
Department of Health, end of project report

**Making home care for older people more
flexible and person-centred**

Factors which promote this

DHP 2069 CP

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March 2005

ISBN: 978-1-871713-88-6

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Chapter 1 Origins of the project and its aims

During SPRU's Outcomes Programme work with older people, the following were noted:

- Sometimes home care staff added thoughtful, 'person-centred touches' which appeared to support customer morale. For instance, a very disabled, housebound interviewee described how, on sunny days, home care staff would move his bed to the balcony, which he much appreciated (Patmore, 2001). A wheelchair user described how home care staff ensured he got a punctual early rise to enable him to be collected daily for church voluntary work. This mattered greatly to him (Patmore, 2001).
- Surveys of older home care customers were undertaken and these showed that a significant proportion could name opportunities for staff to add person-centred elements (Patmore, 2001). For example, an anxious home care customer wished her workers would spend five minutes each morning just sitting with her, since otherwise she could not verbalise any worries. Another customer wanted to receive intimate personal care only from a few familiar workers.
- Home care teams differed in whether they would provide flexible, person-centred features commonly valued by customers. For instance some could readily provide a customer's care through just a few familiar workers, whereas others deemed this impossible. Some team leaders would find reliable plumbers or electricians for customers, while others refused.

This project developed from two lines of thought derived from the above studies. One was the idea that home care services could focus on fulfilling such requests from individuals as an index of service quality (Patmore, 2001). This contrasts with a widespread Social Services practice of pursuing for all service users the most commonly named service user values, like punctuality and familiar regular workers, as established by Henwood and colleagues (1998). The other was the notion that a flexible, person-centred home care service might counteract some common threats to morale among older home care customers (Patmore, 2002a). Some interviewees were encountering disabling health problems of types known sometimes to precipitate depression in older people (Godfrey and Denby, 2004). It was reasoned that, given flexibility, home care staff had opportunity to bolster customers' morale either through supportive relationships or through helping customers redress losses which their disabilities were causing for them. For instance, isolated people could benefit from being taken on walks or occasional outings by car – something which seemed much valued by more fortunate interviewees who already received such help from relatives (Patmore, 2002a). For instance, in the first two examples of person-

centred help, given above, home care staff were helping a customer obtain a rewarding experience, which their disabilities would otherwise preclude. This viewpoint fits well within the preventative approach to depression among older people proposed by Godfrey and Denby (2004).

A guiding principle was that flexible, person-centred help from home care workers is especially important for older people without nearby family or friends who can give them such help instead (Woodruff and Applebaum, 1996). Also, the greater a person's disability, the greater are their likely needs, since there will be more miscellaneous tasks which they cannot undertake unaided. For a frail older person, who is also isolated, their home care worker may be their only practicable source of help for many important matters. Supplementary help from Care Managers, volunteer befrienders or day centres is often either hard to obtain or does not suit the purpose. Social Services may contend that such help is the remit of the voluntary sector. Yet, understandably, it can be very difficult to summon up appropriate help from the voluntary sector when and where it is needed (Salvage, 1998). It is home care staff – and housing wardens – who are widely available and, via existing relationships, well-placed to give flexible, person-centred help to those older people who most need it.

Aims of the project

- To find out how some home care services can add these flexible, person-centred features, which are valued by customers, when others say they cannot.
- To publicise how to promote such flexible, person-centred home care practice.

Chapter 2 Project design and methods

Stage 1: Literature Review

To orient the project, a literature search examined how home care can be organised and how care can be customised to the individual values of older service users. Separate sets of searches were conducted for each topic using the NISW Caredata database and the ASSIA database – for detail see Patmore (2002b).

Stage 2: Telephone interviews with 23 home care provider managers

A set of in-depth tape-recorded telephone interviews was conducted with managers at pairs of independent sector and Social Services providers in each of 12 Local Authority Districts. The latter were selected for their contrasts according to the 1999 Office for National Statistics classification of Authorities (Office for National Statistics, 1999) – for detail see Patmore (2002c). They included, for instance, a mining community, rural areas, an inner London borough, a south coast retirement zone, and a prosperous high growth area with a labour shortage.

The aims of interviews were:

- To identify areas of variation in how home care providers are organised.
- To identify areas of variation in whether home care is flexible or person-centred
- To learn providers' accounts of what factors help or hinder this.

Analysis was conducted via sub-reports, which collated responses to questions which clustered under the headings below. Differences between responses from Social Services providers and independent agencies were identified.

- Workforce characteristics, work patterns, recruitment, and reward.
- Provider size, management structure and teamworking model.
- Methods of management and quality control.
- Social Services' service purchase arrangements and types of service purchased.
- Providers' 'niche' in their local care market.
- How customer requests were treated.
- Responsiveness to specific customer concerns: visit times; number and choice of staff; household cleaning; finding reliable tradesmen; changing light bulbs; taking customers for walks or excursions by car; assisting care of customers' pets; handling written correspondence for blind customers.

Applications of this survey were:

- To inform the selection of a sample of home care services for the Stage Three in-depth investigation.
- To inform research questions for Stage Three.
- A publication for Social Services which would be useful in its own right (Patmore 2003a).

Details of findings from this survey are included in Chapter 3.

Stage Three: In-depth case studies of six provider and purchaser pairs

Stage Three examined six pairs of home care providers and their Social Services purchasers in depth.

Selection of providers

Providers were selected from the 23 providers in the telephone survey because they presented opportunities to investigate factors which the survey had highlighted as relevant to flexible, person-centred care (Patmore, 2002c).

These factors included:

- purchaser willingness to commission help for older people's social or emotional needs;
- provider managers with an explicitly holistic philosophy of care;
- certain Social Services providers where managers had significant discretion to assign care time to customers;
- providers which strove to deliver care through very few workers per customer.

Selection rationale is described in detail in Patmore (2002c).

Details of the providers in the in-depth study

These comprised four independent agencies and two Social Services providers - in six different Local Authorities.

Three of the four independent agencies had block contracts with Social Services. One agency belonged to a national franchise. One was a branch of a large national organisation. Two were single-branch local agencies.

Two of these providers served wholly urban communities. Two served largely urban environments plus a hard-to-serve outlying rural area. One served a largely rural area plus a small town. One served a small former mining community.

For details of providers' staff size, weekly care hours and mean size of care package, please see Appendix Two.

Research methods in Stage Three

- In-depth tape-recorded interviews were first conducted with small samples of service users at each provider. Interviews discussed experience of person-centred care and also identified any strong satisfactions, dissatisfactions and unmet aspirations among service users.
- Next, front-line provider staff and any supervisor staff were interviewed to explore what underpinned the style of service described in their service users' interviews.
- Next, interviews were undertaken with front-line Care Managers for a similar purpose. Comment was sought on anonymised incidents encountered during earlier interviews which illustrated issues in care-giving.
- Interview with the provider manager followed. This likewise investigated issues raised earlier and discussed scenarios drawn from earlier interviews.
- Finally interviews were conducted with senior social care commissioning managers at Social Services. These concerned issues encountered earlier and similarly utilised home care scenarios drawn from earlier interviews.

In total 82 interviews were conducted during Stage 3. Breakdown was as follows:

- Home care customers: 38
Family carers for home care customers: 3
- Provider staff: 23
Home care workers: 12
Supervisors / assistant managers: 5
Provider managers / proprietor-cum-manager: 6
- Purchaser staff: 18
Care managers and service brokers: 9
Heads of service / senior service commissioning officers: 6
Other senior Social Services managers: 3

Alongside interviews, relevant documents were collected and staff meetings were observed. Providers completed a brief diary concerning communications with purchasers.

Analysis

- For each provider, transcripts of service user interviews were analysed to profile the types of flexible or person centred care which service users described – and also any negative experiences. The exercise was repeated using staff interviews and the two accounts were compared. A sub-report was produced which compared the six providers in terms of the repertoires of flexible, person centred care mentioned at each provider.

- Using interview transcripts and other information sources, at each site separately the policies and practices of provider and purchaser staff were compared according to eight themes relating to flexible person-centred care. These themes had been derived from the Stage Two survey. They were:
 - i) Provider's flexibility to exchange a task in the purchaser's Care Plan for a different task requested by a client.

 - ii) How any spare time during a home care visit was treated. For instance, did purchasers or provider managers expect staff to place this time at the client's disposal?

 - iii) How providers should treat client emergencies like discovering a client who was ill.

 - iv) How providers should treat miscellaneous client requests like changing a light-bulb, finding a reliable plumber, assisting pet care, or replacing a broken fridge.

 - v) The provider's role in identifying fresh needs for help, whether extra care or aids and adaptations.

 - vi) Did staff escort clients on excursions outside their homes – whether for leisure purposes, for healthcare appointments or to improve walking ability?

 - vii) Did staff spend time with clients specifically to give social or emotional support?

 - viii) How should providers treat client requests which could be met through privately paid extra help, though not through help funded by Social Services? Should they offer private extra help themselves? Introduce private services from other agencies? May staff offer help free of charge if they wish?

Factors shaping the provider's actual practice on each theme were considered and listed. This information was used to understand the differences noted between providers' repertoires of flexible, person centred care. This enabled overall

conclusions on key factors promoting or hindering flexible, person-centred home care.

Dates when research was conducted

The Stage Two telephone survey was conducted between November 2001 and June 2002. Fieldwork for the Stage Three in-depth case studies took place between October 2002 and March 2004.

Thus the telephone survey took place before the introduction in April 2003 of both Fair Access to Care Services (2002) and the Domiciliary Care Standards (2003).

The in-depth study was conducted almost entirely after both had been introduced. Only interviews with service users and front-line care staff at one of the six providers were conducted before April 2003. Providers in the in-depth study were questioned about changes resulting from the Domiciliary Care Standards.

Other information

Appendix Three supplies information on the research project's Advisory Group, modifications to the original design, and the staffing of the project.

Chapter 3 Summary of findings from Stages One and Two

Outline findings only are given for the literature review and the telephone survey since both have already been fully reported. The literature review was reported in Patmore (2002b). The telephone survey was reported in Patmore (2003a), Patmore (2003b) and Patmore (2004).

a) Outline findings from the literature review

- Flexible person-centred care for older people may depend at least as much on the staff values and the ethos promoted within an organisation as from particular assessment, service planning or review procedures.
- In respect of staff values and ethos, the values of service purchasers merit as much attention as those of providers. The values and priorities of senior purchasers may be particularly influential.
- Possibly a very simple, natural means for developing person-centred home care is to serve each customer through very few, regular workers, who will thus get to know their customers well. Simply spending regular time with an older person and being involved with their daily routines is the best way to learn their aspirations and concerns. Systems which provide regular home care staff should be investigated.
- Some older people would benefit from approaches to home care which bring some of the freedom to direct and customise one's own services, which come from Direct Payments, but without the service user responsibilities involved in the latter.

b) Outline findings from the telephone survey

- There were important differences in provider managers' values concerning flexible person-centred care. At one end of a continuum were provider managers who were committed to a holistic approach to their customers and who were keen to address a wide range of their needs. At the other end were managers who sought to limit help as narrowly as possible to whatever was specified in Social Services purchasers' Care Plan. They did not see enhancing customers'

services as valuable, but only as something which might introduce avoidable risks.

- Many home care providers in both sectors had developed systems for serving customers through a few regular care staff. Notable gains were reported from this, which are relevant to flexible person-centred care. But there were also some problems - and approaches for managing these problems. There were differing strategies for how to serve a customer by regular, familiar care staff and some open questions about which strategies maximised gains and minimised problems.
- There were important differences between independent providers and certain of the Social Services providers in the survey. The latter were providers where managers retained some of the discretion to make decisions which was common at in-house services before division into purchasers and providers. At independent providers, Social Services purchasers were a major influence concerning flexible person-centred care since they controlled many decisions about how provider time was used. In contrast, at some Social Services providers these decisions were in the hands of the provider manager. Also influential was a notable difference between independent providers and some Social Services providers in how they determined the length of a home care visit. For the former, a fixed length of time was assigned by Care Management. At the latter, staff left as soon as the required tasks had been completed.
- Other important differences between independent providers and Social Services providers concerned adverse pay and working conditions for independent sector care staff, like non-payment for meetings or travel time. These could adversely affect home care customers and provider managers, as well as front-line workers. To attract staff despite such adverse conditions, independent providers sometimes needed to recruit people who were seeking such flexible hours that this would bar them from much conventional employment. The fluctuating availability of such workers could pose problems for both customers and managers.
- Some Authorities would commission home care time for older people only for meeting their survival and safety needs. Others would sometimes also provide social or emotional 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.
- Capacity to provide flexible person-centred home care could clearly be affected by local influences like labour shortage in very prosperous localities or whether, as in rural areas, there was much staff travelling time between customers.

- A trend was evident for Social Services in-house providers to transfer to specialist roles as skilled short-term rehabilitation services or as home care providers for younger people and people with complex disorders. It seems likely that in many places standard long-term home care for disabled older people will become the remit of the independent sector. It is in long-term home care that a flexible, person-centred approach has particular importance.

Panel One

Examples of flexible, person-centred home care for older people, encountered during in-depth research at six providers for publicly funded customers. Examples derive from interviews with service users and staff.

A) An isolated customer gets a 90 minute timeslot each week for her home care worker to take her shopping or to the beach or the park as she chooses. She has lost her driving licence following a stroke and is awaiting DVLA re-assessment, which is very important to her. In the interim, her home care worker suggested these excursions, which restore some ability to travel and thus support morale. Social Services Care Management agreed to commission time for this purpose.

B) On sunny days home care staff take a customer with arthritis for a short walk during her lunch visit, if she has been able to make lunch herself beforehand. This is her preferred use of the staff's time, since getting out of the house is very important to her.

C) At his request, home care workers regularly drive a customer to visit the grave of his wife, who died recently. He says he feels much better after these visits. When the customer wishes this, visits occur during spare time in daily 30 minute visits to prompt medication taking. (30 minutes is the minimum visit length which this rural agency provides.)

D) A home care team leader drives a customer to a hospital appliance centre for a shoe-fitting. He has a physical disability and a speech impediment and is very isolated. During the appointment she will interpret for him, if needed.

E) One morning a home care worker finds a customer has been burgled overnight, while she feigned sleep. The worker immediately arranges to be replaced on her scheduled visits and instead spends the morning liaising with police and repair services and comforting the customer.

F) A customer dies. For a fortnight his regular daily home care worker is instructed by her manager to make short daily social visits to his widow. Then the manager visits his widow to assess any future needs.

G) A customer suffers periods of severe mobility difficulties, which make her very lonely and bored since she has no nearby family and cannot get to day centres. To respond to this, her care package includes two hours per week from a home care worker who chats and does puzzles and games with her.

H) A home care worker phones a plumber on behalf of a customer. She then re-arranges the timing of a scheduled visit so that she can be present when the plumber comes. Thus she can assist negotiations and promote the customer's interests.

I) At Christmas, pairs of an agency's staff take pairs of customers out Christmas shopping, if they have no nearby relatives to help them. Likewise they bring Christmas decorations to some customers' homes.

Chapter 4 Findings from the Stage Three in-depth case studies

Certain broad messages emerged from the in-depth case studies of six provider and purchaser pairs.

- Among older home care customers, the type of extra help which was most commonly sought was help to get out of one's home. At all six providers it was much the most common aspiration – and often unmet. Some interviewees wanted to be taken shopping or to places of interest. Some sought help to improve walking. Mobility aspirations have also been found in consultations with older home care customers by Raynes *et al.* (2001).
- At all six providers there were many examples of flexible person-centred help which did not require much departure from conventional home care roles or cost very much time. For instance staff would include special requests like delicatessen items or birthday cards in their shopping. Or they would let customers choose where in their home the worker's allocated cleaning time was spent. On request, some staff would change a light-bulb or dust the tops of cupboards despite rules prohibiting this.
- But differences between providers were evident concerning help which required significant extra time or departure from strict home care roles. Such help is illustrated in detail in Panel One. This was found mainly, but certainly not only, at three of the providers. In particular these three providers stood out for regularly helping some customers to go to places outside their homes as an official part of the service. At the other providers this was banned or discouraged.
- A common pre-condition for flexible person-centred help is the relationship which develops when a customer is served by familiar, regular care staff. Staff get to know a customer's aspirations and become motivated to fulfil them. Systematic linking of each customer with a few regular workers had been found, by the telephone survey, to be common though not universal. It was employed at all six providers in the in-depth study. This practice was promoted by the work of Henwood *et al.* (1998). It seems now accepted by many providers and purchasers as a key quality element in home care.
- Providers differed in how they treated the person-centred initiatives which arose from these relationships between customer and a regular worker. At some providers, for instance, a worker was forbidden to agree to a customer's request to take them shopping. At others this was permissible in paid time and supported

by both provider manager and purchaser. Some purchasers even specially commissioned time for such a purpose. The interpretation has been made that staff will develop person-centred initiatives further and undertake them more often, the more that a provider encourages, approves or actually pays staff for doing so. This climate of encouragement appears the key explanation for why three providers in the in-depth study displayed more time-consuming or original types of flexible, person-centred help. However, even under the most discouraging conditions, certain staff still undertook demanding person-centred initiatives for the benefit of their customers. The latter observation accords with Sinclair *et al.* (2000).

Independent agencies

- Where an independent agency is concerned, it requires decidedly more than a provider manager with holistic values, if the provider is to thus encourage care staff to help in a flexible, person-centred way. Support from the Social Services purchaser is essential. The in-depth study found that there were two broad levels at which a purchaser could promote flexible, person-centred help for which staff would be paid.
 - The first was the explicit commissioning of accompanied shopping trips, 'companionship visits' or excursions like Example 'A' in Panel One. Here, purchasers in the in-depth study divided sharply. Two routinely commissioned such services. Two would not pay for home care time specifically for social support or to enhance quality of life for older people.
 - Secondly, instances of flexible, person-centred help were also found to occur during time paid for by purchasers for other purposes, like Panel One's Example 'B', or during spare time during a visit, like Example 'C'. They were also found during extra home care time for which a customer was paying privately and in staff free time. This second type of time source represents no extra financial costs to the Social Services purchaser. It was clear that enthusiastic, motivated home care providers could sometimes find time so that person-centred initiatives could occur through such means.

An important observation was that no purchaser held a neutral attitude to these latter, 'cost-free' sources for flexible, person-centred help. Some purchasers encouraged them. Others discouraged their agencies from using these opportunities to give Social Services customers extra help which was not in the Care Plan.

- Those purchasers, who explicitly commissioned help towards quality of life, also looked favourably on the various other means whereby their provider supplied flexible, person-centred help - like sometimes changing how a care visit was used, or creative use of spare time during visits. They held a broad,

holistic attitude to care for older people and, if something benefited a customer, these purchasers could see it as having value. They could be labelled 'customer-centred'. These were the purchasers for the two independent agencies which gave more time-consuming types of flexible, person-centred help.

- In contrast, those purchasers, who did not commission such help, also discouraged all the other means for obtaining time for flexible, person-centred extra help, even if it incurred no financial costs to Social Services. They could be labelled 'system-centred' since they evaluated person-centred extra help in terms of possible risks to efficient running of their service, rather than benefits to the customer. For instance, such purchasers saw problems in the very idea of a worker giving extra help which specially mattered to a customer. If such a worker left, they argued, future service could be disrupted by the customer's disappointment. Likewise, they reasoned, it was always possible that extra, person-centred help – whether in spare time during a visit, privately paid, or in staff free time – could result in a disruptive accident to staff, customer or a customer's property. If a customer requested extra tasks during spare time towards the end of a visit, a purchaser said, one day this might lead to a staff injury which, from this viewpoint, was unnecessary. During private extra cleaning, another purchaser pointed out, a worker might break a customer's favourite ornament and bad feeling might then compromise her standard service. Were a customer to privately pay her care worker to take her on an excursion, then Social Services might receive some blame were any accident to occur, a purchaser reflected. To preclude such avoidable disruptions, these purchasers wished service to be always strictly limited to the Care Plan. Occasional risks to smooth service running were treated as more important than gains for customers. At these purchasers' agencies, repertoires of flexible, person-centred help were generally limited to help which required little extra time. However at one agency certain care staff gave substantial help against their manager's instructions.

Discernible connections between purchaser policies and provider action were as follows.

- Accompanied outings and companionship time were commissioned by Care Managers in some Authorities but not others. There was also direct purchaser influence via the tasks and visit lengths which Care Managers commissioned at assessment and revised at reviews. At one provider, for instance, reviews by a 'system-centred' purchaser were being used to reduce visit lengths to the time required for practical tasks only, excluding time for conversation.
- All four agency managers encouraged their staff to follow their purchaser's stance concerning flexible, person-centred care – whether in favour or against it. Sometimes this was an approach which the provider manager favoured

anyway. Sometimes it was contrary to the manager's inclinations. Conspicuously 'customer-centred' norms were promoted by management at some providers and conspicuously 'system-centred' norms at others.

- At all providers, there were care staff whose stance concerning flexible, person-centred care was influenced by their manager. However, all providers also had some staff who behaved in some way contrary to their purchaser's and provider manager's stance. Sometimes this worked in favour of flexible, person-centred care. Sometimes it worked against it.

Limitations from the study's methods mean that these influences cannot be quantified. The conclusion drawn is that the differences between purchasers' policies did have an important influence on the differences between these agencies' supply of flexible, person-centred help. However to some extent this was reduced by the tendency of some home care staff to ignore management policies, as noted by Sinclair *et al.* (2000).

A purchaser's influence is likely to increase in line with its contribution to an agency's income and be maximised where an agency is on a block contract which brings most of its income. The latter was the situation at three of the four independent agencies in the in-depth study. The evidence suggested that, if on a large block contract with Social Services, an agency cannot sustain a flexible, person-centred approach if the purchaser disapproves. One national trend is for publicly purchased long-term home care for older people to be provided by independent agencies. Another trend is for such care to be provided by fewer agencies, on block contracts to Local Authorities (Mathew, 2004). Thus, if our conclusions are correct, purchasers' values and preferences will increasingly influence home care.

No comment can be made from this study on how typical are these 'customer-centred' and 'system-centred' Departments, which purchased the independent agencies in the in-depth study. The two 'customer-centred' purchasers entered the study from the 11 Authorities in the telephone survey partly because they employed interesting policies which supported flexible, person-centred care. The two 'system-centred' purchasers were *not* selected for any sign of their contrasting approach, which was not evident at this stage. Their providers' characteristics were the reason for their participation. Nuances should be anticipated concerning how exactly other purchasers match either label. For instance slight nuances were evident concerning the purchasers of the two in-house providers in the in-depth study.

A firm conclusion from this study is that purchasers can seek to influence many factors relevant to flexible, person-centred care and that, to some extent at least, this has effect. In any work on flexible, person-centred care at independent agencies, a useful starting point could be to thoroughly investigate the priorities and influence of Social Services purchasers.

In-house Social Services providers

The telephone survey showed that at certain Social Services in-house providers, the manager has more discretion concerning how care staff time is used than occurs at independent providers. Two relevant providers were selected for the in-depth study and consequences of this condition were explored.

- This manager discretion gives such Social Services providers greater potential flexibility for some forms of person-centred care – e.g. examples ‘D’, ‘E’ and ‘F’ in Panel One. For instance, in Example ‘F’, had this been at a contracted independent agency, there could be a need first to find a Care Manager who could commission the spending of time on this brief post-bereavement support. Then the question about service user liability for care charges would need to be resolved. At an in-house service it is much easier to discreetly relax a small charge like this (total cost c. £20), when it would be insensitive and counter-productive to try to levy it. In this situation it can be much harder for an independent provider to act in as timely, sensitive and informal a manner as did this Social Services provider– unless unpaid help is given.
- Social Services providers were also better placed for holistic person-centred care by virtue of links to other Social Services resources. For instance at one provider care staff would themselves bring customers disability aids which they thought would be useful, like a special shoe-horn.
- How far a Social Services provider used this potential depended on how holistic was the viewpoint of the provider manager, not the purchaser – in contrast to independent providers.

The latter reflects that flexible person-centred care depends on the values of whoever determines how staff time is assigned. At independent agencies the latter is substantially in the hands of Social Services purchasers via the Care Management process. At some Social Services providers, the provider manager makes some decisions which, for the independent sector, would be made by Care Managers instead.

- Social Services in-house providers could give a high standard of comprehensive, flexible, person-centred care, if the provider manager’s values supported this. However the telephone survey had shown that sometimes the latter is decidedly not the case.

Provider organisation and management – findings common to both sectors

- At the most flexible providers, managers explicitly encouraged staff to respond holistically to customers' needs.
- The same managers based care-giving decisions on prevailing opportunities, rather than following rules and precedents about what their service would or would not do. This allowed them to utilise unpredictable, fluctuating amounts of spare time for flexible extra care. They likewise made decisions on a situational basis, rather than by rules, concerning potential risks like escorting customers or changing light-bulbs. They safely provided services which were prohibited at some other providers.
- A larger management team could greatly increase flexibility – for instance through providing more senior workers who could deal with unexpected or complex care problems.
- Conversely, however small a service, a lone manager can face difficulties on account of the diversity of management tasks in home care.
- Provider managers need to guide and support care workers concerning the emotional costs of the close care worker/customer relationships which underpin flexible person-centred care – and indeed any good care for frail older people. In particular there are unavoidable emotional costs from caring relationships which repeatedly end in a regular customer's decline or death.
- Continuity of care is essential to develop the relationship with care staff on which good care depends. But it may sometimes be preferable to provide this through two or three main workers, where larger care packages concerned. Systems based on a single main worker per customer can maximise negative effects from a worker's limitations and from staff absences and changes.
- Pay and conditions for care staff need to be adequate to obtain and retain good quality care staff. Care staff receive much poorer rewards at independent agencies than at Social Services providers. Probably more important than the hourly pay rate is that agencies often do not pay care workers for mileage, travel time and supervision and training time. Reasons for the latter include disputes over whether purchasers' overhead payments to agencies cover payment to care staff for such purposes. At some providers, non-payment of mileage and travel time was a particular issue for staff.

Social Services Care Management

- Care Managers seemed heavily burdened by large caseloads. Their influence on actual service-giving appeared distant and limited. Care Management services tried different ways of distributing their large long-term caseloads among Care Managers and some changed these during the study. But none of these arrangements were judged superior by interviewees. All entailed more long-term clients per Care Manager than interviewees thought was conducive to personalised care.
- Transfer of home care to independent agencies means that Care Managers now sometimes need to perform various practical tasks which formerly would have been undertaken by in-house Social Services providers - for instance replacing a broken refrigerator. Care Managers are not always well equipped for this.
- Some older home care customers had combined emotional and practical problems which might have benefited from time-limited Social Worker help. It was not clear how readily available is such help.
- Authorities varied in how far the purchaser staff, who were interviewed, followed a consistent local policy. In some Authorities, a corporate line was evident. In others, Care Managers pursued their own individual policies on some issues.
- New, telephone-based automated systems for monitoring home care staff activities are sometimes seen as a threat to workers' flexibility. Feedback from Authorities, where such methods were employed, showed that this need not be the case, if the purchaser holds holistic values which support flexible care.

The importance of values, not methods or systems

Caring values seemed the motive force behind flexible, person-centred home care – whether at the level of the home care worker, the provider manager, or the Social Services purchaser. ‘Caring for the whole person’ was a phrase used by two provider managers to describe the standpoint from which they promoted flexible, person-centred care. It could equally well describe the outlook of purchasers and care staff who held the same values.

‘Caring for the whole person’ seems the prime source for flexible, person-centred care. It is an outlook which seems to develop easily and naturally among many home care staff, once they get to know a customer. Among provider managers, to practice it requires either the command of staff time which is held by some Social Services

provider managers or the support of like-minded purchasers. The importance of purchasers, who value holistic care, is a major finding from the study.

The salience of such values is a far cry from some of the original thinking behind this project. Initially the project had envisaged an important role for special assessment and review systems which might skilfully identify customer preferences and direct staff towards person-centred care. Hence the interest in Kane's innovative procedures for American case managers to ascertain older service users' own priorities during assessment. (Kane *et al.*, 1999. Also summarised in Patmore, 2002b). Likewise the study had expected to find that particular staffing or rota systems could enable superior performance. But, at the end of the third stage, techniques and methods appear at best of secondary relevance. The important thing has been the motivations of those who utilise a technique, method or resource.

A notable shortcoming: can it be avoided?

There are important limitations from a process whereby customer requests and concerns are largely communicated through the informal relationship between customers and their regular care workers – the common theme in the in-depth study. Care workers would respond to those customer aspirations which fitted the worker's personal repertoire of skills, knowledge and interests and the time available to her. What seemed lacking was channels whereby important customer aspirations could be met by other care workers, if their own regular workers could not do so. For instance some staff would offer to take customers on walks or drives, whereas others would not. There were customers, even at customer-centred agencies where such help was fundable, who wanted such help but were not getting it – possibly because their particular care worker did not offer it.

But the issue may be quite complex. It is possible that some person-centred extra help cannot easily take place without an existing relationship between customer and a helper who can supply this. It may not be straightforward to refer it to any member of a home care team. Even at providers with regular team meetings, person-centred extra help could sometimes sound like each worker's private creation for her own customers – for instance resource lists were not shared. However, some person-centred extra help did get provided on a team basis, like Panel One's Example 'C'.

Chapter 5 Guidelines for promoting flexible person-centred care

On basis of this study, some guidelines can be suggested for developing flexible, person-centred home care for older people. The following are key factors.

Belief in 'caring for the whole person'. Belief in the value of flexible, person-centred home care

This is the most important factor. It is important in purchaser, provider manager and care staff.

- The study suggests that, in public purchase from independent agencies, it is Social Services' purchasers' values which are most important. The purchaser may be able to seek out or develop a like-minded provider, whereas an independent provider cannot for long be more person-centred than major purchasers permit.
- But where a Social Services in-house provider has significant managerial discretion, it is the provider's values which are more important, since these provider managers, not Care Managers, shape the detail of how staff use time.

Customers are served by regular provider staff

Familiar, regular care staff

- get to know the customer's priorities and aspiration
- become motivated to help to fulfil these.

Serving older people through familiar regular care staff is already common practice in many home care services.

Except with small care packages, a customer's care may be better spread among two or three regular workers, who can still get to know the customer well, rather than based too much on a single worker.

The provider can deploy some staff time flexibly for ad hoc purposes

Three different means were encountered during this research.

- Acceptance by the purchaser that sometimes, for agreed purposes, a provider can bill for time which has not been commissioned in advance.
- At independent providers, some supplementary management staff who are funded from overhead payments and whose time is hence controlled by the provider manager, not the purchaser.
- Those Social Services in-house providers, where managers have discretion to assign time for ad hoc purposes, have this capacity anyway.

Clear, agreed policies concerning flexibility, use of spare time and assisting customers to find private extra help

Purchasers need to develop policies on the following which are understood and agreed *both* by providers and by Care Managers:

- Broad principles governing providers' discretion to respond to customer requests which depart from Care Management's Care Plan. A degree of provider discretion needs to be legitimised and encouraged. At the same time, key Care Manager concerns, which are expressed in the Care Plan, also need to be supported.
- Broad principles about spare time during fixed length care visits and its use as customers' 'quality time'. Do particular customers need visit lengths which *ensure* spare time for that customer's use? The latter is also worth consideration at services where visits are made on a 'task-centred' basis. Conversely, guidance is needed concerning when regular spare time indicates that visit length should be reduced.
- Requirements for providers and Care Managers to assist customers who want to pay for extra services privately. This includes both encouraging private extra help from a customer's publicly funded home care provider and active brokering of help from other private services like cleaners, plumbers or gardeners.

With respect to the latter point, it could be argued that such enabling of private help should be promoted positively as a direct route to flexible person-centred help. Purchasers and providers could helpfully empathise with some customers' concern to keep their homes attractive through such means, noting the arguments advanced by Clark and colleagues (1998). Low cost, user-friendly services could be promoted which reduce the barriers of cost noted during this study concerning private extra help from independent agencies. (Private extra cleaning from independent agencies incurred the same agency overhead as was charged to Social Services for complex personal care. Private extra cleaning from Social Services provider staff was approximately half the price.) Among opportunities for flexible person-centred help, privately paid extra help was the one least likely to be positively promoted by Social Services purchasers.

Purchasers directly commission interventions to address customers' quality of life

- Interviews with service users showed that, at all providers, by far the most common unmet aspiration was help to get out of one's home. Accordingly a customer-centred purchaser would commission some escorted outings for quality of life purposes for selected customers – and monitor results. Reviews by Care Managers and nominations by providers could be used to select customers with relevant aspirations and without alternative sources of help.

As well as customers who sought transport, the study encountered service users who wanted more practice to improve their walking in on-going programmes with NHS staff. Home care staff can be well placed to give such help – whichever Sector pays for their time.

As well as directly benefiting the customers concerned, such commissioning can develop the repertoires of provider staff, which then can benefit customers in other circumstances. By commissioning escorted outings for quality of life purposes, a purchaser prompts a provider to resolve issues like risk assessment procedures and who pays for increased staff motor insurance premiums (a familiar controversy) or for taxis or special transport. A lesson from this study is that, once such solutions have been worked out, they facilitate further help of the same sort.

A pragmatic approach by provider management to decisions on flexible, person-centred help

To utilise opportunities for flexible, person-centred help, a service needs to avoid making rules or affirming binding precedents about what it will or will not do. One week it may be possible to give some help which may be impossible the next. Some very clear provider feedback was received on this subject.

Staff rewards which can attract and retain high quality care workers

Pay and conditions need to be good enough to attract and retain high quality staff. While pay is rarely these workers' prime motivation, interviewees made clear that reward at independent agencies is sometimes so poor that it can deter good workers. Problems were noted concerning low pay rates, minimal weekend premium rates, no guaranteed hours, no mileage pay and no pay for non-contact time like travel and training. Exactly which of these elements matters most probably varies locally. For instance at a rural provider mileage pay was found to be a major concern for staff. A reward package needs to be able to attract and retain high quality staff like the "natural carers" who were described in the telephone interviews (Patmore, 2003a).

Provider management must be sufficient to ensure basic standards

Part of person-centred care is preservation of basic standards, like visits never being missed, punctuality and customers having confidence in their main helpers. Management capacity needs to be sufficient to monitor such elements. Some managers must be able to separate from office-based roles to visit customers and supervise staff at work. The provider needs to employ sufficient managers to handle the complex workload involved in home care. Basic quality of care needs to be maintained at the same time that creative, flexible care is developed.

Having enough time is always important

Last but not least, having enough time is clearly important. This was notable at two levels.

- The amount of time commissioned for a care visit. Wide variations were encountered. Sometimes spare time was used very constructively. Sometimes purchasers routinely commissioned visit lengths which were so short that personalised service could be difficult.
- A sense of pressure on time is not conducive to person-centred care. At two agencies on block contracts and at one Social Services provider, obligation could be felt to accept referrals for which the service might lack capacity. Serving extra customers could affect the quality of work with established ones. For instance sometimes providers scheduled visits so that the visit lengths commissioned by purchasers could not be given in full.

Chapter 6 Implications from the study

Practicability of flexible, person-centred home care

The study showed that, under certain conditions, it is possible for home care workers to provide a diverse, comprehensive range of help, include creative forms of social support. Certain limitations were noted in how readily such help can be supplied in a systematic or targeted way, since so much depended on the capacities of individual care staff rather than teams. The study nevertheless points to home care staff as an important and flexible resource for improving social care since, like housing wardens, they have unusual regular access to housebound older people. They represent a more available, flexible and reliable resource for this purpose than social workers or voluntary sector befrienders – or, indeed, housing wardens. This study makes a similar case for utilising the potential of home care workers to that presented by Sinclair and colleagues (2000).

In terms of costs, this approach was affordable at three providers in the in-depth study and may well be affordable elsewhere. The study could not assess likely overall costs of adopting this approach. But it has established that, while there are some extra costs, there is also some help which costs Social Services nothing. This is because enthusiastic care staff seek out opportunities, during paid care time, which can be used for person-centred extra help. Some of the examples in Panel One involved extra costs, like Example A. But others did not since they use time already commissioned by Social Services, like Examples B and C. Where cumulative extra costs are involved, these are often transparent and controllable. Example A, for instance, was costing £13.20 in agency fees on each occasion, transport costs begin met by the customer. It was currently commissioned on a weekly basis for a limited period. Some other examples in Panel One involve extra costs on a one-off basis only – like Examples D and F, which would each require one-off extra payment of less than £20.

Relevance to established national policy

Flexible, person-centred home care is relevant to the following Standards in the National Service Framework for Older People (Department of Health, 2001).

Standard One: rooting out age discrimination. This study has described how home care staff can assist older people in areas of quality of life where help has sometimes been more readily commissioned for younger customers, than for older people. Clear feedback to this effect was obtained from home care provider managers in the telephone survey (Patmore, 2003a). These home care provider

managers had an unusual vantage point for observing such age discrimination. They could compare the care packages they received from separate Care Management teams which commissioned care for different age groups. They could also witness changes made to a care package if a customer reached the age of 65. It cannot be assumed that the subsequent integration of services for adults has changed Care Managers' habits in respect of commissioning care for older people. Findings from this study may contribute to the ending of such age discrimination, as sought by Standard One.

Standard Two: person-centred care. The study adds substantially to understanding of what it can mean to take a 'person-centred' approach to care for older people. It transposes to older people's lifestyles in the community some core principles of Standard Two concerning listening to older people, respecting individuals' values, and co-ordinating responses. Application of these principles has been most clearly described with respect to health care and personal care (Department of Health, 2001). This study of flexible, person-centred home care illustrates how the same principles can be applied to a different dimension of care arrangements.

Standard Seven: mental health in older people. As mentioned earlier, a prime reason for interest in flexible, person-centred home care is its potential role in preventing depression among older people – and in supporting recovery. This is based on the case for a preventative approach to depression among older people, like that presented by Godfrey and Denby (2004). There are two broad ways in which home care workers can contribute, if working within a remit which permits flexible, person-centred care.

- They can provide help which compensates for the loss of functioning, owing to physical disability, which is a common precipitant of depression in older people. For instance they can help a customer, who is losing mobility, to engage in valued activities outside their home. In Panel One, examples A, B, C, G and I would be relevant illustrations.
- Some home care staff can provide supportive, confiding relationships – a factor known to reduce the likelihood of depression in response to adversity. Examples E and F in Panel One would be relevant.

The study also notes how sometimes a customer's regular home care staff are potentially useful co-workers in mental health interventions led by a social worker or other professional.

Standard Eight: the promotion of health and active life in old age. Meeting this Standard includes the following:

'Any form of social, physical or mental activity is good for health and well-being.'

‘Promote mobility and social contacts.’

‘Develop policies which reduce disability and ameliorate its consequences in older people, particularly those living alone.’

(Department of Health, 2001)

The last goal has in fact been a focal point for this study, as described just above. Many flexible, person-centred care practices encountered during the study show how the principles of Standard Eight can be applied to wider contexts than health promotion and exercise. Concerning the latter, however, the study also highlighted how home care staff are potential co-workers in NHS mobility rehabilitation programmes.

Potential for development

Concerning promotion of flexible, person-centred home care, some guidelines have been presented in Chapter Five whereby this approach might be encouraged in a top-down fashion by a Social Services purchaser.

But a major quandary exists concerning application of these guidelines. Arguments for holistic, person-centred care are based, in the last analysis, on values. They will appeal to Social Services purchasers who already hold such values. They will appear void if seen from what have been dubbed a ‘system centred’ viewpoint. If the analysis here is correct, ‘customer-centred’ purchasers, who may be attracted to these guidelines, may well be following at least some parts already. ‘System-centred’ purchasers will see no reason for interest – and this follows wholly logically from their core assumptions. The values already held by Social Services purchasers will determine whether flexible, person-centred home care is developed.

How are purchasers’ values shaped in a Social Services Department? How do they change? In the in-depth case studies, behind the system-centred viewpoint could be discerned two separate influences. There was an element which concerned curbing service costs. Service would be limited to only whatever personal care, shopping and basic housecleaning was strictly necessary to maintain an older person’s continued survival in their own home. There was also an element which concerned the smooth or efficient running of the service. This required avoiding anything additional to the Care Plan – even if it cost the Authority nothing – in case one day it might cause some disruption to the smooth running of the service. At one of the two most system-centred purchasers in the study, both cost-curbing and efficiency concerns were clearly evident. At the other, it was smooth, efficient running which was the purchaser’s priority.

At some Authorities in the in-depth study, there were signs of a long-standing general culture among purchaser staff in either a customer-centred or a system-centred direction. At one customer-centred Authority, a specific event a decade earlier had introduced the purchasing of accompanied shopping trips for home care customers. This had then gradually become a routine part of the purchasing culture. At two Authorities a current senior manager was proactively and energetically directing relevant policy – in one case in a customer-centred direction, in the other case system-centred. In the latter case, purchaser staff had been carefully, thoroughly briefed on applying a system-centred outlook to many everyday care decisions. It would take much work to counter this, were new policies to be introduced.

A likely influence towards cost-curbing policies, which narrow the goals for older people's services, is anxiety about the ageing of the population and concern to reduce commitments ahead of anticipated demand. There are common worries both about future costs and about the availability of care workers at any price.

In support of holistic, person-centred home care are concerns about preserving standards of care, addressing older people's quality of life, and resisting 'warehousing' in the community just as in institutions. There are arguments too that such home care roles may forestall or ameliorate some depression among older people, as described earlier. There are also practical arguments that home care risks breaking down if the care time purchased or the staff's remit is restricted too severely. There are practical difficulties in serving older people who are depressed or very dissatisfied or whose household resources have fallen into disrepair as a result of very parsimonious service. Concerning workforce shortage, there are arguments that flexible, person-centred roles attract and retain motivated, conscientious staff, whereas a system-centred ethos may have the opposite effect.

'Independence, Well-being and Choice' and the future for flexible, person-centred home care

At the point of concluding this report, the Green Paper *Independence, Well-being and Choice* (Department of Health, 2005) has been published. The latter takes a stand which considerably assists the flexible, person-centred approaches to home care which this study has investigated. No more is this a matter for Social Services purchasers to decide. The Green Paper:

- Affirms that quality of life is an outcome to be addressed for older people, as for other service users.
- Promotes giving service users choice and control over their services.
- Advances the use of flexible, individual care budgets to produce outcomes tailored to individuals' aspirations.

If individual care budgets become widely utilised in the way intended, this would probably obviate many of the problems in older people's services which this research has noted.

However this research identified obstacles to success which are formidable – though by no means insurmountable. Some Social Services purchasers have developed an organisational culture which is profoundly contrary to key values in *Independence, Well-being and Choice*. Care is needed to recognise quite how large can be the cultural divide between some purchasers and politicians or between differing Social Services purchasers. It can be so profound that major disagreements risk not being recognised – maybe by either party. A step to effective implementation is recognition how huge a change is required in some Authorities – maybe in many Authorities. In some Authorities in this study, purchasers have focussed on instructing home care providers *not to heed* service users, but to heed only the purchaser's Care Plan. Good management has become equated with restraining the tendency among many home care staff to fulfil customers' requests, when opportunity permits. This study found that sometimes purchaser and provider managers could foster exaggerated fears about risk among provider staff so as to deter staff from giving unscheduled, flexible help. Some reasons for these purchaser policies were given on page 15. In some Authorities a well-crafted, very logical management approach has been developed which is fundamentally opposed to the emphasis on quality of life and customer choice in *Independence, Well-being and Choice*.

At the same time, these very obstacles amplify the case for the radical approach taken by *Independence, Well-being and Choice*. Only such a major change as individual budgets can advance flexible, person-centred home care on a large scale. Otherwise, as discussed earlier, the latter's progress would depend on what values already prevail among purchasers in an Authority. In general this research amplifies the case for directions advanced by *Independence, Well-being and Choice*. This research has witnessed how certain approaches to older people's care can enable flexible, creative, person-centred help – as illustrated in Panel One. It has also witnessed how other approaches can waste such opportunities. *Independence, Well-being and Choice* offers major support to the former style of service.

This research is a substantial resource for implementation of some aspects of *Independence, Well-being and Choice*. The study's key achievement is to highlight many, varied issues which merit attention if flexible, person-centred home care is to be promoted – see Chapter Five. Anyone who is minded towards the latter is now much better equipped.

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Appendix 1

Publications from Stages One and Two of the project on flexible, person-centred home care for older people

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*, Social Policy Research Unit, University of York, York.

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Appendix 2

Size and workload of the six home care providers in Stage Three

- The largest provider was an independent agency which provided 1,500 hours of care per week and used around 60 front-line care staff. Mean weekly care hours were circa five hours per customer.
- Two other independent agencies each provided 1,200 care hours per week, while care staff ranged from 40–60 at different periods. At both, mean weekly care hours were circa eight hours per customer.
- A Social Services provider supplied 1,000 care hours per week, using 40 care staff. Mean weekly care hours were circa three hours per customer.
- There were also two much smaller provider units. A Social Services provider team with 20 care staff supplied 450 weekly care hours at a mean of three hours per customer. A small independent agency also used 20 care staff. Its mean care hours for its Social Services customers were over ten hours per week.

Appendix 3

Miscellaneous additional information about the project

Project Advisory Group

The project was assisted by an Advisory Group which included the viewpoints of a Social Services purchaser, independent home care providers, an older people's organisation and researchers on home care. It included two older members who were former researchers.

Modifications to the original design

Telephone interviews were substituted for an intended postal survey in Stage Two, owing to quandaries about defining the provider units for participation. A plan was abandoned for involving Stage Three participants in undertaking a special set of provider-led reviews for the project. It became plain that providers too often lacked capacity.

Staffing of the project

The overall design of the project was undertaken by Charles Patmore with assistance from Hazel Qureshi. Charles Patmore undertook Stages 1 and 2, including 23 staff interviews during the latter. During Stage 3, Alison McNulty conducted 45 interviews - with 34 service users, one family carer and ten staff. Charles Patmore interviewed 28 staff. Additional interviews were contributed by Elinor Nicholas (four interviews with service users and two with family carers) and Caroline Glendinning (two staff interviews).