

**UNDERSTANDING HOME CARE  
PROVIDERS**

Live issues about management,  
quality and relationships with Social  
Services Purchasers

By Charles Patmore

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May this publication help to improve services for frail older people.

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## **INTRODUCTION**

### **What this publication offers**

During 2002 the Social Policy Research Unit conducted a small, in-depth survey which provides valuable insight into important issues in home care today.

SPRU conducted a telephone survey of 23 home care providers, half of them Independent Sector and half Social Services in-house providers. These were in 12 different localities (in 11 Authorities), which had been selected to represent a cross-section of England. The prime purpose of the survey was to help SPRU to plan a larger research project concerning home care for older people (for aims of this project, see Patmore 2002, pages 1-4). However, a side-product is that these interviews offer a window on some interesting and important issues and possible national trends concerning home care services for older people. It is to share these insights that this report has been written.

The survey suggested that many Social Services Departments might soon seek to obtain all routine, long-term home care for older people from independent agencies, while reserving in-house providers for specialised roles.

- Such greater use of independent agencies makes particularly important the systems whereby Social Services Care Management commissions and controls their services. The report describes different approaches taken by different Authorities. It highlights areas where new, more flexible strategies are needed for purchasing care from independent agencies.
- Likewise it becomes more important to understand factors which affect service quality within independent agencies. The report examines independent sector dynamics - including workforce characteristics, how managers monitor care and effects from providing care to private customers alongside people funded by Social Services. It also explores in depth how providers approached aspects of service quality which are known to be important to older people – like service through familiar staff and readiness to give odd extra help. Behind the independent sector's lower costs, which attract Social Services Purchasers, lies a common system of payment which can indirectly confound common Purchaser quality standards like consistency of service, continuity of staff-customer relationships and flexible help. The report cites alternative approaches found at some of independent agencies.

A repeated theme is how much Social Services Purchasers affect the performance of home care providers. While the survey initially intended to concentrate on providers' own systems, their performance proved sometimes plainly to reflect influences from their Social Services Purchaser. Parts of the publication examine

respective contributions to home care quality from Social Services Purchaser policies and from practices intrinsic to a provider.

The report depicts home care in England just before providers were required to adopt the Domiciliary Care Standards in April 2003. At some points, issues are highlighted where implementation of the Standards may prove challenging.

### ***Readership***

- In particular, the publication should benefit Social Services Purchasers. It will help them better understand the situations faced by providers. It will highlight areas where the commissioning and long-term management of care can be constructively developed.
- It can also help home care providers compare their own situations with those of other providers.
- Perhaps especially interesting are the comparisons between independent agencies and Social Services in-house providers. The report should benefit anyone who needs to understand or compare these sectors.

The publication starts by examining how staff are paid and recruited for home care services because this proved crucial for understanding various home care work practices described later. Particularly for people new to home care, there is most definitely a case for reading Section One before any other.

This survey did not examine all current issues in home care. Nor is the sample anything like large enough to estimate the scale of the trends it identifies. Its strength is in-depth interviews which include aspects of home care which are only rarely examined. Readers can use the findings reported here to prompt questions for which they would like answers concerning their local services.

### **How the survey was conducted**

Appendix 'A' gives details of the procedure and the sample.

To summarise, 12 localities were selected to reflect a range of contrasting types of community within the Office for National Statistics classification of Local Authorities. So, for instance, there was a mining community, a south coast retirement zone, a booming Home Counties area, inner and outer London boroughs, northern industrial towns, a rural locality and a new town development. Plainly such communities can differ in ease of recruiting home care staff, for instance, or their proportions of very old people or travel distance between home care customers.

In each locality Social Services Purchasers were asked to arrange for SPRU to conduct two telephone interviews: One with the Social Services in-house home care

provider and another with an independent sector agency contracted by Social Services. Twenty-three providers were interviewed in total (see Appendix). There was substantial variation in the seniority of the managers interviewed at these providers.

A possible source of bias may be that Social Services Purchasers were likely to nominate independent sector agencies about which they felt sufficient confidence to use them regularly. Two-thirds of the independent sector agencies nominated had been awarded at least one block contract with Social Services. Their size and organisation was quite varied however. They included:

- A large national organisation with branches in many parts of the country.
- Medium-sized home care companies which comprised several branches in different parts of the country
- A branch of a large national home care franchise
- Single unit independent home care providers, some of them off-shoots from a residential care home owned by the same proprietor.

Independent providers varied in the amount of home care they provided to self-financing private customers.

### ***Other sources used in this publication***

Subsequent to these telephone interviews, in depth research began at six of the same providers. This involved face-to-face interviews with older home care customers, managers, care staff and Care Managers. Only part of this research has been undertaken at the time of writing. But, where fresh light has been cast on information from the telephone survey, a little of this second stage research has been used.





## SUMMARY OF KEY FINDINGS

- Independent agencies often struggled to staff home care visits in a reliable, regular fashion. This reflected that they could not guarantee staff hours of work and that pay-rates were low - and for weekends far inferior to Social Services home care providers.
- Some independent agencies were overcoming these problems – through introducing high bonus pay for working at inconvenient times and places and quotas of guaranteed hours of work for certain staff. Social Services Purchasers funded these pay improvements in order to ensure service.
- Two contrasting groups of care staff were noted. One was mothers who found home care easier to combine with parental roles than other jobs, especially if they could vary the hours they offered. The other was older women, who offered longer, more regular hours, and who were attracted by job satisfaction from caring. Both groups worked in both sectors. But the former seemed to predominate at independent agencies, the latter at Social Services providers.
- Managers in both sectors strongly preferred – and generally obtained - part-time rather than full-time workers. But in inner London, in contrast, home care staff could work very long hours – often well over 40 hours weekly. Elsewhere nearer London staff also worked longer than typical nationally.
- Ethnic minority workers provide much home care in London – 80% of the workforce at some independent agencies. Managers highlighted a need to address prejudice from predominantly white customers.
- Except for inner London, cars were becoming customary for home care work – and obligatory at some services.
- Staff turnover varied – with signs that it might be lower at Social Services providers.
- Social Services providers sub-divided staff into small teams, each focused on a locality. This was much less common at independent agencies, where staff often formed a single pool of workers serving a larger area.
- Providers differed in how they monitored their service. Some invested much effort in supervision of staff, some in obtaining feedback from customers, some in both, and some not much in either. Feedback from customers was emphasised at independent agencies. Regular team meetings, where care-giving and customers were discussed, was a distinctive Social Services practice. Active supervision of staff was strongest at independent agencies.

- Important questions exist about what results are obtained via these different manager strategies. Are some approaches to service monitoring better than others, when results are compared with the time invested?
- Around half the providers would need to increase frequency of staff supervision to achieve the quarterly supervision required by the Domiciliary Care Standards. Overall there was no difference in frequency of supervision between independent agencies and Social Services providers.
- Five of the 11 Social Services providers were negotiating with Purchasers new specialised roles for themselves as short-term rehabilitation teams or services for complex disorders. Long-term care for older people was to pass wholly to independent agencies. Other Social Services providers had similar aspirations.
- For some providers, many details of service-giving – like timing of visit as well as length and tasks during visit - were prescribed by Care Management, whose permission was needed for any modifications. As well as independent agencies, some Social Services providers had care commissioned this way
- Other providers were allowed some autonomy by Care Management over matters like visit timings. But only certain Social Services providers could make even modest increases in care time without Care Management permission.
- Some Authorities would commission home care time for older people only for maintaining basic survival. Others would sometimes also provide social support and address quality of life. In many Authorities, providers said Care Management would commission home care for the latter purposes for people aged under 65 – but not for older people.
- Some providers completely prohibited staff from tasks like finding reliable plumbers or cleaners, changing light-bulbs, or pet care. But others gave such help. The most helpful and least helpful providers were independent sector. Social Services came in between.
- Providers which gave such miscellaneous help found this non-problematic. Those providers which imposed bans often could not justify them lucidly. The latter often privately regretted their rules and seemed reluctant to enforce them.
- Some independent agencies are not keen to offer privately paid extra help to customers funded by Social Services.
- Independent agencies seemed more concerned than Social Services providers to ensure that each customer had one or two consistent main workers.

## SECTION ONE: WORKFORCE AND STAFFING ISSUES

### **How pay and conditions affect the dynamics of home care**

One crucial key to understanding home care services is the differing arrangements in each sector for how staff are paid. These have wide-ranging consequences for many aspects of service.

Social Services home care staff in this survey were generally employed in a conventional fashion for a guaranteed number of hours per week – for instance 10, 15 or 20 hours. On top of this they often also worked many additional hours, if the service needed it and a worker was willing. If demand for a worker fell however – for instance through a worker's regular customer being admitted to hospital – and if managers could not find them fresh work, staff would still be paid for their full number of 'guaranteed hours'. Pay also covered time spent travelling between customers and in staff meetings. Often, also, each worker was committed by contract to work a fixed number of hours per week, somewhat more than their hours of guaranteed pay, if managers required this. Extra hours on top of this were optional for both parties. *Thus staff had part of their income guaranteed. Managers could guarantee what hours were definitely available from each worker, which helped them plan rotas.*

For independent sector home care workers typically there were no guaranteed hours of pay. Pay was only for time spent actually serving customers, which reflected how agencies were paid by Social Services Purchasers - a key reason for independent sector lower costs. If a regular customer suddenly was admitted to hospital, that part of a worker's income dried up immediately – which could mean substantial loss if the customer had been receiving multiple daily visits. *A consequence of this arrangement, which made a worker's income unpredictable, was that their commitment to work at particular hours could be likewise unpredictable and short-term.* At some independent agencies managers had to establish afresh each week what hours each worker would offer the following week. Travel time between customers was not paid, which could lead to staff refusing visits which involved very time-consuming routes.

Common independent sector pay rates did not compensate for these disadvantages. Where information was obtained, ordinary independent sector pay ranged between £4.44p per hour to around £6 in London and in growth areas. Social Services home care staff pay ranged from £5.27p to £6.12p, though generally under £6. These figures are broadly in accord with average pay rates for both sectors cited by Taylor (2001). For weekend work Social Services provider staff had a large advantage. Often they received a 50% premium on their weekday hourly rate for Saturday work (typically around £2.75p extra per hour) and double pay on Sundays. At the independent agencies in this survey, in contrast, the weekend premium was often 50 pence or 60 pence an hour extra, never more than £1.

The differences in pay arrangements have various consequences.

- A challenge for independent agencies is whether they can guarantee to purchasers that they can provide staff, despite not guaranteeing these workers any regular income.
- A challenge for Social Services providers is whether they can fill all hours of their guaranteed pay with work commissioned by the Purchaser branch of Social Services. If not, they risk paying staff for unused 'down time' hours, which may make them look inefficient or expensive compared to independent providers.

Other consequences were that certain types of staff activity occurred less often at independent agencies. Independent agencies have developed from staff time being spot purchased, whether by Social Services or by private customers. They often avoid any staff activities which are not funded on behalf of specific customers, since the latter is their only income.

- Unlike Social Services home care, Independent agencies only rarely use meetings of home care staff, because there is no funding for staff time not spent with a customer.
- Whereas Social Services home care staff are paid for attending training events, independent sector staff have often been expected to attend, say, induction training in their own time. Training has been less common in the independent sector in consequence.
- Likewise attendance by the staff of independent agencies at review or liaison meetings with, say, District Nurses often would not be funded unless Social Services Care Managers agree to pay for their time. This could mean applying to Care Management for funding on each occasion. (Many activities could be affected. An independent agency manager described applying to Care Management for payment for time spent getting keys cut whenever an extra key was needed for home care staff's access to a customer's home. Some providers must obtain Care Management approval for extra time even before getting help for a customer who is suddenly ill. )

Some independent agencies said that recruiting staff was so difficult locally that their workforce did, in effect, have guaranteed hours because the agency always had enough work to fill any gaps in a worker's timetable. Nevertheless the independent sector pay system would still affect the service on the last three counts and in terms of unpaid travelling time.

### ***Two contrasting groups of workers***

These pay arrangements seemed to influence the sort of staff who worked for a service. Who would work for the uncertain hours, unpaid travelling time and low pay rates of the independent sector? One answer, it seems, is mothers of young or school age children whose parental tasks, especially during school holidays, make it hard to commit themselves to the regular hours required by many employers. Managers interviewed sometimes spoke as if two contrasting groups of staff existed among their workforce. These had different motivations and could offer work at different times of day.

One group was mothers of children of school age or younger. According to the managers interviewed, these would:

- offer fewer hours per week than older workers
- wish not to be committed to a set time table, week after week
- seek to work 9 am – 3 pm (not the high demand earlier morning hours)
- wish to reduce or cease work during school holidays
- offer evening work only, if they were mothers of pre-school children who could only work when their partners had returned home
- seek to periodically change their hours as their children grew older.

The other perceived group comprised generally older workers, often in their fifties, whose children had left school, which gave these women greater freedom to work. They were very much sought after by the managers interviewed. They were characterised as:

- 'mature', 'reliable', 'the ones we like'
- ready to expand working hours to use their earning potential
- ready to work in the hours of high demand before 9 am
- more likely to choose this work because they found caring fulfilling than because they could not fit the time commitments required by other jobs.

Concerning the latter group, interviewees commented on the great value of such 'natural carers', if only you could recruit them. Not only did their caring motivation sustain them long-term despite stressful work and low pay, but their dedication and attentiveness to customers made them high quality workers who could be trusted with difficult cases with little supervision.

Managers often particularly associated 'natural carers' with older workers. But they could definitely sometimes be found among younger workers too. A worker might enlist for hours which were compatible with childcare but, years later, stay with the job because she found the work fulfilling. However, one agency's proprietor said that those staff, who joined while bringing up children, often moved to other jobs once their children had left school. Her older workers had often joined her agency once their parental duties were past.

The managers interviewed were asked to estimate into which age bands their staff fell. *While all described a mixed workforce, there was a clear trend for younger staff to predominate at independent sector agencies, while older staff predominated among Social Services providers.* Thus workers bringing up children will be a larger element among independent agencies. Social Services in-house home care, with its better pay and conditions and its stricter time commitments, would end up with more of the older workers whom all managers wanted.

These interviews, then, raise the idea of two large groups within the home care workforce, who have contrasting reasons for accepting home care's anti-social hours, stressful work and low pay. In one case, home care fits with parental roles more easily than do other jobs. In the other, job-satisfaction from caring is the motive. Additional, quantitative research is needed to establish the extent to which this is true. Neither UKHCA's survey of the independent sector workforce (Mathew 2000) nor UNISON's Social Services equivalent (Taylor 2001) have examined this subject. Of course this does not mean that every home care worker can be categorised within one group or the other. One reason that these staff motives are important is that a common aim concerning home care quality is that customers' visits should come from regular, reliable, familiar workers. Strategic thinking is needed if a motive among many home care staff is in fact to find work which does not require too regular commitments.

#### ***'Fitting the care packages into the work routines of the girls': staff rotas at independent agencies***

Thus independent sector agencies seemed to make more use of staff who sought to vary their hours of work to suit common parents' tasks, to reduce work during school holidays and to make only short-term commitments. Agencies sometimes were very flexible to accommodate such desires in order to retain staff. Some accepted that their staff could change weekly the set of hours each worker would offer. This involved much work for a manager. Revising staff rotas meant 'fitting the care packages into the work routines of the girls', as one expressed it. 'Doing the big jigsaw' was how another manager described her weekly creation of a fresh rota which linked the hours when staff offered to work that week with the visits which customers required.

During school holidays some staff worked less and some stopped working altogether. Some were unaffected because they paid childminders and some actually worked longer because their children were away at grandparents. School holidays and children's illnesses were not the only source of variation. One manager's staff would sometimes ring up during good weather in summer: 'They may just say "I'm not working next week".'

Sometimes home care services requested staff to take turns to cover unpopular weekend hours and, if volunteers did not materialise, managers could spend a fraught Friday phoning round their workforce. At independent agencies, if staff could not be found for a visit, the managers would often step in to provide the care themselves. This included the head manager or the proprietor in person, if the latter were actively managing the service. On the one hand, independent agency managers often viewed such episodes as a constructive opportunity to meet customers and glean their views of their customary service-givers. Indeed, some routinely undertook some such care visits anyway to keep in touch with their service. On the other hand, sometimes managers were clearly stressed by last minute searches for staff or from having to undertake many visits themselves.

Some independent agencies strove for greater commitment from their workers to follow a set rota as a condition for staying on their books. For instance, while one agency allowed staff to drop their shopping tasks during school holidays, it required them to keep visiting everyone to whom they were giving personal care. Another agency questioned prospective staff about childcare plans for school holidays, hoping to maintain routines. However, the plans declared were not always fulfilled.

Agency managers can face hard dilemmas concerning workers who offer only very short-term or irregular work. Sometimes they may be an agency's only means for accepting a referral, because no other staff are available. Sometimes this may have nothing to do with rewards but because in some places, like villages, home care staff are hard to recruit on any terms. Accepting the terms of people, who offer only irregular or temporary part-time work, can expand a scarce pool of potential workers, albeit with consequences for reliability.

### ***Staffing a new referral at an independent agency***

'The Social Services co-ordinator for the contract rings up and says "I've a client from such an area and they want certain days"...I have a box with cards for each worker and I look through and it's mainly for whoever lives in that area. Or, if it's out of the way, I look for who drives a car. And I look at who wants to work days and who wants to work nights and at whether they are already with another client at the times requested... Also it can depend on whether they've requested a mature worker or a young person, because it might be someone young. Then I ring the worker, give them the details and arrange to meet the client with the worker together. So we go along and I do an assessment while I'm there. And then it's running.'

***Manager, independent agency***

### ***The price of reliability***

An important, if small-scale, trend was evident whereby some independent agencies were having to reward staff better in order to cover care commitments more reliably.

- One agency offered staff a special higher pay rate for all hours worked if they consistently co-operated with management requests for flexible working or for volunteers for weekend work.
- Another agency solved its problems in providing weekend care by introducing a mandatory regular rota for weekend working combined with a 50% pay premium for weekend work. Fifty per cent was a weekend premium rate normally enjoyed only by Social Services. Social Services Purchasers funded this rate for this independent agency's staff. At this agency, Purchasers now also paid staff mileage for travel between visits, likewise reducing the difference from Social Services providers.
- Another independent agency no longer needed last minute searches for weekend staff because it had created some weekend care staff posts with guaranteed hours, who could fill gaps in weekend service if other staff did not volunteer. As a result, management now went home at 5.30 pm on Fridays, no longer phoning round for staff till 11.00 pm. At this same agency, Social Services Purchasers funded a new very high pay rate (£8.50p per hour for weekdays and £10 at weekends), plus mileage costs, for staff serving particular villages. Previously staff could not be found for work there on account of lengthy unpaid travel time. SSD Purchasers also funded some new posts, which had guaranteed hours of work, for stand-by workers who could serve new customers from these hard-to-serve areas till other staff could be found. Here too aspects of traditional Social Services provider pay and conditions were making an appearance.

### ***Pay arrangements and challenges for Social Services in-house home care providers***

As mentioned earlier, at Social Services providers each worker's hours and income usually fell into three categories. Staff were often paid on banded hours like '10 -15' or '15 - 25'. For a worker with, say, '15 - 25' banded hours, these three categories would be:

- Pay for at least 15 hours per week was guaranteed, whatever happened. If a major customer had been admitted to hospital, management had to either fill these hours with other work or pay the worker for doing nothing.
- The worker was obligated to work for at least 25 hours each week, any week that management desired this.



- On top of this, the worker might work extra hours if management desired this and the worker was willing.

Thus managers had a significant amount of guaranteed, predictable labour for planning staff rotas. These could more easily be regular, sometimes highly regular. Thus Social Services in-house home care providers were much less affected by the problems described among independent agencies. But, for the following reasons, they were certainly not immune from them.

- Sometimes a Social Services provider drew substantially from the third category of staff hours – those above the quota which staff guaranteed to offer. For instance a staff member on a '10 – 15' hour band might regularly work 30 hours and these optional extra hours could fluctuate just as at independent agencies. Interviewees described how some Social Services home care staff reduced their optional extra hours during school holidays. Sometimes other staff increased their extra hours to balance this in solidarity with colleagues in the small, quite cohesive teams, which were a distinctive feature of Social Services providers.
- As well as their own workers, some Social Services in-house home care providers used 'bank staff' – pools of Local Authority casual workers from which any Social Services unit could draw temporary staff as needed. Two Social Services providers made much use of these. One in particular was hard hit by the reduced availability of these workers during school holidays. Its use of 'bank staff' was on a scale that made it a hybrid between Social Services and independent sector models.

### ***Dealing with 'down time'***

The distinctive challenge in the Social Services providers' staff pay system was what interviewees called 'down time'. This is when tasks scheduled for a worker's guaranteed hours suddenly disappear (say, a regular customer goes into hospital) and the worker must either be found other tasks or paid for doing nothing. It is exactly the situation which independent agency pay arrangements are designed to avoid. The more a Social Services provider is paying for non-productive 'down time' hours, the more the Purchaser side of Social Services may prefer independent sector providers, who thus appear more cost-efficient.

If 'down time' inevitably arose, were there ways of using the worker's time constructively? There were a number of uses to which it was sometimes put:

- Replacing absent workers to do other work which was already scheduled  
Otherwise lower priority services, like...
- House cleaning
- Extra shopping
- Helping customers to have extra baths and showers

- Defrosting fridges
- Wrapping Christmas presents for people with arthritis.

But finding constructive uses for 'down time' seemed often a fraught matter. It could easily lead to conflict between a Social Services Purchaser and their Social Services in-house provider or between provider managers and their own staff. Using 'down time' to replace absent workers raised the question about how far outside their locality team or management unit a worker could be assigned, since working with a different locality team could mean extra travel. There were questions too about whether staff could be expected to work their guaranteed hours at different times of day, if an unmet need could be identified then instead. Some staff certainly resisted.

Using 'down time' for cleaning, shopping or bathing could generate objections that this frustrated customers through an erratic service which would disappear almost as soon as customer expectations had been raised. 'Down time' help would be withdrawn as soon as any higher priority work was commissioned at the same time slot. But older people often want regular arrangements for housecleaning or shopping. Occasional extra help from staff with spare time can, it is sometimes argued, simply divert them from securing a regular, long-term arrangement.

Also, as will be discussed later, many Social Services providers in this survey sought to become formally designated by Purchasers as specialists in skilled rehabilitation and care roles. To increase their cleaning and shopping roles at this juncture might imperil their case for a specialist niche.

Another issue concerned conflict between economy and good practice. If an established customer needed an extra regular visit, older people's common preference for familiar staff would indicate that one of their current regular service-givers should be asked to add this extra visit to their contracted hours. But pressure to use 'down time' could mean introducing instead an extra worker, who had spare hours, to supply the visit.

Two Social Services providers stood out for conflicts over utilising 'down time'. At one, a trade union had become involved. A third service, in contrast, seemed highly motivated to use its 'down time' well. Unique in the survey, this was a former Social Services provider which had been re-established as an independent agency when Purchasers decided to dispense with an in-house service. Many staff retained guaranteed hours from their old contracts, so 'down time' could arise. However, to stay competitive with other agencies, it strove to use 'down time' constructively. While this could be achieved to a point, managers commented how surprisingly difficult it could sometimes be.

### **Managers' quest for part-time staff**

There was strong consensus among provider managers in both sectors about their preferred pattern of staff hours. They very much wanted staff who worked only part-time but could take on extra hours temporarily when required. But whether they could obtain this in their local labour market was another matter.

- Through using many staff, each working only part-time, a service's hours can be concentrated around the times of peak demand – getting up, lunch-time, bedtime. This way many staff can be available all at once to offer the 8.00 am morning visits and not-too-early bedtimes, which so many older people want. This way a home care service can compete to offer morning visits or bedtimes at hours acceptable to customers – an issue which for some Care Managers was crucial in selecting a provider. (The opposite can occur if a Social Services provider still has some staff contracted for long guaranteed hours, a relic from days when cleaning was a core duty and could be done at any time. Such staff have many hours which do not suit breakfasts, lunches or bedtimes, unless they provide these at strange times of day.)
- If staff worked only part-time, this limited the number of hours to fill if a worker fell ill or changed jobs. Some interviewees spoke strongly of the hazards of letting eager workers increase their hours, because of the problem of rapidly replacing, say, someone working 40 hours per week when she fell ill.
- If workers were given somewhat less work than they desired, they would be available to pick up the various short notice demands which a home care service continually encounters – like replacing a sick worker or visiting a new customer. In a sense they would be on unpaid stand-by for extra work.

'What I would aim at, if I had a free hand to negotiate contracts, would be ... that no-one worked more than 20 or 25 hours a week. That way you have more bodies to call on and, because people are not working 37 hours, they've usually got more scope to help you out if you are stuck.'

***Head of Service, Social Services in-house provider***

But, however much it suited managers, part-time working might not supply sufficient earnings to retain staff. Staff might fill up those handy stand-by hours with another part-time job. Or they might leave the service altogether for longer hours elsewhere. Local labour markets determined how far managers could attain the ideal of many part-time workers, keenly waiting on unpaid stand-by for any extra hours. In one former mining community, for instance, home care staff were often the family breadwinner, which meant staff could not be recruited unless enough work was available to provide necessary income. The most striking local influence was the

high cost of living in south-east England and in London in particular. This led to staff working much longer hours than managers might have chosen. London services described staff working very long hours, which contrasted dramatically with the part-time arrangements commonly described by other interviewees.

Interviewees were asked about the number of hours worked by their staff.

- For both Social Services and independent sector, less than 10 hours per week was rare or unheard of.
- Outside London, for both sectors, 20 – 30 hours per week was a common range. At some independent agencies 16 – 20 hours per week was also a common practice.
- Inner London staff worked very much longer hours than anywhere else. At one agency 70% of the staff were said to work over 40 hours a week, sometimes much more.
- Home care staff in Outer London and prosperous South East localities also worked longer hours than common nationally – though, more moderately, in a 31 – 40 hours bracket. This applied to both independent sector and Social Services providers. Cost of living seems a likely influence.

It is possible that the emphasis on staff training in the Domiciliary Care Standards may conflict with the common manager preference for a large fleet of part-time workers, rather than fewer full-time ones. The more separate individuals who need to be trained, the greater the cost to a home care agency.

## **Ethnic background, gender and car-usage among home care staff**

### ***Ethnicity***

Staff ethnicity was raised as important by all four services in London. These had many ethnic minority staff – largely Afro-Caribbean and African, also some recent Eastern European immigrants. Two independent agencies said that 80% of their staff were from ethnic minorities.

These services' clientele of older people was very predominantly white. A notable challenge, some providers said, was dealing with prejudice against ethnic minority workers among some white older people. A few customers could be seriously abusive. Managers sought to protect good black workers from quitting home care after demoralising experiences with racially prejudiced white customers. At one agency, if a Care Manager warned that a new customer was seriously prejudiced, one of their few white workers might be allocated. At another service, management sometimes introduced a black worker to an apprehensive older person through pairing them for a while with a white worker. The latter would be withdrawn when good relations were established. Notable successes in overcoming white prejudice were reported through such measures and this interviewee urged that such persuasive tactics always be tried. Helping older people over their fears, rather than enforcing anti-racist rule-books, was the dominant tone at this service. But it also occasionally suspended or even withdrew service if a customer was seriously, persistently abusive on ethnic grounds.

London was the only site in the survey with many people from ethnic minorities in its general population. Do other cities with large ethnic minority populations have London's high levels of ethnic minority staff in their home care services? The UKHCA home care workforce survey suggested it under-estimated ethnic minority staff because of low local response rates from London and other cities with large ethnic minority populations.

### ***Gender***

Famously, home care is provided by women. The services in this survey divided fairly evenly into those with no male staff, those with very few, and those with a sizable minority of men.

A key factor in services with substantial numbers of male staff is the growth of home care for people aged under 65 in Social Services client groups like people with learning disabilities, physical disabilities or mental health problems. Within one Social Services in-house home care service there was an all-male team which provided personal care for men. Demand meant that it was actually expanding. Another large independent provider used men in its specialist teams for people aged under 65 and in a van-based service which did heavy cleaning and small house repairs. But it never used men for personal care. A smallish local independent

agency had 20% male staff. Its proprietor saw this as enabling it to capture occasional referrals for whom a Care Manager preferred a male worker.

A common view was that, while men were definitely sometimes helpful in home care, they were more often unusable and you could in fact manage without them altogether. Panel 1 illustrates advantages and problems mentioned.

**Advantages and disadvantages of male home care staff, as mentioned by interviewees.**

***Advantages***

- Some men like their company or prefer them for personal care.
- Men can provide evening calls for *certain* clients in situations where there are safety fears for women staff.
- Men can escort women staff on evening calls – though in this survey only some Social Services providers appeared ready to bear the cost of two workers for this purpose.
- Men are better for some work with younger people with learning disabilities or mental health problems.
- Men can do tasks which require strength – like carry heavy shopping, move commodes or furniture, and lift customers.
- *Some* men can put up things like lampshades and shelves.

***Disadvantages***

- Many women will not accept service from men, whereas most men will accept home care from a woman.
- Some older men will not accept male staff, on grounds that home care is unnatural activity for a man or may be token homosexuality.
- Under independent sector pay arrangements, men often quit soon because so many customers object to them that they cannot work enough hours to achieve a breadwinner's income.

**Panel 1**

### ***Car usage by staff***

Cars were now easily the most common form of transport for home care staff in this survey, aside from in Inner London. Independent agencies seemed to be leading a trend towards car ownership becoming a condition for work in home care. But Social Services providers were not far behind.

- At around a quarter of the services surveyed, all of them independent sector, all staff now used cars for work and this was a formal condition for working there.
- There was another quarter where almost all current staff had cars and a car was now officially requisite for new staff.
- A third large grouping was services where a car was officially 'preferred but not essential' for new staff. However, these managers pondered long and hard before engaging anyone without one.

Only a couple of services still used an even balance of cars and bicycles and this probably reflected local geography. Both organised staff in locality based teams, which would minimise travel distance.

Inner London stood out for pronounced non-use of cars. Often staff did not own cars. Managers expected them to use public transport for customer visits. Cars were regarded as a nuisance – they would simply get clamped.

Two other issues were mentioned in connection with cars.

- Cars made staff safer on night visits.
- A worker with a car can serve a much wider range of customers than one without. Thus it increases an independent agency worker's earning power and also the number of referrals their agency can capture through being able to rapidly produce a worker for a new customer. Cars plus the large teams common at independent agencies meant each worker could go anywhere, take on any referral. Without a car and with travelling time unpaid, in many localities money-making opportunities for an independent agency worker could be very limited.

London excepted, the extent to which car usage was the norm was unexpected. Are these results nationally representative or do they reflect a bias in the survey towards mixed urban/rural and urban fringe localities, where cars are obviously necessary? Clearly car ownership has implications for recruitment of staff.

## **Recruiting and retaining staff**

Only three interviewees felt comfortable about their service's ability to recruit staff. Some of the others felt they faced grave problems. This was expressed particularly strongly in localities with high growth and prosperity, where there is minimal unemployment. Two such providers served an ONS 'Prosperous Growth Area' which has featured in national news stories about labour shortages in such places. However, recruitment was also experienced as very difficult in a poor northern community. Supermarkets were seen as an important competitor for staff. Recent growth of 24 hour supermarkets was a special problem, since they offer a more convenient alternative to home care for people who seek work at unconventional hours.

However it was notable that, despite these complaints, providers reported far more often that their workforce had remained constant or had increased during the last 12 months than that it had reduced. Some of the increases were large and these matched Purchaser plans to expand the role of these particular agencies. Whatever their problems in recruiting staff, predominantly this sample was coping successfully for the time being.

An impression emerged that staff recruitment is easier in large communities than small ones. It was hardest of all in villages, whereas in London, as long as sufficient hours were offered to cover London living costs, it seemed relatively easy.

Staff retention raised other issues. One repeated sentiment was that to remain working in home care for any length of time, a person needed to find the work intrinsically fulfilling at an emotional level. Otherwise they would never stick with it when many other jobs with similar pay are much less stressful and offer much more convenient hours. Another common sentiment was that there are only so many of these motivated, 'natural carers' available.

A response to the latter could be pro-active searching for those 'natural carers' who do exist. An independent sector manager described how one of her company's branches had recruited some very capable older women as first-time care workers through holding up-market promotional seminars about care work in smart hotel conference rooms. These provided a professional image and attracted middle-class women with talents for caring, whom customary home care advertising would not have reached.

Another corollary concerning 'natural carers' was that, once you had found them, retaining them was not so difficult. 'You find staff either stay a couple of weeks or they stay for life. They know straightaway if they like it or not', commented a manager at a Social Services home care provider.



But of course 'natural carers' are only part of the home care workforce and sometimes staff quit rapidly. Some home care providers described much lower rates of staff turnover than others. Low staff turnover was 12%, 8%, 3% and even zero staff departures during the previous year. Sometimes staff losses were almost entirely due to retirement or ill-health. Significant or not, these four low turnover services were all Social Services providers. There were other services where turnover seemed extremely high, though estimates seem unreliable and no clear explanations were found. In between the two categories, there were providers where a quarter or a third of staff had left during the previous year. This picture is broadly in accord with Taylor's (2001) citation of annual turnover rates of 12% for Social Services in-house home care staff and 26% for independent sector counterparts.

Finally, there was strong feeling among many interviewees that low pay rates really bedevilled many aspects of their work. 'The only thing which would make our day-to-day operation more successful', said an independent agency manager, 'would be more care staff and, for that, you need to be able to pay them more. People who work at B&Q are getting £8 or £9 an hour and care staff who look after human beings are getting paid £6 an hour. I don't quite see the sense in it.' In fact, at many providers in the survey, care staff got even less.

### **Reflections on reduced care costs and their consequences**

Indeed the independent sector's less generous pay and conditions can have far ranging consequences. They make possible the competitive-sounding prices which are influencing many Authorities to transfer much home care to the independent sector. But they can simultaneously promote styles of service which are contrary to common values among older people and, hence, contrary to common Social Services quality standards based on customer views. Low pay and insecure conditions may sometimes necessitate independent agencies to draw on workers who are seeking only very short-term work or hours which they can rapidly change, even week by week. This can mean the sort of frequent changes in worker or in visit times - or even whether a visit occurs at all - which dismay many customers. Also, low pay can mean that, where agencies do engage long-term family breadwinners, sometimes long daily hours are needed to generate the income required. These long hours may entail some late breakfasts, strangely early lunches and child-like early bedtimes, which likewise risk customer discontent.

Requirement for home care time to be commissioned specifically in advance is another route whereby the same arrangements which reduce costs can also impair service quality. A pronounced example was a home care worker who was upbraided by an agency manager for meeting a sick customer's request to take him straight to the GP. Required procedure was to first phone provider management, who would then phone Social Services Care Management to seek agreement to pay for the extra staff time, and only then authorise help.

Local geography and economy may determine exactly how low pay affects a service. Sometimes, as described, geography may limit workers to people who both possess cars and who find either the work, the hours or the pay sufficiently rewarding, if distance and unpaid travel time deter non-drivers. Where there is greater population density, a broader labour pool may be available. Where cost of living is high, agencies may need to offer very long hours if staff are seeking sufficient earnings to live on. In some localities even that may not be competitive, if less strenuous, better-paid work is plentiful. There, home care agencies may face major recruitment problems.

Notable is the finding, mentioned earlier, that some independent agencies had introduced special high motivational pay-rates for work at inconvenient times and places and also pay for some stand-by workers. Such developments seem necessary in some places to improve service or even to ensure service at all. They also raise the costs to Social Services.

## **SECTION TWO: HOW HOME CARE PROVIDERS WERE ORGANISED AND MANAGED**

### **Differences between Social Services and independent sector providers**

The providers in the survey included:

- Social Services in-house home care services with several sectorised teams covering a single large locality
- large national independent agencies with many locality branches
- small, single branch independent agencies - the three smallest agencies comprised 14 , 25 and 33 staff.

A key difference between sectors was that Social Services providers were almost always sub-divided into teams of 6 - 20 workers which served particular localities. These teams held frequent, regular meetings which planned and co-ordinated work and discussed customers' needs. Such meetings were held at least monthly, sometimes weekly.

At independent agencies, in contrast, staff were often not divided into teams. Thus any worker could take on any referral. This maximised a worker's chances of earning and maximised the number of staff on whom an agency could draw for swift response to any customer. Such undivided groups of workers ranged from 12 to 80 care workers, typically between 30 and 40.

However there were some independent agencies which were sub-divided into teams which served particular localities only. But these teams did not hold frequent regular meetings like Social Services home care.

Independent agencies only rarely held meetings for care staff, if at all. If they ever held meetings, these were quarterly gatherings of all care staff to be briefed by managers on any current issues. (The only exception was a Social Services provider which had been transferred to the independent sector but which retained Social Services features like frequent team meetings and guaranteed hours.)

### **Issues for Social Services providers**

An issue for Social Services providers with their locality-focused teams was how large a team should be and how it should be managed.

- Teams needed to be small enough to be able to plan and review care effectively during face-to-face meetings, yet not so small that too many managers were required or that one manager had to manage too many tiny teams. Some managers led teams of around 20 staff, which they divided into sub-teams of 6 – 10 workers, specifically to promote communication through smaller team meetings. But this meant that a manager needed to attend two or three team meetings rather than one.
- The larger a team, the more likely that a customer will sometimes get service from a team member who does not know them when their regular worker is ill or on holiday. But in very small teams, where all customers are familiar to all staff, each staff absence places proportionately much heavier burden on colleagues. Often such small teams have to seek relief from colleagues in other teams, thus introducing unfamiliar staff nonetheless.
- Some localities appear 'natural communities' which are marked out by major roads or rivers or by being a long distance from anywhere else. It may seem sensible to base home care team size on whatever number of staff are needed to serve such localities.

### ***Team structures at Social Services providers***

Three arrangements for Social Services teams were noted in the survey.

- Teams, typically 15 – 30 staff, which were under a single manager (sometimes supported by one or two senior home care workers) and who met all together.
- Teams in a 15 – 40 size range, which likewise were under a single manager but were in effect divided into sub-teams of 6 – 10 workers, who held meetings separately. Managers visited each sub-team's meetings.
- Small teams in a 6 – 10 range, which are each line managed by a senior home care worker, who was a full-time team member and the only manager at team meetings.

At four Social Services providers, team meetings were held weekly. At three they were fortnightly and at three they were monthly. Only one Social Services provider did not hold team meetings.

### **Team size, frequency of team meetings, and team manager time**

At one Social Services provider, each team manager managed around 30 care staff. These had been divided into three sub-teams of 10 staff and each manager attended their three sub-teams' separate meetings.

To reduce the time which managers spent at meetings, the frequency of team meetings had initially been reduced from weekly to fortnightly.

But this reduction in staff communication manifested in mistakes in care. So the meetings had been rescheduled on a weekly basis.

To assist managers to attend them, each manager's three team meetings were held one after the other on the same day

### ***Staff roles at Social Services providers***

Three roles were evident within Social Services teams.

- Care workers
- The manager or leader of a team
- Sometimes, senior home care staff who helped the team leader through serving the most challenging customers, co-working with new staff as a model worker, maybe deputising during the team leader's holidays. In roughly half the Social Services providers, each team leader had one, sometimes two, senior workers to help them. In the others the team leader was on their own.

In some services the title Senior Home Care Assistant or Senior Care Worker was used for the team leader of a small team, while in others it was used for a senior care worker who helped a team leader, as just described.

One Social Services provider did not fit this general description of division into teams, each serving a fairly small locality or 'patch'. Instead, the whole workforce, supplemented by many 'bank staff', functioned as a single large team regardless of customers' localities. This somewhat resembled a common independent sector pattern.

### **Issues at Independent providers**

As mentioned, the most common independent sector pattern was to function as an undivided pool of staff - so that any worker could take on any incoming referral. Such groups were often between 30 and 40 care workers, though sometimes as many as 80. The two smallest agencies had 12 and 23 care workers respectively.

There were exceptions to this, where locality-based teams were used in the typical Social Services fashion and for each customer there would thus be a limited number of workers who could become involved in their care. For instance, one agency divided its 30 care staff into two teams, each led by a supervisor and which each served a different half of town. Another divided its 60 staff into one team of 30 and two of around 15. This reflected the differing workloads in the three main localities where they worked.

### ***Staff roles at independent agencies***

These could include the following:

- Care staff
- An overall manager. Sometimes this was the agency's owner in person. (At nearly half the agencies, the proprietor was extremely active in shaping and running the service.) Sometimes there was also a deputy manager.
- 'Co-ordinator' was a common independent agency title for office-based staff who spent much time on the phone - negotiating with Social Services Care Managers concerning new referrals, phoning to find staff to visit a new referral or to replace a sick worker, or producing visit rotas.
- Supervisors worked mainly outside the office. They visited customers if there were problems, observed staff at work, gave staff supervision sessions and conducted customer reviews. Even if the staff worked as a single undivided team, supervisors could each have a set of staff whom they consistently supervised.
- Senior home care staff who played a similar role to the auxiliary senior home care staff in Social Services home care providers. They trained new staff and undertook more difficult care work.
- At a couple of agencies there were management figures with a specific role of systematically visiting all customers to hear their views of care.
- In some small agencies all management and co-ordination roles fell on just a manager and her deputy.

Medium and large agencies often kept 'Co-ordinator' and 'Supervisor' roles separate from each other – the former based at the phone, the latter often outside the office. Sometimes there were one or two posts for each type of worker and sometimes as many as five or six. For example an agency with 80 home care staff had four Care Co-ordinator posts and four Supervisor posts. There were other agencies where there were posts for the 'Co-ordinator' role but where the 'Supervisor' role seemed to fall wholly on the overall manager. And one agency where, conversely, the 'Supervisor' role seemed better resourced than the 'Co-ordinator' role.

No equivalent to the independent agency 'Co-ordinator posts' existed among Social Services providers. Social Services home care team leaders themselves organised rotas and arranged cover for staff absences, alongside their supervisor role. But negotiating with Social Services Care Managers might be partly or wholly done by the team leader's own manager. And there was generally less required in terms of the 'Co-ordinator' role because Social Services team leaders had a pool of predictable guaranteed staff hours from which care could be drawn.

Often part of a Co-ordinator's role was to respond to a tentative referral with some attractive combination of start date, visit timing or preferred characteristics of worker, which might persuade the Care Manager to shop there. 'Tele-sales', was how one interviewee described her agency's Co-ordinators. By comparison, Social Services providers sounded distinctly less entrepreneurial, when it came to securing referrals from Care Managers on Social Services' Purchasing side. Sometimes they were supposed always to be offered any new referral anyway. Even when not, they showed little spirit of entrepreneurial competition for trade.

However there were also Authorities where independent agencies did not need to woo referrals through deft offers from Co-ordinators. Some Authorities gave each favoured agency a catchment where that agency would always be offered any referral first. Under such circumstances, entrepreneurial behaviour by Co-ordinators was not needed.

## **Approaches to monitoring care**

During the survey, four contrasting approaches to monitoring were noted.

- 'Hands On' Management, where the immediate line-manager to care staff has extensive contact with staff and their customers and forms a clear picture of customer requirements and staff performance.
- Frequent, regular meetings of small teams of care staff, which discussed customers' progress and immediate problems and planned staff rotas. (Only Social Services in-house providers used this.)
- Regular, systematic surveys of all customers' views – by postal questionnaire or by visits from a specially appointed staff member. (This was found only among independent providers.)
- Management time is invested at the start of care and subsequently there is little systematic monitoring.

Some services clearly invested strongly in one approach only. Others invested in more than one, though to differing degrees of emphasis. Thus the following does not mean that each provider can be categorised neatly under one of the following four headings – although sometimes this was the case.

Each approach will be described in turn.

### **1. 'Hands On' Management**

Certain services stood out for the key role played by the line managers to home care staff in actively finding out how service was delivered and communicating directly with staff about any changes needed to this. Line managers did this through activities like:

- conducting customer reviews and other visits to customers
- directly observing staff at work in customers' homes – sometimes shadowing for a day a care worker chosen at random.
- periodically giving service themselves to some customers of the staff they supervised
- individual supervision meetings with staff
- giving staff fresh instructions concerning longstanding customers, as well as about new ones.

All but one of the services which emphasised 'hands-on' management were independent sector. There was only one Social Services provider in this category



and, interestingly, this was the only one which did not use frequent team meetings to manage, co-ordinate or guide the service.

Three differing illustrations can be given of 'hands-on' management.

#### *Agency 'A'*

At this independent sector provider, two supervisors each managed 16 or 17 staff. Supervisors would:

- Visit and initially give a 'provider's assessment' to each new customer and choose staff whom they thought would suit them.
- Hold reviews with the customer in private and ask them their opinion of care and their satisfaction with their workers.
- Sometimes visit the customer's home to actually observe care in progress.
- They sometimes even watched customers' homes to check staff punctuality.
- Regularly visit those customers where problems in care were being reported by staff. Sometimes for a period they would personally provide services in such situations. Thus they could explore solutions to the problem.
- Give individual supervision to their staff, once every three months (a fairly common frequency).

#### *Agency 'B'*

At a large national independent agency, team managers each managed a team of 30 - 40 staff. There were detailed formal agency structures for customer review and for staff supervision, which explicitly linked them as a management tool.

- Review of every team customer at least once every 6 months was required by an agency Quality Standard. Alongside questions about changes in a customer's needs, these reviews sought a customer's account of staff reliability and punctuality and what services were actually received. The latter could be checked against the tasks on the Care Plan, for which team managers held copies for all team customers.
- An individual supervision meeting with each worker was required every 3 months. At supervision, the manager went through a list of each worker's customers to check for problems and enquire whether service still matched the Care Plan. During supervision sessions the manager could raise any failings which he or she had personally heard about during reviews with that worker's customers. (Such systematic, manager-led discussion of all a worker's customers was quite rare in the supervision methods encountered in this

survey. More commonly, supervision discussed a worker's own concerns and needs and only those cases which the worker chose to raise.)

- A team manager selected and trained their own staff themselves – assisted by one or two senior home care workers in their team.

### *Agency 'C'*

At this small independent agency, a single manager set aside the same two days every week to give the whole 23 strong workforce a weekly individual supervision session. This discussed each customer whom the worker had visited during the previous week and any problems or developments encountered. The meeting also briefed staff on their next week's rota, any new customers and any new tasks. Each staff member received as long as needed. Phone-calls were diverted so the manager could concentrate on this supervision in a private room. This weekly supervision was the key means for management. There were no reviews organised by this provider, though some participation in reviews by Social Services Care Managers.

### **2. Frequent, regular team meetings are the lynchpin of the service**

With one exception, all in-house Social Services providers used active, participative team meetings as an important means for managing and co-ordinating care. This is the 'patch team meeting', conducted weekly, fortnightly or monthly as mentioned earlier. Only one independent sector service employed this type of meeting – and this was a former in-house Social Services provider which had retained various Social Services features when it had been transformed into an independent agency.

Typically these meetings:

- Involve a fairly small group of staff all serving the same area, so that many customers are known to many staff present and thus can be fruitfully discussed.
- Enable staff to share information on problems and recent changes or events affecting particular customers, then plan responses.
- Enable staff to discuss particular customers and improve their understanding.
- Offer a forum when forthcoming staff absences can be announced and arrangements for cover can be worked out by those present.
- Offer a forum where staff can seek help with particular tasks.
- Offer a forum where a manager can give briefings on new customers or on new policies or information relevant to care.

- Provide staff with a feeling of support and develop supportive relationships between staff which may continue outside the meetings.

Thus one aspect of these meetings is collaborative problem-solving – for instance negotiation for volunteers to undertake an absent team member’s duties. Another aspect is to cover some ground which might otherwise be covered in individual supervision or customer reviews.

- Some Social Services providers used these ‘patch team meetings’ as an alternative to individual customer reviews or individual staff supervision. Discussions of customers at team meetings were sometimes explicitly named as fulfilling the same purposes as customer review visits and staff supervision sessions and as reasons why these were not needed.
- But there were other Social Services providers which used weekly patch team meetings alongside programmes of individual staff supervision and customer review which sounded well-developed and robust on their own.
- There were also further Social Services providers where, while formal review and supervision procedures did exist, these were new or uncertain and the patch team meeting appeared better trusted for these functions.

Thus Social Services providers varied in how management functions were divided between team meetings and manager activities outside team meetings.

How readily do traditional patch team meetings combine with other management approaches described here? This is a live question since, whatever occurs at team meetings, the Domiciliary Care Standards (2003) now also require individual staff supervision, observation of staff in customers’ homes, and customer reviews. Some managers may feel forced to duplicate their habitual systems for management.

Innovative ‘hands-on’ management methods had been introduced alongside patch team meetings at two Social Services providers in the survey. These had recently been equipped with a sophisticated telephone-based staff monitoring and briefing system. This enables managers to track closely the activities of individual staff members and to swiftly relay instructions to individual workers or to the whole team. It remains to be seen how much this technology promotes ‘hands on’ management by these teams’ managers. Certainly local managers were noticing far-reaching opportunities which the new technology gave them.

### **3. Systematically listening to customers**

Often independent agencies placed much importance on listening to customers as a source of guidance for managers. Four agencies invested a great deal in regularly, systematically canvassing all customers' views and relaying these directly to the agency head or the full team of senior staff. Unlike many customer review systems, this was done in ways which bypassed both a customer's care staff and their line-manager. Information thus gained was used to regularly check service quality and customer satisfaction and to take specific corrective action.

One of these agencies had invested in a Quality Assurance Officer who visited every customer every three months for a short interview according to a structured quality assurance format. Any problems identified were reported to management and received rapid response. The agency had made some general adjustments as a result, like now always taking great care to tell customers well in advance if their staff are to be changed. It found that some customers were definitely more ready to voice problems this way than through phoning its office or talking to service-givers.

Another agency used a senior manager to give every customer an annual hour-long interview, reviewing changes in need and their views on service quality and staff conduct. Such universal reviews had been found sufficiently useful to maintain the system for over six years.

Two agencies monitored their customers through postal questionnaires, every six months. One agency's questionnaire asked about:

- staff punctuality
- staff helpfulness
- whether tasks were carried out
- how well briefed were staff
- how easily the customer could contact the agency when needed
- how accessible, customer-friendly and responsive was the customer's workers' immediate line manager
- desired changes to service
- suggestions for extra services

Customers' names were marked on questionnaires to enable specific problems to be passed to the relevant manager for action. The other agency, which used written

questionnaires, used the resulting information both to respond to an individual's concerns – like desire for a different staff member – and to modify general practice in the light of common concerns.

These monitoring systems collect the views of all customers, not only those whom a manager feels moved to seek out for an ad hoc review. Also a manager's own performance can come under scrutiny. Aggregation of such customer feedback and comparisons over time can themselves provide useful information – as had occurred.

These monitoring systems appear a distinctively independent sector approach. Besides the four services just described, there were other independent agencies which employed similar procedures but less systematically. It was common for agency managers to phone customers for their opinions on service in the first weeks and months after starting care. There seemed a strong culture of canvassing customers' views among independent sector managers.

There were signs that such monitoring of customers' views might partly supplant some conventional management if an agency were so inclined. If a service can count on learning swiftly when customers experience problems, it might believe it can concentrate management time on these problem situations and cut back on routine supervision of staff. At least one of these agencies seemed low on systematic supervision of staff. But there were others where this definitely was not the case – where systematic monitoring of customers' views co-existed with 'hands on management' methods in the same service.

#### ***4. Invest manager time when a new customer starts care – and later on you can let things run themselves***

Some interviewees conveyed that home care often could be left largely to run itself, as long as managers ensured that each customer's care got off to a good start and that staff would contact managers if a problem later arose.

Some providers stood out both for great attention to the start of care and for greatly reducing management later on. Others also emphasised the start of care – but were not so ready to relax management later on. There were others too for whom the reverse seemed true - they communicated a general hands-off attitude to management more strongly than great care at the beginning. Judgements, though, could be hard to make clearly.

Attention to the start of care could mean:

- Recruiting staff with the right aptitudes, who would then establish successful care relationships with customers with little management or guidance.
- Organising much of each customer's service through a single main worker – so that such staff themselves become experts in their customers' needs and

wishes, needing little management instruction. Relatively little co-ordination of staff is needed because, for each customer, one person does so much.

- Obtaining a good understanding of each new customer through a provider's assessment exercise.
- Choosing a compatible main worker for a new customer, briefing her effectively, and introducing her with care.
- Checking with each new customer that all is going well at strategic intervals in the first few days, weeks and months.
- Through training or other measures, ensuring that staff can identify when they should contact management about a problem in care.

After some months, according to this view, management would know whether a good care relationship had been established. If successful, it could often leave staff to their own devices for the longer term. Well-chosen staff would themselves contact management if problems arose later on. They could do so through the common independent agency practice whereby managers were always available to talk to staff during their mandatory weekly visits to the agency office with their timesheets. From this point of view, regular staff supervision sessions and regular reviews could seem unnecessary for many customers. Some of the control issues, which bothered certain other managers, could look less important. As long as the Purchasers' Care Plan was implemented, did it matter if main worker and customer had privately re-negotiated visit times or arranged extra services in the worker's own time? Indeed such arrangements might seem a natural flowering of a successful relationship between a customer and their main worker. Such views could be found in both sectors.

Some services stood out for their attention to the beginnings of a care relationship. At one small independent agency a manager would visit each new customer to assess them. Any complex or challenging customers would be assigned to a senior care worker or, as a last resort, to a manager. Managers produced a very detailed written briefing for care staff about each new customer. Versions of this briefing were kept by care staff in their files in their own homes, at the customer's home, and on a computer at the agency base. Subsequently managers would visit customers to check satisfaction with service. New staff were trained through working jointly with a senior care worker at first. But otherwise management was rather ad hoc. Formal staff supervision took place once a year. Formal reviews of customers were not held by the provider. Staff were expected to raise any problems during mandatory weekly visits to base.

An interviewee at another independent agency emphasised choosing the right sort of staff – people who were ‘caring persons’ at heart and for whom it was ‘not just a job’. Such people could then be trusted to function well on their own initiative. This manager sought as much as possible to deliver services through a single worker, who obviously would thus get to know their customers’ needs very well. The agency paid for some staff training, not always the case at independent agencies. The manager conducted an assessment, then chose a worker and gave a single verbal briefing - no briefing or prompting documents were placed in the customer’s home. After the first 3 months, a manager would phone the customer to check that all was well, then visit after a further 3 months. Questions would be asked concerning a satisfactory relationship with the care worker, whether the worker performed the required tasks and whether the hours commissioned by Social Services were adequate. If all was well, thereafter there would not necessarily be further review. Staff received individual supervision every six months.

One Social Services provider invested much in induction and training for new staff. The latter received at least 10 days for shadowing an experienced worker. Supervisors gave priority to new staff and to troubleshooting immediate problems. But they could not always sustain regular quarterly individual supervision for all care staff, which was their formal target. Supervisors’ reviews and check visits were, it was acknowledged, very much concentrated on cases where there were known difficulties.

Concentrating management time on new service users and known problematic service users – at the expense of review of the bulk of long-term clients – is a common strategy in social care services. Managers thereby seek to deploy scarce time where it is most plainly needed. In many Authorities in this survey, this approach was pronounced among the Social Services Care Managers who purchased home care from these providers. Often Care Managers made repeated contacts with customers in the early weeks and months after care had been purchased. If all was still well, Care Managers would then withdraw from the case, either officially or unofficially. Where longer-term reviews were conducted by Purchasers, often it would not be the same Care Manager who had originally commissioned the care package.

A common aim for systems of regular, repeated review for all service users is to find unnoticed problems and newly emerging needs envisaged among ‘quiet’ long-term service users. These are the people who risk insufficient attention if managers work only with new service users and those who raise conspicuous problems. The Domiciliary Care Standards (2003) introduced a mandatory requirement for providers to review all customers at least once a year.

### ***The Domiciliary Care Standards and management methods***

The Domiciliary Care Standards (2003) bring pressure on all home care agencies for managers to formulate quite detailed, written prescriptions for how each customer should be served and to have systems for checking that these are being fulfilled. It also requires that certain management practices are followed.

**Table 1 Frequency of individual supervision meetings with home care workers**

	<b>SSD in-house</b>	<b>Independent</b>	<b>All home care</b>
Once per week	-	1	1
Once per month	1	-	1
Once per 3 months	3	4	7
Once per 3 –6 months	1	1	2
Once per 6 months	1	1	2
Once per year	2	2	4
None	2*	2	4
No information	1	1	2
<i>Total</i>	11	12	23

\* One of these offered staff an optional group supervision meeting.

- Standard 21 requires that care workers receive an individual supervision session at least once every three months. Table 1 shows the supervision practices identified in the survey. Around half these providers would need to increase supervision. There is no evident difference between sectors.
- Standard 21 also requires that, at least once a year, supervisors observe their staff giving care in customers' homes – a practice found only rarely in this survey.
- Standard 27 requires visits at least annually by managers to all customers, another practice found among some of the 'hands on' managers' in this survey.
- Standard 27 also requires that all home care providers conduct annual surveys of service users' views like those described under *Systematic listening to customers' views*.

Among the four approaches to management described here, it is '*hands-on' management* which fits the spirit of the Standards. The Standards generally aim to make managers more involved with specifying details of care and routinely checking that they are followed.

Some providers in the SPRU survey were already very close to full compliance with the Standards. The adjustments they still needed would be little trouble for them.



But there were others where simply the review and supervision requirements could bring appreciable burden.

The review requirements may be burdensome to any service which has many customers who receive only a couple of hours of service per week – something more common five years ago than today. For instance there were home care teams in the survey where 20 part-time staff served around 200 customers, many of whom received only a couple of hours home care per week. The Standards now require that the single team manager gives 200 review visits to customers each year. The low hours per customer mean that the Standards require a much higher number of review visits per year than if the team's same total hours of service were delivered to far fewer users of intensive home care. Before the Standards, in fact, one of these managers was already facing a backlog of initial reviews for recent customers on account of large numbers.



## **SECTION THREE: RELATIONSHIPS WITH SOCIAL SERVICES PURCHASERS**

### **Who were the purchasers?**

All the survey's home care providers were contacted because their services were purchased by the Social Services Purchasers for older people in one of 11 Social Services Departments, which had been selected as described in the Introduction. The survey concentrated on a provider's work with customers funded by this same Social Services Purchaser for older people, which will be called the 'focus purchaser'.

However, many of these providers also supplied home care to other purchasers. For instance:

- Other Social Services Purchasers within the same Social Services Department (e.g. Care Management for people with physical disabilities, aged under 65).

And, in the case of independent agencies only....

- Other Social Services Departments located near enough to the agency to also use its services.
- Private customers, predominantly older people.

There were signs that sometimes a provider's overall approach was affected by what they had learned through serving younger people or private customers. Hence some attention was paid to this.

### ***Services for the focus purchaser: types of contract with independent agencies***

All but four of the independent agencies had block contracts with the focus purchaser at the time of the survey – i.e. only four agencies were wholly on spot purchase. Since the survey, one of the latter four also acquired a block contract.

The proportion of agencies on block contracts is high, compared to research showing spot purchase as more common. Partly this may relate to rapid change in the sector and recent spread of block contracts. But it seems likely that agencies nominated by Social Services for the survey – as its typical good independent providers – would be agencies which would receive block contracts for the same reason.

### ***Services for other purchasers: purchasers for other client groups with the same Social Services Department***

Table 2 shows how some home care providers served a significant minority of younger customers alongside people aged over 65. The former included people with physical disabilities, people with learning disabilities, people with mental health problems and people with sensory impairments. There was also sometimes substantial work with children. This could be in families where either a child or a

parent had a disability or in families which received Social Services help on account of parenting problems.

As Table 2 shows, Social Services home care providers were more likely to serve people aged under 65 years than were independent agencies. With one marked exception, the latter were still strongly focused on older people.

**Table 2 Provider estimates of proportion of customers aged under 65**

	Social Services in-house providers	Independent agencies
Zero	-	1
1-5%	1	5
6-10%	-	3
15%	1	-
20-25%	4	-
30-35%	-	1
No information	5	2
Total providers	11	12

***Services for other purchasers: other Social Services Departments***

Insufficient information was gathered to make much comment. At least half of the independent agencies undertook work for more than one Social Services Department. Some held block contracts with more than one Department.

Geography was a key factor. Agencies in London can sell to many different Social Services Departments. A small provider in a sparsely populated rural area worked with three different Social Services Departments. But there were other independent providers for whom a single Social Services Department was the only available corporate purchaser. By way of comparison, UKHCA's survey of independent agencies found that 54% worked within only one Local Authority area, while 22% worked within three or more (Mathew 2000).

**Services for other purchasers: private customers**

**Table 3: Provider estimates of proportion of customers who are private, self-funding: (Independent agencies only)**

<i>Estimate</i>	<i>Agencies</i>
Zero	2
1-5%	2
6-10%	3
15%	1
25%	2
50%	1
No estimate	1
Total agencies	12

There were large variations among independent agencies in the proportion of their customer list who were self-funding private customers – see Table 3. At only three agencies were private customers more than 20% of the total – and only these three seemed really interested in private customers. At one agency were there enough private customers for the agency to survive easily without Social Services business. Indeed, it had functioned successfully as a wholly private agency till only recently taking work from Social Services. (Soon after the survey, another of these three agencies greatly increased its private customers to replace contracts with a different Social Services Department from the Purchaser in this survey.) The absence of any private customers at two agencies is noteworthy. One of these agencies was a former in-house provider, transferred to the independent sector, which explains absence of private customers. But at the other agency, company policy explicitly prohibited any wholly self-financing customers. It was a multi-branch private agency which seemed to exist for corporate purchasers only. Possible significance of private customers will be considered later.

Some independent agencies were very much focused round business with a single Social Services Department with which it had a block contract. Others drew their work from a variety of purchasers - sometimes a mix of Social Services Departments, sometimes Social Services and private customers. By way of comparison, UKHCA's survey of independent agencies found that: 'nearly one half of providers were reliant on Local Authorities for more than three-quarters of their business' (Mathew 2000).

### **Market niches for home care providers**

A market in home care should mean that purchasers can choose different agencies to provide different types of home care, according to their proven talents. Conversely, providers can each hone their services to strive for a particular market niche.

In many Authorities, Best Value Reviews of home care have made both Social Services Purchasers and in-house providers seek a market niche for the in-house provider. Best Value Reviews sometimes note that the in-house provider costs more than its independent sector competitors but cannot find sufficient evidence of higher quality output to justify those costs as a general provider of home care. Continued purchase by Social Services may depend on the in-house provider finding some local market niche for which its distinctive qualities do justify its higher costs, thus making it the best value choice.

The survey's interviewees were asked about any market niche for their service.

### ***Social Services in-house providers sought transformation of roles***

A major finding was that all but one of the 11 Social Services in-house providers were seeking a major role transformation. Many were seeking, in essence, to leave general home care for specialised, high skill roles – often in short-term rehabilitation and re-enablement programmes or in joint work with Health. Such roles would utilize their greater training - and justify their higher costs in Best Value competition with the independent sector.

Five of the survey's Social Services in-house providers had received Purchaser assent to the radical new arrangement they sought. They were being reorganised so that they would eventually provide only specialised, higher skill services, while their routine, long-term support roles were to be transferred to the Independent Sector. At the time of the survey, the transformation of two of these Social Services providers was well-advanced. Subsequent contact with two of the others has clarified that the changes then being proposed did in fact occur. For illustrative detail, the new models for the two most advanced providers are described in Panel 2.

Besides these five providers, which had secured Purchaser approval for full role transformation, five other Social Services providers had related aspirations. Some hoped to wholly specialise in short-term assessment, rehabilitation and enablement work or in intensive care. Others sought that such roles should at least form an important component of their work. Some of these had already received Purchaser approval to develop to a degree in such directions.

## **Planned role change at Social Services providers: two examples**

### ***Social Services home care provider 'A'***

A locality based service was being transformed into specialist teams:

- An Intake Team for all the Purchaser's new home care referrals. For up to six weeks it would assess them and undertake rehabilitation and enablement work to establish what service was strictly necessary. Then, if needed, they would be transferred to an appropriate longer-term provider.
- A team which provided a four week programme to assist hospital discharge, then transfer if needed to a longer-term provider.
- A team of 'generic care workers' who could work jointly with Health staff. They were being trained by District Nurses.
- A specialist home care team for people with mental health problems.
- A home care team for people with physical disabilities, people with learning disabilities, and for children.

Under this arrangement, the Social Services provider eventually would serve all publicly funded home care customers who were aged under 65. But, aside from temporary assessment and hospital discharge work, it would serve people aged over 65 only if they had any sort of mental health problem or more than one sensory impairment. Otherwise long-term service for the 'stable frail elderly' would come entirely from independent agencies.

### ***Social Services home care provider 'B'***

This was dividing into four specialist teams:

- A short-term service for assessment, rehabilitation and enablement work, like Provider 'A'.
- A home care team for people with complex needs - like sufferers from MS, Parkinson's Disease, or strokes.
- A service for people with dementia
- A team of mixed Health and Social Services home care staff serving people needing a mix of Health and social care

**Panel 2**

However two of these services worried that Purchasers might not approve their plans for specialised roles. While information was limited, it was evident that Purchaser reservations might concern their in-house service's performance rather than the principle of specialised teams. Sometimes, it became clear from the survey, relations between a Social Services Purchaser and its in-house home care service can be extremely fraught.

### ***Specialised roles and the independent sector***

Most independent providers described themselves as providing a broad cross-section of home care – without identifiable specialisms. But three agencies did provide specialist services for Social Services, alongside more general care.

- Alongside a large general home care contract, one agency had a separate mental health work contract and yet another contract to support family carers.
- Another independent agency included within its services a hostel-based intensive care programme, which could enable early discharge from hospital or offer an alternative to some hospital admissions.
- Yet another agency contributed to a local scheme for terminal care, which enabled people to live in their own homes during their last months of life.

On the one hand independent agencies could identify with providing a broad cross-section of home care roles. But, on the other, some clearly rejected any idea that they should actually specialise in low skilled roles vacated by Social Services providers – like house-cleaning for instance. One proprietor felt he had invested much in staff training in personal care and thus sometimes rejected house-cleaning referrals, which Social Services Purchasers sought to transfer to independent agencies. In every way he wanted his agency to achieve peer status with the Social Services provider.

### **Issues emerging:**

#### ***Will Purchasers let Social Services providers switch to rehabilitation and other specialised roles?***

Many Social Services providers are seeking to specialise in high skill roles which will make use of their particular training and organisation and justify their higher costs. Such roles may reduce their overall involvement with older people, while increasing their work with younger people with disabilities and complex health problems. Many Purchasers will endorse this change in roles; but some will resist it. Wherever a Social Services provider is seeking to confine itself to specialist, skilled roles, the question needs asking whether it must also downsize to fit the amount of relevant work which exists locally.



### ***Can independent agencies compete as rehabilitation specialists?***

Can either sector provide the rehabilitation services now promoted by government? In some obvious ways Social Services providers seem advantaged. For rehabilitation, staff need autonomy to vary service day by day in response to a service user's progress, since service reduction is an important goal. Purchasers may feel more ready to grant such autonomy to their in-house provider than to an independent agency, where the profit motive might conflict with service reduction. But are there in fact ways of using independent agencies for rehabilitation and re-enabling? How otherwise can rehabilitation be provided in Authorities where home care is now 100% independent sector? How can it be provided where Purchasers doubt the suitability of their particular in-house provider?

### ***It can be hard to find a keen cleaner these days***

Among providers in both sectors, there was widespread reluctance to undertake some traditional 'low skill' home care tasks' like house-cleaning or shopping, once staff had trained in complex personal care. Interviewees conveyed that both staff and managers found this a problem. A Social Services provider commented:

'You may have been involved with a terminally ill person and have to apply knowledge and skills relevant to this and then you have to go down the road and just get the Hoover out....So one minute they're almost nursing auxiliaries and the next minute they're Mrs Mops as it were.'

Also, some managers in both sectors feared that accepting quantities of 'low skill' home care tasks might typecast their service and consign it to the sort of market niche which no-one wanted. They sometimes turned down referrals for this reason. In the case of Social Services providers, there was the particular risk that a future Best Value survey might discover a 'low skill' profile to their work and query their higher costs. But Social Services Purchasers did sometimes turn to their in-house provider to get help for people who needed only shopping or house cleaning, when cheaper options failed.

### **Purchaser control of how providers gave care**

The providers in the survey varied widely in the extent to which Social Services Care Management first specified, then maintained control over the detail of the home care which it purchased.

In the following account of these variations, the term 'Care Management' is used broadly for any front-line Social Services workers through whom Social Services Purchasers dealt with customers and service providers.

- At some Social Services Departments, a single set of 'Care Managers' assessed new customers and devised initial care packages, chose providers, and subsequently conducted reviews and revised care packages.
- At others these roles were divided – for instance into one set of workers who conducted assessments and chose providers, while another set conducted reviews and any other re-assessments.
- Other Departments separated Care Management staff, who solely conducted assessments or re-assessments, from other staff, sometimes called 'Brokers', who chose and negotiated with providers and monitored customers' services long-term.

Here 'Care Management' is used for all Purchasers' agents in any of these roles.

### ***High control by Care Management***

At one end of the spectrum were six providers for whom local Care Management initially specified in detail how each customer should be served and required the provider to seek its permission before making any changes.

Care Management specified:

- how many visits per week
- the exact length of each visit. Some interviewees thus called this a 'time-centred' way of working
- exactly what tasks would be done on each visit
- the actual time of day at which each visit should be given

None of these things could be changed without explicit permission from Care Management. Sometimes requesting changes could involve long delays if Care Managers routinely closed long-term cases and a fresh Care Manager needed to be delegated to examine the provider's request.

'If a service user says "Can you do my shop on Tuesday this week instead of Thursday?" that means a phone-call to the office, then a phone-call to a Social Worker to ask permission to do this.'

***Manager, Social Services home care provider.***

Alongside four independent sector providers, two in-house Social Services providers were purchased in this fashion. These six providers were generally critical of the degree of control exercised by Care Management. Particularly criticised were requirements to obtain permission for any changes to the timings of visits, set according to customer's preferences when a Care Manager first commissioned a customer's service. This could make a customer request, years later, for an occasional late rise, a time-consuming and complex matter. For instance in such rigid timetables of visits, change for one customer can mean that changes for others must also be negotiated with Care Management. A reason for such controls is that often a provider has been chosen for a customer because they promised service at times which Care Management found to suit the customer. Accordingly, if providers can change visit times too easily, providers' convenience might erode customer rights to be served at the time slots bought for them. But providers questioned whether such controls really benefited customers. Some said that customers would get arrangements which suited them better, when circumstances changed, though swift, direct negotiations with providers.

Particularly critical of high control by Care Management were the two Social Services providers in this category. Unlike some Authorities, where Purchasers accorded their in-house provider a privileged, more autonomous status, Care Managers treated these providers no different from independent agencies. Social Services providers could find this distressing. They could feel aspersions on their trustworthiness and competence if, since the Purchaser/Provider division, they had been stopped from making very basic decisions about care-giving. Former Social Worker peers and colleagues could seem transformed into controlling, upstart Care Managers.

Independent agencies, in contrast, seemed to find control by Care Management generally easy to accept, as part of a commercial contract. But they could still criticise the degree of detail to which control was exercised. For instance, one agency believed Care Management should rightfully specify how much time should be spent on particular tasks for each customer. But then they should allow the provider and the customer to work out between them exactly when and how this was done.

***No control by Care Management: Social Services providers which assess, prescribe and provide care all themselves***

At the opposite end of the spectrum were two Social Services in-house providers where the line-manager to care staff assessed each referral, then devised and, if needed, revised care packages. These providers functioned independent from Care Managers, who dealt only with independent providers. Control by Social Services Purchasers occurred via a weekly panel of senior managers who had to ratify every new care package and every major change to a care package – often using their overview of resources available.

The provider staff line-manager could adjust care in the light of overall customer needs at the time. Instead of set lengths for each visit, staff were assigned tasks only and told to spend as long as these tasks required, which varied with customers' health. 'Task-centred, not time-centred' was how this arrangement was sometimes described. These features are all typical of how Social Services home care providers commonly worked before the Purchaser/Provider division. So these two providers illustrate the previous system.

In addition, there was a third Social Services in-house provider which was now reverting to this model of management, as part of its recent transformation into a specialist short-term rehabilitation and re-enablement service, as described earlier. But details had not yet been clarified. Obviously this model of empowered provider suits a rehabilitation and re-enablement service, where a manager may need to rapidly and repeatedly change staff time and tasks in response to a customer's progress. The new rehabilitation roles sought by many Social Services providers might occasion reversions to this model elsewhere.

Between these two extremes - high control by Care Management and no control - lay various in-between arrangements whereby Care Management allowed providers various degrees of flexibility.

### ***Care Management allows moderate flexibility***

There were seven independent providers which were allowed flexibility about the timings when they gave visits. On other counts though – number and length of visits and the tasks undertaken – they were under the same Care Management control as the ‘High Control’ providers.

- For one provider, for instance, Care Managers often set a two hour time-frame within which a visit must occur. The provider and customer could then negotiate a time within this.
- Two other providers were allowed to quickly change visit timings after discussion with a customer without Purchaser authorisation, though they should inform Care Management afterwards.
- Two more providers could negotiate changed timings with customers without even telling Care Management.

On other fronts, too, transactions with Care Management seemed often smoother, faster and more flexible among these seven providers and relationships sounded better. For instance, if a customer seemed to suddenly need more care, one independent provider could count on funding to temporarily increase the time supplied for up to a week, to allow for Care Management delay in re-assessing the case. Payment was assured to them whether or not an increase was eventually agreed. In contrast, at one independent provider in the ‘High Control’ group, the provider had to fund any such emergency increase above Care Management’s initial time specifications. Even if increased time was eventually approved, the provider would receive no back-pay for increased care prior to re-assessment. And delay before re-assessment had been as much as a fortnight.

### ***Care Management allows major flexibility***

There were five more providers who enjoyed various degrees of greater flexibility, additional to re-arranging the timing of visits. This shaded into considerable autonomy for a couple of these providers.

- For its less dependent customers, one independent agency received from Care Management a list of tasks per customer and a weekly time budget for performing these. Thereafter the provider could negotiate directly with the about the number, timings, and lengths of visits whereby this time budget was used.

The other four providers could make limited increases to the actual time they regularly gave a customer - without Care Management permission. All were Social Services providers, as might be expected from the cost implications.

- Two of these Social Services providers were allowed, at their own discretion, to increase the time budget for a customer. In one case, visit lengths could be increased by up to 15 minutes. In the other, total weekly care could be increased by up to three hours per customer. Greater increases required Care Management approval.
- Two more Social Services providers had negotiated a complete or partial return to 'task-centred' working, as customary before the Purchaser Provider division. In one case, Care Managers no longer assigned time-lengths to visits but simply listed goals or tasks. The provider then deployed whatever time proved necessary. At the other provider, while Purchasers initially indicated timed amounts of care, provider staff had some flexibility to work in a 'task-centred' way. The charging system was sensitive to the way in which visit lengths could change day-by-day in response to customers' circumstances.

### ***General conclusions***

There was pronounced frustration with high control by Care Management. Providers generally sought greater flexibility to themselves organise and modify the way they worked.

Friction between providers and Care Management was greatest among Social Services in-house providers. The best relations between Social Services providers and Care Management occurred when the latter permitted more provider autonomy. But even under the latter circumstances, there were still instances of very strained relations. A common problem was feeling among provider managers that the Purchaser/Provider division had given them an unjustifiably subordinate status to people whom they had previously regarded as Social Worker peers. They felt their subordinate status was particularly unjustifiable in view of their much better knowledge of their customers, since Care Managers' contacts with customers were often so fleeting. The trend for Social Services providers to seek short-term rehabilitation roles may reduce the sort of transactions with Care Management which generate friction.

A variety of Care Management arrangements were encountered which delegated degrees of decision-making to providers. This is likely to ease the work of both providers and Care Managers, though with possible risk to Social Services policy on how resources are used. It was notable that arrangements which gave providers discretion to vary amounts of time spent on a customer were confined to Social Services providers. A major innovation would be systems which entrust independent sector providers to make limited increases in the amount of time given a customer. This obviously requires a greater leap than with the in-house provider. Yet, in principle, systems could be devised (see pages 86-89). If long-term home care for older people is to become the independent sector's role, as many Social Services Departments may seek, this would be a key development for long-term care.

The Care Management arrangements which gave providers greatest flexibility seemed to partly restore Social Services providers to the way they worked before the Purchaser/Provider division. Is such flexibility then a mistake? Or is the Purchaser/Provider division itself an obstacle to good care, which is thus being eroded as staff try to improve service? A key issue seemed to be whether a service shifted back to 'task-centred' as opposed to 'time-centred' working. It may be that, once this happens, other features of a service start to change towards the pattern of the two old-style Social Services providers who were not under Care Management. Staff seemed to acquire much more freedom to revise their work in response to circumstances. A customer's service seemed more readily affected by changing circumstances among other customers. Subsequent research is examining this further.

There are large open questions about how customers are affected by different Care Management/provider arrangements or by 'time-centred' versus 'task-centred' working. Subsequent research aims to explore this. Very prescriptive Care Management can be criticised as stopping provider staff from promptly accommodating customer requests or delaying necessary revisions of care plans. But equally it can be justified as protecting customers from having their visit lengths trimmed or their visit times arbitrarily changed to suit the convenience of providers. Some interesting information emerged from these interviews about consequences for customers from 'time-centred' and 'task-centred' working.

- Some independent sector providers stressed how their customers benefited from the spare time left in 'time-centred' fixed length visits set by Care Managers, once home care staff had finished the tasks prescribed by the Care Plan. These providers' managers insisted that staff stay the full length and use any spare time for any small tasks which the customer desired, like making tea, ironing or extra cleaning, or simply talking to them. They believed this had a major effect on customer-staff relationships and on perceived quality of care. But there were other providers where fixed visit lengths did not produce this effect because Care Managers systematically commissioned visit lengths so short that there would never be spare time. Also, at half the providers staff were permitted to leave early if prescribed tasks were completed – sometimes repeated early departures had to be reported to Care Management, as a guide that time could be trimmed. So the benefits from 'time-centred' fixed visit lengths were strictly conditional.
- 'Task-centred' working could preclude such small extra services because finishing the prescribed tasks was the cue for staff to leave. Leaving immediately was part of the 'task-centred' philosophy. Staff would save time whenever possible because they never knew what time-consuming emergencies might be waiting to delay them later in the day. Also, staff could worry that offering extra help could unfairly ensnare low income customers in

extra charges for the time added to the visit. In contrast, in 'time-centred' visits the time costs were already fixed. These factors, managers believed, inhibited 'task-centred' staff from giving time for conversation or small extras. If task-centred workers gave these, one manager said, it would generally be to the last customers on their round.

### ***Spare time during a 'time-centred' visit***

'A straightforward morning visit where you're getting someone up, washed and dressed and making their breakfast – you're usually allowed between 45 minutes and an hour for this. But it can usually be done in 30 or 35 minutes. So they've got that extra time just not to have to rush off. So you've got that quality 10 or 15 minutes to just wash a few pots while you're having a natter with them or a pot of tea. It's a personal touch I think...I think that's why this business has developed so well....That little bit extra. That ten minutes when you can get the vacuum out and vacuum round for them or make a cup of coffee or check the fire's alright or iron that shirt. It's little things like that which make all the difference.'

#### ***Manager, independent agency***

- However, 'task-centred' working could sometimes greatly benefit customers who sought an occasional extra item which might take too long for the spare time in a 'time-centred' visit slot. For instance, in the 'time-centred' model, to be taken shopping would usually require a request to Care Management to commission extra provider time on a one-off basis. This could involve delay and in some Authorities would definitely not get approval. But sometimes customers in 'task-centred' services could get such help (and pay charges for it) without Care Management being consulted – though only if a worker or a manager felt motivated to give it and if the service was not overwhelmed by more urgent tasks. When such conditions were met, some fairly time-consuming items of one-off help could be provided swiftly and easily. For instance when a customer's bathroom was suddenly seriously damaged, a 'task-centred' Social Services provider immediately found, briefed and supervised private sector repair workers without a word to Care Management about the amount of unscheduled staff time required. However, one type of extra help sounded very hard to obtain in 'task-centred' services, even when time was available and when staff strongly wanted to give it – conversation and companionship on its own. 'Task-centred' seemed indeed an apt description.



### ***Conversation time with customers in a 'task-centred' service***

'It all adds to the cost to the customer. We do need to show that we are charging accordingly....It just seems a bit mercenary to sit and chat and get through somebody's problems and at the end of the conversation "Right, that was 20 minutes. That's cost you so much." That shouldn't be what we're about.'

***Manager, Social Services in-house provider***

While, as described, 'task-centred' flexible visit lengths existed officially only at some Social Services providers, at some independent providers a semi-official or unofficial practice occurred which partly resembles this. As mentioned earlier, half the 'time-centred' providers permitted staff to leave a customer early, if they had already completed the tasks on the Care Plan. As will be described shortly, some Care Management services actually wished provider staff to do this whenever possible – and to report the fact – to explore how short a visit was needed. It is not known how early staff left, where they were permitted. Nor is it known whether staff actually left early at those providers where managers expected them to stay for the full fixed-length visit. But the practice is clearly important, if routine, since it amounts to delivery of a type of task-centred service, while the provider is paid for a time-centred one.

There appears a crucial difference between this type of task-centred working and that practiced officially by some Social Services providers. At the latter, visit lengths could be both increased and decreased according to a customer's changing circumstances. But, where early departure from fixed-length visits is concerned, flexibility seems to be only about reducing time. The preceding comparison of time-centred and task-centred visit lengths, found each to offer different benefits to the customer and neither to have clear advantage. The same cannot be said about early departure from fixed-length visits. This definitely offers the customer less than either of the other arrangements.

Standard 6.2 of the new Domiciliary Care Standards requires staff to 'work for the full amount of time allocated'. This prohibits staff from themselves shortening visits. But, if provider managers or Care Managers are inclined otherwise, there might be room for ambiguity about whether a fixed amount of time had been allocated.

## **Purchaser policies which affect quality of service**

### ***For what range of purposes will care management commission home care time for older people?***

Authorities varied in the range of purposes for which Care Management would purchase home care for older people. Where older people were concerned, some Authorities would only purchase help which was necessary for basic physical survival. They would not use home care to support older people's morale or quality of life.

For instance an independent sector provider had unsuccessfully approached Care Management with a request from a customer that she be taken on a very short walk immediately after her lunch. Care Management had commissioned a 30 minutes fixed time-slot to provide lunch and wash up, so there was no spare time for the walk, hence extra time had to be requested. This Care Management service refused this request, though it was usually swift to agree odd extras, like extra meals, which concerned maintaining physical survival.

Care Management services differed both in their general readiness to commission time for older people's quality of life and in the type of help which they would commission. Generally common was commissioning home care time to read or write letters for people who could not do this themselves, if there were no other sources of help. Even a conspicuously parsimonious Care Management service explicitly included time for this in some customers' Care Plans. Less common was Care Management support for feeding and cleaning up after older people's pets. Three Care Management services would routinely commission this, though providers in many other localities actually sometimes provided this on their own initiative. At least three Care Management services did commission some escorted outings for older people, though these were rare events. In contrast, escorted outings were routinely commissioned by many Care Management services for home care customers aged under 65.

One item stood out as an area where many home care providers said their Care Management service would absolutely never commission help for older people. This was companionship, conversation time, relationship time between home care staff and older people. But this certainly does not mean that providers would not supply this somehow. Some of these same Care Management services did sometimes respond to information from home care about a customer's loneliness – but through referral to a day centre, rather than through using home care staff for social support.

However, in contrast, there were four Authorities where Care Management did sometimes explicitly commission companionship from home care. At two of these, this would be in special situations only - for instance following a bereavement or to persuade a challenging customer to co-operate with personal care. But there were

two Authorities where Care Managers regularly specified for selected customers that companionship from home care was part of the care package. For instance for certain customers home care staff were instructed by Care Managers in the Care Plan to make sure they gave conversation during a visit to provide lunch. In a fifth Authority the Social Services home care service itself ran two successful, long-standing weekly social clubs for its own customers.

***Age discrimination and commissioning help for quality of life***

'I personally feel that younger adults with physical disability get a lot more flexible service, as do the children, compared to people over 65. ...Once you get to 65, all those sort of services stop.'

***Manager, Social Services in-house provider***

A widely repeated comment, made by provider managers in seven of the eleven Authorities studied, was that their local Care Management treated requests concerning quality of life more restrictively if they came from people aged over 65. Alongside their older customers many providers served a significant minority of people aged under 65, as described earlier. These were younger people with physical disabilities, learning disabilities, mental health problems or difficulties with childcare. These providers described contrasts between the services they were commissioned to provide to different age groups – and the reductions sometimes made to a customer's services on reaching 65 and being transferred to a Care Management section for older people. For instance an independent sector provider was commissioned to provide regular 'baking together' sessions with a physically disabled woman aged under 65 in addition to her survival care. The interviewee said her agency also served many physically disabled older women who would likewise much benefit from this through companionship, activity and engagement, but such help would not be commissioned for them.

'I'm sure we could provide anything which Care Managers could finance. It's all down to finance. With the Children and Families work, which we do, we do a wide variety of tasks because the Children and Families budget seems to have more resources. We do things like sitting and taking children out and taking them to day centres, taking them swimming. All sorts of jobs which the staff like to do, which is a pleasure.'

***Manager, Social Services in-house provider***

A common example given of age-influence in commissioning was escorting people on outings for leisure purposes. Providers were regularly commissioned to take younger customers' children on outings to parks or to accompany isolated younger adults with mental health problems or learning disabilities to restaurants or leisure activities. Rarely or never would such time be commissioned for older people. There are issues here relevant to the struggle against age discrimination required by the National Service Framework for Older People (Department of Health 2001) and reiterated in Fair Access to Care Services (Department of Health 2002).

### ***Authorities which prioritised reduction of costs***

Providers in five Authorities made comments about how short were the visits commissioned by Social Services - whatever the purpose – or about how Care Managers strove to shorten visits wherever possible. For instance one Care Management service had reduced the minimum time for the visits it would commission from 30 minutes to 10 minutes. The independent provider, which described this, felt 10 minute visits could be very unrealistic, for instance if a customer simply needed time to get to the door. It had countered by setting a 20 minute minimum length as its own terms of business. An independent agency in another Authority refused to make visits which lasted less than 30 minutes. The proprietor explained:

‘Some of the visits may need only 15 minutes for tasks but the other 15 minutes is dealing with the client’s emotional needs. I just feel that if you’re going in to do something which takes just 15 minutes, like giving someone a quick wash or changing an incontinence pad and then walk out, I think that is very intrusive care. I think you have got to have time to speak to the client before you start personal care. You also need time afterwards to speak to them, to check that they’re alright, make sure that the house is safe, that they’ve got everything they need.... But we are being pushed all the time to lessen our hours, to make 15 or 20 minute calls, which I feel is so unkind to a client.’

Some Authorities did not want providers to use spare time at the end of a fixed-length visit to talk to customers or fulfil any requests. While they would pay for the full visit, they preferred home care staff to leave early and record this fact, as evidence for reducing visit lengths if it happened regularly. Some providers cooperated with this. But some did not. An independent provider for a highly cost-conscious Authority commented: ‘We don’t hurry them out of the door, if they feel that a particular person could do with a cup of tea, which may not be on the task list. The care planning from Social Services can be quite restrictive’. Social Services, she said, would have preferred rapid departure and notification to Care Management.

In the opposite direction were two Authorities where providers praised Care Managers for their holistic concern for customers’ welfare and for understanding the

realities of home care. One Care Management service routinely commissioned visit lengths slightly longer than usually necessary, to allow for periodic unforeseen problems. Providers were expected to use any spare time for conversation or for meeting quick customer requests.



## **SECTION FOUR: PROVIDER POLICIES WHICH AFFECT QUALITY OF SERVICE**

Besides Care Management's commissioning policies, another key influence on service quality was policy and attitudes among the providers themselves.

For instance, whether or not Care Managers would commission escorted outings for older people, there were four Social Services home care providers which refused any such work. There was another Social Services provider which would not give even minimal, occasional help with customers' pets - even when its own Care Managers had made specific requests. Some providers instructed staff to fulfil any customer requests during spare time after scheduled tasks were finished, whereas others let staff leave immediately. Some providers prohibited their staff from fulfilling some common customer requests under any circumstances, whereas others seemed concerned to accommodate customers as much as possible. Prohibition on changing light-bulbs for frail older people has become a somewhat proverbial example of such bans by provider managers: these providers varied widely in their stance on light-bulbs.

Other important areas for customer satisfaction are the number of different workers who visit each customer and the punctuality with which visits are made. Providers can differ widely in the extent to which they succeed – or indeed attempt – to serve customers through staff who know them and their requirements. Visit times and their punctuality reflect a mix of policy and practice by both providers and Care Managers.

Policies and practices of providers are now reviewed in each area in turn.

### ***Provider flexibility in response to customer requests***

To explore this general area, provider managers were asked how they usually responded to a variety of miscellaneous requests, which older people sometimes find that home care staff refuse. Examples included:

- getting light-bulbs changed,
- finding trustworthy plumbers, gardeners or repair services,
- shopping for non-essential items like a birthday card,
- getting a letter written,
- extra house-cleaning,
- basic help with customers' pets
- helping a frail older person to get out for a little fresh air on a sunny day.

Older people are known to value highly home care services which can help them flexibly in such ways (Henwood *et al.* 1998, Clark *et al.* 1998). Of course many older home care customers do not need such help from home care because they have nearby relatives or helpful neighbours or sheltered housing wardens who can do these things for them. But for frail older people who know no-one helpful nearby, the

attitude of their home care service may make all the difference for their quality of life (Woodruff & Applebaum 1996).

There is an open question about how far interviewees' responses show how their staff actually behaved, since it is well recognised that many front-line home care staff ignore instructions which they feel conflict with acting in a caring way (Sinclair et al. 2000). Indeed, often interviewees themselves conveyed that they did not enforce their service's bans on certain types of help because they disagreed so strongly. For instance the head of an in-house Social Services provider combined mention of her service's restrictions on pet care with a paean on the benefits of pets for older people and frank statement that she knew customers for whom the restrictions were currently flouted. Likewise, even where managers try to enforce a restriction, it is possible that staff may privately ignore this. But it does seem more likely that staff will be more comprehensively helpful to customers at agencies which encourage this than at agencies which try to restrict them.

### **Provider managers' general responsiveness to customers' requests**

Two independent sector interviewees stood out for their contrasting responses.

Manager A, at a small independent provider, stressed the importance of helping customers with sundry practical and social needs and how necessary for older people's quality of life was such comprehensive care. On every topic investigated, this manager actually required her staff to officially provide types of help which were often, at best, given only as covert favours at other services. For instance, recommending private tradesmen, like plumbers, gardeners or electricians, was widely forbidden in home care. Manager A, however, not only recommended such services but, if needed, would also have her staff phone them on behalf of their customers and be present to promote a fair transaction when the worker called. She commented:

'They're asking the home carer to do it for them because there isn't anyone else to do it for them – they've got no family, friends or neighbours to rely on ... We've always done it. It's part and parcel of caring for someone really.'

Hers was one of only two services which changed customers' light bulbs on an official and routine basis, though many providers seemed to countenance this being done covertly. Unusually, her staff were encouraged to meet customer requests for impromptu outings, like accompanied shopping, whenever commonsense dictated it safe and practicable. She saw no grounds for many common home care regulations and felt they compromised a service from taking a commonsense 'caring' stance to important requests. In Manager A's view, if staff were competent to perform their core caring duties, which involved significant judgement, they were also competent to decide on when it was safe to let a customer come shopping with them. She had never encountered any problems from her 'can do' approach.



In contrast Manager B, the proprietor of another independent sector provider, focused on minimising any risk to his agency. He commented:

‘Beware that if you start giving some help which was an extra, that you didn’t have to give, that if any problems result from it, you may be held accountable by Social Services and others ... The easiest way is you just don’t do it’.

He was serious about his ban on staff changing light bulbs. He acknowledged that he lacked a clear rationale for it. But, since the Social Services home care provider banned it, it was something that he did not need to provide in order to compete with the latter - and a problem might always be possible one day. Concerning requests for private repair services, he would tell older customers to look for adverts in the newspaper.

Between Manager A and Manager B come the other providers, some closer to the one and some to the other. For each provider there would be some topics where response to requests was restricted or prohibited. Providers differed as to which topics these were and whether, as mentioned, managers contravened these restrictions to some degree or other. Some providers supplied staff with lists showing which requests were always prohibited and which required a phone-call to a manager for guidance, if asked to do them.

On each category of request, a wide range of responses were encountered. Some activities got routine permission if time was available. Some activities were permitted only if other options, like asking customers’ relatives, had been exhausted. Sometimes activities were always banned but managers indicated disdain for the rule and no real enforcement. (‘We’re not allowed to change a light-bulb but I would say that 99% of my staff would do so’. *Manager, independent provider*). Sometimes interviewees affirmed support for a ban – but in such a tired or apologetic fashion that it was hard to believe it was well enforced. Sometimes interviewees sounded serious about a prohibition, though one could not know if they succeeded in enforcing it.

### ***Getting a light-bulb changed – responses from 23 home care providers***

As mentioned, restrictions on home care staff changing light-bulbs have become a near proverbial instance of new bureaucratic interference with quality and comprehensiveness of service. Accordingly the full picture at these providers is worth presenting.

- 2 independent providers changed light-bulbs as an explicit, routine part of home care, using any suitable aids including sturdy chairs
- 1 Social Services provider would likewise officially change light-bulbs, but only if no other means were available.
- 8 providers could officially change light-bulbs if using a step-ladder which met local specifications (e.g. in one case a rail at the side)

At only one of these services was a step-ladder provided – via the agency’s mobile special tasks squad in a van.

At five of the others it sounded as though many staff changed bulbs without a step ladder without managers worrying, though some staff did refuse.

At the remaining two, managers seemed to enforce the step-ladder rule firmly.

- 11 providers where staff were officially banned from changing bulbs under any circumstances

At three, it sounded as though the ban was often ignored – with private approval by the managers interviewed.

At four, the manager interviewed supported and strove to enforce the ban.

At four others, the manager’s position on the ban was less clear. It seemed probable that it was quite often breached.

- One provider said it had never been asked to change a light-bulb. (If ever asked, guidance from head office would be sought.)

Thus, whether by the rules or in spite of them, at most of these providers home care staff would change an older customer’s light-bulbs, if no-one else could do this.

### Getting a light bulb changed

'We're not allowed to change a light-bulb. We have to contact an electrician. It can be either Social Services which does this, the Brokers or Care Managers, if we tell them we've had this request, if they don't have family that is. If they have a warden, we'd contact the warden. If they have family, we contact them.'

***Proprietor, independent agency***

'We'll change light-bulbs with no problems.... I can understand people not wanting to stand on a rickety table to do it, but if you've got a step-ladder or a sturdy chair, there isn't a problem.'

***Manager, independent agency***

'Light-bulbs have been a particular problem of ours....In theory there's no reason why a home care worker cannot change a light-bulb as long as she does it safely....UNISON would define safety as being a small step-ladder with rubber feet, whereas most normal people would define it as a chair that's stable. We know that home care workers change bulbs but officially we don't tell them to do this unless we gave them all step-ladders.'

***Head of Service, Social Services in-house provider***

'The home carer ...shouldn't stand on more than two rungs of a step-ladder. But I'm sure it happens. These home carers are people first and they're running their own homes and changing light bulbs.'

***Manager, Social Services in-house provider***

'I've got a feeling that my home helps would do it. I'm sure they would do it. But it's not recommended under Health & Safety unless they've got ladders with a rail at the side. We try to discourage it. I know it sounds very petty. But I'm afraid it's the way we're going at the moment.'

***Manager, Social Services in-house provider***

'We wouldn't. We shouldn't. But I know on occasion it has happened....I know one or two carers that wouldn't leave an old person without a light'

***Manager, independent agency***

'We would look, I'm afraid, towards the next-of-kin on most of those sorts of things.'

***Director, independent agency***

### ***Recommending household repair and maintenance services***

One category of request stood out for prohibitions which managers seemed genuinely concerned to enforce. This was recommendation of plumbers, electricians, gardeners, private cleaners etc to older people who sought trustworthy tradesmen. Social Services providers in particular seemed restricted from recommending any private tradesman. Worries included possible consequences for the home care service if the tradesman proved disappointing or if the customer failed to pay the bill. One manager feared that staff might recommend someone who had not been police-checked, although left to their own devices customers would face at least as much risk anyway. There were fears that recommendations might compromise Local Authority impartiality regarding fair trade. Instead of recommending tradesmen, five Social Services providers referred customers to local voluntary organisations, like local Age Concern, which had produced their own lists of trustworthy tradesmen in response to this common problem. Sometimes these lists were very well researched and updated. There were other providers though who simply gave customers a long general list of tradesmen without any information or recommendation. This may not have been so helpful. There were two providers which referred such requests to Care Managers. Another pair preferred to avoid responding, lest they be dragged into the complications feared to surround such requests. However there were also five providers which did make direct recommendations to their customers and had never encountered problems from doing so. One of these was in fact a Social Services provider, which would also contact and negotiate such private services itself. It had done this for years without incident. A couple of home care providers actually undertook some small repairs themselves. One large independent provider had a special squad for such tasks with a van.

'It does seem extremely hard when you get a 98 year old lady being reviewed and having her housework taken away. At that age it's obviously very difficult for her to go out into the world and find somebody who's appropriate. It seems a big issue to them. Reviewing Officers will give them the leaflets but it's up to the older person to make the arrangements.'

***Manager, Social Services in-house provider***

### ***Escorted outings***

Only a few providers, both independent sector and Social Services, could let older customers accompany them on shopping trips without specific prior arrangements. But some did this completely routinely.

All independent providers would offer shopping or other excursions, if Care Managers commissioned extra time for this. But Care Managers did this for older people only rarely or never, as mentioned earlier. A few independent providers also routinely gave customers unscheduled outings, like shopping trips, somehow squeezing in the time.

Social Services providers divided fairly evenly between:

- those which prohibited any escorted outings whatsoever
- those where outings were sometimes specifically authorised by provider managers or were commissioned by Care Managers
- those where staff routinely took customers on unscheduled outings, usually for shopping, when time permitted.

‘Somebody, rather than having their shopping done, would rather go out for a walk in a wheelchair. It’s difficult because we’re not supposed to take people out... Social Services won’t pay for people to go out walks. So it’s very difficult unless we lie.’

***Manager, independent agency***

### ***Pet care***

Care of older customers’ pets raised some particular issues, though this topic was not explored with all interviewees. Sometimes pet care was explicitly commissioned by Care Managers. Sometimes Care Managers had not noticed the pet - maybe the assessment had been done by phone. Sometimes an Authority would never commission pet care. But customers’ pets were nevertheless hard to ignore. Cleaning up after pets could be disgusting and difficult for some staff but, for a service in the hygiene business, even more difficult to ignore. Some staff feared certain pets, whereas others liked them. Sometimes a service imposed a total ban on any pet care – in the interests of protecting staff. Several set limits as to the type of pet-care which they would provide. Other providers seemed ready to do anything asked of them, as long as adequate time was commissioned. One Social Services provider sometimes assigned staff for likely rapport with a new customer’s pet. If a home care worker themselves kept the same type of pet, problems of staff fear or disgust were very much less likely. Some interviewees spoke passionately about the gains for older people’s morale from companionship from a pet.

### ***Restrictions on home care can appear in private services too***

While private, self-funded home care sometimes promotes very customer-responsive service, it is worth noting that inflexible codes of restrictions can sometimes appear in wholly private services, as well as those for publicly funded customers.

One independent provider, which actually had the largest proportion of private customers, had created a code of restrictions for its private and Social Services customers alike.

- Even wholly private customers could only get light-bulbs changed if they supplied a step-ladder.
- They could not get recommendations about private tradesmen
- Nor have heavy furniture moved during house-cleaning.
- While they could get as much other pet-care as they paid for, dog-walking and the cleaning of cat-litter trays was totally prohibited.

These restrictions aside, private customers could have as much in the way of cleaning, conversation and accompanied outings as they paid for. This code had developed in a service which till recently had served only self-funding, private customers. It was also the smallest provider in the survey.

More often flexibility and customer-responsiveness seemed easier for small, single branch providers, like Manager A's agency, which could make informed decisions on a case-by-case basis. In contrast, local branches of large providers, whether independent sector or Social Services, sometimes had written rules about prohibited activities imposed by head office.

But here was an example how a small private provider could create its own code of routine restrictions on services.

### ***Help given in staff's own time***

Help given by staff in their own time could play a significant part. All providers smiled on staff giving their own time for small items like buying birthday cards on behalf of customers. But providers varied markedly concerning more time-consuming help. Some seemed generally unconcerned, whereas others would worry about anything much more than buying a card. The latter might fear it could lead to an over-involved relationship which would eventually exploit either worker or

customer, as described elsewhere. At one Social Services provider, staff were regularly transferred from a customer if it was discovered that they were routinely giving extra help in their own time.

### ***Differences between Social Services and independent sector providers***

The picture is complex. The providers which seemed most consistently and energetically responsive to customer requests were independent sector. But so were those which were least responsive and which imposed blanket prohibitions on particular types of help - a rather larger number in fact. In-house Social Services providers came somewhere in-between these contrasting clusters of independent agencies.

It was noticeable that the two independent agencies which were most responsive had substantial numbers of wholly private customers and that they were also generally keen to offer privately-paid extra services to customers funded by Social Services. As will be described shortly, other independent agencies often had few wholly private customers and seemed little interested in giving privately paid extras to their Social Services customers. It is possible that the former two agencies had developed a general 'can do' attitude to customers' requests in the course of building up their private clientele. They may have transferred such customer-responsive attitudes to their Social Services customers.

In contrast some other independent agencies seemed to regard the Social Services Department itself as the customer, rather than the older service users whom it funded. What mattered to the Department was what mattered to them. They were very concerned to give satisfaction on block contracts. Assisting requests which were not on Social Services' Care Plan may have seemed of marginal importance.

To an extent, Social Services providers seemed more likely than independent providers to know how their customers could obtain help from elsewhere, if they were not allowed to meet requests themselves. They were likely to know how, in theory at least, Social Services believed a need should be met and to know wider Social Services resources. For instance one Social Services provider could refer light-bulb changing, via Care Managers, to a team of unqualified social workers who were somehow rated as safer hands for this task. When an independent agency likewise declined a request, it was less likely to name alternatives, unless to inform the Care Manager or next-of-kin.

### ***Was it really necessary to routinely prohibit certain types of help?***

Across both sectors, there seemed a puzzling lack of clear explanations for comprehensive bans on activities like light-bulb changing or recommending tradesmen – even from defenders of these bans. They were often ascribed to inscrutable higher authorities, imagined hazards or the following of trends at other services, rather than specific problem incidents which had proved them necessary.

Sometimes 'insurance' was cited as a reason but the interviewee could not explain the issues or else contradicted this through other activities which they did undertake. A contrast was the restriction on close staff-customer relationships at some services, where interviewees readily cited specific incidents which had prompted the restriction. A contrast too was the clarity among interviewees whose services did change bulbs, sometimes take older people out, or organise help from electricians or plumbers. They could say immediately why they believed it right to do this for selected customers. For every activity which some service prohibited because of conjectured problems, there was another service which was routinely performing it without difficulties and for clear purposes.

### ***Managers' priorities for additional help for their older customers***

Interviewees were asked about improvements which they believed would particularly benefit their current customers. Most common responses were:

- Time to take customers out of their homes – to shops, to any remaining relatives or friends, to parks, to cafes, or just for walks. This was the most common response.
- For people who cannot be taken out, time to talk to them or read to them at home.
- Bathing and showering more often and for more people – including longer, relaxing baths without time pressure.



### **Privately paid extra help for customers funded by Social Services**

An obvious means whereby home care customers might obtain extra help of importance to them is to pay privately for some extra time.

- One way this can occur is for an independent agency to charge a customer, whose main care is funded by Social Services, for some extra help from agency staff. In the telephone interviews, independent agency managers were asked whether they sometimes provided help on this basis.

But it is worth noting other possible routes to private extra help which were not explored during the interviews.

- Independent agency staff might make their own freelance arrangements with customers to work extra for them and receive direct payment from the customer. At many agencies this is strictly prohibited, not least because of the threat it poses to any self-funding, private clientele. For, once introduced to each other, worker and private customer might negotiate their own pay arrangements, which offer the worker more while costing the customer less, than if the agency were levying its standard private charges. However, the survey was to discover low interest in income from privately paid extras among many of the independent agencies in this survey. So possibly freelance extra work by staff might not have always been so unwelcome to these agencies as anticipated.
- Another route to private extra help is for the staff of Social Services home care providers to make freelance arrangements with their customers in the same way. While not systematically investigated, it emerged that such private working sometimes occurred at two of the Social Services providers at least, though prohibited at some of the others. The head of one in-house home care service made it clear that such work was undertaken and that she saw its benefits for customers, although 'it is not accepted policy procedure'. At the other provider, there were unwritten practical codes among provider managers whereby staff could keep privately paid extra services separate from their Social Services work with the same customer. But it was unclear how Social Services Purchasers might regard the practice.

Social Services provider staff could see such freelance work - typically house-cleaning - as offering older people extra help through familiar, trusted workers who already knew their preferences and their homes. It saved customers the strain and the hazards of seeking private helpers elsewhere. It was also much cheaper for the customer, since no agency took a cut. It harmonised too with Social Services' common preference nowadays for staffing home care through part-timers, who thus might need extra earnings. It responded to older peoples' distress at the widespread reduction of the house-cleaning offered through Social Services home care. Your same home care worker could still clean for you, despite the cuts in cleaning, just

that you now paid her separately for this. In view of such persuasive rationales, freelance extra services by Social Services staff may be more common than sometimes anticipated.

### ***Privately paid extras from independent agencies***

A surprise from the survey was how independent sector providers were often not very interested in supplying privately paid extras to their Social Services customers.

As presented earlier in Table 3, independent sector providers varied in the proportion of their total customer list who were wholly private customers. Three stood out as much more accustomed to private work than others. For one of these, fully private, self-funding customers comprised 50 per cent of their list and for the other two they were 25 per cent (whereas for many others they were less than 10%). These latter two agencies reported privately paid extra services for Social Services-financed customers as relatively common. These were the same two agencies which seemed most responsive to miscellaneous customer requests, as mentioned earlier. Their privately paid extras were typically house-cleaning, curtain washing and dusting of ornaments or china cabinets. The third agency was new to Social Services customers. Interestingly, it commented how requests for privately paid extras did not come naturally to many Social Services-funded customers. Rather, the option needed to be advertised to them. When a Social Services-funded customer had made them such a request spontaneously, it had been a former private customer who had transferred to Social Services funding.

At many agencies only a few Social Services-funded customers paid privately for extra services, sometimes very few. One factor was costs, which some agencies believed to be well beyond the means of Social Services-funded customers. Charges quoted ranged from £7 per hour to £9.25, the latter in a wealthy high growth area where labour was scarce.

Also, some independent sector providers seemed reluctant or ill-at-ease about offering private services to Social Services customers, such that they would never advertise the possibility. 'We won't shove it in their face but, if they ask us, we notify them of their options', commented one agency. 'We don't go out to sell', said another. If the latter were asked by a Social Services customer for extra help, this agency would not mention private services to the customer. Instead it would pass the request to Social Services Care Management, which might either commission more time or itself contact the customer to point out possible private extra service. Then the Care Manager might recontact the agency to discuss a privately paid addition to the care package. There may be good reasons behind this approach, but it is not a swift, flexible, customer-friendly response. Some agencies wanted any private extras to be included in the paperwork and charging administered by Social Services Care Management.

Behind this seemed to lie agency viewpoints that Social Services Departments were their customers of importance. Some spoke of the over-riding importance of performing well on recent – and prized – block contracts with Social Services. Private customers or private extras for Social Services customers could look irrelevant from this viewpoint – and might even interfere. One issue was raised by an agency with many private customers, which had recently begun taking Social Services customers too. This interviewee suggested that agencies might fear appearing ‘unprofessional’ to Social Services Care Management if apparently ‘touting for trade’ by advertising private extras to Social Services customers. Another provider said that they did not advertise private cleaning to Social Services customers because they were short-staffed and would not risk disrupting delivery on their block contract.

Much private extra service concerned cleaning which could not be obtained through the Care Package. It could be restricted by the same rules concerning ladders, climbing or furniture moving which applied to an agency’s publicly funded services. A different use of private payment followed a dispute between a customer and Social Services Care Management over the amount of time needed for a personal care visit. To avoid feeling rushed, the customer paid privately for 30 minutes extra so the same tasks could be done slower. This occurred at one of the independent agencies with much private work.

### **Staffing systems which provide service givers whom customers know**

A major issue for home care service quality is staff continuity - whether a customer is consistently visited by staff who know their requirements and whom the customer knows and likes. This is commonly named as important in investigations of customer preferences among older users of home care services (e.g. Henwood *et al.* 1998). One factor is that older people often dislike having workers who feel like strangers in their home. Another is enjoyment of conversation and friendship with home care staff when a customer does get to know them. Yet another commonly named factor is customers' frustration at repeatedly having to show unfamiliar home care staff how they wish tasks done or where equipment is kept in their home. Blind or immobile home care customers can find this especially upsetting. If a person receives two or three visits daily on seven days a week, which is not uncommon nowadays, ten or more different staff can get used unless there are systems for ordering things otherwise. Standard Six of the Domiciliary Care Standards presses for consistent use of familiar care workers.

There are two aspects to ensuring that customers get service always from people whom they know.

- Ensuring the number of staff per customer is small enough for staff and customers get to know each other through seeing each other sufficiently often. Customer satisfaction will grow through the relationships which develop and through tasks being done in ways which reflect knowledge of customer preferences. Also, the better a worker knows a customer, the better they can monitor changes in health or ability.
- Ensuring the number of staff is not so small that customers end up with workers whom they have never met when, as is inevitable sometime, their regular staff are off sick, on holiday, are called away to emergencies or change jobs. Many interviewees from both sectors stressed the importance of customers becoming familiar with at least a small group of staff so that, whatever staff illnesses or changes occur, there will always be some staff available who know a customer. A Social Services provider manager commented: 'We try to say that no customer should have less than three workers. Because, if they do and one person goes on annual leave and another is sick, then we're in a very traumatic situation where they don't want somebody that they don't know and there isn't anybody left. So we've tried to keep it so that they are familiar with three workers at least.' In this service, in fact, five workers per customer sounded more typical.

A further concern, voiced by some interviewees, was that customers should not develop close, exclusive relationships with one staff member only, who thus acquires a monopoly of communication with that customer. Strong customer complaints can arise when such staff leave, because often they are supplying many unofficial services in their own time and no replacement worker can measure up to them.

Also, some interviewees contended, it is within such close, exclusive staff-customer relationships that abuses or allegations of abuse – in either direction – become more likely. A home care relationship can become too close or exclusive for the comfort of either customer or the home care worker, some interviewees maintained. Either party can become exploited.

### ***Supplying care through a couple of regular workers***

'We try to limit it to as few workers as possible. So if they're having one visit per day, seven days a week, it could be done by one care worker but we like to introduce two for reasons of cover and holidays. But it won't be any more than two. Even with two or three visits daily, seven days a week, it may be that you have one worker doing the morning and the lunch time visits and another doing evenings and weekends. And that could be limited to two or three care workers.'

***Manager, independent agency***

### ***Providers' approaches***

The practical measures taken by providers fell into three categories.

- Around half the providers strove to create for every customer one care worker who was clearly that person's main worker. Perhaps surprisingly, only three providers (two independent sector, one Social Services) made this policy explicit through a formal title for this main worker – like 'Named Carer' or 'Regular Care Worker'. Some independent agencies provided a customer's home care wholly through this main worker, backed by one or two other familiar regular workers - who could also replace the main worker when ill or on holiday. These agencies said they could even supply twice daily visits, seven days a week, through only two different staff. A somewhat different pattern was used by two Social Services providers. They believed that, as long as customers received their weekday morning service from a single main worker, they could accept several different workers for evening and weekend visits which were hard to staff.
- Around a third of providers strove to create for each customer a small group of staff who became their familiar service-givers. This increased the chances that, when a scheduled carer was absent, a familiar person could always be found to substitute. Maybe four to six staff might be used for people with a large care package. One Social Services provider had experimented with a complex arrangement whereby each customer was assigned three workers, who should provide cover for each other. But this system proved very vulnerable to staff illness.

- Some providers from both sectors focused on preventing relationships where abuse or exploitation might arise or where management might lose control – as described earlier. Preventing close relationships was their target, rather than deliberately creating relationships with a small group of staff. One Social Services provider aimed to supply intensive, seven day care packages through four regular workers per customer. Each customer received an annual review. If the review revealed that a worker had been giving extra help in their own time, that was seen as indicating a controversially close relationship and might trigger a change of worker.

‘We’ve known situations where they’ve done their garden and other little jobs in their own time. But that is creating a relationship with the client and ... when that carer goes on holiday all hell breaks loose because they’re not having these little extra things done. So we have to keep professional guidelines on that.’

***Manager, independent agency***

### ***Social Services and independent providers compared***

In general there was much similarity in the concerns raised and positions taken. But on balance the interviews suggested that *to a moderate degree* the independent providers took more trouble than the Social Services providers to organise care so that customers had one or two main workers, whom they knew well.

Social Services providers should have been well placed to cover absent staff with colleagues known to a customer, since they were organised in teams for particular localities. This in itself should limit the number of workers who can be used for each customer. But only two Social Services providers reported that they could always or almost always cover emergencies through other team members. Eight others said that periodically they had to seek cover from outside a customer’s own team. Four of these could always find such cover from other teams in their own home care service. The other four sometimes needed to look further afield – to Social Services ‘bank staff’ or even to independent agencies.

Among the independent agencies, two said they found it commonly easy to cover for staff absences. Among independent agencies, the first place to look for cover was spare hours among your part-time staff. You could first phone staff who already worked with that customer. If you were one of the London agencies, where many staff were already working very long hours, you had to look for staff who had recently lost customers through events like hospital admissions. Here the chance of finding workers who also knew the customer would be smaller.

One agency took on some temporary staff to cover summer holidays. None turned to other independent agencies when in difficulty. Typically their last resort for cover was for managers to provide care themselves – and this included some proprietors. At some agencies this was routine, for instance during school holidays. Some interviewees highlighted positive aspects of managers providing care themselves - in terms of getting to know customers and discovering what customers had come to expect from their usual service-givers. At some of these agencies managers routinely did brief spells of care-giving anyway to investigate reported problems. One proprietor commented how, when managers stood in for care staff, they liked to tell customers who they were. She believed it gave customers confidence that managers understood their realities. But at another agency managers did not reveal themselves when giving care during staff shortages. They feared it looked unprofessional to thus mix roles.

### ***Customer requests about particular staff members***

Sometimes customers asked to be served regularly by particular home care staff – or conversely not to be served by a certain worker.

- Some managers would seek, whenever practicable, to grant any request from customers to be served by a particular staff member. However room for manoeuvre was often not great.
- Others had a policy of ignoring, on principle, any request from customers to be served by a particular staff member. One reason was a view that such requests merely reflected attachment to whomever a customer happened to have met first. Another reason was suspicion that requests for a particular worker indicated a controversially close relationship, as mentioned earlier. Sometimes such a request could actually reduce the amount a customer saw a particular worker.

A common view was that it was always nice for customers to get the staff whom they asked for, but that this was often hard to arrange. And that often it did not really matter because there were many staff whom almost any customer would end up liking equally.

But objections by customers to particular staff members seemed often to be taken seriously and to be investigated in a careful, discriminating fashion which considered the interests of all parties. These objections seemed treated as possible warning signs– foretelling either a difficult customer or a problematic staff member. Managers were concerned to find out immediately what lay behind an objection. Some managers would routinely fulfil any requests *not* to be served by a particular staff member, though they would ignore positive requests for a particular worker.

### ***Staffing weekend and evening visits***

A particular challenge in ensuring customers are served by familiar staff comes at evenings and weekends – a focal point for complaints on this subject according to Sinclair *et al* (2000). Indeed, some interviewees in SPRU's survey spoke as if it were hard enough to assign any staff to customers at weekends, let alone familiar staff.

Pay rates for unpopular working times are important. Social Services providers in this survey paid much better weekend pay incentives than independent agencies.

There are two basic arrangements whereby a home care service can staff weekends and evenings. Some services used just one arrangement and some used a combination of both.

### ***Regular weekend and evening workers***

Some providers had recruited staff specifically to work at these hard-to-staff times. Sometimes these were people who worked only in the evenings or only at weekends. Sometimes they also supplied home care on some weekdays too. For instance a worker might work on the same five days every week, but one or two of these might always be Saturday or Sunday.

It was generally easier to find people who would regularly work evenings than weekends. Evening work commonly suited women with pre-school children, who could be relieved from childcare when their husbands returned from work.

Social Services pay rates could be an important motivator for weekend working. Some weekend services offered long 12 hour shifts. If you worked both days at a high pay premium, your total earnings for a weekend could surpass five weekdays.

Even without good weekend pay, some independent agencies in London reported easy recruitment of weekend workers. Sometimes, for instance, these workers had office jobs on weekdays and switched to home care at weekends to supplement their earnings. London's large pool of avid extra earners may make it easier to recruit regular evening or weekend staff than elsewhere. Recruiting staff for unpopular hours requires finding people whose circumstances make it expedient to work those hours. The larger the labour pool, the higher your chances. However, there may be a significant downside concerning quality of care if weekend service is coming from keen earners who work extremely long hours in total.



### ***Pay incentives to work at weekends***

- The most common Social Services weekend pay arrangement was 1.5 times on Saturday and double time on Sundays (basic hourly pay ranged £5.27p - £6.12p)
  - The two lowest Social Services weekend pay rates were 1.3 and 1.5 times the weekday rate for both days.
  - Often Social Services providers paid 1.2 times the ordinary rate for weekday evenings.
- All but one independent agency paid a much lower weekend premium of around 1.1 or 1.15 times the weekday rate. This could mean 50 or 60 pence extra per hour.
  - £1 extra per hour was the highest independent sector weekend premium. Even in London it could be as low as an extra 45 pence per hour.

There were two ways in which regular evening or weekend staff were organised.

- The same evening or weekend staff always provide the same visits to the same customers. This would ensure an expected, familiar worker for these problematic visit times – until that worker falls ill, goes on holiday or leaves their job.
- Alternatively, workers can be organised in evening or weekend teams which cover the scheduled visits through a rota. This will mean customers get a larger number of different workers but may provide an element of continuity when staff are ill or on holiday. For instance, at one Social Services provider a 12 worker team provided evening and weekend services for all the customers of five weekday teams. This evening and weekend team worked round a rota of changing visit assignments, which ensured that team members got some weekends off but also meant that customers saw many different staff.

‘We tend to recruit care workers for particular hours. So we have workers who just want to work weekends – maybe they have other full-time or part-time jobs. So we try to recruit a varying mix of hours to cover the work needed. So some staff are taken on from the beginning with the understanding that they’ll only be working weekends or evenings.’

***Manager, independent agency***

'They work a two-week programme so that staff who work Saturday and Sunday one week will have two other days off in the week. Then the following week they'll have Saturday and Sunday off and work Monday to Friday. And within that two-week programme they've got set calls and they know exactly where they're going to. But it has to be a slightly changed one each week because of the days off changing.'

***Manager, Social Services in-house provider***

*Rotating weekday staff, who take turns at weekend and evening duties*

The other approach was to get weekday workers to take turns at covering weekend and evening visits.

- This could be a voluntary rota whereby some weekday workers volunteered for periodic weekend and evening work. Since voluntary, managers could not control how many workers shared the burden nor how often they worked weekends. They might need to accept whatever offers they got. This arrangement could mean that customers never quite knew who would be visiting at weekends. Since staff were volunteering, managers often had to let them choose whether to take days off in lieu. Some managers would have preferred no days off in lieu because of the disruption this caused to weekday rotas and continuity of care. Others hoped staff would take some time off, fearing the strain which keen earners could bring on themselves – and hence their risk of collapse, leaving many hours of care to cover. Quite often those managers who used voluntary rotation of staff were seeking a better system.
- Other services required staff to take regular turns at weekend work as a routine condition of service – for instance every other weekend at two teams, one weekend in three at another, one weekend in six at yet another. Time in lieu was usually given. Under such systems a customer's weekend service-givers would be predictable, if not constant, something which also matters to many older customers. There was also room to design rotas so as to limit the number of service-givers whom a customer saw in total. Only one independent agency used such a mandatory rota. This was part of a new package to tackle problems with weekend staffing. Weekend pay at 1.5 times the weekday rate, unique for independent agencies in this survey, was combined with a requirement to work alternate weekends, no time off in lieu. This had proved successful.

Different services provided weekend and evening visits through different combinations of these broad arrangements, as described in Panel 3.

## **How evening and weekends were covered**

### **Social Services home care providers**

- Four providers provided all weekend and evening visits through weekday staff taking turns at this.
- Three providers used only regular weekend and evening workers.
- Two providers covered evenings through regular evening workers (usually easier to recruit) while weekends were covered by rotating weekday staff.
- At two providers, some teams used only regular weekend and evening workers, while others rotated weekday staff. Sometimes different locality sub-teams, under the same team manager, used different arrangements.

There were eight Social Services providers which rotated weekday staff for some part of their weekend or evening service. At five, this was on a mandatory regular rota. At three, it was voluntary.

### **Independent home care providers**

- Four providers provided all weekend and evening visits through regular weekend and evening workers. (Three were in Greater London.)
- Two relied wholly on rotating weekday staff. One was the service, already mentioned, with the mandatory fortnightly weekend work and the 50% pay premium. The other used a voluntary rota, which was not working well.
- The rest used combinations of regular weekend and evening workers and voluntary rotation of weekday staff – as changing circumstances dictated. Time-in-lieu from other scheduled duties would generally be available if a weekend volunteer wanted it. One agency, as mentioned earlier, employed on guaranteed hours two weekend workers to undertake any visits for which its voluntary rota could not find cover.

**Panel 3**

### *Lessons about weekend service*

Across both sectors, several providers expressed dissatisfaction with their current weekend and evening systems and were contemplating changes.

- While changes were being contemplated in all directions, on balance it seemed that services based wholly on regular weekend and evening workers were more confident of their approach than those where weekday staff took turns at evening or weekend work. Some of the former were very confident. But, as mentioned, viability of this approach may depend on the local labour pool. It is voluntary weekend rotas which are particularly problematic. But independent providers may have no choice but the latter.
- Weekend pay rates seem very important. Unsurprisingly, independent agencies more commonly expressed worry about weekend cover than did Social Services providers with their much better rewards. Worth remembering is the case of the independent agency which solved a long-standing weekend staffing problem through raising weekend pay to a level comparable to Social Services providers, which supported a Social Services-style mandatory weekend rota. The extra pay was funded, by necessity, by Social Services Purchasers to ensure that reliable service was available at weekends.

### **Visit times and customers' preferences**

Another classic concern among older customers is the times at which visits are made (Henwood *et al* 1998). Some issues about visit times have already been described in some detail, like the stances of different Care Management services on whether these could be freely revised without their permission (Section Three). Other broad general issues are as follows.

- Providers' greatest everyday challenge was supplying getting-up calls between 7.30 am and 9.00 am, a period when very many people wanted service. Many customers wanted the same 8.00 am breakfast slot. Another common challenge was preferences for bedtimes, which customers usually wanted no earlier than 7.00 pm.
- The most difficult part of the week was weekends, when fewer staff would be on duty and hence able to serve fewer people around popular times.
- The most difficult place to give customers the visit times they wanted was the countryside. Where much travelling time was involved, the more likely that customers who lived near each other would be visited one after the other, rather than according to their preferences.
- Often early first calls were allocated first and foremost to people who must be got ready to be collected by transport to day centres or to families where children must be got ready for school. Another priority group was people who are bed-bound and who may be in discomfort.
- Once such priority customers have been assigned early visits and arrangements made for pairs of 'double-up' workers to meet in homes where there are hoists, there may be little room left for others to have morning visits at popular times.
- Some customers want visits at specific times. Others care much less about visit times or whether they are punctually adhered to.
- Some provider managers felt supportive of certain customer requests for specific visit times – like bed-bound people who wanted to get up early. But there were other visit time requests which they dismissed as unnecessary.
- When customers wanted visits at difficult times, one Social Services provider encouraged them to pay independent agencies privately for these visits, while the Social Services provider supplied the rest. This was said to satisfy people who could afford it, like those with Attendance Allowance.

- Some providers believed that Care Managers rather exaggerated the importance of specific visit times to customers. At assessment Care Managers would ask all customers to name desired visit times and, according to these providers, these times would feature in the contract with the provider, whether or not it mattered much to the customer. The provider might even be chosen because they could supply it. Permission from Care Management could be needed to change this visit time, as a term of service purchase, even if provider and customer both wished this.

***Factors which affected ability to supply visits at preferred times***

The more staff on duty at any one time, the more customers who could be served at that time – for instance during the high demand period before 9.00 am. Services could perform better if they used many different part-time staff who worked all their short hours during peak periods. Providers would be disadvantaged the more that staff worked long hours, some of which might end up being used for very late breakfasts or early bedtimes. Long staff hours could arise from any remaining old-fashioned full-time contracts for Social Services home care staff, dating from the days when much cleaning was supplied. Long staff hours were found too in London in particular, where they seemed to reflect earnings requirements and high cost of living.

A specific example of how pay can affect customers' visit times was given by an independent agency manager. She described how she felt forced to create some 6.00 pm bedtimes – a much criticised practice in home care – in order to offer staff enough money to obtain any evening work at all. With low rates of pay and unpaid travel time, it was difficult to induce staff to come out to do evening visits unless there were sufficient visits per worker to make it worthwhile. This manager said that, while customers preferred bedtimes between 8.00 pm and 10.00 pm, she had to design rotas whereby bedtime visits were all done by only a few staff each evening, working between 6.00 pm and 10.00 pm. Thus these workers could earn more through having done more visits each. Only through creating a long enough 'run' of visits per worker could she obtain volunteers for evening work.

**Overall: providers which give customers better value quality**

Some large differences intrinsic to providers were found in how much they offered extra value through respecting common customer concerns - like getting service from familiar staff or at desired times, or help to change a light-bulb, or find a reliable plumber, or care for a pet. Some providers in this survey regarded such attentiveness to customers as part of their core mission and actively promoted it. Others routinely curbed staff helpfulness, for instance prohibiting light-bulb changing or discouraging staff-customer friendships. Sometimes a provider would refuse even when Care Managers tried to spot purchase flexible extra help for a customer. Some of these differences were down to attitudes, policies or management methods intrinsic to a provider. In this sense some providers offered clearly better value to

customers than others. (Sometimes, even, a clear difference was apparent between two providers for the same locality and this difference was confirmed during a later stage of the research by customers who had sampled both providers.)

But it is important also to recognise how sometimes ability to respond to customers' values and preferences depends on factors at least partly outside a provider's control. An obvious example is the extra travelling which rural home care might incur if serving each customer at their preferred time, rather than visiting neighbouring customers one after the other. Another example is the agency, just cited, which gave some customers 6.00 pm bedtimes because it could not attract evening workers for less pay than a four hour 'run' of visits could supply. Here a constraining factor is the rate of evening pay which Social Services would fund. Another example would be a high growth locality with a pronounced labour shortage, where home care roles were kept to the minimum to conserve scarce staff time for priorities. Yet another example would be the relatively easy recruitment of dedicated weekend workers from London's huge pool of labour, which makes possible more reliable, consistent weekend service than in some other localities. Local presence of voluntary sector resources for older people can make meeting some requests much simpler – a locality with good transport and home repairs projects was a reminder of this. Whether many staff have cars may affect how easily staff can meet miscellaneous requests like extra shopping, accompanied shopping or short excursions. Many of the workforce factors mentioned in Section One can have a bearing on how readily a provider can respond to customers' values and preferences.

So do the policies of Social Services Purchasers, mentioned in Section Three. There is the adequacy of the visit lengths which they commission – some spare time is crucial if a customer-friendly provider is to have opportunity to treat small customer requests in a customer-friendly way. Essential for more time-consuming customer requests is the readiness of Purchasers to commission extra time on a one-off basis. A similar major influence is licence occasionally to add extra time at a provider's discretion, as described concerning certain 'task-centred' Social Services home care providers. This can make it much easier to help customers with occasional time-consuming extra needs, like replacing a faulty fridge. At one Social Services provider for instance, a very customer-friendly style reflected a marriage between customer-friendly staff attitudes and the opportunity from a flexible service purchasing system. On its own, neither factor would have produced this effect – as another Social Services provider with a similar purchasing system illustrated.

Certainly some providers seemed more responsive to customers' preferences and requests than others, whether in accord with their own rules or in spite of them. While partly this certainly reflects the stance of managers or staff, there are also important influences from locality characteristics and from Social Services Purchasers themselves.





## **POSTSCRIPT: TOWARDS THE FUTURE**

### **Payment and independent agencies**

This Report has repeatedly mentioned problems concerning staff rewards at independent agencies, which may become the chief suppliers of long-term home care for older people, as described in Section Three. It has also highlighted problems of inflexibility in how independent agencies are themselves paid by Social Services .

#### ***Payment to staff***

One issue is how independent agencies spot purchase the time of their care staff – without any guaranteed hours of work nor payment for travelling time - and yet are funded to pay only low hourly rates for this. Elsewhere in the UK economy, market forces often mean that insecure, temporary freelance work secures higher pay rates to compensate. But pay rates at independent agencies rarely compensate staff for such disadvantages. In particular, common weekend pay rates are much poorer than those at their Social Services provider counterparts, though the latter enjoy the security of some guaranteed hours. Consequences include difficulties obtaining staff and the uncertain, changeable staffing sometimes provided by workers who can be attracted by the terms on offer from many independent agencies. Managers of independent agencies often complained about low pay rates for care workers.

Section One described a variety of improvements to pay which were appearing at certain independent services in order to obtain staffing more reliably. For instance substantial premium payments had been introduced to secure work at inconvenient times, like weekends, or inconvenient places, like remote villages. One agency offered a bonus rate to workers who would habitually respond flexibly to requests to do extra work. Some agencies had introduced mileage payments on travel between customers. Some now guaranteed set quantities of work each week to some care workers to ensure that staff would be available for certain purposes.

In order to ensure reliable service from staff of suitably high quality, independent agencies in general need to be funded to offer higher pay rates. They should also develop a greater diversity of improved rewards, like those just described – a mix of bonus rates for particular purposes, enhanced rates for skilled, experienced workers, and guaranteed hours for some workers. Using market forces constructively should mean flexible, ad hoc reward strategies to meet particular customers' care requirements at particular times and places, like the examples given. Section Four described independent sector difficulties in providing reliable weekend service, when offering rates well below the premium through which many Social Services providers traditionally secured weekend service. It also described how one agency's weekend service became much more reliable after Purchasers agreed to fund a 50% weekend pay premium. Arguably, independent agencies' common difficulties at weekends

reflect non-market pay rates, in contrast to many Social Services providers which often pay what proves necessary to deliver weekend service. Independent sector rewards should be allowed to rise to what the market shows necessary to secure suitable staff and to deliver service of the standard sought by Social Services Purchasers.

This is certainly not an argument for wholesale copying of traditional Social Services provider pay and conditions and for making guaranteed hours once more the norm. Rather, it is an argument for diverse, flexible, improved reward strategies which are targeted on a provider's particular difficulties in obtaining staff – for instance a mix of premium hourly rates, travel payments and payment for some stand-by workers. Where service dynamics suit payment only when work is available, higher hourly rates should compensate such insecure arrangements if quality staff are sought. As described in Section One, nowadays some Social Services providers obtain staff hours from a mix of guaranteed hours, from spot-purchasing extra hours from regular staff, and from 'bank staff' or 'casuals'. Pay arrangements in both sectors are thus beginning here and there to converge. The way forward is to develop whatever arrangements can deliver good standard service in each provider's circumstances.

Demand for home care hours has been rising and the skill and judgement required from staff has increased as Social Services uses home care for older people with ever greater disability. Yet pay and conditions for the staff who nowadays undertake this work has generally become poorer, as service has been transferred to the independent sector. Follow this course and, by the law of demand and supply, quantity or quality of service will suffer. An agency manager was quoted earlier: 'People who work at B&Q are getting £8 or £9 an hour and care staff who look after human beings are getting paid £6 an hour. I don't quite see the sense in it.'

### ***Funding independent agencies to sometimes give customers extra time***

Another payment problem requiring resolution, concerns the 'time-centred' system, described by interviewees, whereby Social Services purchased care for a customer from independent agencies. Usually Social Services purchased a set of fixed-length visits for each customer, each visit linked to essential tasks in the Care Plan. If a one-off need for extra time arose, an independent agency needed agreement from Care Management to fund such time. Sometimes such permission could be obtained the same day but sometimes delays of a fortnight could be involved.

Examples of such needs for extra time, encountered during this research:

- A customer's health has suddenly deteriorated. Extra time for extra care tasks is needed.
- Home care staff need to get a key cut for their own routine access to a disabled customer's home.

- Health staff request a customer's home care worker to join a single meeting about co-ordinating care.
- A customer's fridge has suddenly broken down. Home care staff time is needed to organise replacement.
- Home care staff find a very dependent customer has been burgled overnight. Time is needed immediately to liaise with police and comfort the customer.
- One particular day, a customer, who normally receives lunch at a day centre, is staying at home and needs a single lunch provided.

These are tasks which home care ought to be able to undertake in a system of comprehensive care – and, indeed, did undertake at some of the providers in this survey. Those Social Services providers which worked on a traditional 'task-centred' approach to time were fully able to perform them without contacting Care Management, as described in Section Three. Some other Social Services providers were given discretion to add limited extra time to the amount of time initially commissioned by Care Management. But only one independent agency was officially empowered in this direction – an agency allowed to increase daily care time at its own discretion for up to a week, if a customer's health deteriorated. If independent agencies are to become the dominant source of long-term home care for frail older people, systems are needed which empower them to sometimes spend occasional extra time without delays seeking Care Management approval.

Obviously Purchasers need control over use of public money by autonomous private businesses. This explains why the systems which gave providers routine flexibility concerning extra time were found only among Social Services in-house home care services. But, particularly where block contracts exist, solutions can be envisaged. For instance an independent provider could adequately deploy extra staff time if Purchasers allowed an agency, on a block contract, a finite monthly budget of unallocated hours on which it could draw for any extra time required. A Purchaser representative could discuss each use of this time budget retrospectively with a provider's manager at a monthly meeting and thus illustrate what use was permissible in future. The monthly time budget could be adjusted as circumstances warranted – increased, decreased or terminated. Purchasers could thus maintain great control. Purchasers would face strictly limited claims for extra resources, no higher than all the unallocated hours. A Purchaser could, indeed, compare how much different providers claimed from these time budgets.

An important merit of this approach is that it would add one of the great strengths of 'task-centred' working – flexible response to major new events – without losing the strengths of the 'time-centred' approach, which would still govern routine service-

### ***'Time-centred' and 'task-centred' visits and visits***

These are terms sometimes used by home care staff to describe two contrasting ways of deciding how long a home care visit lasts.

- In both cases, for each visit there is a prescribed set of tasks which should be undertaken during that visit.
- In 'time-centred' visits, Care Management also sets a fixed length of time during which the home care worker must complete the prescribed tasks as best as possible. The worker should stay for the full time set for the visit, unless the customer wishes otherwise. If they finish the prescribed tasks early, in the remaining time often they do small extra tasks which the customer requests - or may simply chat.
- Some Care Management services set the lengths of 'time-centred' visits a little longer than the prescribed tasks will normally require. This is because tasks may take longer when a customer's health fluctuates. But other Care Management services commission very little time margin.
- In 'task-centred' visits, no set time is prescribed. The worker takes as long as is needed for the prescribed tasks that day, then leaves straightaway. (Sometimes each visit has an approximate amount of time assigned – for instance to guide replacement workers on planning their visits. But the visit can take more or less than this time.)
- 'Task-centred' services are often able to deal immediately with unforeseen customer problems which need much more time than usual. In such events, 'time-centred' workers may need to phone their manager, who may ring Care Management to sanction extra time and then obtain a worker to supply it.
- 'Time-centred' visits are easier to deliver punctually, since workers can plan a day's routine around fixed time slots. Since the length of 'task-centred' visits is less predictable, so are staff arrival times at their next customer. 'Task-centred' services often prefer customers to have loose expectations about arrival times.
- 'Time-centred' visits are easy to calculate charges for – both to customers and to Social Services Purchasers. This is harder for 'task-centred' visits, since their length can vary on each occasion. It is done sometimes through notional average times, sometimes through timing each visit.
- 'Task-centred' visits are the traditional approach of Social Services home care providers and were their norm before the Purchaser/Provider division. Today some Social Services providers use this, while others have adopted 'time-centred' visits. 'Time-centred' visits are the traditional approach of independent agencies – and still the way their service is usually purchased.
- Variables affecting 'time-centred' visits:
  - how much time is purchased for the required tasks and whether any spare time.
  - any restrictions on what staff may do for customers during spare time (some services allow any task staff can squeeze in; some permit only conversation).
  - crucially, whether staff actually stay for the full visit time commissioned.

giving. For as well as leading to inflexibilities, purchase of 'time-centred' fixed-length visits has important merits. It can bring benefits like spare 'quality time' in conversation or small extra jobs after Care Plan tasks are completed, which boost customer morale and satisfaction - see Section Three. It can also mean protection against erosion of service-time per customer when demand on a service rises, which can be a problem for traditional task-centred Social Services home care. 'Time-centred' fixed visit lengths should mean that, when demand outstrips resources, this shows up swiftly and appropriately in Care Management's budget figures - rather than insidiously in reduction of service quality, if the same staff hours are squeezed to serve ever more customers. Intrinsic to the purchase of 'time-centred' fixed visit lengths is some protection of service quality for the customer.

Thus this solution should combine strong points of both traditional 'task-centred' Social Services providers and the 'time-centred' pattern of service introduced by the separation of Care Management from providers. There might be other purposes too for which Purchasers could use this idea of finite budgets of unallocated hours, whose usage Care Management monitored retrospectively. It might prove a way of utilising providers' ingenuity and close contact with customers while maintaining Care Management's control of resources and the purposes for which they are used.

### ***A trend to beware of***

But, if the merits of 'time-centred' and 'task-centred' working could be combined through the measure just described, Section Three noted a third approach to home care visit lengths which combines the disadvantages of both. This was some managers' tolerance of staff finishing fixed-length visits early, if they could complete Care Plan tasks in less than the time allotted. Some half of provider managers permitted this – sometimes on grounds of fairness, considering that staff were not paid travel time to their next customer. Some Care Management services actually wanted care staff to leave early, as a guide to how fast Care Plan tasks could be finished and hence how future time-purchases could be cut. These were the managers' positions. We do not know how often staff actually left early, nor how early, nor whether the practice also occurred covertly at those providers where managers expected staff to give customers every minute they were paid for.

This is an approach to care which can only give the customer less for the same money, a version of 'task-centred' working where flexibility can mean only reduction of the time given. Customers get neither spare 'quality time' at the end of a visit nor staff flexibility to occasionally give extra time when needed.

Introducing a counter-measure, Standard 6.2 of the new Domiciliary Care Standards requires staff to 'work for the full amount of time allocated'. But, if provider managers or Care Managers have endorsed early departures, might there not now be room for ambiguity about whether a fixed amount of time is allocated? Any official acceptance is worrying because it is an evolution to something inferior to both the

traditional Social Services 'task-centred' model and the independent agencies' traditional spot-purchased fixed-length visits. One can see how permitting visits to be shortened might address in unofficial, unsatisfactory ways the problems of low pay-rates and unpaid travel time at independent agencies, which were mentioned earlier. Low hourly pay-rates are unofficially improved if staff work less time than they are paid for. Ease the requirement to stay the full prescribed time and you might encourage poorly paid staff to rush through visits as the norm. Arguably, Social Services Purchasers should stick to commissioning service through fixed-length visits and make clear that they want Standard 6.2 observed to the letter.

## **Future demands, tackling age-discrimination and an Authority's broad goals for older people's services**

Looming behind all questions of service quality and improvement is an ageing population, increasing demand on older people's services and uncertainty about the scale of these demands and how they can be met. In this light it is not axiomatic that Local Authorities are governed by desire to improve services. Some Authorities may aim to limit, or actually reduce, their commitments to older people with a view to the costs of future service usage and envisaged very heavy demand. Such concerns could make sense of practices noted in this survey - like limiting service goals to assisting basic survival or shortening home care visits wherever possible. Authorities probably vary in the relative importance they place on the improvement of services for older people or, with an anxious eye to the future, on containment of their costs. Differences in their position will mean that issues raised earlier, like improving rewards for home care staff or ensuring older people get full use of the home care time they pay for, may appear in different lights in different Authorities. A very real challenge is appraisal of the true scale of future demand, something which is decidedly open to debate.

A watershed for Authorities, concerning the future of their older people's services, may emerge from the government's challenge to age discrimination through the National Service Framework and Fair Access to Care Services. Section Three noted common areas of quality of life where people aged under 65 quite often received publicly funded help which was not available to older people. For an Authority keen on improvement, Fair Access to Care Services offers a stimulus for extending to older people with disabilities the more holistic services often received by their younger counterparts. Home care workers can play an important part in delivering such enhanced services in an individually tailored fashion. This is well demonstrated by their use for social support or for promoting socially valued roles among younger people with physical or mental disabilities. According to some interviewees in this survey, such roles are themselves a job reward to the 'natural carers' whom so many managers sought for their workforce, as discussed in Section One.

But other responses to Fair Access to Care Services can also be envisaged. An Authority might balk at enhancing older people's services, if it is battenning down the hatches for anticipated large increases in demand. Conceivably it might seek instead to avoid age discrimination by serving younger people with disabilities no better than the much larger number of older service users. The future for long-term home care might include audits of Care Plans to focus on a narrower range of survival needs, and further general prohibitions on home care roles now deemed to be luxuries. Some 'natural carers' might be leaving to work at the tills at supermarkets - or a DIY outlet perhaps.

In April 2003 a set of Standards began to govern activities by provider staff which shape the standard of home care. This survey, conducted just before that change,

includes salient reminders of how much the standard of older people's home care is also shaped by the policies of Social Services Purchasers

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## REFERENCES

Clark H, Dyer S and Horwood J (1998) *'That bit of help': the high value of low level preventative services for older people*, Policy Press, Bristol

Department of Health (2003) *Domiciliary Care Standards*

Department of Health (2002) *Fair Access to Care Services*

Henwood, M., Lewis, H. & Waddington E. (1998) *Listening to Users of Domiciliary Care Services*. Leeds: University of Leeds, Nuffield Institute for Health, Community Care Division

Mathew D (2000) *Who cares? A profile of the independent sector home care workforce in England*. United Kingdom Home Care Association, Carshalton Beeches, Surrey

Office for National Statistics (1999) *The ONS classification of local and health authorities of Great Britain: revised for authorities in 1999*. London: Office for National Statistics

Patmore, C. (2002) 'Towards flexible, person-centred home care services: a guide to some useful literature for planning, managing or evaluating services for older people'. University of York, Social Policy Research Unit.. Available at SPRU's website: <http://www.york.ac.uk/inst/spru>

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

Taylor M (2001) *Home care, the forgotten service*. UNISON, London

Woodruff, L. & Applebaum, R. (1996) Assuring the quality of in-home supportive services: a consumer perspective. *Journal of Aging Studies*. 10 (2) 157 - 169



## **APPENDIX**

### **The telephone interviews: procedure and sample**

A telephone survey was conducted with managers at 23 providers of home care for older people in 12 selected English local authority districts. It aimed to establish how these services were organised, how they treated customer preferences and requests, and any apparent connections between the two. The phone interviews each lasted approximately one hour long,

English local authority districts were sought to represent each of the seven 'families' of local authority district which the Office for National Statistics (ONS) identified in its 1999 classification of Local Authorities (ONS 1999).

In each local authority district a phone interview was sought with a manager of a Social Services home care provider service and with a manager of an independent sector agency which supplied home care for older people on contract to Social Services.

Interviewees were sought via contact networks involving Social Services purchasers at any local authority district which would fit the set of 'families' to be represented. These Social Services officers were asked to arrange co-operation from the Social Services home care provider service and to nominate an independent sector agency from whom they regularly purchased care, whether on block contract or spot contracts.

### ***The sample of home care providers***

For the two largest 'families' of local authority districts, 'Mining, manufacturing and industry' and 'Urban fringe', three districts per family were included, each from a different ONS 'cluster' within their family. For the next largest family, 'Prosperous England', two districts were included from different clusters. For other families it was one district each. This totals 12 English local authority districts.

One of these local authorities turned out to have converted its own home care provider service into an independent sector agency, years back. So this agency was interviewed in lieu of an in-house Social Services provider, alongside another local independent sector agency.

Co-operation was not obtained from the designated independent sector agency in the Rural Areas family. However information on issues in rural service was available from three other districts with substantial rural hinterlands. In one of these, rural service was a key function for which purchasers used the independent sector agency which was interviewed.

Thus, in the event, managers were interviewed at 23 providers of home care in 12 English local authority districts. Twelve of these were independent sector providers and 11 were in-house Social Services providers.

Communities covered included:

- an inner London Borough and an outer London suburb
- northern industrial communities and mining communities
- a high cost-of-living growth area near the M4, where staff recruitment is extremely difficult
- rural communities where home care visit times are governed by staff travel
- a south coast retirement zone, where older people are a high proportion of residents
- a historic cathedral city and a new town development.