Nuffield Institute)

²⁵ Mathew D (2004) *Ibid.*

It is not unknown for providers go through the whole process and make the considerable investment involved in a tendering exercise only for it to culminate in no decisions and no contracts awarded.

Many councils have reduced the number of providers in the area, taking them off the authority's Approved List in the process which also undermines their ability to operate in the private market. The intention is both to reduce transaction costs and to enable surviving suppliers to acquire viable volumes of work. This has been one of the chief causes of business failures during the last three or four years, mainly affecting small providers.

Small agencies often operate in only one local authority area and are therefore especially vulnerable when the authority imposes unacceptable prices or terms, or cuts providers²⁶. As already stated, small agencies are less likely to participate in a tendering process or to win a block or cost and volume contract. Yet small organizations often have a lot to offer. The management is likely to be very close to and involved with service delivery and the service will be more individual and personal. High staff loyalty means a more stable workforce and better continuity. Most small providers come from a care or nursing background and are more interested in providing a good service than in growing an empire. They may well also fulfil niche market requirements, specializing in some aspect of service provision or providing to a geographical area or community which would otherwise not be covered and which also enables them to charge a premium price. Some local authorities which value small providers will support them in gaining registration assist with training and use small scale or locality contracts to ensure that they have some financial stability.

Polarisation, with larger organizations concentrating on public sector contract work and smaller organizations doing only privately funded work, is likely to continue. This is partly in response to funders' preferences (local authorities moving to larger contracts and private purchasers preferring the personal and individual approach which smaller organizations can offer); also partly a proactive decision by providers.

Strategic commissioning and partnership working

Local authorities are required to work in partnership with health colleagues and should also be working with Housing, the voluntary sector, independent service providers and service users (and those who advocate on their behalf) to develop a 'holistic' approach to supporting older people²⁷. All partners, including service providers and service users, should be involved in agreeing needs and development of plans. Although much joint planning is going on at the PCT/local authority level, the extent to which other stakeholders are involved varies considerably from area to area.

One aspect of this work is the need to develop a wider range of services to assist in preventing hospital admission or facilitating rapid discharge. Many have done this very successfully and re-ablement services of different kinds appear to be very effective. They often, if not always, have a home care component. Staff recruitment and retention is proving easier in such schemes, since staff perceive that they have a health role, a higher status and a valued

²⁶ Mathew D (2004) Ibid.

²⁷ under the Building Capacity and Partnership in Care Agreement 2001 and Building Capacity – Principles into Practice 2003 key stakeholders in the care economy are required to work in partnership

position in a team. PCTs, however, have no previous experience of working with the independent domiciliary care sector and there is some concern at their marginalization. Unless these new opportunities are open to independent, as well as in-house providers, it will be impossible for the former to build up a dependable and stable workforce.

Partnership between key players is central to ensuring that there are effective services to support older people at home. Some characteristics of successful partnership are:

- Respect for each other
- Trust – confidence in each other
- Continuous communication
- Agreeing objectives, principles and the value base
- A culture shift to 'own' problems collectively and work collaboratively to solve them
- Responsibility at a strategic level to create a climate in which problems can be surfaced with some realistic expectation of support and resources to resolve them

There is still a long way to go before relationships between independent domiciliary care providers and public sector purchasers could be described as having reached the status of partnerships on these criteria, although in some authorities there has been progress. The Audit Commission and SSI have commented on both the progress and on the continuing adversarial approach of some authorities²⁸. There are problems on both sides.

Providers in the independent sector have long held the view that in-house services, where they survive, receive preferential treatment. This is to some extent backed up by the Audit Commission which drew attention in 1997 to weakness in strategic commissioning in that purchasing and provision functions had often not been separated and in-house services were under no contractual arrangements. They also suggested that more clarity about in-house costs was needed and an end to the "in house first" policy when putting together a care package²⁹. This has now largely changed although over a third of in-house providers in the commissioning survey reported no contractual arrangements yet in place and there is no standard method established for calculating in-house costs.

Much of the tension is about price. The commissioning survey suggests that there is little understanding about the real costs of providing the service and that Best Value reviews have not contributed to the knowledge. There were also some indications of social services staff acknowledging that the price paid was not adequate to secure a quality service. Where reasonable price increases had been agreed which took into account providers' increasing costs, relations improved and providers and councils were able to move forward.

One measure of partnership is the extent and quality of communication. Indeed, some authorities are said to judge the commitment of providers on the basis of their attendance at meetings. It is important that any meetings are genuinely useful, with openness, opportunity to exchange views and real consultation, not just calling people together to tell them what you are going to do. Early involvement of providers in the development of strategic planning, listening to their views and helping to solve difficulties in service delivery would greatly improve the quality of communication. The importance of communication in resolving contractual problems has already been noted. Many providers do not meet local authority staff except for contract officers and care managers and these meetings may be very sporadic. Over two-thirds of

²⁸ Social Services Inspectorate (2002)

²⁹ *Take your choice – a commissioning framework for social care* (1997) Audit Commission

independent providers in the commissioning survey³⁰ reported that they never met social services directors. Over 85% never met with local councillors.

Negative attitudes towards independent providers may be based on one bad experience. Contracts staff may have worked hard with providers to help improve standards and stress the importance of monitoring data in demonstrating that the quality of their services is similar to in-house provision if these changed attitudes are to permeate the rest of the department.

Much work is needed in order to achieve real partnership by all players in the domiciliary care industry but this is essential if capacity problems are to be solved and if the most effective use is to be made of scarce resources

Contact details

1. *Scheme to support people in rural areas – Keith Ralph, Agincare, 01305-769418
keith.ralph@agincare.com*
2. *Scheme which aims to rehabilitate over specific timescale – Keith Ralph as above*
3. *Palliative care service – Ros Matty, SPDNS, rosalindmatty@btconnect.com*
4. *Details of live-in care suppliers – UKHCA 020-8288-1552*
5. *Service for people with acquired brain injury – Barbara Scandrett, Complete Case Management Holdings Ltd. 01952-293449 or rachaelpickford@completegroup.co.uk*

³⁰ Mathew D (2004) *ibid.*

Chapter Two

WORKFORCE AND TRAINING

Background to the workforce problem

Although there is undeveloped (and often unrecognised) potential for home care to make a major contribution to services which reduce the need for hospital, or other long term care, beds – this will not be realised unless workforce problems are addressed and resolved. Demographic and economic changes have led to shortages of labour, particularly in areas where retail and other developments have provided comparable, and possibly more attractive, opportunities for work. In all sectors, providers are facing major difficulties in recruiting and retaining a suitable workforce.

Home care is a significant employer of labour, employing across all sectors over 200,000 staff, more than in the motor vehicle industry or in the police force. Sixty-five percent of these work in the independent sector – providing, in 2003, over 66% of state funded home care (3.1million hours per week) and nearly 1million additional privately purchased hours per week³¹. Private funding, however, is no more likely to ensure that a domiciliary package is available just when needed than is state funding. The workforce crisis is affecting all sources of provision. The industry welcomes the introduction of criminal record checks but there has been anxiety that delays in getting them, and POVA checks, may act as a further deterrent to applicants. The Department of Health have now agreed that, so long as new staff have completed their formal induction training, they may work pending the confirmation of clearance.

Recruitment problems are set to continue. The workforce is currently composed predominantly of women aged over 40 years, with quite large numbers aged over 50 years³². Younger people are not coming into the service (in the independent sector only 19% of workers were aged under 30) and turnover rates are high, averaging 16.1% in the public sector³³, but 26% in the independent sector. It is suggested that retention is more difficult than recruitment. The majority in both sectors work part time.

Anticipated demand for growth in the social care sector workforce over the next few years is around 2.5%-3% a year. However, while demand for labour is increasing, the labour supply is forecast to grow by less than 0.5% a year in the near future. Further off there is room for more optimism. Although those aged 80 and over are set to more than double by 2040 there will also be an increase of almost 4m in the number of people of working age³⁴.

³¹ Mathew D., (2002) *ibid.*

³² *Social Services Workforce Survey 2002*. Social and Health Care Workforce Group, Employers' Organisation, London, reports that 47% of local authority home care staff were 50 or over

³³ *Social Services Workforce Survey 2002 (Ibid.)*

³⁴ *Modernising the Social Care Workforce – the first national training strategy for England, 2000, TOPSS England*

The Workforce

What makes home care work rewarding?

If workforce planning is to be effective, it is important to understand what attracts people to work in the home care industry and what are the disincentives.

Pay rates and security of income

Labour is the largest component of the total costs of home care. Home care providers are increasingly being forced to pay more and to improve their terms and conditions if they are to be in a position where they can continue to provide a service. The pressure on wage rates varies from place to place, being most intense in areas of high employment. Headline pay rates are probably not as important, however, as security of income and (particularly in the independent sector) pay for time spent travelling between service users' homes, and reimbursement of travel costs. The potential to work flexibly, around family commitments etc., is an attraction to many staff – particularly younger women with child care responsibilities, but employers need to be able to guarantee at least minimum paid hours each week. Also the preponderance of visits in the early morning and late evening and the pressure to work at weekends, bank holidays etc. is disliked³⁵. To attract young people into the service, full time work is necessary and also career potential. Although headline rates may not be key in some areas, staff who have acquired the necessary knowledge and skills, and are achieving NVO2, in a workforce which now has responsibility (and often sole responsibility) for extremely dependent and vulnerable people, will necessarily attract pay enhancements or inducements. Pay rates at unsocial hours and non-pay benefits also cause some concern.

Responding flexibly to service users' needs and preferences

Care workers dislike the pattern of provision which depends on a series of short, or very short, visits, particularly when the required calls may be spread out over a wide geographic area. It is not unusual for a home care worker to spend up to a third of her working day travelling between assignments. A key attraction of home care work is the quality of relationships built up with service users and the ability to respond flexibly to their changing needs, using their own initiative. Both service users and care staff complain when visits are rushed. The rigid specification of tasks and times which have been a feature of commissioning and purchasing home care services for most of the last ten years, have also done nothing to promote satisfaction from this work^{36,37}.

There is a real danger that providers will be unable to sustain services unless we can find ways of making the work more satisfying and rewarding to care workers. The demanding nature of the work and the level of anxiety they carry for service users whom they often feel are extremely vulnerable and are not receiving adequate support, leads to high levels of stress –

³⁵ Survey of over 2300 care workers as part of a review of the home care services of a major national voluntary organisation, including small number of exit interviews. 37% response rate. (unpublished) 2001). Sawyer L

³⁶ Sinclair I, Gibbs I, Hicks L, (2000) *The Management and Effectiveness of the Home Care Service* University of York

³⁷ Patmore C, *Flexible individual-centred home care for Older People*. unpublished on-going research, SPRU University of York

another disincentive to staying in the home care industry³⁸. There is evidence that some younger recruits to home care leave the industry because of the isolated nature of the work

The status of home care work

The perceived status of home care work is a disincentive both to taking up the work and to remaining in it³⁹. The level of support received from managers is critical to care workers' feeling that their work is appreciated. Being informed of changes or developments in their service users' care plans and having an opportunity to contribute to any discussion confers value to the role⁴⁰. As home care diversifies and undertakes more innovative types of provision, such as rehabilitation, rapid response, or intermediate care, and particularly as there is a move towards generic care/health teams, recruitment will be easier and retention rates better⁴¹. It is important that opportunities to provide such services are not restricted to the public sector.

All sectors need to be able to offer staff a wider range of work and a potential career structure if they are to continue to provide reliable services and to increase capacity.

The Personal Social Services Research Unit (PSSPRU) at the University of Kent is currently bidding for funding for research which will aim to explore in much more detail the motivation and career plans of people in the home care industry. They have a particular interest in older and more experienced care workers. **Contact** – *Dr. Ann Netten* 01227-823644
A.P.Netten@ukc.ac.uk

Workforce Initiatives

One of the largest projects in the UK is Greater Manchester Workforce Development Confederation's project *Delivering the Workforce* launched in 2002. This award-winning project is focused on health and social care staff but primarily aims at attracting into the workforce mature people with low educational attainment who are keen to work in health and social care. A new role of 'assistant practitioner' has been developed which, after a generic first year, encompasses nursing, therapy, social service, technical and therapeutic skills – variable depending on the patient group. Two universities are supporting the training programme which is a new 2-year foundation course, based on 'learning through doing'. The qualification is a diploma in health and social care. The participating organisations (now up to 22) employ the recruits during their training. Seventy five candidates have now qualified and there are currently 700 trainees. Key to the success of this project has been:

- The redesigning of work roles to focus on patients/users in order to improve services
- A work, earn and learn approach
- Good partnership working across health and social care, including some new joint roles

³⁸ Ballogh S., McClean J., Fisher M., (1999) Satisfaction, stress and control over work, in *Social Services: working under pressure*.

³⁹ Robison J, (2002) *Consulting Home Carers: an exploration of the views about quality and values, and the status of domiciliary care*, The Quinn Centre

⁴⁰ Focus groups of care workers – part of a project on quality standards for the Alzheimer's Society. Sawyer L, (2000).

⁴¹ Henwood M (2001) Delivering quality – an ambitious agenda, in *Quality Matters: striving for excellence in home care*. Report for Help the Aged Conference. Henwood draws attention to the importance of status and job titles of care workers, as well as the massive issue re pay, for recruitment and retention of staff.

- Giving staff the opportunity to influence and change roles in a meaningful way for users of the service and for themselves

The project, which has been an effective response to the need to modernise the workforce, is being externally evaluated and is being watched carefully by a number of national bodies such as the Skills Council, Department of Health etc. **Contact** – *Chris Mullen, Project Director, 0161-237-2327, chris.mullen@gmsaha.nhs.uk*

Sunderland SSD also recognised training as a vital part of their recruitment and retention strategy when they were faced with an ageing workforce and difficulties in recruiting younger people. Their response was to move from a one-day induction to an intensive week-long induction programme. Training sessions are held 4 evenings a week over a 3-week period to suit the availability of new staff. NVQ training has also been linked to the new induction and foundation course with an aim of getting all new staff through NVQ2 within a year of commencing employment. Feedback from staff is that they feel better prepared for the work and gain greater job satisfaction. They also view home care as a real profession with career opportunities. Recruitment and retention is improved and feedback from service users is excellent. **Contact** – *Philip Foster, Sunderland SSD, 0191-566-2100, homecare@ssd.sunderland.gov.uk*

Another more local initiative is the Social Care Access Programme (SCAP) piloted in Ealing. SCAP was developed by an independent consultancy, Making Vision Reality Ltd (MVR). The aims are to:

- Promote the social inclusion agenda by providing meaningful employment for the local community
- Promote a pride in working within the social care arena
- Address the skills gap and lack of qualified social workers
- Eliminate the use of agency staff

In the pilot the scheme operated in partnership with New Deal/Employment Services which subsidised candidates for six months and provided a personal Advisor to each candidate on the scheme. The scheme was advertised widely and innovatively and was open to all, especially to people with disabilities, single parents, ethnic minorities etc. The training and assessment programme lasted 6 weeks, during which candidates were paid at 2/3rds of the normal rate. Training included a mix of theory and practice, both in class-room and in field. Flexible working was designed into the philosophy and programme. The success of the pilot is that from the 20 people who joined the course, sixteen new staff came into post and turnover has been minimal to date. The cost per trainee was £750. **Contact** – *Craig Williams, Making Vision Reality Ltd., 01825-712373, craig@makingvisionreality.co.uk*

There are a number of evaluations in progress at Manchester University, including the evaluation of Greater Manchester Workforce Development Confederation's project described above.

Strategies which will also support workforce development in the independent sector

Strategies to support independent sector workforce development are also important – 64% of state funded home care is now provided by independent organisations. Improved reliability and increased capacity both depend on having an adequate and dependable workforce. Initiatives such as the ones described above may not be helpful to independent providers for one main

reason, that is their inability to offer security of employment and income at the end of the project. There are some projects which take account of this problem:

For example, under the auspices of Central Cheshire PCT, the Employment and Community Services Regeneration Manager runs an Intermediate Labour Market which aims to give those outside the labour market a bridge back into work by improving their employability. A 6-month programme is offered which includes supported employment, training and personal development and assistance with job search. The key thing about this programme is that it is a Job with Training, rather than a training scheme and people are paid the wage for the job. It is very much about developing the future health and social care workforce and is inclusive, bringing in voluntary and private organisations as well as statutory sector employers. Where organisations cannot provide full time employment, the scheme is able to subsidise. **Contact – Yvonne Clarke, Central Cheshire PCT, 01270-415300, yvonne.clarke@ccpct.nhs.uk**

Introducing a Wages-Plus basis for purchasing home care could also have a big impact on independent providers' ability to recruit and retain adequate workforces. There is empirical evidence that substantial increases in pay can attract many new people to paid caring. A number of local authorities are willing to pay independent providers more money in order to offer much better terms and conditions to staff, but they need reassurance that all of the extra money will go to increase care workers' pay rather than to meet overheads. The principle behind Wages-Plus is that current competition between providers may well drive down wages, consequently damaging recruitment. The solution is to separate the wages element from other costs within the tender price, leaving providers to compete on the efficiency of their operations and sensible management of staff. In practice the local authority would agree to accept and include hourly wage rates up to a maximum level, which would automatically become the standard rate as no provider would have an incentive to pay any less. Competition is then based on the gross margin, rather than the total cost of providing the service. At present a number of authorities are considering this approach. **Contact: Philip Mickelborough, Laing & Buisson, Pjm@mickelborough.com**

One key message to service commissioners has to be that if they want a source of reliable and good quality services they need to start developing real partnerships with service providers in which there is openness, risks are identified and shared, and providers are able to offer guaranteed work to their staff and to reimburse them properly for the time and costs of travelling between service users.

Measures which will assist the independent sector to recruit and retain staff are:

- Commissioning services in such a way that providers can offer staff
 - enough work
 - some security of income
 - work spread out through the day (ie not just in the mornings and evenings)
- Ensuring that all providers have the opportunity to tender for specialist services rather than developing these in house on the basis of joint working between PCTs and Social Services
- Recognising the cost of travel and the need to pay for staff travelling time
- Commissioning on the basis of outcomes rather than need and giving providers the autonomy to respond flexibly as they work to achieve agreed outcomes

- Commissioning on the basis of specific localities, rather than across a whole authority area, which will enable providers to use staff more cost effectively and reduce staff travel time

Individual home care organisations also have their own strategies for workforce development. Some we are aware of are: Carer of the Month awards; an annual draw with a really worthwhile prize such as a car; providing child care; etc. Others are taking even more proactive steps, setting up companies outside the UK in order to undertake recruitment in those countries of suitable care staff, and then organising all the necessary paperwork, travel and accommodation.

Integrated health and social care - a strategy for workforce development

The experience in a number of areas is that recruitment to posts which are clearly health related, or are seen as having a more positive objective (Rehabilitation Assistant, Health Care Assistant, etc) is much easier than to conventional care worker posts. Retention rates of staff in these posts are also improved, particularly where they are working as part of a multidisciplinary team. There are suggestions from Surrey that there might be a need for fundamental shifts in the philosophy of care provision, and also that the potential for development of the care assistant level of the workforce must be maximised⁴². Similar experiences are reported in other areas, for example Dorset, North Derbyshire etc.

A good example of a commissioning strategy which takes account of both the preference for health related work and the satisfaction conferred by a degree of autonomy is quoted in the Quinn Centre study⁴³. This describes a short term hospital discharge service where staff have both the responsibility and flexibility to decide how much time they need to spend and at what time they should visit each client. A large range of both personal and practical tasks are undertaken and support is reduced over the defined period as the user recovers and regains independence. The ability to organise their own work and to give users the time they seem to need without being rushed is an important contributor to the job satisfaction. They also enjoyed seeing people get better.

These individual initiatives towards integrated health and social care were given some central support and impetus from the Workforce and Older People's Team at the Department of Health. This short term project aimed "*to ensure the availability of an integrated health and social care workforce, which promotes the independence of older people*" and to improve policy development ensuring that workforce policy is integrated with Health and Social Care policy for older people. The team included both a core group working nationally on the development and implementation of policy related to workforce and older people, and a number of external stakeholders. Primarily this team explored ways of building connections nationally to support local practice, and also to ensure that policy is implementable and likely to achieve the intended outcomes. Their work, supporting the implementation of the flexible Health and Social Care Support Worker, aimed to identify the hurdles to achieving an integrated workforce, e.g. regulation; conceptual issues; legal and insurance issues; professional resistance; education and training; resources and funding streams, and considering how they can best be overcome. The work of the group has now finished but a helpful source of information can be found at www.integratedcarenetwork.gov.uk

⁴² *Workforce Planning and Delayed Discharges* (2002) a report on a project undertaken in East Elmbridge and Mid Surrey PCT, Kent, Surrey and Sussex Workforce Development Confederation

⁴³ Robison J. (2002) *ibid.*

The drive towards integrating services for older people through an integrated workforce makes excellent sense. For too long older people have been at risk of falling through the gap between health and social care, or professionals have squabbled about such absurdities as whether a bath was a 'health' or 'social' bath as they attempted to shift the responsibility elsewhere. It also advances the continuum running from purely domestic and practical tasks, through personal care and into health care – and gives it formal status. Over the last few years domiciliary care workers have been required to do more and more which was, hitherto, the territory of nursing assistants – catheter care, PEG feeding, sterile dressings etc. and although they are required to have specific training before undertaking these tasks there has been nothing laid down about who is competent to do the training, or how the care worker is deemed competent, once trained.

To repeat the point already made above - it is essential that, if independent providers are to be in a position to provide reliable high quality home care services, they must share the opportunity to provide integrated services.

Recruitment campaign

The Department of Health ran a £3M campaign to attract people into the care workforce. launched in February 2004 with a target of 30,000 new care assistants. The campaign was based around three TV scenarios, two of which were home care settings, and the message was "doing the little things that make a big difference". People were able to respond via a website, with a specific helpline to Job Centres where staff had been trained to deal with the expected enquirers. There were around 70,000 responses to this campaign of which 10,000 were referred to Job Centres and the remainder were sent recruitment packs. Some agencies reported better recruitment figures in the aftermath of the campaign. This campaign was potentially helpful although the inability of most agencies to offer guaranteed or full time work may have posed difficulties. The recruitment campaign is to be repeated in January 2005.

Beacon status

Several of the councils which won Beacon status during 2004 were chosen on the basis of excellent services in the way in which they supported social care workers.

- Tower Hamlets' specifically supported people from its Bangladeshi and Somali communities in achieving qualifications. They also raised the pay of social care staff.
- Westminster introduced recruitment and retention bonuses for qualified staff, allowed sabbaticals and established secondments, some of which were into the independent sector. They spend more than double the national average on training and run a special course for ethnic minority staff. They also make some significant financial awards for excellence
- South Gloucestershire has specifically supported independent provider care staff as well as their own staff. This is primarily through training, including funding a small number of staff through social work degree courses. In their survey of staff satisfaction they found 88% of social care staff were satisfied with their jobs.

There is also an ongoing Market Enquiry to respond to the looming crisis around workforce issues in the London area, undertaken by Kings Fund. This is also considering wider issues such as the range of services and whether they are what users want; whether there are shortcomings in the services and whether these are being addressed; whether the particular needs of older people with mental health problems, and older people from minority ethnic

groups are likely to be met . **Contact:** *Janice Robinson or Penny Banks, Kings Fund 020-7307-2400, j.robinson@kingsfund.org.uk*

Training

Training requirements

Very little information exists on the training or qualifications of care workers in either the statutory or independent sectors. Data from the 1998 workforce survey suggests 96% of SSD home care workers were unqualified, whilst information from the UKHCA report in 2000 suggests that the percentage was slightly lower in the independent sector⁴⁴.

All organisations are now required to ensure that home care workers undertake training based on the TOPSS induction standards. The evidence in 2001 was that statutory sector was generally aware of this requirement but that independent providers, especially smaller organisations not belonging to any of the industry organisations, were not so aware. By 2004 almost all domiciliary care providers will have had at least the pre-registration visit from CSCI inspectors and many will also have experienced their first annual inspection. As part of that process they will have to satisfy inspectors that they are providing induction training for all care workers and that this includes a minimum 3-day orientation programme covering the induction training syllabus before they work unsupervised in a service user's home.

Training to NVQ level 2 is also a mandatory requirement for regulation of the industry. Fifty percent of the care delivered by an organisation is to be provided by NVQ2 workers by 2008. Organisations will all need to have an annually updated staff development and training programme and will need to provide evidence that they are undertaking staff training. New staff are required to register for the relevant NVQ within the first six months of employment and complete the award within 3 years. Existing unqualified staff employed for less than 2 years at April 2003 have to be phased in to the relevant NVQ within 2 years. In addition, as discussed above, training may be an important part in the recruitment and retention strategy of organisations.

Given the background, achieving the targets is going to be difficult, especially given the high turnover of staff and the shortage of appropriate training resources. Smaller independent home care organisations are known to be very concerned about training costs. There is a great need for training and independent providers are gradually getting geared up - many face a steep learning curve, with no experience of undertaking a training needs analysis and often with little knowledge about NVQs. The majority are keen to train their staff but the prices they charge have rarely reflected the additional costs involved. The margins available are usually far from adequate to absorb the very significant additional labour costs involved in training the workforce, in addition to any specific training costs. There is also anxiety about the reluctance of the many older women in the workforce to undertake training.

⁴⁴ Mathew D. (2000) *ibid.*

There have also been some concerns about the relevance and adequacy of NVQ for domiciliary care since it pays little recognition to the issues which arise from working in an individual's home, health and safety in a domestic environment, working in isolation, etc. Also the specific conditions which care workers will encounter in their work, such as dementia, sight loss, Parkinson's disease, diabetes and others, are not included in the NVQ syllabus. Changes now implemented by TOPSS, as part of their Review of National Occupational Standards and Awards in Care, will resolve at least some of the anxiety by reducing the initial NVQ to 4 core units intended to demonstrate initial competence to practice safely:

- Communication
- Health and safety
- Personal and professional development
- Principles of Care

and then to supplement these with further optional units to aid more specific competency as well as lateral progression. The latter may be particularly important in view of the regulations and NMS for Domiciliary Care which state – *"there is at all times an appropriate number of suitably skilled and experienced persons employed for the purposes of the agency"* (Reg. 15 (1)(a)) and *"each employee of the agency (a) receives training and appraisal which are appropriate to the work he is to perform"* (Reg. 15 (2)(a)). Whilst these clauses may sound innocuous, they are problematic within the context of current commissioning of domiciliary care services which tends to be for generic services. Inevitably this means that care workers are likely to visit service users with a wide variety of conditions during the course of their work and, given the volatile nature of home care provision with often fairly high turnover rates, they may also encounter a rapidly changing client-mix. Technically, inspectors could demand that a home care organisation must identify each category of service users for which it intends to cater and that it must be at least working towards providing staff specifically skilled and experienced in working for that client group. This would indicate either radical changes in service commissioning with far more specialised services, or a very considerably enlarged training syllabus.

There has also been work at Stirling University on a 'Home Care Practice Licence' which provides a way of ensuring that people who have completed their induction training are competent to practice. It is based on the model of the theory part of driving licence test with a series of multiple choice questions. This is currently being piloted in a number of local authorities and is proving popular and cost effective. **Contact:** *Noni Cobban 01875-340343, noni@v21.me.uk*

Funding

The funding situation for training is both fluid and complicated. There is a great deal of money available for training but it is not easy for independent providers to access and they also usually have to contribute varying amounts, depending on the source from which they obtain support. Intervening organisations (such as the UKHCA) are channelling funds into the home care sector.

The majority of money is still going to local authorities, both to train their own workforce and to transfer to organisations with which they contract but there is great concern in the independent

sector, which appears to be justified, that authorities are not necessarily sharing the funding. There is also concern about the needs of independent providers not contracted to local authorities. Reports from providers indicate that college courses are fully booked and that they are finding it difficult or impossible to locate training resources at affordable prices.

The main sources of funding are:

- Via regional consortia
- Via industry organisations
- Local authority training support funds
- Learning and Skills Council (LSC) (47 different regional projects)
- European Social Fund (ESF)

Small organisations are not likely to be in a position where they can manage the complex application process on their own, often not having either the skills or the resources. If they are to develop and train their staff successfully they will need considerable support.

Training Initiatives

Some training initiatives have already been discussed above, on the basis that they are primarily an attraction to workforce recruitment and retention. Below are a number of other initiatives which are primarily supporting independent sector care providers:

One example of good practice in supporting organisations is the partnership between West Cheshire College and West Cheshire Workforce Collaborative, hosted by Ellesmere Port & Neston PCT. As part of the Local Jobs for Local People project, the college employs a Business Development Adviser who will visit any private or voluntary care organisation within the area and assist them with aspects of company training development such as undertaking a training needs analysis, assisting with funding bids, etc. **Contact** – *Rosie Foster, Business Development Manager, West Cheshire College 01244-670664, r.foster@west-cheshire.ac.uk*

The key message to local authorities is the need to work in real partnership with independent sector colleagues to help them achieve essential training targets. Joint training programmes, support for consortia of providers, assistance with training needs analysis and planning etc. A number of authorities have already grasped the nettle and are busy developing opportunities for shared training. **Contact:** *Hampshire SSD - Nikki Griffiths 01962 845976, Medway SSD - Amanda Rogers at amanda.rogers@medway.gov.uk,*

The whole approach to workforce development in the Cheshire and Merseyside SHA is inclusive. Local health and social care employers are working closely with the Learning and Skills Council, local education providers – universities, FE colleges and schools – Job Centre Plus and Connexions. There is a recognition that people move around within the health and social care communities and that there is therefore a need to bring together people with common interests and concerns. There is also a recognition of the need to promote a positive career image for the sector across all age groups in the face of severe competition from other sectors in the local economy. There are a number of local health community based workforce collaboratives being developed to produce comprehensive and innovative workforce strategies that are socially inclusive and address recruitment, retention, training and development.

Contact – Sandra Shorter, Workforce Development manager (Head of Social Care), Cheshire and Merseyside SHA, 01925-406000, sandra.shorter@cmha.nhs.uk

Training resources are often the main hurdle for providers so the Tyne and Wear Care Alliance, which acts as a broker commissioning training which is then supplied at no cost (other than the cost of releasing staff whilst they undertake training) to employers, is providing all round support. The Alliance is a collaboration of workforce development professionals and employers in the care sector working together to raise the quality of care. Employers as members of the Alliance are encouraged to participate in the development and management of the individual networks in Sunderland, Gateshead, S.Tyneside, N.Tyneside and Newcastle. The objective, based on the fact that the majority of both residential and domiciliary care is provided by the private and voluntary sectors, is to ensure that care staff are enabled to reach the government care standard targets of TOPSS induction, NVQ's levels 2 & 4 and RMA. They have £6.9M of funding through LSC, ESF and TOPSS. **Contact** – Pauline Wiper, 0191-5656052, pauline.wiper@sunderland.gov.uk

UKHCA have established an Assessment Centre and have a number of training consultants strategically placed around the UK who are able to support organisations coming forward and applying for training funds. They use a workbook approach which is proving very successful with, for example, 37 out of 40 candidates obtaining NVQ2 within 5 months in one area. UKHCA have also produced a comprehensive guide to training. **Contact:** Carolyn Gratton, UKHCA 01425 622412, email@carolyngratton.com

In a number of different areas organisations are banding together in order to obtain training funding. In Sheffield the Quality Care Partnership acts as a brokerage for training funding in South Yorkshire. Durham Employer Care and Health Alliance (DECHA), the Tees Valley Partnership are just three of these. Organisations need to be aware that there can be conflict where strong groups such as these appear to be gaining more control over funding than colleges or social service departments.

The Surrey Learning and Skills Council, in partnership with TOPSS and the Surrey Care Association hosted Surrey Skills to Care, a day which brought service providers together with a huge range of training providers, local colleges, commercial training organisations, national providers of distance learning systems, basic skills courses, specialist training for specific user groups etc. The exhibition attracted a large number of service providers from all sectors. They were also able to attend any of the many seminars which took place throughout the day. This was an excellent way of enabling providers to see what was on offer and to assess what might be useful for their particular workforce.

The project in Elmbridge and Surrey (*mentioned above*) suggests a number of initiatives, including: the importance of building training options and career development into any workforce development programme; the use of a 'training' home; 'on the job' training schemes. With regard to the last of these it is pointed out that for many people traditional training routes may be off-putting or inappropriate. The need for family-friendly schemes is also crucial.

The independent sector is also beginning to show initiative in its approach to training. Prime Care Community Services Limited ("Prime Care"), a domiciliary care company in East Sussex, for example, has always made training a fundamental part of its business. Their courses are all provided internally through a dedicated in-house training team of NVQ assessors, and staff are

paid for training and supervision time. Supervision and monitoring is seen as an important aspect of training and development and is delivered via a rolling monthly programme for all care staff. Additional leave is allowed to enable staff to complete their preparation for NVQ assessments. Prime Care also recognises the stress of care work and provide a free and confidential counselling service for all their staff. They report very low turnover of staff and take the approach that increased expenditure on training is directly linked to greater retention and decreased selection and recruitment costs. Prime Care were recent winners of the Sussex Business Awards as the best staff development and training company across all sectors in the counties of East and West Sussex, following an audit by the Sussex Learning & Skills Council. .
Contact – Steve Allan of Prime Care on 01273-677314, help@primecare.uk.com

Chapter Three

COSTING DOMICILIARY CARE

By 2002 some 64% of domiciliary care funded by local authorities was provided by independent sector organisations. The lower cost, as well as comparative flexibility of service offered by independent organisations, has made externalisation of home care services attractive but there are now indications that the discrepancy between the costs of in-house and externally provided domiciliary care are reducing. Purchasers are having to review the prices they are prepared to pay and are anxious that increasing home care prices are justified. Best Value reviews will also look critically at costs in relation to quality.

Recent (2002) estimates of home care costs were £16 per hour for in-house services. When independently provided services were added to the analysis, the unit cost reduced to £12 per hour. Clearly therefore the prices being paid for independent care are considerably lower. Figures indicate prices between £9.30 and £10.50 per hour⁴⁵.

Background and key factors leading to pressure on prices

Both independently provided and in-house care services are feeling the pressures. Cost and quality was one of the recurring themes in the submissions to The King's Fund Care and Support Inquiry – *Future Imperfect* (2001). The report commented that there was a striking consensus and that the key themes transcended differences that might have been expected between different groups.

Independent sector providers of home care have traditionally charged for their services at rates which are low relative to the costs of such services provided directly by local authorities⁴⁶. Despite changes in employment law and other pressures on workforce costs which have, to some extent, been recognised by price increases, rates have still not reached the necessary level to cover the real costs of providing the service and to give a reasonable margin to allow for risk or to enable a realistic return on the capital involved in providing the service..

In-house teams in many areas have experienced changes designed to make them more competitive in the market. For some this has meant reductions in guaranteed hours, changes in terms and conditions, restructuring of services. Much in-house provision has now been externalised

⁴⁵ The mean hourly cost of local authority home care is based on PSS EX1 2001 uprated by the PSS Pay and Prices Index. Calculation of the hourly cost of independently provided home care was drawn from a study of 155 personal home care providers in 11 different local authorities in 1999. This has been uprated using the PSS Pay Index. Quoted in: *Unit costs of Health and social Care 2002* A. Netten, PSSRU, University of Kent. In discussion Ann Netten agrees that these figures are not very robust and that the real cost of local authority home care may well be considerably higher.

⁴⁶ When local authorities first started to purchase home care, agencies went into the market at prices similar to those they had charged private clients, where the objective was to match up people who wanted part time flexible work with other people who needed and wanted a flexible service. Providers had little idea of the additional costs associated with supplying services to such authorities, nor of the real costs of establishing and maintaining the large workforces needed to deliver services under contract, in particular the increasing need to pay staff for non-contact hours. The belief was therefore established that home care could be provided cheaply by independent providers and it has proved extremely difficult, over the years, to raise prices to a more appropriate level. Indeed, often rates have been negotiated even lower by authorities who argue the benefits of economies of scale. Margins in the independent sector are very low and some major home care provider organisations are currently struggling to survive, with one already disinvesting from home care provision.

Key reasons for cost increases

Workforce costs

Europe-led changes in employment legislation over the last five years have added considerably to costs. Key among these are the requirement for holiday pay, the Working Time Directive, minimum wage legislation etc. On top of this, demographic and economic change resulting in shortages of labour have presented challenges to the care industry generally, particularly in areas where there is competition from retail and other developments which provide comparable, and possibly more attractive, opportunities for work. The demands on home care workers: to work at non-social hours; often fragmented assignments; rigid and unsatisfying work schedules; and, in the independent sector - unpaid time spent travelling between service users; insecurity of income – to name but a few, have led to an unprecedented crisis in recruitment and retention. A further point is the extent to which domiciliary care has changed over the last 10 years. Even people who are very highly dependent are now being cared for at home and this trend is continuing. Eligibility criteria reinforce their position as the prime focus for services. What was primarily a domestic service is now a highly technical and sensitive personal care service for which staff need to have specific skills and to take on considerable responsibility. To attract and retain a workforce of this calibre, domiciliary care providers must offer major improvements in terms and conditions.

Regulation

Regulation is imposing new costs on the industry. Training and supervision are thought to be the two major cost drivers, but registration fees, the development and implementation of QA systems, cost of CRB clearance for the existing workforce and many other aspects of the National Minimum Standards are also adding to costs. Initially providers also found that they had been given false assurances – they had to bear the cost of initial registration and an annual inspection in the first year (for every branch office) when they had been told that these would be spread out over the first two years. They are also faced with much higher costs for CRB checks than they had anticipated. Providers are anxious to obtain increases in fees which allow them to meet the requirements of regulation. Purchasers will have concerns that demands for higher fees are genuinely necessary and are employed for this purpose.

Non-contact hours

One of the chief reasons for the cost discrepancy between in-house and externally provided services has been the extent to which in-house staff have been paid for non-contact time, ie time which is not spent in service provision. Staff in the independent sector, on the other hand, have tended to be paid only for the time they were working with a service user. Increasingly non-contact time is now also having to be paid in the independent sector. This is likely to be primarily for:

- time spent travelling between service users – more with increasing numbers of very short visits
- time spent training
- time for supervision
- guaranteed time

One of the complaints about services is that care workers do not always stay with the service user for the full length of time expected. This is clearly unacceptable but it can result directly from intense pressure on services to 'fit another service user in' to an already full schedule,

coupled with the failure to allow for, and pay for, travelling time. The introduction of electronic timesheet systems is providing validation of arrival and departure times, as well as many other potential benefits and cost savings, in some areas.

Best Value

Best Value has also led to focusing on costs, with claims that higher costs can be justified by a better quality service and, on the other hand, anxiety that Best Value may be interpreted merely as lowest price. Some independent providers are particularly concerned that the prices they are able to command do not allow them to provide a service which might be judged as the best value.

It is certainly true that there are large variations in the prices being paid for, on the face of it, similar services. This applies to both in-house and independent services. Closer analysis may reveal that the differences are largely related to type of service with premium rates being charged for some very specialist services. Higher than average prices may also be associated with extreme difficulties in recruiting and retaining staff, particularly in relatively affluent areas where there are plenty of opportunities to obtain other, more attractive, work. Higher prices may also reflect the fact that a local authority has recognised and is reflecting the costs of travel in the price they pay, compared with others who have not. What is clear is that there is not likely to be a direct relationship between higher price and better quality.

On the other hand, although reviews have found no close correlation between price and quality, there is a threshold below which it is not possible to produce a quality service, primarily because of the impact of low price on the workforce. Organisations which are not able to secure a realistic price will not be able to provide security of income for their staff, nor to pay them for time spent travelling and the consequent rapid turnover in staff will inevitably lead to unreliability and a lack of continuity (as was seen all too clearly in the Panorama programme in 2003). Some evidence of the effects of very tight margins can be drawn from research which showed providers in the independent sector able to survive in home care only by cross subsidising from other services or by reducing wages and administrative costs^{47,48}.

The King's Fund report again – *"The conclusion is unmistakable that the requirement to bear down on costs has led to a damaging preoccupation with price at the expense of quality. We accept that the concept of Best Value is intended to address both cost and quality issues. However, the evidence to the Inquiry demonstrated repeatedly that cost control has left virtually no room for further efficiencies. In some instances, the impact on service quality is threatening the continuation of the social care market. There is a point at which the parallel objectives of securing continuous improvements in service quality, while also making efficiency savings, generate conflicting tensions."*

⁴⁷ Matosevice T, Knapp M, Kendall J, Forder J, Ware P, Hardy B (2001) *Domiciliary Care providers in the Independent Sector* Discussion paper 1605 from Mixed Economy Programme (PSSRU and Nuffield Institute for Health) Based on interviews with 155 providers 12.5% had to cross subsidise and 25% could only achieve costs equal to income by reducing wages and administrative costs.

⁴⁸ Henwood M, (2001) Delivering quality – an ambitious agenda, *Quality Matters: striving for excellence in home care* Report for Help the Aged Conference 13th June

Information on the costs of services

1. The Personal Social Services Research Unit (PSSRU) at the University of Kent and LSE is a key source of data. They publish annual detailed reports on the unit costs of Health and Social Care. www.pssru.ac.uk/UC2002htm
2. A number of local authorities have also undertaken reviews of home care costs. Hampshire for example moved from price negotiation based on just an inflation increase to recognising that providers had other additional costs that in certain circumstances needed to be taken into account. They therefore awarded above inflationary increases which sometimes meant up to 25% for specialist services or where certain conditions applied.
Contact: Claire Foreman 01962-847208, claire.foreman@hants.gov.uk
3. Secta Ltd (previously Starfish Consulting Ltd.) in conjunction with the ADSS run performance networks (previously known as benchmarking clubs) in a number of areas. This started in Greater London in 1998 and has now spread to involve a total of 70 authorities, including the South Eastern, the Eastern and the West Midlands ADSS regions. CIPFA financial data which was, at that time, used to calculate unit costs of services was the basis for the initial work. PAF data has now largely replaced the CIPFA data and the focus is on wider performance management matters. There have been several projects on home care:
 - Unit costs – analysis of the constituent costs
 - Cost-influencing factors, eg staff productivity, training and supervision, etc.
 - "Intensive" vs. "Non-intensive" home care
 - Commissioning costs of Home Care – internal vs. external provision costs

Contact: Simon Adams 020 8673 7888, simon.adams@secta.co.uk

4. The UK Home Care Association (UKHCA) have received financial support from the Department of Health through Section 64 funding to undertake a thorough analysis of the costs of providing home care services. From this a costing model has been produced which can be used in a variety of ways:
 - to produce a 'reasonable' unit cost in a specific area or region
 - to produce a unit, or range of, cost(s) for a specific service
 - to produce a national average 'reasonable' unit cost
 - it will provide an opportunity for benchmarking nationally, regionally and locally once the model is being used extensively

This model should be useful both to individual home care organisations and to the industry more generally. It will provide a more reliable basis for judgments about best value. It will help commissioners to understand legitimate costs. The government will have a clearer yardstick by which to assess whether or not authorities are being funded at an appropriate level to enable them to purchase the necessary volume and types of home care support. Perhaps most important of all, the model will introduce some transparency into the whole question of costs and funding.

An Expert Group with representatives from a wide group of key stakeholders, including both independent and public sector providers, leading health care analysts, government etc. steered the project and input was also sought from a number of providers. The model was developed by Starfish Consulting, well known for their work with the LGA etc. The model was tested in a number of sites which comprised a range of different types of provider organisations such as: a large voluntary organisation; a small private agency in a rural area; an in-house service; etc., seven in all. The first, and major, stage of this work, which effectively enables organizations to analyse current costs and establish credible unit costs, was formally launched at the ADSS conference in Brighton in October 2003. The second stage of the work will add to this model to enable organisations to achieve viable costs and prices for planned service development. The costing model is available FREE. Over 800 organisations were using it by October 2004, including a number of local authorities. Some work is being undertaken on validation in Kent, overseen by Ann Netten from PSSRU, and an evaluation of the model is planned. **Contact:** Kim Grove 020 8288 1713

Complexities of cost

Domiciliary care is a far more complex service to cost than residential or nursing care. (Even though Starfish Consulting had already been involved in benchmarking with local authority providers, they expressed considerable surprise at the number and extent of the variables which had to be taken into account in developing the costing model for UKHCA). Some of the complexities are suggested below but these are not exhaustive:

Care workers' wages

Variations reflecting time/day may run to 12 or more different pay rates; part hours (cost usually not derived pro-rata from the hourly rate); as time goes by increasing proportions of staff will have NVO2 and will be paid at enhanced rates; senior carers or team leaders may spend part of their time on direct service provision and part performing a management function. Travel costs for care workers will be affected by the rural or urban nature of the area served and by the number and length of service visits. Below are some suggestions:

- consider commissioning on the basis of localities so that providers can use staff more cost-effectively and cut down on traveling time and costs – and so that they have the confidence and ability to develop the workforce for that area with some expectation that they will be able to provide enough work and at least some guarantee of income (larger providers could take on more than one contiguous locality, this would also enable smaller providers to stay in the market).
- specifications for services should include indications of the volume of service to be provided at non-social hours – otherwise organisations preparing tenders may try to minimise risk by basing calculations on an over-estimate of the number of such hours.
- for similar reasons providers will need to know what proportion of visits would be likely to be for part hours
- consider moving to a Wages-Plus basis for purchasing home care which could have a big impact on providers' ability to attract and retain an adequate workforce (*see Chapter 2 for a more detailed description of this approach*)
- consider responding to the demands for more complex skills and expertise by introducing a banding system which rewards those who are competent to provide this level of care

Non-contact wage costs

Will relate to: guaranteed work (which may vary between individual care workers); training time, supervision time; travel time between service users (which will vary between individual care workers and vary from week to week); paid breaks; booking errors etc.

Management

The main complexity of management costs relates to the extent to which specific management functions are centralised, or devolved to branches (in larger organisations) – and whether or not costs of central management are identified and allocated to branches. In organisations which provide other services such as residential care, as well as home care, there may be no clear analysis or allocation of the costs of the human resource function, marketing function etc. Another factor which will affect management costs is the level of administrative and other support provided for managers. Because the model will also need to deliver information on the resourcing of specific functions, such as training, the facility to breakdown by function is necessary.

Monitoring requirements and other transaction costs

Transaction costs fall on both providers and purchasers/commissioners and they are rarely fully taken into account despite the fact that they can have a big impact on costs. It is in the interests of both sides to consider how these can be minimised. Below are some suggestions:

- agree standardised monitoring requirements, invoicing formats etc. with other authorities and ensure that the documentation required is not additional to the reports which should be produced by any efficient organisation to monitor their progress
- pay promptly – helping providers to reduce their borrowing costs
- requiring providers to collect and account for service users' charges, or to supply timesheets with each invoice, or to administer complex accounts where the costs of service are shared between different funders, will all increase costs
- agree referral protocols which minimise the duplication of work by care manager and by service manager
- build in some flexibility to service specifications/care plans so that providers can provide additional support to a service user when there is a particular need, or can change the day or time of service provision in response to a service user's preference, without having to negotiate authorisation.
- consider moving to an outcomes-based way of working, giving providers more autonomy and reducing the day to day interaction at the interface between providers and purchasers (see Chapter 4)
- offer joint training opportunities or training resources

Intensity of service and turnover of service users

Each additional service user adds cost, through briefing and management of staff, reviewing service, liaising with care manager and other key individuals, maintaining records, invoicing etc. Thus winning a contract to provide 1000 hours of care per week is likely to be very bad news if it involves 1000 service users each receiving one hour of help, but very good news if there are only 100 service users each receiving 10 hours of help. Rapid turnover of service users also

adds cost. Each new user will require a home visit from the manager, health and safety assessment, documentation to be set up, staff identified and briefed, possible changes in work schedules to accommodate the new assignments, etc. These two factors are some of the reasons why there can be no direct relationship between increased volume and reduction in unit cost.

- Because of the current pressure on residential places people are often now supported for longer in their own homes. However because of increasing frailty they may be subject to frequent short term hospital admissions and/or periods in respite care which can make it very difficult both to plan and to provide services. One means of securing the reinstatement of a service would be to pay a retaining fee to the service provider, perhaps for a limited period

Fixed or variable costs

The other reason why economies of scale are not necessarily achievable within domiciliary care lies in the extent to which costs are fixed or variable. Analysis suggests that relatively few of the components of the cost of providing the service are truly fixed. Even the office from which the service is managed, usually considered a fixed cost item, may not suffice as additional management staff have to be taken on. Labour, which comprises by far the largest part of the total unit cost, inevitably increases in direct relation to increased volume. Provider organisations will vary in the extent to which they have the ability to expand capacity without incurring additional costs but most are working with such small margins that they will have reduced any unnecessary overhead expenditure, so that increased volume is likely to lead to additional infrastructure and management costs. Factors such as these introduce further complexity into the costing of domiciliary care and will largely be taken into account in the second stage of building the costing model.

Commissioners need to obtain value for money and to pay a fair price for the services they are commissioning. This chapter seeks to identify and explain the main factors which lead to demands for increased prices for domiciliary care. Because those demands will come from independent providers, the document has mainly focused on the pressures that sector is currently facing in terms of costs. It may, however, have suggested some areas of comparability with in-house service costs and has provided information about a new costing model which has the potential to enable much greater transparency and comparability in domiciliary service costs.

In addition to the current pressures on costs there is also an overriding agenda to increase the capacity of mainstream services to support people in their own homes. So far specialist services such as Intermediate Care projects, rehabilitation schemes, generic health/social care teams etc. which are largely being joint funded, have only rarely been commissioned on the basis of open tendering, so independent providers have had little opportunity yet to get involved or to demonstrate that they are capable of contributing to these more innovative ways of working. It is important that this changes and that all providers develop better ways of working across organisational boundaries in order to develop a wider and more flexible range of integrated services to support people in their own homes.

There is little expansion at present and unless providers are able to obtain realistic prices which really cover their costs (including the additional costs of building up a viable and skilled workforce and, where appropriate, the higher costs associated with specialist services) and offer a reasonable margin for surplus or profit, expansion will not happen.

Chapter Four

OUTCOME BASED WORKING IN DOMICILIARY CARE

Introduction

There is a lot of talk about developing outcome-based approaches in social care, however there is still considerable confusion about what this really means in practice. The concept has so far only rarely been applied in useful or meaningful ways despite the fact that recording of outcomes is an important aspect of demonstrating the effectiveness of social care. Increasingly authorities are exhorted to move in this direction but are not clear about the implications and lack information about, and access to, the available resources.

Increasingly national policy objectives are expressed in terms of the outcomes they are intended to deliver for service users. For example, the National Service Framework for Older People, Intermediate care, Modernising Social Services and Valuing People. An outcome-based approach is relevant to much of what social services do but the use of outcomes as a basis for working in domiciliary care has particular potential:

- **In contributing to more person-centred services** - a way of moving from common over-rigid prescription of tasks and times to a service which is able to respond to users' changing needs and preferences based on outcomes identified by service users and agreed by practitioners
- **In providing clarity of purpose** – an outcomes-based approach encourages clarity about what it is that services are trying to achieve for service users. People working in this field have noticed that the thing that often excites staff about the outcome-based approach is that for the first time in their careers, they are clear about the results they are trying to achieve
- **In setting out the expectations for partners in working to achieve outcomes** – well-crafted statements of the desired outcomes of partnership work can help build a shared purpose – both at an operational and at a strategic level
- **As a positive means for promoting independence** - Outcomes may be about maintenance or about change. Where the desired outcome is about change this is likely to be a very effective way of promoting independence - ensuring that efforts are focused on the outcomes which have been agreed as significant by individuals and by local/central policy
- **In providing information to judge the effectiveness of services** – through enabling routine evaluation of the service user's perceptions of services and the achievements of services. Using this information to develop management information which helps staff understand "what works" and supports evidence based planning for continual improvement
- **In assisting in recruitment and retention of home care workers** - through making the work more fulfilling and satisfying

Not only is flexibility and responsiveness a required standard for regulation, it is also identified as an important aspect of quality by service users (see Chapter 5). In addition the main

problem impeding growth in capacity of home care, i.e. recruitment and retention of staff, will be partially eased by an outcome based service which enables staff to work in a more responsive and responsible way (see Chapter 2).

Outcomes are likely to be time-limited or, even where they are about maintenance, monitored on a regular basis. Having agreed the outcome and an appropriate budget the aim should then be for the service provider to negotiate the day to day details with the service user and to have sufficient autonomy to respond flexibly to the user's needs and preferences. Thus the key relationship should be between provider and service user, rather than between provider and purchaser.

One of the local authorities working with the Social Policy Research Unit (SPRU) at York University has been working on developing an outcome-oriented approach to service improvement⁴⁹. They have found that focusing dialogue on outcomes is a useful way of engaging support staff, such as Finance, Training and Human Resources, Information Systems and so on. Key to this is using everyday language to describe statements of desired outcome, familiar to older people and other service users. For example an outcome which is maintenance oriented might be "keeping active and alert" (rather than "maintaining physical and mental functioning within the limitations of resources").

So long as outcomes are used in a way which is meaningful for service users this can be a very effective way of involving them in thinking and planning for their own services

What do we mean by Outcomes?

An outcome-based approach may be seen as too close to the medical model and the situation of individuals needing social care support as too complex or varied to lend itself easily to a very specific approach. The development of a useful conceptual framework by York University⁵⁰ offers clarity and a way forward.

The framework distinguishes between maintenance and change but also recognises the importance of the way in which services are delivered. Some examples might be:

Maintenance:

Feeling fresh and clean

In order to achieve this outcome the service provider would be expected to negotiate with the user and agree what help was needed, within an agreed budget. Rather than specifying a bath or shower on a certain day each week, the service could respond more flexibly to the user's needs and preferences.

Change:

Improved ability to get about

Although domiciliary care might have a role in helping to achieve this outcome, it is likely that there would be a multi-disciplinary approach which might involve adaptations, equipment, physiotherapy or mobility

⁴⁹ North Lincolnshire – see contact details at end of chapter. Also Ball S, Mudd J, Nicholas E, Oxley M, Pinnock M, Qureshi H (2004) *Make Outcomes your Big Idea: Using Outcomes to Refocus Social Care Practice and Information*, Journal of Integrated Care: Vol.12: Issue 5, October

⁵⁰ Qureshi H & Nicholas E, (2001) *A new conception of social care outcomes and its practical use in assessment for older people*, Research, Policy and Planning 19.2 11-25

training etc. The key point is that all members of the team are focused on achieving the agreed outcome for the individual.

Some change outcomes will be more specific, (including possibly time-specific) for example: **Regaining the skills and confidence to prepare a simple meal within a 4-week period.**

Service process:

Feeling valued and treated with respect

This outcome is likely to mean different things to different people. For example, for some it might mean that the service is culturally sensitive, for others that they are treated with warmth and friendliness, or that the service is reliable. Setting service process outcomes may only be possible once the user has already received some service. Both the staff (attitudes, competence etc) and the logistics of the service provider organisation will affect the ability to achieve this outcome.

Service users themselves, from a variety of user groups, also defined the process of accessing the service as an outcome. This suggests that there is a possible need for standard setting around access to, and eligibility for, services⁵¹.

It is likely that purchasers will also have a range of corporate outcomes that they want delivered, for example:

- a decrease in the numbers admitted long term to care homes
- a decrease in the size of care packages over time
- a more effective means of monitoring independent service providers
- the achievement of regular and timely care package reviews

What is important is that these corporate outcomes are not allowed to conflict with the individual outcomes upon which each care plan should be based.

An example given in SPRU's resource pack (*details below*) of an outcome approach to hospital discharge:

- For (name of user) to return home
- For help to be clean and comfortable and to have a varied diet at suitable times of the day
- For (name of user) to feel safe in her home
- For there to be sufficient human contact through day and night
- For (name of user) to have, as far as possible, choices in relation to who provides support
- For risks in relation to pressure areas to be minimised
- For (name of user) to be transferred in a way that reduces the risk of physical harm to herself and others
- For (user's) confidence and morale to be improved

⁵¹ *Social service users' own definitions of quality outcomes* (2003) Joseph Rowntree Foundation (JRF) Findings

Moving to Outcomes

Barriers to implementation

- Conceptual problems
- The difficulty of moving from focusing on needs and services to focusing on desired outcomes
- Workload and existing demands for recording
- The demands and pace of other national changes in policy and practice
- Need to find resources for training, briefing, analysis and reporting
- Lack of a Project Manager – this is key to achieving change
- Lack of trust between commissioners/purchasers and service providers
- Capturing data that can tell us something about progress towards desired outcomes
- Lack of a common language around outcomes

Key resources for outcome working

The Social Policy Research Unit (SPRU) at the University of York has been the main resource for those seeking to implement outcome focused work. Professor Hazel Qureshi (now retired) initiated and carried through a programme of research and development in partnership with two authorities, which was designed to address at least some of the barriers. The concepts have been thoroughly thought through and five researched development projects, between them, got to grips with many of the practical problems of applying the ideas in practice. The projects illustrate practical ways to:

- Support care managers in summarising and recording intended outcomes for older people as part of assessment
- Brief front-line home care providers about intended outcomes, user preferences and required actions
- Use an outcome focus and research-based structured tools to improve practice and recording during assessment and review with carers
- Develop a feedback survey of users of equipment and adaptations, including questions about outcomes
- Organise and run a programme of “customer visits” to enable senior managers to see first hand the outcomes of services and discuss them directly with service users

Short reports on all the above projects can be found on the web at www.york.ac.uk/inst/spru/

A further programme of research and development has been funded by the DH and is underway at SPRU (2001-2006). One of the key areas of focus for this work is **flexible person-centred home care for older people**. *For more details see the SPRU website (at above address)*

Resource pack

An excellent and comprehensive resource pack is available from SPRU⁵².

The pack is in 2 sections:

Understanding and using outcomes in social care

Including:

- Why focus on outcomes?
- Defining outcomes in social care
- Outcomes focused care management
- Outcomes information
- Making it happen

Resources for training and development (ring binder + CD – can be photocopied)

Including

- Sample programmes
- Presentation materials
- Exercises
- Handouts
- Practice tools

The SPRU Resource Pack can be obtained from York Publishing Service. It costs £90 plus £4.20 p&p (20% reduction on orders of five or more resource packs). For more details of the pack and how to purchase, see the SPRU website: www.york.ac.uk/inst/spru/

Outcomes into Practice network

In addition there is an informal network which aims to build on the links set up between those authorities taking part in SPRU's research and subsequent work so that others interested in, or developing outcome focused working, have access to support and can share information. The Outcomes into Practice Network is to become independent of SPRU from January 2005 (future arrangements still to be confirmed)

Contacts:

Authorities either involved in the SPRU projects or currently moving towards a greater focus on outcome based working:

Medway – Medway has produced a specification for home care services based entirely on outcomes and have commissioned locality-based services in which assessment and service provision reflect the new specification. Training has been provided for care managers, service providers and care workers and the new contracts commenced in April 2004 – **contact** - Amanda Rogers - amanda.rogers@medway.gov.uk

Hartlepool – Hartlepool have now awarded contracts with a specification focussing on outcomes for service users and giving care managers options for agreeing flexible individual contracts with the service provider. It is anticipated that the level of flexibility offered will

⁵² Full reference: Nicholas E, Qureshi H, Bamford C (2003) Outcomes into Practice: Focusing practice and information on the outcomes people value. A Resource Pack for managers and trainers. York: Social Policy Research Unit, University of York

increase in proportion with the level of trust as positive relationships develop. Further work will continue to support providers in their efforts to empower care workers through training and development. A significant piece of work will be undertaken during 2005 to evaluate the impact of the new arrangements, which are already producing positive results. The setting up of a user reference group and promoting user led monitoring and evaluation of the service will be a key element of this.. - **contact** - *Phillip Barker on 01429-523946, Phil.Barker@hartlepool.gov.uk*

Thurrock – Thurrock is moving towards implementing outcome based commissioning and purchasing for all their home care provision, both from in-house and independent providers started in August 2004. Two pilot projects, one with the in-house team and one with an external independent provider. They report that there is already some evidence of service users appreciating the increased flexibility and responsiveness of this approach. **contact** - *Carole Rainbird -carolerainbird@aol.com*

West Sussex – is planning to pilot an outcome approach in one area - **contact** - *Nigel Turner Nigel.turner@westsussex.gov.uk*

Bradford *Jan Burrows – jan.burrows@bradford.gov.uk* Care management and assessment. Much of SPRU's initial research and development work was done in Bradford.

Northumberland *Stephen Corlett – Stephen.Corlett@northumberlandcaretrust.nhs.uk* Outcome-focused community care standards (primary focus eligibility for support). A more recent scheme involves a home care team carrying out an initial assessment function based on achieving outcomes determined by the care manager.

North Lincolnshire *Mike Pinnock – mike.pinnock@northlincs.gov.uk* Outcome-based approach to performance review

Kensington & Chelsea *Carol Fletcher – carol.fletcher@rbkc.gov.uk* Outcome oriented purchasing in home care

Consultants able to support, provide training etc.

Acton.Shapiro – contact Phillipa Hare or Liz Newbronner on 01653 691351 or e-mail philly@actonshapiro.co.uk

Community Care Research & Consultancy – contact Lucianne Sawyer on 020-8788-5625 or Michael Heap on 01285 652732 or e-mail sawyer@dircon.co.uk

Chapter Five

WHAT SERVICE USERS SAY ABOUT DOMICILIARY CARE SERVICES

Background

Over the last ten to fifteen years there has been something of a seismic shift in both policy and practice for the domiciliary care service. No longer is it a predominantly domestic service offered, almost routinely, to frail older people and others, on a weekday. Even before the 1990 NHS & Community Care Act the policy thrust was towards supporting the most dependent through more intensive services providing mainly personal care tasks, in a bid to keep them out of residential or nursing home care. The Act gave local authorities the power and the funding to organise services to meet assessed needs in the most appropriate way and in order to keep people out of residential care this meant flexible round-the-clock services. More recently a further incentive to intensive service provision has been the Performance Indicator for social service departments which relates to the proportion of intensive domiciliary care provided (in relation to numbers in care homes or receiving non-intensive home care) with 'intensive' interpreted as 10 or more hours delivered in 6 or more visits per week. Although the number of hours of home care overall has continued to rise, the number of service users has fallen, despite increasing numbers of older people in the population. Recent demand pressures result from increasing government emphasis on domiciliary based care as the service of choice and the drive to reduce or eliminate delayed hospital discharges.

Another key change has been externalisation of provision. The Act required local authorities to become 'enablers', not only providing direct services, but also purchasing from private and voluntary organisations. By 2002 some 64% of all home care funded by local authorities was provided by independent organisations. Using independent provision has assisted councils to keep costs down and, indeed, has been very successful in 'managing the market' (seen as one of the key responsibilities of local authorities). Low prices, however, have contributed to the present workforce crisis, preventing capacity expansion to meet increasing demand.

Getting the views of service users

The most important measure of the success of a service is what the users of that service tell us about it.

- What is important to them?
- What do they want from the service?
- Does the service meet these needs/preferences?
- What is their experience about the actual delivery of services?

We may think the answer is fairly obvious – reliability, continuity, flexibility, kind and competent staff surely that's what everyone wants? But is it really as straight forward as that? This paper considers relatively recent research and service feedback findings in order to explore in more detail what older service users really want from home care services.

Getting this sort of information from service users in a domiciliary care setting is difficult. Care providers struggle to get valid feedback. Postal survey forms are not well received, and may often be completed by someone other than the person using the service (even the care worker in some cases).

The problem is particularly acute with older people (80% of users of domiciliary care) because, researchers tell us, older people may be reluctant to criticise for fear of losing the service or because they do not want to cause trouble for staff, or to be seen as a trouble maker. There may also be a culture in which people have low expectations^{53, 54, 55, 56}.

Personal characteristics and circumstances also affect people's views about the services they receive. Research shows that people who are in poor health or are depressed or lonely may well have negative views about services, whereas those who have good personal relationships and generally feel well may be more positive^{57, 58}. Also, as this chapter will show, people have different priorities. What is important to one older person will not necessarily be so important to another. User satisfaction is certainly complex and there should always be awareness of this in interpreting feedback surveys.

Also, although there is evidence that some service users do understand the context, generally they do not discriminate between concerns which rightly relate to the service provider and concerns about the service which relate to the context in which the service is delivered, including the commissioning of the service.

Having stated these reservations, many surveys report very high levels of satisfaction with domiciliary care services and there is a large body of evidence which very usefully provides a good deal of information on older service users' views and on the views of their family carers. This paper summarises their main interests and concerns.

- Getting valid feedback from people who are dependent on domiciliary services is difficult
- User satisfaction is complex and there should always be awareness of this in interpreting feedback surveys

⁵³ Williams G, Keating J, (1998) , Grateful for what you've got? *Community Care*, March 15, 1212, pp30-31.

⁵⁴ One way of obtaining feedback is to use other older people to talk to service users. This approach has been used in some research programmes successfully. Brighton & Hove commission a voluntary organization which recruits active elderly people to undertake regular visits to service users for this purpose and report that this is both popular and effective (Contact: Malcolm Price, Malcolm.Price@brighton-hove.gov.uk).

⁵⁵ The value of focus groups has been found to be efficient and not to generate different ideas from individual interviews (Raynes N, Temple B, Glenister C et al (2000) *Quality at home for older people: Involving service users in defining home care specifications*. Joseph Rowntree Foundation. Policy Press)) however other researchers found that those of 80ys and over did not tend to come to focus groups (Patmore C, Qureshi H, Nicholas E (1999) Tuning in to Feedback, *Community Care*, 24-30 June, pp28-2). It is clearly important that the very dependent housebound service users are able to contribute their views. Other groups often not represented are those with dementia, those from minority ethnic groups, older people from widely dispersed rural communities

⁵⁶ Despite the stated reluctance of older people to criticize, managers were found to be effective interviewers and benefited through getting views of a cross section of service users and learning about how services worked on the ground (*Research Works* – quoted below). In another study a range of staff were trained to undertake interviews with service users for whom they had no part in providing a service. This also worked well and was appreciated by both service users and staff (Herbert G, Sawyer L, Townsend J, Mathew D – unpublished, 'Listen and Learn' exercise, part of a larger development project undertaken in two local authorities promoting user-centred support for older people, Nuffield Health Institute/Joseph Rowntree Foundation (forthcoming))

⁵⁷ *Research Works: Learning from older community care clients* (November 2000) Social Policy Research Unit, University of York.

⁵⁸ Cheslerman J, Bauld L, Judge K, (2001) Satisfaction with the care-managed support for older people. *Health and Social Care in the Community*, 9(1), pp31-42

- Service users may not discriminate between concerns which relate to service providers and concerns which relate to the context, such as commissioning or resources

Potential for conflict between policy and older people's views

There are some areas where policy potentially conflicts with older people's priorities and preferences. For example the requirement to promote and support independence may get a mixed response from service users since some will feel that the role of home care is to do things 'for' them, not 'with' them (particularly as they are being charged for the service). The authors of one study suggest that a 'sea change' in opinion is required before service users are persuaded of the virtue of the 'enabling' ethos⁵⁹. This does not apply to all older people, however, and some want a service which supports them to care for themselves. Other research, and particularly evaluation of some of the newer Intermediate Care services, may begin to show a different picture. We need to:

- be clear about what we are trying to achieve - educating both public and service users re benefits of independence
- understand that only some people will improve or become more independent – for many it may be more about maintaining their level of independence as long as possible
- be clear about the difference between short term intervention programmes and longer term services when we are discussing options with service users

There are other areas where policy potentially conflicts with older people's priorities and preferences, the wish for domestic help being probably the highest on the list.

What makes a quality service?

There are differing views about what is important in terms of quality. The range of quality concerns identified and replicated by many researchers, set out in this paper are not disputed but caution is needed in applying them to any specific individual because of the part that personal preferences play in determining the relative importance of specific qualities. Some of the work on outcome-based approaches to domiciliary care has been able to make use of this to ensure that the stated outcomes for a service reflect the individual user's priorities in terms of quality rather than global views of a quality service. Also because this paper is specifically about what makes services better, or worse, for the service user it inevitably reports concerns or causes of dissatisfaction. The reader needs to remember that in most cases these concerns are expressed by only minorities of those in the samples.

A priority for older people (and for younger people whose health and mobility are impaired) is to be in control of their lives and to have choices about how they live. The health and social care

⁵⁹ Francis J, Netten A, (2002) *Homecare services in Medway: Client and provider views*, unpublished Discussion Paper, University of Kent

system is complex and confusing. Home care is greatly valued because it enables people to stay in the familiarity of their own homes^{60,61}.

Adequacy

Getting an 'adequate' service is important – that means both getting enough and that it is value for money. Some people may have family or friends who meet some of their needs, or may use other services, such as a lunch club, but others may rely on home care to meet virtually all of their needs. The extent to which the home care service 'fits' with other aspects of the user's life, for example with visits or help from other family members, or with cultural and religious preferences is another aspect of the service which users value⁶². Issues of adequacy are discussed in greater detail below.

- Assessment should involve older people in identifying their own needs and what is most important to them
- Care plans need to be flexible
- Training for care workers must include learning about cultural needs and preferences

Adequacy of service, and timing of visits

Lack of time

One of the most frequent complaints about home care services nowadays is that staff are in a rush⁶³.

Users say that they don't have time to talk or that their care workers seem in such a rush that they cannot ask them to do anything other than basic necessities and even then tasks have to be skimped⁶⁴. In some cases shortage of time in which to undertake complex personal care tasks could well lead to danger for the user or, at the least, low standards of care. Care workers are concerned that they cannot 'go at the user's pace' and of course, in terms of promoting independence, rushed staff will tend to 'do for' rather than 'do with' because the latter takes longer. Users appreciate that care workers have to hurry because they had other clients waiting for them, but nevertheless care workers being rushed is also frequently a source of dissatisfaction⁶⁵. Service managers report that time allocations could often be unrealistic and needs assessments inappropriate⁶⁶.

⁶⁰ Qureshi H, Henwood M, (2000) *Older People's definitions of quality services*. Joseph Rowntree Foundation, Policy Press.

⁶¹ Hardy B, Young R, Wistow G, (1999) Dimensions of choice in the assessment and care management process: the views of older people, carers and care managers. *Health and Social Care in the Community*, 7 (6) pp 483-491.

⁶² Qureshi H, Henwood M, (2000) (Ibid.)

⁶³ Henwood M, Lewis H, Waddington E (1998) *Listening to users of domiciliary care services: developing and monitoring quality standards*, Nuffield Institute for Health and UK Home Care Association. Workers being in too much of a hurry was one of the key dissatisfactions of service users.

⁶⁴ Sinclair I, Gibbs I, Hicks L, (2000) *The Management and Effectiveness of the Home Care Service*, Social Work Research and Development Unit, University of York

⁶⁵ Durand MA, Jowett S, (2001) Best Value Case Study: Commissioning research on the views of older service users. *Managing Community Care* Vol.9, Issue 5, pp25-35

⁶⁶ Francis J, Netten A, (2002) Ibid.

There is a difference between care workers who are rushed because very little time has been allocated for the visit and care workers who are not staying for the full allocated time. The latter is much disliked, especially since the service user is being charged for the visit. The literature contains surprisingly few mentions of this problem but there is much anecdotal evidence. It would be surprising if it did not happen, because of the demands made on agencies and because travelling time between users is often not allowed for (and not paid).

Another aspect of adequacy, related to the shortage of time available, is the focus on personal care at the cost of domestic tasks and on time available for emotional support and other more general roles. Older people had strong views, particularly on the importance of help with cleaning. This will be discussed in more detail under Flexibility and Responsiveness, below.

Budgetary pressures, as social services are trying to support increasing numbers of older people, can lead to minimum time allocations. Also the thrust for independence dictates that services should only provide what is necessary to support an individual in making the best use of their own capacity. The problem lies, in the latter case, in getting this judgment right, especially where there has not been sufficient input to enable the person to regain confidence and skills. There is also the issue of cost effectiveness, since increasing numbers of shorter visits – unless they are within a very concentrated area – will inevitably mean that much valuable care worker time will be spent traveling between service users.

- The cost of travel and travel time must be taken into account in determining the price paid for home care
- The time taken to achieve essential tasks should be realistic and allow for assisting the user to help themselves and for unforeseen circumstances such as delay in obtaining entry to the user's home, difficulty persuading someone with dementia that it is time to get dressed, the need to help a user more than usual because they are unwell or because their medication has not worked (as can happen with Parkinson's disease)
- IT systems which record arrival and leaving times of care workers could be used

Timing of services

Users often have little choice about the times of services. Such decisions are usually agreed at assessment.

The times at which services are delivered can be very important, but only to some users. For someone who has to be up, dressed and breakfasted in time for transport to the day centre, timing is crucial. Medication may have to be taken at a specific time, and there may be other needs which dictate the times of visits. More generally, if people are dependent on help to get up or get to bed, then it is likely to be important to them that this service fits in as much as possible with their normal lifestyle.

- Service users should be able to state what their own priorities are
- Referrals must specify where service time is crucial and the appointed provider must be one who is able to meet this specific need
- Providers must then ensure that monitoring arrival time for these users is part of their quality system

Reliability

Whilst the service user's ability to influence the time of service can be important, what seems far more important is whether or not the care worker actually arrives at the agreed time.

- Unreliability is one of the things most often mentioned as a cause of dissatisfaction⁶⁷
- Reliability is particularly important for people who may be very physically dependent and who have few, or no, contacts other than with support staff
- Some people will feel that their ability to retain control over their lives is compromised when carers arrive late, or don't turn up⁶⁸
- Service users may be at serious risk if a visit is missed altogether

About half the users and carers in one study rated reliability as an important quality. Some people said it was more important to know their home carer would arrive at some point in the day, rather than at a precise time⁶⁹. Older people also offered views as to why their care workers did not always arrive at the planned time and were aware of the pressures they were often under⁷⁰.

- those for whom reliability is crucial or important are identified – one way of achieving this is through adopting an outcomes-based approach
- the achievement of reliability targets is monitored
- providers must allow time for travelling between user visits and travelling time must be paid
- the time allowed for service visits must be realistic
- contracts for services based on localities may reduce travelling between users

Continuity of care

Advantages of continuity

Another key quality for service users is that they have a regular care worker, or care workers. Having to explain over and over again what is to be done, how they like it done, where equipment is stored etc. to a series of new care workers is very wearing⁷¹. Competence and confidence are both likely to increase as a worker gets to know a regular client. Conversely, frequent changes of worker will mean disrupted routines and less confident staff. Opening the door to strangers (even with ID cards) is a source of anxiety and the importance of informing users that there will be a change of worker, and the name of the replacement, cannot be over emphasised⁷². Too many changes could also be felt to be an invasion of privacy.

One study describes the importance of 'keeping an eye' on clients. This might mean signs of developing pressure sores or that their health was deteriorating in other ways. It might mean that they were becoming forgetful, or that there was little food in the fridge, or that they were experiencing increasing difficulty in getting around, that their home was very cold, or that they

⁶⁷ Henwood M, Lewis H, Waddington E (1998) (Ibid.)

⁶⁸ Francis J, Netten A (2002) Ibid.

⁶⁹ Francis J, Netten A (2002) Ibid.

⁷⁰ Service users in this study recognized that there was usually a good excuse for care workers not arriving on time, for example they could be delayed by traffic or by an emergency with the previous person. They also suggested that care workers were required to make too many visits in too little time over unreasonable distances. (Francis J, Netten A, (2002) Ibid.)

⁷¹ Raynes N, Temple B, Glenister C et al (2001) (Ibid.)

⁷² Raynes N, (2002) At Home with Quality, *Community Care*, 7-13 Nov.

were unusually silent. The ability to identify these worrying signs and to act on them depends crucially on familiarity⁷³.

Positive relationships between service users and care workers

There are many examples in the literature of very positive relationships which are clearly a major source of satisfaction for both service user and care worker. These relationships are built up over time and only happen where there is continuity of care.

Despite the importance which both service users and care workers place on continuity, some care managers and/or provider managers actively discourage home care organisations from systems which enable or encourage these relationships. There are a variety of reasons given for restricting the opportunities to develop close relationships, for example the potential for exploitation of service users where they were emotionally dependent on care workers, unfairness as a result of a worker doing more for, and spending more time with, a particular client than she did with others, the danger of other care workers being judged as inferior if they replace a care worker who had a particularly close relationship with a service user⁷⁴.

There are also workforce considerations since all the research evidence is that one of the main satisfactions for care workers is the good relationships they are able to build up with service users as is indicated above.

Difficulties in achieving continuity

Increased dependency is likely to be associated with increased numbers of care workers visiting the home. A client receiving a moderately heavy package of care might require 14 visits in the week (to assist them to get up in the morning and to assist them to bed at night). At the minimum this client could expect to have two regular workers, and at least a third to cover holidays (who would be likely to change as he/she got regular clients of their own). Some users have as many as five visits a day, some of them very short, which will have to be organised to fit in with other service users in the vicinity (who will, themselves, be changing). This inevitably means that there are likely to be a number of different care workers and that there will be changes in the team.

It is not always appreciated the extent to which domiciliary care is an extremely volatile service in which there is constant change. Staff recruitment and retention is a major problem and, because most organisations cannot afford to guarantee work, the workforce is not necessarily a dependable resource.

Older people can also lose long standing and valued relationships with care workers as the result of a contract changing hands although staff may move to the new providers as a result of TUPE. Nevertheless when contracts change hands there is often discontinuity and resulting distress to service users⁷⁵. The protocol around letting contracts which Brighton & Hove Council have introduced avoids this by phasing in all contracts incrementally. Only new service users are taken on by the new providers, leaving existing service users with the original care provider (and the same care worker(s)), unless they wish to move over. This approach is

⁷³ Sinclair I, Gibbs I, Hicks L, (2000) *The Management and Effectiveness of the Home Care Service*, Social Work Research and Development Unit, University of York.

⁷⁴ Sinclair I, Gibbs I, Hicks L., (2000) *Ibid*. In addition to the information from the survey this report also discusses the organisational issues and some of the conflicts of principles which underlie the work of home care workers.

⁷⁵ Henwood M, Lewis H, Waddington E (1998) (*Ibid*.)

reported to be very popular with both service users and providers. **Contact:** *Malcolm Price, 01273-296416, Malcolm.Price@brighton-hove.gov.uk*

- Providers may organise care workers in small teams to cover a given locality so that continuity will be with the team, rather than with the individual.
- Commissioners must work with service providers to ensure that workforce needs are addressed and that working in domiciliary care is attractive and satisfying
- Monitoring continuity should be part of providers' quality systems
- Authorities should consider how best to protect continuity when contracts change hands

Flexibility and responsiveness

When service users talk about flexibility they refer both to the range of tasks which home care workers undertake and also to the ability of the service to change and adapt tasks and times to respond to their changing needs and preferences on a day to day basis.

Range of tasks

The main concerns older people express about the range of tasks are:

- their need for domestic help
- their need for help to get out
- their concern that their carers are supported adequately
- the importance of house maintenance and gardening

Researchers stress the importance to older people, especially women, of having a clean and orderly environment and point out that the focus on personal care has been at the expense of help with domestic tasks⁷⁶. It is not that no housework is done, although this is true for some service users, but that domestic help is regarded as very low priority. If a user needs additional personal help due to temporary illness or incapacity, time often has to be found from what had been allowed for housework or other practical tasks. There are also tasks which care workers are not supposed to undertake – changing light bulbs, dusting the tops of high cupboards, taking down net curtains so they could be washed. For many people there may be no-one else who can give this help. For many older people the inability to get these tasks done is a real threat to their quality of life⁷⁷.

Another concern of many older people who receive domiciliary support is that they never get out⁷⁸. Unlike other service users, taking an older person out is almost never part of the care plan. Research shows that shopping contracts with local supermarkets are disliked by older people both because this constricts choice and because they would prefer sometimes to be taken out to the shops so that they could feel part of the local community again⁷⁹. Services which include taking people out of their homes are very highly regarded by older people.

⁷⁶ Clark H., Dyer S., Horwood J., (1998) *That bit of help – the high value of low level preventive services*, Joseph Rowntree Foundation in JRF Findings Ref 768

⁷⁷ Raynes N, Temple B, Glenister C et al (2001) Ibid.

⁷⁸ Raynes N, Temple B, Glenister C, et al (2001) Ibid.

⁷⁹ Francis J, Netten A (2002) Ibid.

Older people, who are sometimes very conscious of being a burden, felt strongly that their carers should receive some help with the domestic tasks when they were undertaking all the personal care tasks themselves, but because it was not normally policy to provide domestic help unless it was part of a package with personal care, this was rarely forthcoming.

Older people's concern about the lack of flexibility over specific tasks is shared by many care workers and also by service providers and even some commissioners. Research shows that some care workers keep rigidly to the care plan - if a task is not included there, it cannot be done. On the other hand many care workers undertake tasks not identified in the care plan, either within the allotted time, or in their own time^{80,81}. This willingness to do what people say they need done is what most older people mean by 'flexibility' and is highly prized⁸². It can be particularly important to people who live alone. One researcher comments that as many as 70% of care workers in their survey agreed that it was sometimes necessary to breach the rules in order to do a good job⁸³. On the other hand some older people report that they have been confused about what care workers were allowed to do or not allowed to do⁸⁴.

Deteriorating domestic conditions may lead to anxiety and confusion so that older people lose the confidence to continue living at home. Low level preventive services, including domestic help, gardening laundry, home maintenance and repairs are all important in older people feeling that they can continue to 'manage' at home⁸⁵. Arguably these types of support would not be the responsibility of home care services but might be arranged by them in conjunction with the voluntary sector⁸⁶. What is then important is for there to be a means of identifying those who need the help and appropriate signposting systems in place.

- Assessment and care planning should take account of the full range of older people's needs including their quality of life
- Low level preventive services will have an important role in giving older people confidence to continue to live at home
- A whole-system approach is more likely to meet the needs of older people in an appropriate way

Ability to respond to changing need or preference

Flexibility is not just about tasks, it is also about having the time to respond to people's changing needs or the ability to change the time or day of a visit without undue process. There is a whole range of reasons which dictate the need for some flexibility in home care services:

- Older people particularly can change very rapidly in the level of support and help they need., for example a chest or urinary infection can lead to rapid deterioration.

⁸⁰ Sinclair I., et al (2000) *ibid.*

⁸¹ Patmore C,

⁸² Francis J, Netten A, (2002) *Homecare services in Medway: Client and provider views*, unpublished Discussion Paper, University of Kent.

⁸³ Sinclair., et al (2000) *ibid.*

⁸⁴ Raynes N, Temple B, Glenister C et al (2001) *Ibid.*

⁸⁵ Clark H, Dyer S, Horwood J, (1998) *Ibid.* reported that this was particularly important to older women, who perceived that others judged their identities as competent adults by the standards and appearance of their homes

⁸⁶ Clark H, Dyer S, Horwood J, (1998) *Ibid.* reported that having access to help from reputable organizations was important to older people's sense of safety and security, particularly those requiring help with home maintenance or repairs.

- Someone with Parkinson's disease can experience times of almost complete immobility if their medication is overdue or is ineffective so they will need a longer visit than usual
- The degree of confusion experienced by those with dementia can fluctuate markedly, or someone with dementia can take time, on occasion, to understand and agree to the tasks which must be done.
- A service user may be particularly depressed and need some extra time to talk
- Someone may have had a fall.
- A daughter may be coming to visit and the service may need to be changed to fit around this

Older people in research studies comment on the inability of services to respond to changing needs and circumstances and at lack of time to respond flexibly on a visit⁸⁷. Service providers point to delays in getting reassessments which might lead to more permanent change.

In some cases when services are commissioned and purchased a small amount of additional time is built in so that care workers can use it flexibly within their caseload to respond to people's immediate and additional needs, or simply to allow a little extra time for someone who cannot get going as quickly as normal. This by no means happens routinely or regularly. Providers are frustrated at being unable to respond more sensitively and reliability can be compromised as a result of care workers being delayed with one or more users on their schedule of visits.

- Adopting an outcome-based approach will help to address the problem of rigid task specification
- The reasons for restricting care workers from undertaking certain tasks need to be carefully considered since other care organisations allow them without harmful consequences
- Allowing care workers a little slack time in their schedule to deal with unexpected needs will result in a better service and reduce unreliability
- Service providers should have the ability to change days/times of service to meet the changing needs or preferences of users without undue and costly process

Competence and attitude of care workers

Personal qualities

The attitude and personal qualities of care workers are very important to older people. This has been discussed already to some extent, for example their willingness to help, friendliness, or not appearing to be rushed. Service users also mention cheerfulness, kindness, understanding and empathy, patience and an instinctive caring nature, sensitivity. They need to be matter of fact in dealing with 'accidents' and other potentially embarrassing incidents, and careful to leave the house as they find it, clean and everything in its place. The ability to communicate well is important and service users need to feel confident that the care worker is trustworthy. For some older people that means they could say anything to the worker and know that it would not be repeated. For others it is rather more about honesty and feeling that

⁸⁷ Henwood M, Lewis H, Waddington E (1998) (Ibid.). Inflexibility and unresponsiveness of the service was a key concern of service users.

they could let carers into their homes with confidence that they wouldn't take anything or interfere with their personal possessions^{88,89}.

Some complaints made about care workers by service users were of laziness and inefficiency, or of abusing the system, of lateness arriving and going before the time was up, that they used cleaning agents extravagantly, left bathrooms and kitchens untidy, did not put things away or handle equipment with care⁹⁰. Care workers could also be regarded as over-familiar and not sufficiently respectful. As one of the quoted research studies claimed, however, no research studies in this field has found any evidence of widespread dissatisfaction with home care workers and in their own study, from both the postal survey and from interviews, there was almost uniformly high praise of regular home care workers and strong evidence for widespread good relationships⁹¹.

Training and competence

That there is specific training for care workers is not necessarily important to service users. Some older people say that they want care workers trained in tasks and listening skills⁹² but others don't associate skills and competence with training. In fact, most users feel that their care workers are skilled, but they tend to judge this on the 'caring motivation' or human approach, or experience of the care workers⁹³. Providers, however, are convinced of the importance of training, especially in the face of higher and increasing dependency levels. In future all home care organisations will have to provide induction training before care workers commence working unsupervised on assignments. They will also have to have undertaken training needs assessments and have a training plan. All new care workers will have to commence training for NVQ level 2 with an aim of 50% of the care provided by 2008 being done by qualified staff. The training targets do not sound unreasonable, especially given the extended timescale for getting qualified staff in place, but providers are very anxious about costs and the availability of training resources. Turnover of staff is also going to make it difficult for them to attain the necessary levels.

Choice of care worker

Since the personal attributes of care workers are clearly so important, service users might regard it as important that they had some choice of who provided their care. This issue does not appear to have been raised much by service users in any of the surveys quoted – with one exception. The one aspect of choice which service users can feel very strongly about is that they want to be able to select on the basis of gender. For the older people in one study this was an overriding concern⁹⁴. Older people from black and minority groups also wanted culturally specific languages, foods and activities⁹⁵. Interestingly, studies of Direct Payments, or similar schemes in the US and elsewhere, are also beginning to show that one of the main attractions of such schemes is the ability to choose who provides your care⁹⁶.

⁸⁸ Reed R, Gilleard C, Elderly patients' satisfaction with a community nursing service in Wilson G, ed. (1995) *Community Care:Asing the Users*. London Chapman and Hall

⁸⁹ Francis J, Netten A, (2002) *Ibid.*

⁹⁰ Sinclair I, Gibbs I, Hicks L (2000) *Ibid.*

⁹¹ Sinclair I, Gibbs I, Hicks L (2000) *Ibid.*

⁹² Raynes N, Temple B, Glenister C, et al (2001) *Ibid.*

⁹³ Francis J, Netten A (2002) *Ibid.*

⁹⁴ Henwood M, Lewis H, Waddington E (1998) (*Ibid.*)

⁹⁵ Raynes N. (2002) *Ibid.*

⁹⁶ Weiner JM, Tilly J, Evans Cuellar A, (2003) *ibid.*

- The personal qualities and attitude of candidates needs to be stressed in the recruitment and training of care workers
- Local authorities should be sharing training resources and opportunities with their independent service providers
- The cultural needs and gender preferences of service users should be taken into account whenever possible when selecting care staff for individual older people

In-house or independent domiciliary care provision?

Service users rarely have any choice about service providers but they tend not to be concerned about this as long as the service is competent⁹⁷. There are a number of studies which find little difference in terms of quality between the independent and in-house domiciliary care services⁹⁸. One major study, however, reports significant differences in quality, with independent provision performing relatively poorly particularly in terms of reliability. Older people gave both independent and in-house providers the same quality ratings and some people did not know who provided their service.

- **It does not matter to older people who provides the service, so long as it is competent**

⁹⁷ Hardy B, Young R, Wistow G (1999) Ibid.

⁹⁸ Durand MA, Jowett S (2001) Ibid.

Appendix A

Other Work from the London & South East Capacity Development Programme

Cat Website : www.changeagentteam.org

Work Stream	Outcome and Where to Find Out More
Development of a commissioning workbook, <i>A Catalyst for Change</i> , Janet Crampton & Simon Ricketts	Available on the CAT website and available free to systems on a facilitated basis. Contact janet.crampton@dh.gsi.gov.uk
Checklists and good practice guides: <i>Commissioning and the Independent Sector</i> , and <i>Fair Commissioning</i>	Available on the CAT website
Domiciliary Care Commissioning Survey	Report of findings available on CAT website and also UKHCA website, www.ukhca.co.uk
<i>Engaging the Independent Sector</i> , Pauline Spencer and Mike Padgham	Available on the CAT website
Independent Brokerage Projects	Report and Evaluation to be available on CAT and Commissioning LIN websites Winter 2004
Independent Brokerage Project Toolkit	Available Winter 2004
Forecasting Supply and Demand	Modelling tool available from the Department of Health Economic and Organisational Research Department
Various Factsheets on commissioning topics	See CAT website (available from December 2004)