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**Domiciliary Care Agency Responses to Increased User Choice:  
Perceived Threats, Barriers and Opportunities from a  
Changing Market**

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## **Executive Summary**

In December 2007 the Government announced the intention of introducing personalised budgets for everyone eligible for publicly-funded adult social care in England. Personalised budgets aim to allow users to exercise more choice and control over the support they receive. Currently, most LA-funded home care in England is provided by independent sector agencies through a variety of contractual arrangements; care managers purchase care for individual users from contracted agencies. The capacity of home care agencies to adapt from providing predominantly LA-commissioned services to much greater purchasing of services by individual personalised budget holders is not well researched. This study explored the potential impacts on home care agencies and the wider implications for the home care market of these changes.

### **Key findings**

For most home care agencies, LA contracts provide the majority of their business. As resources have become tighter, the range of tasks purchased by LA care managers has been increasingly restricted to personal care.

Local authorities in the study had recently introduced contracts with independent home care agencies based on geographical zones. With each agency concentrating its staff and activities in one locality, personalised budget holders' opportunities for choice of agency could be restricted.

LA commissioning managers were committed to greater use of personalised budgets, but knew little about the local home care market apart from their directly contracted services.

Agencies with higher than average proportions of privately paying clients may be smaller, employ more mature workers for longer hours per week and experience lower staff turnover. Agency managers found it easier to deliver flexible support to private paying clients as they were able to negotiate directly rather than through care managers. Managers also anticipated that, as smaller agencies had more personal contact with their clients, they were better prepared for negotiating care arrangements directly with personalised budget holders.

On the other hand, larger agencies were expected to be better protected against new financial risks arising from personalised budgets. Risks included non-payment of bills by individual clients and increased demand for flexible and intermittent timetabling of care.

Other risks anticipated by home care agency managers included personalised budgets being set too low to allow users to purchase agency care, leading to reduced demand for services and the loss of workers to private employment arrangements.

Personalised budgets also offered new opportunities for agencies, including new markets and demands for new types of support, such as help with shopping and social activities. While the latter could increase care workers' job satisfaction, there were implications for staff recruitment and training and potential new costs for agencies. Agency managers expressed concern about the costs of maintaining a qualified workforce in the future.

Agency managers did not have clear strategies for advertising their services to potential personal budget holders; in any case, publicity material was targeted at LA contract users whose care managers generally purchased a narrow range of support.

Agencies used a range of incentives and controls in both care worker and client contracts to retain workers and discourage them moving to work privately for a personalised budget holder.

## **Background**

Since 1993 local authorities have been encouraged to purchase care services from independent sector providers. A decade later, over two-thirds of all LA-funded home care in England was purchased from independent agencies. Since 1997 service users have had the option of receiving their social care in cash direct payments rather than services. However take-up has been low. Other methods of giving disabled and older people greater choice and control have since been introduced – the In Control programme for people with learning disabilities and the Individual Budget pilots that include additional funding streams.

In December 2007 the Government announced the extension of personal budgets for everyone eligible for publicly-funded adult social care in England. This will have impacts on the providers and commissioners of services.

The aim of this study was to examine the perceived threats and opportunities among existing independent home care providers for responding to increases in user choice through personalised budgets and similar mechanisms.

## **Findings**

Agencies had seen little impact from direct payments to date and were therefore unprepared for the expansion of personalised budgets.

## **Private clients and agency characteristics**

Secondary analysis of survey data on the organisational and workforce characteristics of home care agencies showed that agencies with above average percentages of privately paying clients tended to be smaller, to employ older care workers for more hours per week, and to experience lower staff turnover.

## **LA purchasing contexts**

Despite differences on key variables, the local authorities in the study were similar in their experiences of financial pressures on the funding of home care services and their concerns about the supply of care workers. All had recently moved to locality or zone-based contracts with home care provider agencies. Because travel out of a zone for individual clients was not considered cost-effective, choice of home care agency was likely to be restricted to the zone provider for personalised budget holders. Despite their commitment to the introduction of personalised budgets, LA commissioning managers knew little about the market and availability of home care services for people purchasing their own care (whether privately or with a personalised budget).

## **Delivering flexible support**

Home care agency managers thought that LA contracts and care management purchasing had actually become less flexible. Funding constraints limited care only to those essential tasks set out in care plans. Agencies providing supported living services were able to exercise greater flexibility of tasks within overall contracted hours. It was also easier to deliver flexible support to privately paying clients, without the need to negotiate changes with a LA care manager. However, flexibility for both LA and privately paying clients was restricted by staffing constraints.

## **Perceived risks from more personalised budget holders**

Agencies had experienced problems with late or non-payment by personalised budget holders; it could also be difficult to obtain outstanding payments after the death of a client. Agencies planned to overcome these problems by requiring direct debits to be set up. Other financial risks were anticipated from people using services intermittently; some agencies were considering introducing holding fees so that personalised budget holders could retain their care services while in hospital or respite care.

Agency managers perceived serious risks to their current client base. Because of their overheads, agencies charged more than self-employed care workers. Moreover, LA direct payments were sometimes too low to allow users to purchase agency care.

Both factors were expected to encourage personalised budget holders to employ carers privately rather than through agencies.

Opportunities for care workers to earn more per hour by working privately for personalised budget holders were also anticipated, thus losing agencies a return on their investment in staff training. However, some agency managers believed that other benefits of being employed by an agency – including management support, free uniforms and Criminal Records Bureau (CRB) checks, and subsidised driving lessons - rather than working privately for an individual personalised budget holder would deter staff from leaving.

Personalised budget users were also expected to want help with a wider range of activities than the personal care currently purchased by LA care managers. This could require retraining existing staff and/or recruiting new staff.

### **Perceived opportunities of more personalised budget holders**

Overall agency managers perceived fewer opportunities than risks. Some thought personalised budgets offered more opportunities for families to ‘top up’ a LA payment and purchase more services. Some agencies anticipated supporting individual clients outside their current LA contracted zones; others saw opportunities to offer new types of services, such as reablement, rapid response and 24 hour live-in support. Proactive support from local authorities in developing new services was considered desirable.

### **Identifying personalised budget holders**

Agency managers planned to realise these opportunities by advertising their services and the potential flexibility of personalised budgets. They anticipated relying on word of mouth, networking and emphasising their established reputation. LA assistance in identifying personalised budget holders would be helpful, perhaps by offering a list of agencies to personalised budget applicants. However, agencies currently used the same literature for all potential clients, whether receiving care manager-purchased services, using a personalised budget or purchasing privately. This raised concerns of confusion and unrealistic expectations, as some services that might be purchased by personalised budget holders (for example, support with shopping or social activities) were not currently purchased by care managers for their clients.

### **Incentives and controls to retain care workers**

A third of agencies had experienced staff leaving to work privately for direct payment users because this could offer more hours work; however, in most cases care workers had returned to agency employment at a later date.

To discourage staff from leaving to work privately for a personalised budget holder, agencies commonly included a clause in clients' contracts requiring payment of a 'finder's fee' if they poached staff. Though probably not legally enforceable, such clauses were regarded as effective deterrents.

Care worker contracts also required staff to repay induction and training costs if they left an agency within a year of joining. Other incentives to retain staff included mentoring and supervision programmes, guaranteed hours of work and opportunities for varied work with different clients. In particular, agency managers considered that total earnings and regular guaranteed earnings were more important to care workers than the possibility of higher hourly rates for fewer, and less secure, hours working privately for an individual client. A minority of agencies offered financial bonuses for long service.

Similar incentives were used to recruit new staff to agency employment. However, it was believed that increased training requirements were a barrier to recruiting new staff, especially for part-time employment. Some agencies had therefore started recruiting abroad for senior carers.

### **The impact of personalised budgets on the overall home care market**

Agency managers thought that larger agencies would be better able to manage financial threats and invest in new services for personalised budget holders, while smaller agencies were more likely to have experience of dealing directly with service users.

The potential impact of personalised budgets on the costs of delivering home care services was not clear. On the one hand, greater exposure to bad debts and increased administration costs were expected to lead to increased costs; on the other, greater competition between agencies for individual clients and less exposure to LA contracting regulations could reduce overall costs. Differential pricing was already being used – private clients (including direct payment users) were typically charged more per hour than LA care managed clients.

Agency managers had serious concerns about the quality of home care provision with a growth in personalised budgets, especially the employment of unqualified carers when the home care market as a whole was increasingly subject to regulations designed to protect staff and clients.

### **Implications for policy and practice**

This study covered a range of different LA purchasing environments and agency characteristics. However, neither local authorities nor agencies had had extensive experience of direct payments or other personalised budgets to date. Not

surprisingly, therefore, few anticipated much impact from personalised budgets in the future. However, the study was conducted before the Government announced the extension of personalised budgets across the whole of adult social care.

Many features of the independent home care agency market have been shaped by local authorities' role as the main purchasers of services. Some of these features are likely to present barriers to agencies wishing to offer flexible individualised services to personalised budget holders; for example, the recent introduction of zone-based contracts may restrict user choice of agency. On the other hand, the stability offered by large LA contracts combined with other regulatory requirements, has allowed agencies to invest in training and career opportunities for an otherwise low paid and low status workforce. Local authorities will need to consider carefully how the potential barriers created by their monopoly purchasing position can be reduced, while at the same time retaining the benefits.

The study suggests that choice for personalised budget holders may be restricted if agencies are unable to advertise to them or advertise only the limited range of services currently purchased by LA care managers. These constraints could be overcome if local authorities actively offer information about the range of local agencies and the services they can provide.

Furthermore, personalised budget holders' and private purchasers' current choice of agency may be restricted as a result of LA zoning. However, this situation may change as more people opt to use personalised budgets and local authorities begin to commission services for fewer people; the importance to agencies of income from personalised budget holders may increase, leaving them more willing or, perhaps, with no option but to travel outside their zones in order to retain business.

The combined effects of the training requirements for agency care workers, and the high cost of agency care relative to private care and some direct payment levels, might mean that agencies begin to find recruitment and retention even harder than at present. However, staffing problems might be alleviated if new people wishing to undertake social support rather than personal care could be attracted to join the existing pool of care workers. Relaxing some of the training requirements for someone wishing to be, for example, a domestic or companion worker might help ease these problems.

Finally, there is an important role that local authorities could play by engaging in a dialogue with providers about personalised budgets and the changing nature of the market for home care services, including the types of demands that personalised budget holders might reasonably make. There is an argument for some form of LA transitional support to help agencies to act quickly and develop new forms of support when needed.

## **Methods**

This research comprised two stages. The first stage involved secondary quantitative analysis of data on the organisational and workforce characteristics of 99 home care agencies. The findings helped to inform the sample selection and content of interviews in the second stage of the study.

Stage two was the main focus of the study. The fieldwork was undertaken in 2007 in four local authorities in England. We selected local authorities with a diverse range of characteristics, such as take-up rate of direct payments and geography. A commissioning manager from each LA was interviewed about the local context for commissioning and home care services. We then interviewed managers of 32 home care agencies based in these four local authorities. These semi-structured interviews comprised questions on: the background of the agency and local issues of importance; the impact so far of personalised budgets; the perceived threats and opportunities from any future expansion of personalised budgets; strategies for marketing services to personalised budget holders; workforce recruitment and retention issues; flexibility of services for LA and private clients; and issues affecting the wider home care market. Transcripts of the interviews were coded under these themes and subsequent analysis paid attention to any differences or similarities in relation to the characteristics of the agencies.





# 1. Introduction

The rationale for this project was the changing face of the consumer side of the social care market. Traditionally, local authorities have acted as proxy purchasers through their care management and commissioning systems. These systems are undergoing change as more responsibility for choosing care packages is being devolved to individuals through the introduction of personalised budgets. This study looks at the perceived impact on domiciliary care agencies of these changes.

## 1.1 Policy background and previous research

Increasingly, the general public and users of welfare services expect, and are expected, to play a greater role in decisions about the care and support they receive. In England, the green paper *Independence, Well-being and Choice* (Department of Health, 2005) presented a vision of social care where services help to maintain the independence of individuals through giving them greater choice and control over the way their needs are met, a vision that was confirmed in the *Our Health, Our Care, Our Say* (Department of Health, 2006) and the concordat *Putting People First* (HM Government, 2007).

Since 1997, service users have had the option to receive their social care in cash rather than services in the form of direct payments. Take-up has been low; the highest percentage take-up in any local authority (LA) was seven per cent in 2005/6 with the average only 2.48 per cent (The Information Centre, 2007). Take-up of direct payments in the over 65 age group has been even lower. Other methods of giving disabled and older people greater control and independence have been introduced, namely the In-Control programme for people with learning difficulties and Individual Budget pilots which comprise funding streams in addition to the social care budget and are available to a wider range of service users. Each of these mechanisms give people personalised budgets. The result of these initiatives is likely to be that an increasing number of people are able to exercise an increasing amount of control over what support they receive, when, how and from whom.

The move towards more self-directed support has impacts not only for service users, but also for the providers and commissioners of those services. There have already been enormous changes in the home care market in the last decade, particularly the rise in the number of independent home care providers following the Community Care reforms of the early 1990's; there are now over 4,500 home care agencies registered with the Commission for Social Care Inspection (CSCI). From a position of solely LA in-house provision, over two-thirds of the hours of care purchased by local authorities are now provided by independent agencies (Mathew, 2004, Commission for Social Care Inspection, 2006). As the number of LA funded service users electing to take their care in the form of a cash equivalent goes up, other things equal, the number of

users for whom the LA continues to commission or provide services in the traditional way will go down. This means that agencies that provide care will be faced with a larger number of smaller purchasers as LA contracts reduce in size and are replaced by individual purchasing. In addition, users may expect to exert more control over the details of their support and be able to more easily change to an alternative supplier than when their support was commissioned through a LA.

Not only do these newer forms of cash options allow individuals to purchase care from different agencies, they also allow individuals' friends, relatives and others from the local community to be paid for providing care. This may have the effect of expanding existing pools of labour by creating the option to become a paid carer to two new groups of people: those whom previously would not have either considered or been able to formalise their existing informal caring role and those who have simply not considered becoming a carer but have responded to local advertisements or requests from relatives. Evidence from Flanders (Breda *et al.*, 2006) suggests that both these new groups are likely to have been in employment before becoming paid carers, with paid friends and relatives being more likely to reduce their hours in other jobs (perhaps maintaining the option to return to other work in the future) but new carers being more likely to quit their old jobs. Although increasing the existing pool of domiciliary care staff, both these shifts could have a knock on effect of creating stronger competition in local markets for employees carrying out roles comparable in skills and remuneration to domiciliary care work. In addition to competing with other industries, domiciliary care agencies will have to compete for staff with each other and with the new private workforce of families, friends and local other contacts. Concerns have been raised also that, by expanding the pool of potential workers in this way, the care workforce might become deskilled, with subsequent threats to wage levels and a reduction in investment in training (Kremer, 2006).

Independent home care agencies have developed because of a system in which the vast majority of home care has been commissioned by local authorities, with private purchasers accounting for only about 20 per cent of the home care market (Poole, 2006). Agencies have concentrated on competing to win block contracts or to be approved as providers eligible to receive spot contracts. Thus, through their commissioning and contracting systems, LA's have exerted a major influence over the nature and volume of the supply of home care. As the number of people using personalised budgets increases, the volume of LA contracts with agencies will decrease. In the future, agencies will have to compete for personalised budget holders; market power will be transferred in part to individual service users. Astute providers will make efforts to find out what it is that these individuals want from their support (Walker, 2007). Although the early waves of people opting for personalised budgets are likely to be those least satisfied with current provision through agencies and thus most likely to purchase support from the private support worker market, over time, as the use of personalised budgets expands, the proportion of people preferring to use agencies may increase as well. It should be remembered also that

increasing choice and control applies not only to people opting for personalised budgets. Those people for whom the LA continues to commission support from agencies should also be able to have more personalised and flexible support if desired (Commission for Social Care Inspection, 2004). Both domiciliary care agencies and LA's will need to learn how to work within these dual systems.

For domiciliary care agencies to compete and survive within this changing market, and to be responsive to what users want, they must be motivated or at least face appropriate incentives. Previous research into the development of the mixed economy of care in the 1990's has looked at the motivations of providers of domiciliary and residential care. Evidence suggests that managers are motivated by the desire to attain professional accomplishment, to have a sense of independence and autonomy, a desire to meet the needs of service users and to fulfil a duty to society (Mixed Economy of Care, 1996b). Providers were found not to be motivated primarily by profit (Mixed Economy of Care, 1996a) but to get satisfaction from using profits to further their other goals, such as meeting the needs of service users. In a more recent study of the motivations of care home providers, meeting the needs of older people was again found to be the most important motivating factor (Matosevic *et al.*, 2008). If this is still the case for home care providers, then one would expect that domiciliary care agencies would be enthusiastic about the increase in personalised budgets and the opportunities to meet clients' needs in this way.

However, whilst there may be a desire on the part of domiciliary care agencies to be responsive to clients' demands, it is not clear how far agencies will be able to respond. LA contracts, with their closely monitored care packages and short (often between 15 and 30 minutes) visits, have shaped the provision of care by agencies for over a decade. We might expect that personalised budget holders would act similarly to private purchasers, but we know little about home care agencies' experiences with privately purchasers; there is little information available about what tasks are carried out and whether these focus less narrowly on personal care than do LA contracts (Poole, 2006).

There are indications that some independent sector domiciliary care agencies are reluctant to respond to requests from social services-funded clients for additional privately purchased services (Patmore, 2003). This is in part due to being short staffed and concerned about the risk of disrupting delivery of LA block contracts by using staff for private work. It is also in part from a fear that advertising for custom may appear unprofessional to LA care management staff. Although responding to requests from social services-funded clients for additional privately purchased services and responding more generally to requests from people using different forms of personalised budgets are not the same, there may be similar concerns around capacity.

The lack of availability of a suitably flexible, qualified and reliable workforce may limit the opportunities for domiciliary care agencies to respond to clients' demands. If service users are to request alternative forms or quantities of care, agencies must have sufficient capacity to respond at relatively short notice if those requests are to be met (Lewis and Jones, 1997). Given estimates of the rise in demand for personal assistants by direct payment users, perhaps to tens of thousands in the next five years (Scourfield, 2005), it is unlikely that this additional capacity will exist at short notice. The pool of domiciliary care workers is limited, particularly in rural areas, and there is already competition with other service industries such as hotels and supermarkets (Scourfield, 2005). Any increase in demand combined with a fixed supply of workers should, in theory, lead to an increase in the wages offered and therefore an increase in the supply of personal assistants. However, because much of social care is publicly funded with tight spending limits, employers in the domiciliary care market feel unable to tackle these issues by raising rates of pay (Yeandle *et al.*, 2006).

Nevertheless, personalised budget users may be able to offer higher rates of pay per hour by employing domiciliary care staff directly, thus avoiding the overheads associated with agencies. Indeed, it has been shown to be the case in Queensland, Australia that service users using cash options to purchase care have negotiated different rates of pay and hours (Spall *et al.*, 2005). In addition, as the demand for personal assistants rises, the demand for personal assistants employed directly by clients rather than through agencies may also rise (Poole, 2006). This means that user choice, for personal assistants at least, may be exercised through the private (and unregulated) market rather than through agencies. Competition between agencies and private employers for care workers will further limit the ability of domiciliary care agencies to retain sufficient capacity to offer flexible responses to users.

## **1.2 Theoretical background**

The main mechanism shaping the new market in social care is the devolution of control to individual clients through personalised budgets. This should offer users more choice over what is provided and who provides it, thereby encouraging providers to be more responsive. Clients will be able to purchase care directly from agencies. They should also be able to specify more precisely their requirements and to choose to purchase care from family, friends and others in the local community who may have previously provided it voluntarily. It should be remembered, however, that LA's will continue to commission services for people who do not wish to exercise choice through personalised budgets. Each agency may face two systems running alongside each other, with some services being purchased directly by individual clients and others being commissioned by LA's. Agencies will therefore have to learn to manage both purchaser types simultaneously.

One way of capturing these changes is through the use of principal agent theory. Principal-agent theory deals with problems associated with delegated choice. It examines the situation where the purchaser of a service (the principal) depends upon another person (the agent) for its delivery.

Principal-agent theory's central concern is how a principal can persuade an agent to perform in a way that satisfies the principal's requirements. Its contemporary usage considers more generically the relationship between the purchaser of a service and the agent who subsequently provides on their behalf (Powell and Dowling, 2006). The principal agent framework has been used to explain new contracting arrangements in health care (Propper, 1995, Smith *et al.*, 1997), as well as the relationship between local authorities and care agencies in social care (Smith and Wright, 1994). The framework is applicable also in relationships where formal contracts do not exist (Mooney and Ryan, 1993, Rees, 1985), for example doctor-patient relationships (Scott and Vick, 1999).

The new market in social care involves the transfer of purchasing power from the LA to the individual client. Previously, the LA purchased care on behalf of the client, with clients wishing to purchase additional care having to find additional money from their own sources of income. Now clients are able to use both their own resources and the budgets delegated from local authorities to purchase care from a range of providers - from established care providers through to those they may wish to employ from their local family or community. LA's will retain commissioning responsibility for those clients not wishing to have a personalised budget and, at the same time, may need to continue to play a role in ensuring services are available locally for individual purchasers. Initially, LA's will continue to commission on behalf of the majority of their population, but this proportion will reduce as the uptake of personalised budgets increases.

Care agencies therefore face a range of different situations. Formerly they provided care for local authorities, who would purchase care on behalf of their local population, or for clients who wished to purchase care privately using their own or their family's resources. Providers were therefore agents to both LA and private principals. This situation is likely to continue. However, agencies may lose the contracts with LA's for some or all of the care currently commissioned, either through a reduction in the volume of care commissioned or a reduction in the number of providers from which an LA commissions. Agencies may also lose contracts if LA's reduce or otherwise change the providers they commission for reasons not associated with the increase in personalised budgets. We do not know at present the country-wide picture or how it will develop. In either scenario, however, both the reality and the threat of a reduction in care commissioned by an LA will be likely to shape provider behaviour.

It was estimated (albeit from data that is incomplete and uncertain) that in 2004 the private purchase of care accounted for 20 per cent of the total hours per week of domiciliary care purchased in England (Wanless, 2006, Table 22). Some care agencies will be in the relatively secure position of continuing to provide care to local authorities as well as to individual clients whose care may be either purchased through direct payments or through private resources. In order to stay in business, care agencies that lose LA contracts or face a reduction in their volume (for any reason) will have to resource their activities entirely through work from individual clients.

Central to the functioning of the relationship between the care agency and the client are the carers the agencies themselves employ. The employment of a carer is a more classic principal agent relationship as agencies employ carers to provide services on their behalf, services which the agency often does not directly oversee. Agencies are therefore the principals to carers, but the agents to clients, as resources pass from either the LA or the client to the agency and then from the agency to the carer. The structure of the new social care market is likely to cause particular pressures on this chain of relationships for care agencies.

First, care agencies are likely to face a stronger market logic than before, with fewer or smaller LA contracts available. This means that to expand or even survive, they must find new clients, and they must enter into more direct relationships with individual clients. This means they must find ways of marketing their services to potential clients. This raises a series of questions. How do care agencies find out who to market their services to? Is there evidence that care agencies are marketing their services to attempt to get clients to change their existing care arrangements by persuading them to change their care provider or by taking up direct payments and purchasing direct from an agency? And how do agencies manage having to deal with a larger number of individual clients with the additional costs of invoicing and payment management, perhaps at the same as managing their contractual obligations to LA's?

Second, with the introduction of personalised budgets, care agencies must consider carefully the principal agent relationship with their clients. A key research question therefore is what are care agencies doing to become and to appear more responsive to both individual clients and to local authorities in order to retain their contracts? Key tensions here are between the need to be more flexible and to provide a responsive service that may include support of an unplanned nature or support that is not easily measured, and to provide a standard range of services that can be more carefully controlled, staffed and priced. There may also be tensions around the type of support wanted by direct payment holders, which may not include the personal and other care services that care workers have been trained to do.

Third, there appears to be a strong incentive under direct payments and other forms of personalised budgets, including private purchase, for existing carers and service users to contract directly with each other rather than through agencies. If carers contract directly with clients they may be able to receive an increase in hourly rates of pay, as they receive the whole payment rather than the payment minus the agency management fee. From the individual client's perspective, they can either increase the pay of individual carers or purchase more care from them at the same rate carers receive from an agency or a combination of both. Equally, individual clients can choose to purchase care from carers already outside domiciliary care agency arrangements, perhaps friends and family. Care agencies therefore have to devise strategies to encourage existing and new clients to purchase their services rather than to purchase from domiciliary care workers direct. A key research question therefore is how do agencies market their services to encourage clients to continue to contract with them rather than with individual carers, and how do agencies contract with their carers to make sure that the carers do not attempt to contract with individual clients instead?

Thus in the new market arrangements, we would expect, according to a principal agent framework, to see a number of behaviours from agencies.

First, we would expect that care agencies would, in line with NHS organisations that have received devolved budgets, face increased transaction costs (Mays *et al.*, 2001, p6). These would arise from having to make a large number of separate arrangements with individual clients rather than a single agreement with a LA to cover all clients. Care agencies would have to find ways of minimising the cost of operating in the new social care market. They may look to contract with clients for as long a period as possible to minimise their own transaction costs, but also to reduce the risk of losing the care contract to another provider. This could be marketed to clients as taking away the confusion of the new market arrangements, offering guaranteed care, or perhaps offering the continued services of a particular preferred carer.

Second, we would expect care agencies to want to compile greater information about the particular activities of their carers in relation to individual clients. This would enable agencies to monitor how responsive they were being to clients' requests, to assess which carers were able to provide particular services to particular clients, as well as to more accurately price the service. At the same time, agencies might want also to avoid only one particular carer ever providing services to a client, thus increasing the risk of that carer attempting to contract directly with that client. A tension here could be that clients prefer the stability of receiving care from the same carer, and part of a carer's unique service is a result of who they are, not just what they do. Without this stability a client may be tempted to go elsewhere for care.



Third, we would expect those care agencies that had lost or feared losing contracts with local authorities, or faced a reduction in contracted volume of care, to have strong incentives to market their services to individual clients, and to attempt to increase clients' take-up of direct payments in order to continue to work in the social care market. Increasing take-up of direct payments would mean more potential clients were available to them.

Fourth, we would expect that care agencies would have to balance the need for carers to work as flexibly as possible for them with the need to avoid carers either contracting with clients directly or possibly setting up rival care agencies in the new market place. We would therefore expect to see care agencies changing their employment contracts in order to reduce the risk of carers leaving to work privately for a client or, perhaps, to employ carers they regarded as not signifying a threat in terms of direct client contracting on a different basis to those that they did feel were a threat.

### **1.3 Research objectives**

The aim of this study was to examine, from the perspective of domiciliary care agencies, the perceived threats of, barriers to and opportunities for responding to increases in user choice, exercised through mechanisms such as direct payments, other personalised budgets and private purchase.

Specific research objectives were:

#### **Stage one**

- a) To analyse existing survey data to determine any differences in characteristics of domiciliary care agencies with high and low proportions of privately paying clients, using the proportion of privately paying clients as an indicator of experience of self-directed support packages.
- b) To use the analysis of survey data to refine research questions and inform the sample selection and content of interviews in the second stage of the study.

#### **Stage two**

- a) To explore the role of LA commissioning managers in shaping the local market and liaising with providers.
- b) To explore how domiciliary care agencies perceive an increase in the proportion of users purchasing through direct payments, other personalised budgets or privately may affect current patterns of service and delivery, in particular, how agencies expect to become more responsive to individual requirements.;
- c) To determine what domiciliary care agencies perceive as the threats, barriers and opportunities arising from the structural changes in the market place, including:

- i. a shift from a small number of large LA contracts to a large number of small individual client contracts;
  - ii. greater competition for clients with other agencies and with self-employed carers, family and friends;
  - iii. greater competition for a suitably qualified and dedicated workforce resulting from the increased opportunities for carers to provide care directly to clients.
- d) To investigate, from the perspective of domiciliary care agencies, how any such barriers can be overcome and opportunities realised, for example through changes in:
- i. marketing strategies;
  - ii. contract types and specifications (with both clients and staff);
  - iii. services provided and monitoring of those services.



## **2. Study Design and Analysis**

The research was carried out in two stages. The first stage involved secondary quantitative analysis of survey data collected previously by the Personal Social Services Research Unit (PSSRU) in Kent. The purpose of stage one was to refine the research questions and inform stage two. Stage two was the main focus of the study. It comprised qualitative analysis of semi-structured interviews with domiciliary care agency managers and LA commissioning managers. Ethical approval was obtained through the University of York's Research Ethics Committee.

### **2.1 Secondary analysis - design**

Stage one was designed to meet, through analysis of existing survey data, the first two study objectives, namely:

- a) to determine any differences in characteristics of domiciliary care agencies with high and low proportions of privately paying clients, using the proportion of privately paying clients as an indicator of experience of self-directed support packages.
- b) to refine research questions and inform the sample selection and content of interviews in the second stage of the study.

PSSRU conducted the telephone survey in 2003 to investigate the relationships between the prices, costs and quality of home care services and the characteristics and employment conditions of the home care workforce (see Netten, Jones and Sandhu, 2007).

In brief, 127 domiciliary care agencies were surveyed. Ninety-nine of the respondents were independent, voluntary and other non-LA organisations; the remainder were LA in-house providers. It is the responses for these 99 domiciliary care organisations that were re-analysed. Whilst the original analysis investigated relationships between home care providers and their workforce, our secondary analysis concentrated on the answers to selected questions in order to investigate associations between agencies that had high or low percentages of privately paying clients and the following factors:

- Organisational issues
  - The range of services offered and the characteristics of clients (for example, chair/bed bound or needing a double visit).
- Workforce issues
  - The size of the organisation; age and ethnic diversity of the workforce; the length of service of care workers, the proportion working towards an NVQ; and the proportion of workers working a large or small number of hours a week.

- Commissioning-related issues
  - The type of LA contracts (for example, block or spot contracts).

The quality of the data was good except for one section of the survey which asked for details about pricing structures, specifically, the prices paid by private compared to LA clients and any cross-subsidisation of services. Unfortunately, the combination of the poor quality data and the low number of responses for these questions meant that it was not feasible to undertake any analysis of pricing structures.

We chose the percentage of clients purchasing services privately as an indicator of provider experience with individual purchase and a proxy measure of responsiveness to individual choice. This assumes that privately paying clients demand (and receive) greater choice and flexibility.

## **2.2 Secondary analysis – method of analysis**

Respondents were divided into two groups: one had a high percentage of privately paying clients and the other a low percentage. These groups were created in two different ways and results are given for both. First, the total sample was split at the median, that is, the 50 per cent of agencies with the lowest percentage of privately paying clients were labelled as the low percentage group (49 agencies) and the 50 per cent of agencies with the highest percentage of privately paying clients were labelled as the high percentage group (48 agencies). Second, the total sample was divided at the fortieth and sixtieth percentile, that is, the 40 per cent of agencies with the lowest percentage of privately paying clients became the low percentage group and the 40 per cent of agencies with the highest percentage of privately paying clients became the high percentage group (39 in each group). Using this latter method, the 10 per cent of agencies that lay either side of the median were excluded from the analysis. The percentage of privately paying clients in these agencies was clustered close to the median. By removing these agencies from the subsequent analysis we removed some of the element of chance in whether these agencies were included in the high or low percentage of privately paying clients groups and thus created more clearly defined groups.

We selected 13 questions for analysis. We believed the answers to these questions were most likely to show any differences between agencies with a high or low percentage of privately paying clients. Multiple response options to some questions meant that we actually undertook tests on 27 sets of responses. For example, a question about the age structure of the agencies' workforce asked for the percentage of workers falling into each of five age bands, thus resulting in five sets of responses and five separate tests.

For continuous variables, we used independent samples *t*-tests to test for differences in the means between the groups with a high or low percentage of privately paying

clients. We tested for equality of variance using Levene's test and report the p-values and 95 per cent confidence intervals of the difference in the means. For categorical variables, we undertook cross-tabulations and report the chi-square and p-values at the 5 per cent significance level. Outliers were removed.

### **2.3 Selecting the local authorities**

Stage two of the research was designed to meet the remaining objectives through research interviews and qualitative analysis.

The study sample was selected purposively to reflect diversity in factors expected to be important according to theory and evidence. We did not use the domiciliary care agencies that responded to the survey as a sampling frame for a number of reasons. These included the high turnover of domiciliary care agencies (CSCI, 2006) which means that many of the agencies that responded to the survey in 2003 may no longer have been in business, and the fact that we wanted a sample with a diverse range of experiences and situations which may not have been available from the agencies surveyed.

We used a case study design in which first we selected four local authorities that we considered would reflect different purchasing environments and different geographical settings.

With regard to different purchasing environments, we hypothesised that agencies based in LA's championing the move towards more self-directed support would have different experiences and expectations to agencies based in LA's that were not. Therefore we selected LA's with different levels of take-up of DP's with the assumption that if the LA was pushing DP's, the take-up rate would be higher. It should be noted, however, that the take-up rate was low, especially in the over 65 year old age group; at the time the sample was selected, the percentage take-up of direct payments by eligible people aged over 65 ranged from 0.22 per cent to 5.73 per cent (The Information Centre, 2007). Thus we selected local authorities with relatively high and low take-up rates. We selected also LA's with different levels of deprivation to capture areas where private purchase might be more (or less) widespread. This would enable us to recruit managers with more (or less) experience of user choice as expressed through private payment.

Our premise in relation to geographical settings was that urban agencies would be able more easily than rural agencies to market their services to potential clients and to access a greater number of potential carers. They would also, however, have to compete with other urban domiciliary care agencies for the same pools of clients and with both domiciliary agencies and employers from other sectors for care workers. Rural agencies may have more difficulty in offering flexible support due to travel

times. Therefore we selected two predominantly rural and two predominantly urban LA's.

We used information from the 2005 Referrals, Assessments and Packages of Care (RAP) returns and the Department of Communities and Local Government (DCLG) 2004 Summaries of Deprivation Scales to inform our selection. These databases provide details of the take-up of DP's by LA and of deprivation scores respectively. We ensured we selected rural and urban LA's with different types of purchasing environments.

## **2.4 Interviews with commissioning managers**

We interviewed commissioning managers for domiciliary care in each of the four chosen LAs. The interviews were semi-structured with the aim being to elicit background information about the local domiciliary care market, specifically: any differences between independent and in-house services; differences in provision to physically disabled and older people; recent changes in contracts and commissioned providers; local strategies to encourage the take-up of self-directed support; and the future nature of commissioning activities within the context of increases in personalisation. One purpose of these interviews was to help us understand the role of the local authorities' commissioning activities in shaping local home care markets.

## **2.5 Selecting and interviewing domiciliary care agencies**

Once commissioning managers had agreed to take part, we identified and sent a short questionnaire to all agencies in the four selected LA's. We identified agencies and obtained their contact details from the CSCI register of agencies and any lists of providers available on LAs' own websites. The purpose of the questionnaire was to obtain simple descriptive information and expressions of interest to take part in a research interview. The content of the questionnaire was informed by the results of the secondary analysis of survey data, in particular, questions relating to the size of agencies, measured by the number of management staff and by hours of care provided each week. From the responses obtained, we selected, where possible, four large and four small agencies from each LA. We supposed that large agencies would be able more easily to absorb increased transaction costs resulting from an increase in the number of clients contracting directly with them rather than through an LA. Large agencies might in addition be able more easily to offer different types of contracts and services to meet the diverse needs of clients. In addition, we ensured we selected as diverse a sample as possible in terms of, for example, agencies being for-profit or not-for-profit, or whether or not agencies offered specialist services.

The 32 agencies selected were contacted by telephone and a face-to-face interview lasting an hour was arranged with the manager. For practical reasons of cost and

travel time, a small number of interviews were conducted over the telephone. Each interview was recorded and transcribed verbatim.

The interview topic guide included sections on: the background of the agency and local issues; the impact so far of personalised budgets; the perceived threats and opportunities from any future expansion of personalised budgets; strategies for marketing services to personalised budget holders; workforce recruitment and retention issues; flexibility of services for LA and private clients; and issues affecting the wider home care market. In developing the questions for the section on how personalised budgets might affect the wider home care market, we drew in particular on the findings from the secondary analysis which suggested differences in the size of agencies and some workforce characteristics might be important.

## **2.6 Interviews with commissioning and agency managers – method of analysis**

The interviews with the four LA commissioning managers were transcribed and a short summary of each was sent to the respective managers to be checked for accuracy of interpretation. These interviews were not coded at this stage but were used; with the findings of the secondary analysis in stage one, to help develop topics for the interviews with the managers of domiciliary care agencies.

The interviews with the managers of domiciliary care agencies were transcribed and coded with the aid of a computerised qualitative software package. The coding frame was based broadly on the topic guide. In addition, we labelled each transcript with characteristics related to the agency in question and its corresponding LA case study site.

The results of the secondary analysis in stage one suggested that the size of agencies, the type of contract held and certain workforce characteristics were different for agencies with higher or lower than average percentages of privately paying service users. Although we did not have sufficiently accurate data on the workforce characteristics of the agencies involved in stage two interviews, we were able to consider differences in responses according to agency size and whether or not the agency was a zone provider.<sup>1</sup>

Therefore we labelled each transcript with characteristics including those used for the purposive sampling and resulting from the secondary analysis. These enabled us to consider any emerging patterns. The characteristics included LA levels of deprivation, LA direct payment take-up, geographical situation, agency size, whether

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<sup>1</sup> A zone is a geographical area for which one provider is commissioned to provide domiciliary care to all service users within the LA contract. A provider may win contracts for more than one zone.



the agency was a main/zone provider or not, and the agencies' main source of funding (LA or private purchase).

We aimed in the findings to draw out any patterns that we observed in relation to any of the following: agency size; the type of contract held; geographical location; level of take-up of direct payments in the LA; local deprivation rate; and the main source of funding in agencies. However, there were no clear patterns. Therefore, we present the findings in the main sections of the report for all agencies together.



### **3. Findings from the Secondary Analysis of Survey Data**

This section reports on the characteristics of home care agencies with more or less experience of providing services to privately paying users. These findings are based on the secondary analysis of the survey data described in section 2. The results of this analysis were used to inform the sample selection and content of the interviews with domiciliary care managers.

Ninety-nine independent domiciliary care providers responded to the survey. Of these, 83 were private organisations, eight were voluntary and eight were classified as other (for example, not-for-profit organisations). Information on the number of privately paying clients was missing for two providers, leaving a total sample of 97. The mean percentage of clients that paid privately for their care was 18 per cent (median 15 per cent). At least one agency had no privately paying clients. The maximum percentage of privately paying clients in an agency was 57 per cent.

A significant difference between the means of the group of agencies with a low percentage of privately paying clients and those with a high percentage was found for the responses to six questions. Tables 3.1 to 3.5 present the results for each question and for each of the two sample groups (median split and fortieth/sixtieth percentile split). Some figures presented do not add correctly due to rounding errors.

Table 3.1 shows the mean number of management or supervisory staff employed by agencies. The means are just not significantly different for the groups split at the median but become statistically significantly different when split at the fortieth/sixtieth percentiles. The mean number of management or supervisory staff employed by agencies with a low percentage of privately paying clients is higher. An analysis of variance of the three groups (agencies with the lowest 40 per cent, middle 20 per cent and highest 40 per cent of privately paying clients) using the Games-Howell test for groups with unequal variances confirmed that the agencies with the lowest percentage of privately paying clients had significantly higher numbers of managers or supervisory staff, but showed that the middle group did not have a significantly different number of managers or supervisory staff from either of the other two groups. However, it did suggest a trend for the number of management or supervisory staff employed to decrease as the percentage of privately paying clients increases.

Table 3.2 shows the mean number of administrative and support staff employed by agencies in each group. Using a median split to derive the two groups, agencies with a low percentage of privately paying clients employ significantly more administrative and support staff. This significance disappears when the groups are analysed using the fortieth/sixtieth percentile split.

**Table 3.1: Number of management/supervisory staff employed in the agency**

	<i>P-value</i>	<i>Mean</i>		<i>Difference</i>	<i>95% CI</i>
		Low	High		
Group 1 – median split*	0.062	6.5	4.8	1.7	-0.09 to 3.51
Group 2 – low/high 40% split*	0.033	6.7	4.5	2.2	0.19 to 4.23

\* equal variances not assumed (Levene's test  $F=4.65$ ,  $p=0.034$ )

3 outliers were removed from the 'low' group in each group

**Table 3.2: Number of administrative and support staff employed in the agency**

	<i>P-value</i>	<i>Mean</i>		<i>Difference</i>	<i>95% CI</i>
		Low	High		
Group 1 – median split	0.047	4.1	2.9	1.2	0.02 to 2.38
Group 2 – low/high 40% split*	0.061	4.2	2.9	1.3	-0.07 to 2.73

\* equal variances not assumed (Levene's test  $F=5.17$ ,  $p=0.026$ )

The results shown in Tables 3.1 and 3.2 suggest that agencies with a low percentage of privately paying clients may be larger than those with a higher percentage.

However, there was no statistically significant difference between the groups in the number of clients served in the week prior to the questionnaire being completed.

Therefore we cannot make the case for the population as a whole but, in our sample, there did appear to be a tendency for agencies with a low percentage of privately paying clients to have served more clients in the previous week (mean number of clients served 223 v. 180, 95 per cent CI of the difference -9.9 to 96.4, median split).

In the analysis of this question, the responses from five (10 per cent) agencies in the group with a low percentage of privately paying clients were removed as outliers; they each stated that they had served over 1000 individual clients in the previous week. We do not know why these agencies appeared to be so large in comparison to the others in the sample; the data may be inaccurate or these agencies may indeed be very large.

Another result related to the size of agencies but which did not show a significant difference between the two groups was the number of care workers on the agency books. Again, in our sample, the mean number of care workers on the agency books was higher (but not significantly so) in the group with a low percentage of privately paying clients (mean 71 v. 56, 95 per cent CI of the difference -3.3 to 34.3, median split). Responses from five (10 per cent) agencies in the group with a low percentage of privately paying clients were removed as outliers from the analysis of this question as well. A larger sample is needed to test these potential differences further. However, these non-significant results within our sample do seem to reinforce the significant differences found in the number of managers and number of support staff shown in Tables 3.1 and 3.2.

Table 3.3 gives data on the age of care workers. It shows that a higher percentage of the workforce in agencies with a low percentage of privately paying clients is aged between 25 and 39.

**Table 3.3: Percentage of care workers aged between 25 and 39 years**

	<i>P-value</i>	<i>Mean</i>		<i>Difference</i>	<i>95% CI</i>
		Low	High		
Group 1 – median split	0.021	40.3	33.1	7.3	1.10 to 13.43
Group 2 – low/high 40% split*	0.015	40.4	31.8	8.7	1.73 to 15.59

\* equal variances not assumed (Levene’s test F=5.94, p=0.017)

In our sample, in each of the older age group categories (40-49, 50-59 and 60+) there are no statistically significant differences but there is a tendency for agencies with a high percentage of privately paying clients to have a higher percentage of their workforce in each of these age categories than agencies with a low percentage of privately paying clients.

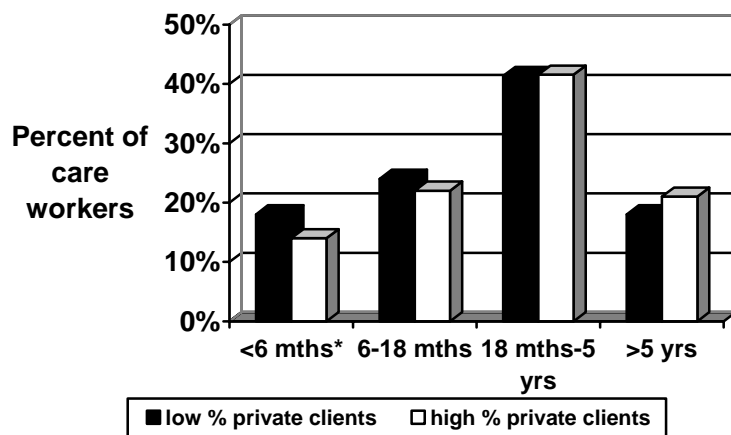
The questionnaire asked about the length of time that members of the agency workforce had been employed. Response categories for length of employment were less than six months, between six and 18 months, between 18 months and five years, and over five years. Table 3.4 shows a higher percentage of care workers employed by agencies with a low percentage of privately paying clients had been employed for less than six months at the time of completion of the questionnaire.

**Table 3.4: Percentage of care workers employed for less than six months to date**

	<i>P-value</i>	<i>Mean</i>		<i>Difference</i>	<i>95% CI</i>
		Low	High		
Group 1 – median split	0.048	18.2	14.1	4.1	0.03 to 8.18
Group 2 – low/high 40% split	0.086	17.8	13.9	3.9	-0.55 to 8.29

The difference between the two groups was not significantly different in any of the other categories, but there was a trend in our sample towards a greater length of employment of workers in agencies that had a higher percentage of privately paying clients. This was evident in the shift in the position of the confidence interval of the difference between the means (not shown). The difference between the means for the low percentage of privately paying clients group compared to the high group shifted from being wholly above zero for the category less than six months to being mainly below zero for the category more than five years. Figure 3.1 illustrates this shift.

**Figure 3.1: Length of service of care workers by type of agency**



\* statistically significantly different (14.1% v 18.2%, diff=4.1%, 95% CI 0.03% to 8.18%)

The results given in Table 3.5 show a clear difference in the pattern of hours worked by care workers in agencies with a low percentage of privately paying clients compared to those with a higher percentage. Significantly fewer workers work a ten to 30 hour week in agencies with a low percentage of privately paying clients and significantly more work more than 30 hours a week. The difference between the two groups in workers working less than ten hours a week is not significant.

**Table 3.5: Hours worked in the previous week - percentage of care workers**

	<i>P-value</i>	<i>Mean</i>		<i>Difference</i>	<i>95% CI</i>
		Low	High		
<i>Between 10 and 30 hours</i>					
Group 1 – median split	0.030	42.6	52.2	-9.7	-18.4 to -0.94
Group 2 – low/high 40% split	0.037	41.9	52.1	-10.2	-19.8 to -0.66
<i>More than 30 hours</i>					
Group 1 – median split	0.038	42.0	30.9	11.1	0.62 to 21.6
Group 2 – low/high 40% split	0.029	43.3	30.0	13.3	1.37 to 25.22

Other results that are not statistically significant are reported below.

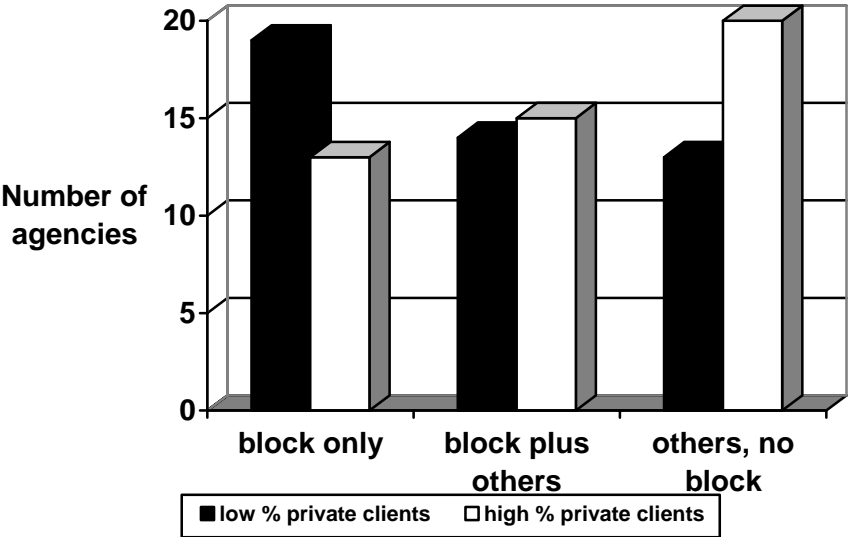
We analysed responses to two questions about the type of care provided to clients. First, we considered responses to a question that asked which of 11 home care services each agency provided. We hypothesised in advance that agencies with a high percentage of privately paying clients would offer a wider range of services. This was not the case; in fact, the mean number of services offered by agencies with a low percentage of privately paying clients was marginally higher but not significantly different from those offered by agencies with a high percentage of privately paying clients (mean 9.3 v. 8.7,  $p=0.065$ , 95 per cent CI -0.03 to 1.25 for the median split). Second, the questionnaire asked what proportion of clients had certain

dependency characteristics. These were being chair or bed bound, being incontinent, suffering from dementia, or needing a visit by more than one care worker at a time (for example, for lifting a client into a hoist). None were significantly different between the two groups, but it is worth noting that the only agencies that had no clients who were chair or bed bound were from the group of agencies that were the 40 per cent with the highest percentage of privately paying clients.

There was no difference between the two groups in the percentage of the home care workforce who either have or are training towards an NVQ level two.

Our investigation of commissioning arrangements was limited to an examination, using cross-tabulations, of differences in the types of contracts each group of agencies held with their LA. We considered the use of block contracts and spot contracts. Block contracts comprise payments by the LA for a number of hours of care or number of clients whether or not they are all utilised. For spot contracts, a price is agreed and paid at the time the service is provided. Our interest was in the security offered by block contracts and the relative insecurity of spot contracts. For analysis, we categorised the use of block contracts into three distinct groups: block contracts only; block contracts plus other types of contract; and other types but no block contracts. The use of spot contracts was divided into spot contracts only and spot contracts plus other types. Almost all (94/97) agencies had a contract of some sort with one or more LA's. There was no significant difference in the use of any contract types between agencies with a low or high percentage of privately paying clients. However, Figure 3.2 shows fewer of the agencies with a high percentage of privately paying clients had block contracts and more had other types of contracts (such as spot contracts).

**Figure 3.2: Types of contracts by type of agency**



In relation to the future plans of agencies, we considered answers to the question “Do you think the use of direct payments will have an impact on your service?”

Possible responses were yes, no or sometimes. Whilst there were no differences between the two groups of agencies, it is notable that almost a quarter of those responding said no they did not think the use of direct payments would have an impact on their service.

Thus, the key findings from this analysis were that agencies with a lower than average percentage of privately paying clients tended to be larger than agencies with more private clients, to employ more younger care workers, to have a greater turnover of care workers and care workers who worked for longer hours. Sections 2.5 and 2.6 have shown how these results were used to inform the sample selection and interview topic guides.





## 4. LA Contexts and Issues of Importance for Personalised Budgets

In this section we summarise the main contextual issues of importance across the four local authorities and draw out factors that might be expected to be important in relation to views about the future expansion of personalised budgets. These issues were explored in both the LA commissioner and agency manager interviews. This section thus draws on evidence from both. More detailed information for each LA is given in Appendix 1.

Over the past decade, the independent sector home care market has increased rapidly in size and has been shaped substantially by the commissioning and contracting activities of local authorities. Thus, we purposively selected four local authorities with different purchasing environments and geographical settings. We then identified domiciliary care agencies based in each of these LA's. Our expectation was that agencies with experiences of different LA purchasing environments would hold different views about their future with more personalised budgets.

We planned in our analysis to investigate whether agency managers views of the impact of personalised budgets on them were related to their host LA's characteristics. For example, we expected that LA areas with low levels of deprivation would have relatively high levels of privately paying clients, thus domiciliary care agencies would have more experience with private purchasers and have a different set of views about personalised budgets than agencies in more deprived areas. Table 4.1 gives the characteristics of the four local authorities selected for the study. Subsequent analysis showed that these characteristics and the wider contexts within which local authorities were working were not in fact important in shaping provider experiences and views. The actual percentage uptake of direct payments in the four local authorities ranged from one per cent to 5.5 per cent of all eligible people.

**Table 4.1: Characteristics of local authorities**

	<i>Type of CASSR*</i>	<i>Direct Payment Take-up Rate</i>	<i>Deprivation Score</i>	<i>Geography</i>
LA A	Two-tier	High	Low	Rural
LA B	Two-tier	Middle	Low	Rural
LA C	Unitary	Middle	High	Urban
LA D	Unitary	Low	Moderate	Urban

\*CASSR: Council with Adult Social Services Responsibility

During the interviews with the commissioning managers from the selected local authorities, it became apparent also that each authority was using a system of geographical zones (areas) for commissioning domiciliary care. The main providers within each zone held block or cost and volume contracts. In addition, some agencies acted as supplementary providers and were offered spot contracts if the main zone providers had insufficient capacity. Table 4.2 shows the number of zone and supplementary providers in each LA. These numbers do not include some home care agencies commissioned by specialist mental health or learning disability teams; however, all agencies supported people with a range of impairments including mental health and learning disabilities.

**Table 4.2: Numbers of zone and supplementary providers**

	<i>Number of zone providers</i>	<i>Number of supplementary providers</i>
LA A	17	16
LA B	10	6
LA C	11	15
LA D	4	0*

\* Learning disability and mental health teams in LA D referred service users on a spot contract basis.

One reason for the lack of differences in the views of agency managers working in urban and rural settings may be that the use of zones had introduced into urban areas a problem that existed already in rural areas. One of the problems in rural areas is that it is not cost-effective to travel long distances to provide support to a single client. In urban areas this has been less of a problem. However, with the introduction of zones, agencies have begun to provide support in geographically restricted areas (a zone) rather than across a whole city as previously. Indeed, in one urban LA, the commissioning manager reported that the purpose of creating zones was to encourage the development of community-based providers that would be aware of local issues, reduce travel costs and avoid the anomaly of two providers working in the same street. Thus, agencies based in urban areas were employing care workers who lived in or close to the zone area to provide support to clients within that zone. A short visit to a single client in an out of zone area was reported by agency managers to be no longer cost effective. It appears, therefore, that as well as reducing some of the differences between urban and rural areas, one result of zoning might be that personalised budget holders are left with no choice but to employ a care worker from the local zone agency or to employ someone privately. In the case of rural service users, the lack of local trained care workers could mean local family and friends, or neighbours, might be the only option.

Financial pressures were an issue also in each of the four local authorities. These issues were raised by the agency rather than commissioning managers. One of the impacts of these social care funding problems was a reduction in the number of new

referrals to domiciliary care agencies. For some zone providers the reduction in referrals had resulted in spare capacity; care workers had been newly employed or transferred from other providers only to find that there was insufficient work. This in turn meant that home care agencies reported that they were finding it difficult to offer secure hours of work to care workers. Agency managers noted that a further impact of the financial pressures was that they were often unable to increase care worker wages on an annual basis; this was a result of low level increases in pay for contracted work from local authorities to agencies. In two of the areas, managers of agencies felt pressured into submitting low cost tenders for zone contracts with the result subsequently that they were not able to recruit and retain staff at the wage level offered, and thus unable to provide sufficient capacity. The consequence of each of these impacts was an exacerbation of recruitment and retention problems in an already difficult to recruit workforce. Low unemployment levels in urban areas and a small pool of workers from whom to choose in rural areas added to staffing problems. These reported financial issues raise the question of whether personalised budget holders offering higher rates of pay per hour to care workers might encourage a migration of staff from agencies to the private market.

Commissioning managers in the two predominantly rural local authorities each reported taking action in the past to stop destabilisation of the labour market. One authority that had a select list of agencies it contracted with had restricted the size of this list due to concerns about watering down the quality of the limited supply of care workers; with a fixed supply of care workers and new agencies entering the market, they were concerned that established agencies would begin to lose workers and thus quality may be reduced. The other had introduced zone contracts in part to deter new agencies entering the market and offering higher wages; not only were established agencies being destabilised by care workers leaving to work for more pay in the newer agencies, but the LA was having to pay higher prices for spot contracts with the new agencies because the established agencies no longer had sufficient capacity. A possible consequence of the greater use of privately employed care workers resulting from increased numbers of personalised budget holders means that these authorities will risk losing this level of control.

LA commissioning managers had little knowledge of the private market for domiciliary care. They did not see how they could use their LA commissioning role to ensure sufficient capacity for private clients, but were trying to ensure all providers were registered with CSCI and, in one authority, looking at ways of signposting private clients to CSCI-regulated agencies. In the urban authority with high deprivation (LA C), agencies perceived there to be limited demand for private work but plenty of LA funded service users. In each of the other areas, agencies thought there was ample care work from privately paying clients and that this would continue into the future.

Each LA had commissioned support for direct payment users from an independent organisation; these organisations offered help such as accountancy, human

resources and managing payments to direct payment users wishing to employ their own staff. LA D also offered free CRB checks. Local authorities A and D were planning at the time of the interviews to expand the use of personalised budgets over the next three years to at least half the eligible population. LA C had appointed a self-directed support programme manager to look at ways of taking personalised budgets forward, but expected to continue using predominantly cost and volume contracts for the next three years. LA B was considering introducing an element of guaranteed hours into agency contracts; their current policy was to guarantee all new home care referrals would be sent to zone providers, but with no minimum number of hours.

In summary, the main factors at play in each LA were similar, despite initial selection on the basis of differences in measurable characteristics such as geography and deprivation. The factors which made local authorities more alike than different were issues around zone providers, financial pressures and local labour market concerns. Local authorities were also similar in their concentration on the provision of home care for social services-funded rather than private clients and in their general commitment to moving towards the greater use of personalised budgets. However, the fact that three local authorities were tied into block or cost and volume contracts for a number of years, and the fourth was considering introducing a guaranteed element into provider contracts, suggest that progress may well be slow.



## 5. Characteristics of the Domiciliary Care Agencies

This section describes the characteristics of the domiciliary care agencies that took part in the study. We aimed to interview managers of eight agencies in each LA. However, due to a limited number of expressions of interest to take part in a research interview and to time constraints for those managers who did respond, in two local authorities we were able to interview only seven managers. We have included in our analysis two pilot interviews carried out with managers of agencies in LA A and LA D. The number of interviews included in each LA is given in Table 5.3.

**Table 5.3: Number of agency managers interviewed by LA**

	<i>Number of agencies</i>
LA A	9*
LA B	8
LA C	7
LA D	8*
Total	32

\* includes one pilot interview

Table 5.4 gives the characteristics of the sample of agencies. These agencies were not randomly sampled and thus are not representative of all domiciliary care agencies but do comprise as far as possible agencies with a range of with different experiences. The sample was informed in part by the results of the secondary analysis of the survey data. For example, we ensured that agencies of different sizes were included. We included also as many agencies as possible that relied primarily on funding from private clients, however, the main source of funding for the majority (21/32) was LA contracts. Most agencies were providing services to very few direct payment users but we tried to include in the sample those with at least some direct payment users.

**Table 5.4: Characteristics of agencies**

<i>Characteristics of agencies</i>	<i>Number of agencies</i>
Agency size	
Large (>1500 hours a week)	14
Medium (500 to 1500 hours a week)	10
Small (<500 hours a week)	8
Main source of funding	
LA contracts	21
Private purchasers	6
Both (approx. 50/50 mix)	4
Missing	1
Number of direct payment users (approx.)	
None	11
1-2	6
3-9	10
>10	5
Contracts with study LA	
Zone provider	12
Supplementary provider	11
No contracts in study LA	4
Other grants/mixed funding sources	5
Agency type	
Standard DCA	22
Specialist DCA (e.g. brain injury or learning disabilities)	4
Employment agency (including nursing)	2
Other (supported living, living-in care, carers' support)	4
For-profit	26
Not-for-profit	6
Independent agency	18
Branch of larger group	13
Franchise	1
Member of UKHCA	17





## **6. Findings from the Interviews with Agency Managers**

The previous two sections have described the LA contexts within which agencies were working and the characteristics of those agencies included in the study. We expected that agencies from the same LA might hold similar views about personalised budgets – based on their experiences of the same purchasing environment – but this was not the case. This may be because the number of agencies from each LA was too small and the diversity of their characteristics was too large, or it may be because there were no real differences, perhaps because the LA contexts were in fact more similar than they were different, as discussed in Section 4. We looked also for any patterns in the interview data that related to the size of agencies, their experiences with privately paying clients or other characteristics listed in Table 5.4. Although there were few of note, these are highlighted where relevant.

Thus, in each of the following sections we present findings drawn from the interviews with all domiciliary care agency managers together. We begin by comparing managers' views of delivering flexible support to service users within LA contracts and to private clients. This is followed by agencies' experiences of delivering support to direct payment users. The remaining sections are based on agencies' experiences with direct payment users only and report on: the perceived threats and opportunities to agencies of personalised budgets; plans for identifying and attracting personalised budget holders; and workforce issues.

### **6.1 Agencies' views on the flexibility of services and experiences of personalised budgets**

As part of the overall exploration of agency managers' views on the future for them of more personalised budget holders, we were interested in the amount of flexibility agencies were able to offer already to their LA contract and privately paying clients. One of the aims of personalised budgets is to enable service users to have more choice and personalisation of their support. What was not clear was how much choice and personalisation of support was available already and if different types of clients were able to receive different levels of flexibility. The following three sub-sections present findings on the flexibility of support for LA and private clients respectively, and the impact on agencies of direct payments so far.

#### **6.1.1 Views about delivering flexible support within LA contracts**

The majority view from agency managers across all the LA areas was that LA contracts and care management systems were not flexible and in fact had become more rigid over the last few years. Agencies were able to provide only the support

that had been set out in the care plan; any variation had to be approved by going back to social services. One of the reasons reported for this was that care workers were only insured to undertake tasks included in the care plan. In LA A, agencies had to absorb the first two weeks of additional costs from a service user needing extra support; if the extra need continued after two weeks, they had to refer the case back to social services to approve an increase in the care package. There were concerns that this was very hard for service users, for example, if they were confined to bed awaiting approval for a double-up visit during which two care workers could use a hoist. Extras such as emergency care had to be claimed retrospectively, sometimes paid six months in arrears. Phrases such as ‘forever chasing social workers’ [ID117] to ask for a piece of paper and ‘it’s a nightmare’ [ID18] illustrate the frustrations felt by agency managers across all the LAs.

However, there were positive experiences with regard to flexibility. Although the support tasks undertaken by care workers and the overall time allowed to undertake these tasks were ‘set in stone’ [ID43], there was some flexibility in the actual time at which support could be delivered. For example, if a service user wanted an afternoon rather than a morning call, this could be accommodated so long as staffing rotas allowed. In particular, agencies providing supported living seemed more able to offer flexibility within overall contracted hours. Some agencies also commented on the pragmatic nature of social workers who were happy for agencies to offer flexible support as long as this was monitored and overall hours and service user needs were met each week. An agency in LA B noted that although written contracts were not flexible, historic practice was. Agencies in LA D expressed mixed views about flexibility. Some were concerned about the very short 15 minute visits that were stipulated in contracts and the detailed monitoring forms that needed to be completed; others felt that the LA was becoming less rigid in its attitude.

One of the main factors felt to facilitate opportunities for flexibility within contracts was having a good relationship with care managers. Regular communication both ways and trust in each other enabled flexible working. Communication and negotiation between agencies and service users was important as well; agency managers talked about honing care packages to meet individual needs and swapping days between service users if new service users had particular preferences.

Agency managers commented more on factors that constrained them from offering more flexibility. Funding was felt to be a big constraint; lack of funds was seen as limiting the ‘fun things’ that care workers could do with service users, restricting support to the “daily grind” of personal care [ID2] and reducing the time allowed for each visit. The other big constraint across all agencies was staffing; although not related specifically to contracts, without appropriate staffing levels, agencies could not offer flexible delivery of support. (Workforce issues are considered in detail in Section 6.5 of the report.) LA staff changes and the lack of confidence by ‘blinkered’ [ID20] trainee care managers to think outside the box also hindered flexibility. In LA

A, the introduction of a call centre system for contacting duty social workers was felt to have reduced flexibility as messages had to be relayed through a call handler and decisions on changes in a service user's needs often took a number of days. While trust was cited as a facilitating factor, a lack of it was seen as a barrier to flexibility, for example, flexibility was reduced by contract monitoring systems that forced care workers to tick tasks performed off a pre-agreed list.

### **6.1.2 Views about delivering flexible support to private clients**

Agency managers were asked how flexible they were able to be in delivering support to privately paying clients. On the whole, there was agreement that it was easier to be flexible in delivering support to privately paying clients than to service users funded through a LA contract. One of the main reasons for this was that agencies dealt directly with private service users rather than through a third party (the care manager); dealing directly with clients cut out the time needed to contact care managers, and for care managers and clients to agree any changes, thus changes could be introduced more quickly. Private clients could also decide themselves what support they want, for example, if as a client you want a carer 'to come in and stand on their head for three hours a day then that's exactly what you can have' [ID43]. In addition, agencies undertook their own risk assessments for private clients and thus were not limited by perhaps stricter LA risk assessments. At a more basic level, it was noted that privately paying clients could choose which agency they wished to purchase from; service users within a LA contract could not.

Despite overall agreement that it was easier to be flexible for privately paying clients, most agencies claimed they treated all service users equally in terms of the support provided. Private clients were commonly charged a higher rate than local authorities, but care workers usually did not know how service users were funded. For example, if an agency was a branch of a national company the head office might deal with finances leaving the branch to arrange delivery of care. Exceptions arose if there were monitoring forms to be completed as part of LA contracts, making care workers aware LA-funded clients. Just one agency made a distinction about private purchasers that 'they are not just the client, they're the customer because they're paying as well. So, we try and keep the customer sweet...' [ID18].

In terms of barriers to enabling flexibility, staffing was again the main issue. Although privately paying clients could pay for additional hours, these could be supplied only if the care workers were available. Many agency managers stressed the importance to care workers of routine in their working lives. To facilitate this, staff rotas were sometimes arranged a month in advance; unless individual carers were willing to accept changes, flexibility could be hindered. Some service users in an agency relying mainly on privately paying clients did call the agency a month in advance with their diary commitments so that their support needs could be fitted in with rotas. The nature of personal care meant also that at the peak demand times of early morning,

lunchtime and bedtime, care workers were invariably busy; however service users were funded, they had to be flexible themselves and accept a visit close to their desired time but not necessarily exactly at that time. The only way round this problem was to pay carers to be on-call and have them waiting for requests to come in. This, however, would cost more money and not suit many carers who are 'doers' [ID200] and like to be occupied rather than sitting waiting. No agencies in our study were using this method. The point was raised that care workers working privately for two or three direct payment users would have the same problems with both peak times and downtime.

A constraint mentioned only by agencies in the large city LA C was private clients requesting care workers who were not, for example, Black or Hungarian; some younger service users made requests based on how fashionable a care worker looked. Agencies did not agree with allowing these choices and in any case noted that it was against the law for them as agencies to be discriminatory. The risk to care workers of being out late at night was also raised as a barrier to enabling flexibility in LA C.

### **6.1.3 The impact so far of direct payments**

We were interested in finding out about the impact of direct payments on agencies so far and how, if at all, these impacts had affected agencies' views about personalised budgets in the future. In fact, the reported impact of direct payments to date was so minimal that it has not been possible to relate these to views about the future. For the majority of agency managers interviewed, direct payments had had virtually no impact on their agencies. The majority of agencies had experience of only a handful of direct payment users. Comments such as 'it's never quite materialised' [ID139] and 'it seems to have bypassed us completely' [ID205] were not unusual. Some managers felt the lack of impact was because they served predominantly older people and people with physical or sensory impairments, whereas younger people and people with learning difficulties were more likely to have personalised budgets such as *in-Control*.

Despite having little overall impact on agencies, managers were able to recount a number of experiences arising from the few direct payments users to whom they had provided support. There were no obvious differences in the experiences of agencies of different sizes, in different local authorities or those more or less reliant on LA contracts for funding.

Positive impacts for the agencies were limited to gaining some direct payment users who had tried to recruit and manage their own staff but found it too hard to do so, and to gaining others from outside contracted zone areas. The issue with zones arose in all areas when geographical zones were introduced or boundaries altered. Service users whose care would be transferred as a result from their original zone agency to

another were usually offered direct payments as an alternative, so they could choose to remain with their original agency. Some agencies welcomed the opportunity to retain clients in this way. Others would retain them only if they lived close to the zone boundaries or other service users on the agencies' books and could therefore form part of a care worker's 'run' of calls; the time and travel costs to the agency of visiting one client outside the zone area were considered prohibitive.

More agency managers reported negative impacts from direct payments. These included losing staff to direct payment users. Whilst there was a specific example of care workers colluding and setting up in business themselves to deliver support to two people with large care packages who opted for direct payments, the more general concern was of losing individual trained care workers. The loss of trained care workers not only meant having to recruit new workers but having to train them as well. Agencies were concerned also at the loss of investment in training and that they were effectively 'train[ing] up people who'd be directly competing with us' [ID159]. As a result of these experiences some agencies had introduced more detailed staff and client contracts to help alleviate the problem of poaching. (Further details of incentives and controls within staff and client contracts are presented section 6.5 on workforce issues.) Other negative experiences were agencies having difficulties getting payments from direct payment users and the hourly rate local authorities pay as a direct payment being below the rate charged by agencies. (Both these issues are raised section 6.3 on the perceived threats of personal budgets.) A specific example of the latter was of an agency having successfully provided an intensive package of care to an individual who was allegedly 'coerced' into transferring from the LA contract to direct payments, only to discover that the direct payment rate was insufficient to purchase the agency senior care workers that had been providing support. At the time of the interview the situation was not resolved. The wider concern of the agency manager was that direct payment rates were sufficient to purchase standard agency care but not specialised care, but as most people funded by local authorities have high levels of need, for most people the rates would be too low. Finally, whereas some agencies had gained clients who opted for direct payments as a result of the introduction of zones or changes in zone boundaries, some clients were lost because they were too concerned about having LA money in their own bank accounts to take on direct payments in order to retain their current provider.

#### **6.1.4 Are direct payment users more demanding?**

We asked also about the 'choosiness' of direct payment users, that is, if they were any more demanding than other service users. We expected that direct payment users might be acting as active consumers rather than passive recipients of services. In response, agency managers thought direct payment users were choosier than service users receiving care commissioned through a LA contract but perhaps on a par with private clients. Three main reasons were put forward for this choosiness.

First, it was all about cost and value for money; agency managers believed that when people were spending what was in effect their own money, they became more concerned about its use – ‘when it’s not your own money, you know, not writing out the cheque, you’re not quite as fussy’ [ID95]. Second, direct payment users were empowered by being able to terminate their support if they were not satisfied with it and they were led to believe that direct payments would give them more power. Third, there was a belief that direct payments attracted the kinds of people who were choosier – this was described as a ‘chicken and egg’ situation – and attracted younger people who were more challenging and clear about what they wanted. The combination of these three elements of choosiness resulted in some direct payment users expecting more than was possible, but after an initial period of demands that could not always be met, some direct payment users had settled into relationships comprising more given and take.

A few agency managers did not believe that direct payment users were choosier than other service users. They noted that all service users were treated equally and thus received the same services. We do not know whether this means that direct payment users did not make more demands or whether they made demands that were turned down. Other managers did not feel they had the experience to be able to comment as direct payment users didn’t use domiciliary care agencies.

Agency managers were asked additionally about any impact that dealing with direct payment users had had in terms of increased demand for greater flexibility and choice. We anticipated that increased pressure to provide responsive services to direct payment users might result in greater flexibility for other clients as well. Because of the lack of overall experience with direct payment users, there were no spill-over effects. As presented in the earlier section on flexibilities for privately paying clients, if there was any spill-over effect it was from LA service users to others, in the form of LA policies and procedures governing all of an agency’s business. A specific example of this came from an agency planning to start charging private clients (and direct payment users if they had any) to keep packages open while clients were in respite or hospital; the LA already paid for this service. Another example of direct payment and private users being influenced by LA contracts was that agencies tended not to advertise non-personal care services such as shopping in their brochures. The reason was that the same brochures were used for all services users and it would “open up a whole big can of worms” [ID10] if LA funded service users began to ask why they couldn’t get their shopping done.

## **6.2 Perceived threats from more personalised budget holders and plans to deal with these threats**

A substantial section of the interviews with agency managers concentrated on their perceptions of the threats and opportunities to them as agencies that the greater use

of personalised budgets might bring. The views presented in this and the following section are thus speculation about the future, based on experiences of direct payments so far. Some agency managers found it difficult to give any views as their understanding of personalised budgets was minimal. Others considered the impact from the expansion of personalised budgets to be minimal, primarily because direct payments had not ever taken off, so why would personalised budgets? Again, the findings are so varied that it has not been possible to identify any definitive patterns according to characteristics such as agency size, location or experience. By far the most emphasis was placed in the interviews on the financial threats to agencies but we discuss also the perceived threats to capacity and to the workforce. Workforce issues are discussed further in Section 6.5; the views included in this section were given as unprompted responses to a general question about the potential threats from the greater use of personalised budgets.

### **6.2.1 Perceptions of financial threats**

#### ***Non-payment of bills***

The perceived financial risk to agencies from 'bad debts' came across very strongly in the interviews. Many agencies had experienced problems with non-payment from direct payment and sometimes privately paying service users. In addition to non-payment or late payment, agencies were aware also of problems and delays in payment after the death of a service user. Agencies talked about their 'fear' of invoices to direct payment users not being paid [ID193] and it being 'quite horrendous' to get money from people receiving direct payments or Independent Living Funds [ID200]. For smaller agencies the consequences of non-payment could be a particular issue as they would not be as able as the larger agencies to carry the debts. One large, national agency providing living-in care stated that:

'When direct payments came there, the first and ongoing and most serious problem was that of bad debts .. and I expect that will become with everybody. If you look at my detailed accounts for this year I've written off an enormous amount of money for bad debts, something like £80,000.'  
[ID53]

In contrast, for a small agency providing very local, generic domiciliary care:

'There's always, always going to be that fear, is are they going to pay us, and what happens when they die, and they're in probate? It's six months sometimes when you get the cheques coming through. I mean, yeah, medium to, to large companies can, can accept that, I can't, not when you're talking about anywhere up to, you know, it could be £1,000, it might not be, it might be an insignificant amount to a larger company but to a smaller company like me, it's not.'  
[ID131]

One agency told a story of a woman who managed funds on behalf of her disabled son. She spent the money on a funeral for someone else and the agency had to



threaten to withdraw care from her son if they did not receive the money she owed them. Another woman, described by the same agency as being in her forties, 'quite with it', who used the internet and ordered online from the supermarket, never paid her care bill, always promising the cheque was in the post but it never arrived. These examples caused stress for both the agency staff and the service users. The agency carers were being asked by the finance director to withdraw care, but found this difficult to do. The service users were under stress because they had a bill to pay and no money with which to do it. This agency was not alone in their view that 'if we had a choice we wouldn't have direct payments' [ID200].

Agencies did have plans for dealing with the non-payment of invoices. Most commonly, agencies planned to ask direct payment users set up direct debits to pay for their care. One agency already carried out credit checks on people paying their own bills; if their credit check is poor, they are asked to pay by direct debit. Direct debits may reduce the risk of non-payment, but they do not eliminate it. One solution was to ask people to pay in advance; another was to ask the LA providing the direct payment to give a written undertaking to the agency that should the direct payment user default, the LA would pay. The large, 24-hour living-in agency that had suffered £80 000 losses in a year, had taken further steps to ensure direct debits were paid. Their practice (and advice to others) was to know the client's cash flow and ensure that the direct debit demand hits the client's account two to three days after their direct payment is placed in the account. (This agency did accept that for them this was easier to manage than for typical domiciliary care agencies, as they had fewer clients to deal with and each was a high spending client.) The same agency was exploring using a "top up credit card" system. In this system, an individual's direct payment or other funds would be paid onto a form of credit card and only certain approved people or organisations would be able to take money from the card. It was hoped that in this way people would not be able to spend their funds on items that were not care-related. An agency that dealt mainly in providing home care staff to LA in-house teams used a system of factoring invoices through a bank, so financial risk was transferred in part to the bank. As a last resort, agencies may be forced to use debt collectors or to take non-payers to court. Both agencies suggesting these methods would not be happy to use them, mainly due to the greater stress that would be placed on clients, and would plan to try and solve the non-payment person to person first.

The one factor that agencies thought would help them to deal with non-payments was if the local authorities would retain control of direct payment and other personalised budgets, perhaps acting as a buffer and chasing non-payers. One agency gave the example of housing benefit being paid direct to landlords rather than tenants and questioned why this system couldn't be used for direct payments. Another suggested sending one invoice to the LA at the end of the month, covering services provided to all personalised budget holders. This would be less risky for the

agency than sending invoices to perhaps 400 individual clients and would also reduce transaction costs.

### ***Intermittent use of services***

In addition to the risk of non-payment is the financial difficulty of coping with people who use services on an intermittent basis. Although mentioned only once, the financial instability created by a service user who goes in and out of hospital or respite care on a frequent but unpredictable basis is likely to be more common. The LA of the agency concerned paid for care for up to three weeks while the service user was in hospital or respite care in order to keep the package available; private and direct payment users did not do this. This could create financial instability. Some agencies also highlighted that the notice period for direct payment users to withdraw their custom from an agency (cited as between 48 hours and seven days) created additional financial insecurity in terms of lack of guaranteed funds to pay the workforce.

The only suggestion put forward for dealing with the financial insecurities resulting from people stopping using services temporarily while in hospital or respite was to introduce a holding fee for direct payment users. Some local authorities did this within their own contracts, but some did not; some agencies were also considering extending this 'retainer' system to private clients.

### ***Inadequate direct payment hourly rate***

Agencies were concerned that the rate per hour that direct payment users received to purchase care was less than the rate per hour charged by agencies. In one example, the hourly charge was affordable for direct payment users, but the proportionately higher half hourly charge was not. In many, the hourly charges for both generic and specialist care were above the direct payment rate. The consensus was that direct payment users would have to choose between opting for fewer hours of care at a more expensive rate from high quality agencies and purchasing their care elsewhere. As one agency put it:

'...direct payments is just another way that we're going to go forward but equally we're going to have to cut our cloth accordingly. You know, if you've got this much coming in then this much money can go out to leave us this much money left as a margin to make it worthwhile. What we don't want to get is, into a situation whereby it's costing x, x, we've got £x coming in £y going out and minus £z left in the account. You'd just be, it doesn't become viable.'

[ID43]

There were few planned solutions to this problem. A lone voice suggested looking at their own hourly charges to see if they could be reduced in any way. Another planned to enter into a dialogue with the LA to see if they would be prepared to increase the direct payment rate in order to maintain quality care. More commonly, agencies were adamant that their hourly charges were already pared to the bone and

that if clients (and local authorities) wanted high quality care then they had to pay appropriate charges. Agencies themselves wanted to continue to deliver high quality care with one agency stating that:

‘we’ve always said we would rather not provide a service than provide a poor quality one, and there’s that saying, you know “If you pay peanuts you get monkeys” and we have to pay people what they’re worth to do the job.’

[ID43]

Having said that, this same agency was aware that a way round the problem would be to set up a subdivision within the agency that would provide cheaper, although still good quality, care to direct payment users, using less skilled care workers. If direct payment users then chose to receive the “bells and whistles” that private payers received, they could negotiate it as an extra.

An agency that had focussed and built a reputation on high quality intensive care packages was considering re-dressing the balance within the agency and concentrating more in the future on low level support packages that were more affordable through direct payments and also more profitable for the agency, although the downside was that they were less rewarding for staff to deliver.

## **6.2.2 The threat of losing clients**

Agencies were concerned about losing clients. They were very aware that the rates they charged for an hour’s support were not competitive when compared to those charged by self-employed care workers. This, combined with agency hourly charges sometimes being higher than direct payment rates, led to expectations that clients opting for direct payments would not purchase support from agencies. The rates agencies charged for high level or specialist support needs were a particular worry. High agency charges resulted from the overhead costs of managing the workforce and meeting national care standards and staff training requirements. There was a very strong view from agencies that direct payments meant that there was not a level playing field for agencies versus private care workers:

‘I mean all business is about competition. If competition changes that’s tough on us. I, I, I’m just saying that, the fact is, that .. it undermines the economics of the sector. So the facts could well be .. it’s a .. what shall we say? I, it, it threatens to undermine them. I mean you, you need to protect elderly people, and .. that’s why we have CSCI, and that’s why we do that sort of stuff and we know there are a lot of very, unpleasant people out there .. who, who really would rather like to .. do what they wanna do in their own way, and what that’s saying really is, in effect is, yeah, agencies are jolly expensive, get the better deal by recruiting someone who doesn’t work for an agency, who doesn’t have the overheads.’

[ID159]

The concern about the loss of clients was tempered by a belief that service users might soon realise that recruiting and managing privately employed care workers was not as straight forward as anticipated. As a result, service users would go back to agencies. Agreements would then have to be reached between the direct payment users and agencies about the level of support that could be purchased, given the level of direct payment received. Some agencies might not be able to provide support for the price direct payment users were able to pay; others may negotiate suitable packages. One agency introduced a special, lower rate for existing clients who transferred to direct payments but retained the higher private rate for direct payment users who were new to the agency. (Competition from private care workers is discussed in more detail in section 6.5 on workforce and retention.)

A further specific concern relating to the loss of clients came from an agency that provided support to carers. They were concerned that carers would not prioritise their own needs by using their direct payments to purchase carer-specific support such as respite care.

Despite all these concerns, there was still a view that choice and competition could lead to gains as well as losses.

Agencies recognised that marketing methods may have to change to help deal with the potential loss of clients. They were accustomed to social workers referring new clients and as a result agencies marketed to a few key social workers. There was very little advertising to either direct payment or private service users; agencies relied instead on word of mouth or had made conscious decisions not to advertise because staff shortages meant that too big a response could leave an agency unable to cope. Agencies talked about targeting their advertising in the future, perhaps not at direct payment users but at well off retired people who may become private purchasers. Having a shop front location so that service users were aware of the agency and could drop in at any time was also seen as a way to attract new clients. Others thought they would advertise in local papers, with social workers and make sure they were listed by the LA. Some already advertised to GPs, social workers and community nurses and felt they would need to advertise more widely. Maintaining a good reputation was also considered important for attracting direct payment clients; one agency was planning on going one step further by targeting direct payment users and putting forward the view of how much more secure it is to use an agency than employ someone directly. As discussed in the section on financial risks, one agency offered discounted rates to existing clients switching to using direct payments. Another would consider offering discounts on some complex or large packages of care.

### **6.2.3 Perceived threats from a new type of client**

We discussed earlier the impact of direct payments to date and the views of agencies on the relative 'choosiness' of direct payment users. The higher expectations that direct payment users might have were mentioned as a potential threat as well. The issue here was that direct payment users (along with private clients) tended to be more demanding ('power crazy clients' [ID93]) and believe they had more rights than people whose support was arranged by the LA. There was a view that keeping the LA as a 'go-between' with more 'clout' [ID10] to manage these expectations would be advantageous.

Only one agency gave any suggestions for how to deal with the potentially excessive or inappropriate demands of direct payment users. These comprised turning them away (mainly due to a lack of carers and thus an unwillingness to 'throw valuable carers at dodgy contracts') and also developing more rigorous terms and conditions in contracts to allow for 'stunts which we haven't thought about yet' [ID159]. This agency had had a bad experience involving the daughter of a client (whose care was provided through the LA contract) placing the client in a residential home and suing the agency for compensatory damages.

### **6.2.4 Perceived threats to administration**

The administrative impacts of more personalised budget holders were rarely mentioned as a potential risk. For larger agencies or agencies that were branches of larger companies, the administrative department or head offices were expected to deal with any additional workload resulting from extra invoicing, spot checks and other administrative duties. However, when prompted to consider the administrative impacts, there was some concern about increased administration, although only by a handful of agencies. In addition to recovering debts and trying to attract new clients, the increased administration was expected to come from more invoicing (in comparison to larger LA contracts) and managing rotas to enable more flexibility for users. There was also concern that there may be complications related to packages funded by multiple budgets (such as part social services, part direct payments and part Independent Living Fund) and different rates charged to different types of purchasers. The latter may be particularly confusing for administrative staff where existing clients switching to direct payments are charged a different rate to new clients using direct payments.

### **6.2.5 Perceived workforce threats**

Agencies were concerned that the expansion of personalised budgets would impact on their ability to recruit and retain care workers. In particular, agencies felt that the levels of pay they would be able to offer compared with the rates care workers could receive if employed privately by direct payment users would not be competitive. Add

to this the widespread belief that privately employed care workers may not always pay tax on their earnings and the recruitment situation for agencies was anticipated to become even more difficult.

### ***Loss of investment in staff training***

Many agencies raised the issue of losing their investments in training staff.

Regulations and care standards meant that they had to spend quite large amounts of money on training new staff and updating existing staff. There was perceived to be a risk that care workers would join an agency, stay a sufficient length of time to receive appropriate training, then leave to earn more per hour working privately for a direct payment user. As one agency put it – ‘So we’d be paying our competition. So we trained up, we trained up people who’d be directly competing with us’ [ID159]. Nevertheless, not all agencies were concerned about staff leaving. Some agencies believed that the benefits available to care workers from being employed by an agency outweighed the financial benefits of a higher private wage rate. These benefits included training updates, paid holidays, secure hours of work, national insurance contributions and support in situations where clients may make complaints or unreasonable demands. In particular, care workers who worked privately and did not receive regular training updates were felt to be removing themselves from the market for future agency work; agencies would not look favourably on employing someone who had not been trained in, for example, lifting techniques, for many years. The realisation by care workers that these benefits were lost through private work may mean that staff either would not leave agencies or, if they did, would return to them quite quickly.

Plans to deal with staff losses and the associated losses in training costs included asking staff to pay back the costs of their training if they left the agency within a specified period after the training and asking private and direct payment clients to pay an introduction fee. (There are further details on agencies’ responses to staff being poached by clients section 6.5 on workforce issues.) Other potential responses to possible staff losses included plans by an agency to set up more training courses internally with the intention that the costs should be reduced and so the staff losses reduced also, and, with regard to staff leaving, encouraging both service users and care workers to come back to the agency if private employment does not work out.

### ***Changes in job security and services provided***

Not all personal budget holders will choose to employ care workers privately. Many were expected to continue to use agencies. This in itself was expected to create other problems. The short notice period for direct payment users to withdraw from an agency was highlighted as potentially creating workforce planning problems. Agencies were concerned that care workers employed on a permanent basis would be left with insufficient hours of work if clients were able to withdraw suddenly. As a result, job security within agencies may be reduced. The type of support that direct

payment users might want to receive from agencies was a further concern. Most agency care workers were trained to provide personal care but managers were concerned that some service users may want support with social activities instead. There was a belief that current staff did not necessarily want to change the style of care provided. As a result, agencies may need to recruit different types of care workers to deliver a new range of support and care activities.

An important view, expressed by an agency that relied mainly on private clients, was that workforce equality may become threatened by direct payment users. This agency saw themselves as an equal opportunities company that would send care workers from any background to any client's home but, based on the demands of some of their long term clients, the manager expected direct payment users might insist on not receiving care from, for example, black or Asian care workers. As he put it: 'their bigotry will be allowed to creep in' [ID93] without the power of social services to say no to such demands.

Other than recruiting care workers who were willing to provide a different type of support, the only plan for how to deal with these changes was for agencies to ensure that direct payment users were only taken on if there were sufficient in an area to make the travel worth while, especially if one or two withdrew suddenly. This was also one of the issues that had arisen in relation to LA contracts based on geographical zones.

### **6.2.6 Other perceived threats**

Particular concerns for agencies that offered supported living were problems that might arise from having three or four agencies providing support to three or four people living in a single house. In the interest of choice, supported living agencies are moving towards drawing up tenancy agreements as separate arrangements from the domiciliary care agreements. The separation would allow tenants who opt for a direct payment to choose the agency (or person) that provides their support, rather than having to use the agency that provides the housing. However, a potential result was thought to be confusion and possibly arguments between the service users. One agency talked of petty problems arising from shared bathroom and kitchen facilities if a different agency was helping each tenant to, for example, shop and cook – there could easily be disagreements about the ownership of food ('that was my milk you used' [ID64]). Another thought a solution may be to provide a core level of support (such as safety and security for tenants) from a single agency but support for social activities could be provided from different agencies if desired.

## **6.3 Perceived opportunities from more personalised budget holders and plans to realise these opportunities**

Managers were asked about the opportunities they perceived from an increase in the numbers of people using personalised budgets. They were prompted to think about opportunities in relation to capacity, development of new services and for more flexible packages of care. Overall there were fewer perceived opportunities than threats.

### **6.3.1 Opportunities to expand capacity**

Some agencies saw direct payments (or other forms of personalised budgets) being used in the future as a contribution towards care costs, thus expanding the number of people able to purchase certain kinds of support. For example, direct payment users or their families may be willing to top up their direct payments in order to buy types of support for which direct payments alone are not sufficient or that local authorities do not commission. Specifically, a national, living-in agency (funded equally by LA contracts and private clients) explained how they saw the expansion of direct payment use opening up the market for living-in care. In a situation where the level of LA funding to enable someone to live at home was so high that it was believed to be more cost-effective to place the service user in residential care instead, that level of funding could be taken as a direct payment and topped up by family until it was sufficient to buy living-in care and thus retain independence. The agency gave a particular example of a daughter/son not wanting a parent to live in residential accommodation, especially if any inheritance such as a house might be used to pay for that accommodation. The agency felt they should in the future be advertising to let people know that, with direct payments, this kind of flexibility was an option.

A number of agencies thought that more use of personalised budgets might give them the opportunity to expand provision outside their contracted LA zone areas. Some had spoken when describing the big issues in their local area about how the use of contract zones had created a lack of choice for service users. As well as local authorities using only one agency in an area, the lack of choice was created because providers tended to recruit care workers from the area in which they would be providing care. Thus, within a zone, the majority of people who wished to provide care through an agency were employed by the zone provider. Other agencies were therefore not able to recruit staff in that area and were not prepared to send staff in from another area that might involve lengthy travel time. Private and direct payment users were thus limited in their choice of agency. However, if the number of people using direct payments increases in the future, there may become a sufficient volume to justify an out-of-zone agency sending a care worker to the area to cover a number of calls. Ultimately, the situation was seen as akin to the old style of spot contracting that many local authorities used to use.



One LA was planning to change its zones. This was seen by one agency as a one-off opportunity to explain to clients who would be lost to another zone provider that they could opt for direct payments and choose to continue to purchase care from their current provider. This would work both ways, with some gains and some losses. Another agency in the same LA was planning on marketing itself as offering simple billing and good quality staff in the hope of making itself attractive to direct payment users. The result for both would be to go against the LA system of one provider per zone.

One large, zone provider saw direct payments as an opportunity to refuse to take on additional work. Within their block contract they were obliged to take on additional LA referrals in their zone if they were below their contracted capacity. They described times when they did not feel they could provide a quality service as required, but had to agree to do so anyway. This was felt to be unfair to the service user. With direct payments, the agency felt free to turn down a package if they could not deliver a good quality service. The reverse, however, was true also; they would have opportunities to agree to take on large packages or long calls outside their contracted zone area if this was worth their while financially.

### ***Plans, barriers and factors to facilitate realising capacity opportunities***

Agencies planned to help realise these opportunities to expand capacity by advertising - in part to make people aware of what agencies could offer but also to help raise awareness of direct payments and how they could be used flexibly. There are further details on advertising to personalised budget holders more generally later in the report.

Two agencies, both medium sized and reliant mainly on private purchasers, recognised the opportunities that direct payments brought to expand, but did not necessarily wish to do so. One stated that they never had sufficient staff to expand and preferred to keep a personal, quality service where the manager knew the names of all the clients; the other saw an opportunity to offer specialised support to, for example, people with learning difficulties, but was concerned about having appropriately trained staff. Both were concerned that as the agencies grew in size, standards might fall. Others also spoke about staffing problems in relation to expanding capacity, one medium sized zone provider referring to a 'chicken and egg' situation [ID10] of not wanting to recruit staff until there was sufficient need, but being aware that when the need arose it could be too late to recruit staff.

The main factor that might hinder agencies from expanding was staff shortages. As well as the chicken and egg situation described, an agency that was already advertising on the internet was concerned that they might 'be embarrassed' [ID53] by their inability to recruit and train sufficient care workers quickly enough if too many potential clients made enquiries at the same time. They solved this problem by

turning their internet advert on and off every few weeks, depending on their capacity to respond.

Factors perceived to facilitate expansion were the opposite of the barriers, for example, sufficient trained staff and good advertising. Other facilitators mentioned were a direct payment rate set high enough to enable service users to choose to purchase from good quality agencies, and a LA support structure that helps direct payment users to identify agencies.

### **6.3.2 Opportunities to change services**

The majority of agencies that saw opportunities to develop a broader range of services were funded mainly or wholly through LA contracts. Potential new services included more supporting and enabling services such as help with developing movement skills and exercise as well as expanding in more traditional areas such as rapid response and 24 hour or living-in support. Some agencies, particularly those offering supported living, already provided day services and social as well as domestic support. They felt they were already in a niche market and saw opportunities to continue and expand the provision of these services. Services provided included accompanying people to the gym, taking riding lessons and going to the cinema. There was a view that a different type of care worker, possibly less skilled, would be needed to offer social rather than personal care. One agency talked about companions rather than care workers and felt this may be a route to develop; it was noted that CSCI regulations might be less strict for companions but the agency planned still to undertake basic training and CRB checks. Large agencies and those that were branches of national companies discussed tapping in to the expertise available within the company. Specifically, one agency talked about developing services around acquired brain injury, people with mental health problems and making use of occupational therapists; in each of these areas the appropriate expertise existed elsewhere in the company.

Two agencies that talked about taking the worry out of direct payments and making things easier for people by working 'in partnership' [ID18] with them were both not for profit agencies. One saw an opportunity to work with people by offering support planning services to help people arrange whole packages of support; the other saw an opportunity to focus on managing direct payment bank accounts for people with no advocates and also acting as an agent that 'does no more than... sends staff out' [ID20] to direct payment users and deals with tax and National Insurance (thus taking the stress out of financial management). Another agency saw opportunities to expand to direct payment users an existing service they offered to clients to help recruit carers. They did this by identifying members of their own staff who might be able to work privately and sending their CVs to the direct payment user. They would consider charging an introduction fee for the service. This was a large agency that was a branch of a regional company and already supplied staff to residential care

homes, nursing homes and hospitals in addition to running a domiciliary care business.

### ***Plans, barriers and factors to facilitate realising service development opportunities***

Agencies suggested a number of factors that they felt would facilitate them in realising the potential opportunities from more personalised budget holders. There was a belief that more proactive support from local authorities might help, particularly in the early transition stages when agencies were developing new types of services. One supported living agency would like to have the stability of an LA contract for the first two years so that tenants could see that the agency was a good organisation and the agency would have more time to plan and develop support services. Specialised training to ensure that the right staff had the right skills and were placed with the right service users was also seen as an important facilitator. Increased advertising was mentioned, with the purpose being to let direct payment users know how agencies could help them but also to let them know what they could do with their direct payments as 'a lot of people don't have a clue what they can and can't do' [ID199]. One agency felt it would help if there was a way to identify direct payment users so that marketing information could be targeted at them.

Workforce recruitment was perceived to contribute to the success or failure of realising these opportunities in a number of ways. In addition, it was believed that some recruitment problems may be alleviated by the changing nature of support services. Simply, if sufficient and appropriate staff could be recruited to provide services, then these new services could be provided; if not, they could not. However, the fact that agencies would need to recruit the 'very different beasts' [ID159] that are companions or personal assistants may mean that recruitment becomes easier as a greater pool of potential care workers is opened up.

Other than recruitment, the one factor mentioned as a potential hindrance to service development was insurance coverage. A single agency had previous experiences of carers wanting to use their own cars to take service users out (and vice versa) but this was not allowable under the agency's current insurance policy. If agencies were to develop new services, they would need to ensure care workers were insured to offer these types of support. A similar situation arose for service users receiving support commissioned via the LA contracts; unless services were listed in the care plan, care workers were not insured to undertake them.

### **6.3.3 Other perceived opportunities**

Some agencies believed the greater use of personalised budgets would mean less paperwork. Where local authorities commissioned and monitored care, both the regulations and associated paperwork were time consuming for administrative departments. Agencies felt that when dealing directly with individuals, it would be

easier to make changes to care packages. One stressed that they would not cut any corners, but the systems would be simpler. Experience and enthusiasm to make the new system of personalised budgets work were both seen as factors that would facilitate progress.

A large living-in agency saw one of the benefits for them compared to other living-in agencies as their ability and experience of thinking up flexible financial arrangements. Half of this agency's clients were private clients. For a fee, the agency managed payments on behalf of private clients who used self-employed care workers by paying the care workers and claiming this back monthly from the clients. The chairman of the agency was an ex-accountant and enjoyed thinking of innovative solutions to financial problems. He felt that the agency's experience in using these systems would stand it in good stead as more people began to use personalised budgets.

#### **6.3.4 Opportunities to develop brokerage and other support services**

If managers did not talk about developing support services such as brokerage for direct payment users (and most did not), we prompted them to tell us about any plans to do so. Specifically, we prompted managers to talk about brokerage (advising on services), provider accounts (managing care funding on behalf of clients), and offering recruitment and payroll functions.

Generally, providers interpreted brokerage as assessing and planning a package of support and then finding one or more providers to provide that support. One concern was that providers offering this service would not be independent in the advice they gave; agencies would always look at themselves first to see if they could offer the services required, even if they were not the best option. One agency, dependent mainly on funds from private clients, already offered a benefits advice service that helped people to identify and claim benefits. However, they were aware of the professional and ethical conflicts that might arise if they were advising people to claim benefits that were then being used to pay the agency for care. In each of the local authorities, specialist agencies were commissioned to provide support to DP users so a general view was that the space to offer these services was not available at the moment. Others talked about brokerage as a way of expanding their businesses if staffing levels allowed, and also if the agency already possessed appropriate expertise. It appeared to be quite important for agencies to see new services as a 'natural bolt-on' [ID95] to existing ones. There was also a concern that agencies' good reputations could be put at risk if they subcontracted to other companies that had lower standards. Having said this, one agency was already helping to manage DP users' money and was developing a business plan to expand this and to help people find good support workers. Another would need training and guidance on personalised budgets, but with that training would be happy to offer

advice to older people over the phone or through visiting older people's meeting places.

There was little discussion of managing care funding on behalf of clients and no discussion of provider accounts as a method of allowing clients to invest funds with an agency and "call-off" services as required. A single agency offered account management through an 'appointee service' [ID85] but thought it strange that people were given DPs in order to increase control, but then handed over the budget to a provider to control on their behalf. They did not manage DP budgets on behalf of their own clients as this would be a conflict of interests. In the future they may consider splitting the company into two independent halves; one would deal with financial management of DPs and the other with care provision.

Only larger agencies discussed offering recruitment or payroll services. One was prepared to consider becoming a recruitment agency for people wanting personal assistants (perhaps in addition to continuing as a domiciliary care agency) but the remainder that gave an opinion were quite negative about the idea. One of the main reasons was time and staff; as one agency put it: 'we have enough problems doing our own recruitment and payroll without doing it for someone else' [ID129]. Others raised the issue of administrative time associated with managing care workers and payroll functions, especially for care provided on a day-to-day basis rather than for longer term live-in care. A further concern arose that was similar to the worries about loss of reputation if brokering a deal (that is, subcontracting) with a lower standard company; if an agency recruited someone for a service user and that care worker didn't perform as the user wanted, the agency might be criticised and held to blame.

About a third of agencies gave very general views about expanding into new service or support areas. Some ideas for expansion were as umbrella organisations for undertaking Criminal Records Bureau checks, offering internal training courses to external bodies, taking on additional training for some staff to meet the complex needs of individuals looking for one to one support and offering domestic support. However, a common theme was that if an agency was providing a service already, they might consider expanding it, but where agencies had worked for years to gain a good reputation, why risk losing it by trying to expand into an area they're not familiar with?

'It's almost universally true that the first thing you do is what you're best at and when you try and diversify, so you do it wrongly.'

[ID53]

Thus, in summary, although there was some willingness to offer new services, this was tempered by concerns about loss of reputation, conflicts of interest and a lack of time or expertise to commit to diversification.

## 6.4 Identifying and attracting personalised budget holders

It is not clear at the moment how, as more people begin to use direct payments or other forms of personalised budgets, domiciliary care agencies will be able to identify, and thus be able to market their services to, potential clients.

There are incentives with personalised budgets for carers and service users to contract directly with each other rather than through agencies, thus avoiding agency overheads. A personalised budget holder can choose to pay a carer a higher hourly rate than they would receive through an agency or to purchase more hours of care from them at the same rate as that paid through an agency; they may also choose a combination of both. Equally, individual clients can choose to purchase care from carers already outside domiciliary care agency arrangements, perhaps friends and family. Care agencies therefore have to devise strategies to encourage existing and new clients to purchase agency services rather than to purchase from domiciliary care workers direct. We were interested therefore in how agencies market their services to encourage clients to continue to contract with them rather than with individual carers. Thus we asked agency managers about these issues and about any plans they had to try and retain clients they currently provided for through a LA contract but who opted for personalised budgets. Most managers talked specifically about direct payments as these were the kinds of budgets they had heard of or had experience of.

Managers found it difficult to envisage where or how they would identify direct payment users. They were seen as a 'dispersed group of quite vulnerable people' [ID177]. Few managers had any ideas at all. Other than the usual marketing strategies of targeting GP surgeries and other places where older people congregate, managers were planning to rely on networking, word of mouth and having a good reputation. Some felt it would be helpful if there were a LA system through which direct payment users could be identified and approached with advertisements, for example in a direct payment applicant's pack, but they weren't aware these packs or even lists of direct payment users existed.

Although a number of agencies had won or lost LA clients as a result of changes in zone contracts, only one explained how, in response to care workers mentioning that some clients did not wish to leave the agency after it failed to win a block contract, they had given the care workers written briefs to help them explain to clients that they could opt for direct payments in order to retain them as provider. This agency was concerned however not to look as if they were undermining the LA's zoning strategy. It is not clear whether or not the LA knew that this agency was offering such advice to its clients; in any case, the LA had itself offered the same advice to all its service users when the zone system was introduced. The same agency manager described another agency (not taking part in this study) that did write to all its service users

explaining about using direct payments to retain their current provider and this was not looked on favourably by the LA.

We asked about plans to retain service users who opt for personalised budgets in the future. Most managers had no specific strategies to encourage these service users to stay with their agency. A common view was that there would be no point in trying to encourage them to stay – ‘Why would someone want to go direct payment if they’re with me already? Only if they’re unhappy with me’ [ID95] and ‘if somebody elderly went from social services to direct payments, there would probably be a very burning reason for that’ [ID96] given the amount of time and stress it can take to set up. Some managers expected that if service users were happy with the services they were receiving, they would choose to stay with an agency, but these managers did not question why someone might opt for direct payments in the first place. Others planned to stress the choices available within the agency, for example, opportunities to change carer workers or the timings of care (within the limits of capacity and staff rotas). Many did not believe that current service users would want to use an alternative agency as continuity of care worker is very important to most people. One agency planned to point out the drawbacks of hiring a care worker independently, rather than through an agency.

We asked managers if they had any experiences of marketing their services to people who had recently opted for direct payments. None had done so and, as outlined above, did not know how to identify and target such people. We asked instead about plans to market services to personalised budget holders in the future and specifically about the key messages that they would try and get across.

The key messages that agency managers wanted to get across to potential or actual personalised budget holders were predominantly positive messages about the benefits of using an agency but included also some negative messages about the risks of employing a care worker privately. For many agencies, key messages to direct payment users would simply be an extension of those used currently.

The positive messages about using an agency were mainly about quality and reliability. With regard to staff quality, commonly used words and phrases were: continuity; training; experts; CRB checks; in-depth recruitment and selection; one-to-one care; friendly; passionate; and caring. With regard to the quality and reliability of the agencies themselves, managers talked about the following key selling points: free needs assessments and tailor-made packages; 24/7 emergency phone contacts and supply of care workers; the length of time in business; problems dealt with and no worries over paperwork; and membership of local provider associations. Other key words included independence, dignity, choice, rights and privacy. Some small agencies and those in more rural areas stressed in addition the importance of being small enough for all staff to know all clients and of being part of the community. For larger agencies the benefits included national support and back-up. It was noted,

however, that all agencies would be saying the same things. Managers of agencies providing support to specific groups, such as carers or supported living tenants, planned to highlight messages appropriate specifically to their potential clients, for example, asking carers to think about how they would like to spend their time while the person they care for is being supported or stressing staff skills in developing the independence of clients.

A minority of agency managers spoke about some of their key marketing messages aiming to stress the risks to service users of opting to employ a care worker privately. One called this 'fear marketing' [ID53] – raising questions in service users' heads about friends caring for them, but what happens when they fall sick? Others planned also to emphasise the risks of employing private care workers – such as holiday and sickness cover, training and CRB checks – and the greater protection against abuse that agencies could offer.

A very specific concern about publicising key messages was that the same literature was used to market agency services to all potential clients, whether they were personalised budget holders, private clients or funded through LA contracts. This raised concerns about apparent differential treatment of service users, for example, advertising shopping or companion services is relevant for personalised budget holders or private clients, but not available to LA service users. Agencies did not want to have to explain to people with LA care managed plans that they could not receive help with shopping while other people could. None of the agencies were considering producing different advertisements aimed at different client groups; the consensus view was that any form of advertising was a financial struggle given agencies' increasingly tight profit margins.

In general, the plans that agency managers had to market their services to personalised budget holders were either not well thought out yet or not different from their current strategies for privately paying service users. In addition it was noted that, given the personal nature of the support offered, it was unwise to be too 'pushy' [ID219] with advertising. A number of agencies had experienced very little response from adverts in the past and these experiences had impacted on their future plans, for example, one agency had tried advertising in local shops, papers and the post office, on their website and using flyers, but a poor response meant that they had decided to hold-off advertising for direct payment users. Another had had a similarly poor response from carers after advertising a short breaks service – the agency manager was more optimistic about older people and disabled children but 'the learning disabilities community, not a chance because a lot of people are latched into the fact that it is a social services problem' [ID20].

Examples of the places that agencies placed adverts currently include: settings where older people meet (for example, churches, day centres); local amenities (for example, post offices, local shops); places where people with poor health go (for



example, GP surgeries, hospital radio); and local or national reading materials (for example, parish magazines, the local paper, some magazines, leaflets/flyers and web sites). There were mixed views on whether older people would look at internet sites. No one suggested any new places to advertise to personalised budget holders; the plans that there were included more of the same, with emphasis from a number of agencies on voluntary groups for people with conditions such as MS or Parkinson's disease and on word of mouth.

One of the problems raised was that until service users become more aware of what direct payments or other forms of personalised budgets are, it is hard to advertise appropriate support. Many agencies included in their standard advertisement leaflets and brochures a statement that they provided support for direct payment holders, but they were aware that only those people who already had a direct payment knew what they were, and there was no space within agency brochures to explain personalised budgets to others.

A large minority of agencies had no plans yet to advertise to personalised budget holders. Reasons for not advertising included having no funds to do so and, for branches of larger companies, relying on headquarters for guidance. There was also a view that for agencies with a zone contract from the LA there was no need to advertise for direct payment users as they had no choice of another agency - no other nearby agency would provide services to a single client in another agency's zone because of the excessive travel times.

## **6.5 Workforce recruitment and retention**

Throughout the interviews with the agency managers, problems with care worker recruitment and retention were raised in association with virtually all the other topics covered. We were interested particularly, however, in issues related to care worker recruitment and retention given the incentives under direct payments and other forms of personalised budgets for existing carers and service users to contract directly with each other rather than through agencies, thus avoiding the additional costs of agency overheads. If carers contract directly with clients, they can receive an increase in hourly rates of pay, as they receive the whole payment rather than the payment minus the agency management fee. We expected that care agencies would have to devise strategies to encourage care workers to remain in agency employment. Thus we asked agency managers about their experiences of staff leaving to work privately for personalised budget holders and about any incentives and controls in their contracts with care workers to encourage them not to contract with clients privately. We asked also about recruiting new staff, particularly how care workers might be motivated to work for an agency rather than privately.

### 6.5.1 Experiences of care workers leaving

In about a third of the agencies, a small number of care workers had left the agency to work privately for direct payment users. More often than not, these direct payment users were already being cared for by these care workers through the agency. It is important to remember that the majority of direct payment users using domiciliary care agencies in this study were doing so as a way of staying with an agency or a particular carer after changes in LA zone areas; they had not opted for direct payments as a way of shopping around for more flexible care or the most appropriate agency. As a result, the service users had long standing relationships with their carers. One agency manager described some of their care workers colluding to provide privately to two of the agency's direct payment users who had large packages of care. Another explained how staff had left to undertake domestic rather than social care for people they had worked for via the agency. These losses did not have big impacts on the agencies but added to problems in an already difficult labour market. The impact on agency clients was also quite widespread as often a single care worker might work for eight or ten clients; on that member of staff leaving, those clients remaining with the agency would lose their continuity of care worker. The reasons why staff left were to work more hours, particularly in the social care 'downtime' between early morning, lunch and evening calls, and due to a belief that the 'grass is green on the other side of the fence until you get there' [ID20]. In the majority of the cases described, the care workers returned to working for the same or other agencies at a later date. We do not have many details about why they returned, except in one case where the service users' expectations were too high and the demands on the care worker too much. As well as staff leaving to work for direct payment users, some agencies had experienced direct payment users asking them to provide cover while their now privately employed care workers were off sick or on leave. Two agencies refused to provide this cover:

'it's not my job to bail out someone who has decided to go down direct payment and the personal assistant's let them down. You know, that's why they should be coming to companies such as us.'  
[ID95]

Although the impact had not been huge so far, there were some concerns about the expansion of the use of personalised budgets in the future and more care workers leaving to provide support privately. Agency managers had noted the increasing number of adverts being placed for private care workers, some offering to pay £8 or £9 an hour, which is two to three pounds an hour more than agencies are able to pay. One agency manager knew:

'service users' families that are going through the direct payment route approaching our support workers asking them if they want any private work, so it's all, it is happening'.  
[ID18]

Others, however, did not consider that care workers leaving to work privately would be a big issue. Many agency managers commented on the fact that care workers are dependent on their incomes rather than it being 'pin money'; as a result they are very aware what is best for them and of the potential pitfalls of working for someone privately, for example, the loss of income if the service user dies. (This is consistent with one of the findings from the secondary analysis reported earlier that 30-40 per cent of care workers work over 30 hours a week.) In addition, there is no flexibility in private work in terms of choice of hours worked. A further factor suggested as making it unlikely that care workers would leave to work privately for direct payment users was that, to make it worth the care worker's while, the package of care would need to be very big (to provide sufficient hours and thus income); however, large packages of care often need double-up visits for moving and hoisting people, so two care workers would need to leave the agency to work privately together. As an opposite extreme, there was a view that the ubiquitous short, LA-stipulated 15 minute visits most service users received meant that it would be difficult to find sufficient direct payment users willing to purchase care privately to make it worth a carer's while.

An additional concern about the future voiced by two agency managers (both from LA area B) related to the impact not on agencies of care workers leaving to work privately, but on the care workers themselves in terms of the demands that might be placed on them by service users and the loss of professional distance that could result if carers become too involved with clients. There was a view that the caring nature of care workers sometimes meant that they overstepped the professional boundaries of relationships, for example by taking people into the care workers' own homes because they felt they were part of the family, not always understanding the possible repercussions.

### **6.5.2 Strategies to retain care workers**

All but a handful of agency managers were able to describe the strategies they had in place to encourage care workers to remain in agency employment.

The most commonly mentioned contractual control formed part of the client, not the care worker, contract. A clause in clients' contracts stated that they would pay the agency a 'finder's fee' if they poached staff and employed them on a private basis. Some agencies did not include a finder's fee but did ask clients to give signed agreement not to employ privately an agency care worker within, for example, six months of the care worker leaving the agency. Although written into the contracts, there was a general view that these clauses were probably not legally enforceable but did act as deterrents. Furthermore, only privately paying clients signed contracts with the agencies; for service users funded through LA contracts, the contract was signed by the LA. Thus for service users opting to transfer from a LA contract to direct payments, there was no such control. One agency did ask their service users

funded through the LA contract to sign an agreement to pay a finder's fee, but was not sure whether or not the LA knew they did this.

There were also controls within care worker contracts. A few agencies included clauses similar to those for private clients – care workers were prohibited from working privately for an agency client for a specified time period after leaving the agency, for example, six months. One agency did not allow their care workers to take second care work jobs without the agreement of the agency managers – this was as a result of previous experiences of carers letting the agency down in preference for private care work commitments. Again, the enforceability of these clauses was not known. One agency had, nevertheless, taken successful legal action in the past against a care worker who left to work privately for a client and would take such action again. The main control used in care worker contracts, however, was to insist that care workers paid back some or all of their induction, NVQ and other training costs, and the costs of their CRB checks, if they left an agency within a year of joining.

Managers' thoughts on introducing contractual controls in the future included more agencies putting clauses about finder's fees into client contracts but also two agencies were considering 'restraints of trade' and 'restrictive covenants'. Both controls were aimed at stopping care workers leaving an agency and setting up as a rival business within a specified number of miles of the original agency or employing care staff previously employed by them.

We have interpreted incentives as financial or other rewards aimed at motivating people to act in certain ways. Non-financial rewards were the most commonly cited types of rewards used by agencies to encourage staff not to leave to work privately.

Social care work was viewed as potentially isolating; carers often worked alone throughout their shifts, visiting clients but having little or no contact with other care workers. To compensate for this, many agencies ensured that mentoring or supervision programmes were in place, offering care workers regular contacts with management and other staff. Some also made sure that care worker rotas included gaps between visits during which care workers could meet for coffee. Others had 24 hour telephone support for care workers who needed to discuss difficult situations.

In terms of CSCI regulations, only care workers working alone are considered self-employed individuals and thus not subject to CSCI registration and regulations; someone undertaking care work in partnership with another is subject to registration. Despite this, back office support to take out the stress of meeting these regulatory requirements was raised as an incentive to stay with an agency. As one manager put it:

'I think they've got enough to cope with ... they're very aware of CSCI and what we have to do ... I don't think they're paid enough to worry about that'.

[ID83]

Care workers were also offered secure hours and hours to fit their preferences where possible. The death of a client, sickness cover, maternity pay, compassionate leave – these are all issues that a privately working care worker would have to manage themselves and were all cited as factors that should motivate carers to work for an agency. Some agencies allowed staff to swap shifts with each other. A few highlighted the opportunities within an agency to undertake a variety of types of support for a diverse group of clients, and to be transferred to another client if a relationship broke down.

Most agency managers highlighted their investment in staff training which was usually offered free of charge. This could be considered a financial incentive as in effect it saves care workers from paying for their own training. Although some considered expenditure on training care workers was a double edged sword ('like turkeys voting for Christmas' [ID159]) as there was a tendency for carers to join an agency, become trained and then leave to work privately or elsewhere, the majority saw it as an incentive for care workers to stay with the agency. Most training involved induction and NVQ courses; in some agencies, managers and care workers took turns in suggesting courses that would be useful. There was also a minority of agencies that encouraged career progression within the agency, encouraging care worker promotions to senior carer and management positions.

Other rewards that involved agencies giving care workers free access to things they would otherwise have to pay for included: uniforms; work-related mobile phones; bus passes; subsidised driving lessons and mobility vehicle refresher courses; subsidised leasing of cars; and dental care schemes. A single agency reversed this form of incentive – they made care workers pay for uniforms and CRB checks but reimbursed them after a specified number of hours had been worked for the agency.

Some managers noted the importance of simply valuing staff and treating them well; little things like saying thank you and just being nice were considered important for this group of workers for whom money was not viewed as the main motivator. Many cited the importance of staff social gatherings such as Christmas parties, particularly if they were paid for by the agency.

In spite of the emphasis on non-financial incentives, a minority of agency managers talked about financial bonuses for long service. These took the form of loyalty bonuses related to attendance paid on an annual basis, increments in wages after continuous employment for, for example, every three years, and increased holiday entitlements. The recent increases in holiday entitlement across the social care

workforce had resulted in one agency planning to change its holiday bonus scheme to a financial scheme related to overtime and absence. Two agencies offered a higher wage rate to care workers once they had gained an NVQ.

Other factors that were mentioned that might encourage care workers to stay in agency employment were the good quality policies and procedures related to employment – something that was viewed as not necessarily being available from private employment by personal budget holders – and other pitfalls of private employment such as lack of insurance and training updates. Some agency managers highlighted these risks to staff who were considering leaving for private employment.

A small number of agencies were considering introducing incentives in the future to try and encourage staff not to leave for private work, but none were different to those described already.

### ***Strategies for attracting and recruiting care workers***

As well as the challenge of retaining care workers by encouraging them not to leave to take-up private employment for a personalised budget holder, domiciliary care agencies face the additional challenge of competing directly with personalised budget holders in the recruitment of new staff.

The majority of methods used to attract new care workers were the same as those used to retain care workers: free training, uniforms, sick pay, guaranteed hours and back up and support. Some agencies placed some details in adverts but the main problem was reported to be getting people through the door to start with so that the benefits could be explained. A small number of agencies offered details of other methods they used. These included rewarding care workers with a £250 payment for introducing new workers if the new person stayed more than six months. One agency was involved with social care diplomas at a local college, with the aim of showing young people that they could have a full time career in social care work; a live-in care agency had recruitment centres based overseas, with the aim of ‘catching them when they’re at home’ [ID53] and sorting everything out for care workers before they arrived in London and found private work there. A couple of agencies had recently dropped their requirements for carers to be experienced. They had concerns about inexperienced care workers undertaking visits alone, but, in conjunction with CSCI, one had introduced a shadowing scheme which enabled inexperienced people to be employed but receive some additional on the job training after their initial induction training. Another had introduced more ‘funky’ adverts [ID85], stressing that experience was not necessary as long as peoples’ values were right.

Despite comments about money not being the main motivating factor for many care workers, offering good rates of pay in job adverts was cited as a recruitment incentive.

Managers described using the following techniques: monitoring local care worker pay rates and paying the average or slightly more; advertising senior staff rates; paying more in hard to recruit areas; and paying more than private employers offered. However, there was also a belief that total earnings were the most important factor, so earning a lesser amount an hour but for a greater number of guaranteed hours a week was more popular than earning slightly more per hour but for a limited number of hours that resulted in lower total wages.

Although agencies were using these different methods to attract new staff, the only evidence managers gave of competition from private employers or direct payment users was an increase in the numbers of adverts for private care workers being placed in local newspapers, and this was noted by only a handful of managers. There was evidence that some care workers were aware of the opportunities to work privately; one agency manager described care workers visiting older people's sheltered accommodation complexes and offering to undertake care work privately if the older people transferred to direct payments. Managers perceived that competition from private employers (that is, personalised budget holders) in the future would be unfair competition as they were not bound to ensure that their care worker employees were appropriately trained or CRB checked; the overheads incurred by agencies meant that agency staff were always going to be more expensive than private staff. There was some consolation with regard to staff recruitment in the evidence of care workers returning to work for agencies after forays into the private market as personal assistants proved too demanding.

Plans to address the risk of care workers being tempted to leave agencies were limited and were a way of responding to new demands from clients for more personalised support as much as they were measures to help with competition from the private personal assistant market. A small number of agencies reported plans to train management staff to assess the specific, perhaps condition-specific, needs of people preferring personal assistants and to recruit care workers particular for these clients. For example, care workers who were knowledgeable about and thus able to facilitate clients' participation in their hobbies might be targeted. Some agencies, particularly supported living agencies, offered these services already. One manager was considering advertising for both clients and care workers on the same leaflet; in addition to saving money this system would offer an opportunity to show potential clients the standards and types of care worker the agency provided.

The biggest problems with recruiting care workers were not, however, related to competition from the private sector; competition came from other service industries such as hospitals, care homes and supermarkets. Care work was not seen as:

'an attractive prospect compared to going and stacking shelves in Sainsbury's sadly, because we can't afford to pay the carers what they're worth.'

[ID129]

The poor pay combined with the general poor image of care work, resulting in part from bad press and scrutiny of care homes, made recruitment difficult.

A common view from managers was that the increased training requirements for care work were putting off a lot of people. Specific examples given were of women in their fifties who wanted part time work or those in their thirties who wanted to fit work around children. It was felt that these people did not want to undergo all the required training for just a few hours of work and more generally that many care workers:

‘want a job as a home help, you know, not a professional carer, and of course the money belies that as well.’

[ID96]

Similarly, care workers were being put off NVQ3 training as they did not want the added responsibilities that went with it. Some managers had begun to recruit abroad for senior carers in an attempt to overcome this problem; Poland and the Philippines were mentioned specifically. For a live-in care agency, overseas recruitment was a definite advantage over recruiting in the UK as fewer people in the UK were willing to live in.

## **6.6 Views on the impact of more personalised budget holders on the home care market as a whole**

In addition to domiciliary care managers' views on the anticipated effects of increased user choice on their own agencies, we were interested how they saw the impact on the home care market as a whole. In particular, the results of the secondary analysis had suggested that agencies providing support to a higher than average percentage of privately paying clients may be smaller, employ more older care workers who were more likely to work part time and remain employed by the same agency on a longer term basis. Thus we wanted to know if managers expected that agencies with these or other characteristics might be better suited to adapt to an environment in which the use of personalised budgets was more widespread. We asked also for views on any expected changes in the costs of delivering services, differential pricing, the skill mix of care workers and the quality of care provided.

### **6.6.1 Agency size**

There was general agreement that larger agencies were in a better position than smaller ones to deal with the threats and opportunities from more personalised budget users or private purchasers. Agency managers felt that the greater financial capacity of larger agencies would help to cushion them from the effects of temporary or permanent losses from late or non payments, and also from cancelled care packages due to unplanned hospital admissions or delayed discharges. They were also considered to be in a better position to absorb changes in the costs of delivering



services. Furthermore, the relative financial strength of large agencies was believed to give them an advantage over their smaller competitors by enabling them to invest in existing services and develop new ones in response to demands from personalised budget holders. Larger agencies were felt also to be in a stronger position to comply with increasing regulatory and other requirements from CSCI and the General Social Care Council (GSCC), such as increases in staff holiday allowances. Furthermore, economies of scale were perceived as enabling larger agencies to develop specialist services such as marketing and contracting services and to appoint specialist personnel such as staff with specific responsibility for CSCI inspections or for staff development and training.

Nevertheless agency managers did recognise some advantages for smaller agencies. For example, managers suggested that small agencies were more likely to have had experience of setting up care packages in direct negotiation with service users, that is, without the support of social services care managers, and this would give them an advantage in dealing directly with personalised budget holders. In addition, managers noted other advantages of smaller agencies, but which were not specific to the increased use of personalised budget holders. These included a belief that managers of smaller agencies were much less remote and possibly more 'in tune' with the local market, perhaps resulting in closer working relationships with clients and carers. In turn this was felt to give small agencies more control over the quality of care provided. Finally, it was commonly believed that small agencies were more likely to be family concerns and thus they would have access to family members who could be prepared to help out if necessary, thus offering additional flexibility.

### **6.6.2 Independent agencies versus branches of larger companies**

Agencies that are a branch of a larger organisation were seen by domiciliary care managers as being in a stronger position to benefit from more personalised budget holders than were independent agencies. In much the same way as with large agencies, this was believed to be the case because they had a big team behind them with, for example, specialists in advertising, training and IT, as well as more resources available to expand existing services and develop new ones. It was also felt that these large organisations would have a 'louder voice' when it came to influencing policy and practice, and would be better able to keep their branches informed of national developments that may affect them. On the downside, a general view was that agencies that were part of a larger group would not have as much flexibility to implement changes as a small, independent agency.

### **6.6.3 Workforce characteristics**

Agencies typically employed a mix of young and older care workers to suit the personal preferences of their clients. Some managers noted that if personalised budget holders are predominantly young rather than older, then the demand for

younger carers may well increase. However managers often referred to older care workers as more popular, reliable, committed and experienced. Interestingly it was suggested that the demand for male carers may increase as more male personalised budget holders look for companions to take them to football matches and other social activities. In this respect carers would need to be flexible which, it was argued, may be easier for younger workers without family commitments.

Similarly most agencies employed a mix of part time and full time staff. However, the consensus amongst managers was that part time workers were preferable to full time workers because they offered more flexibility and could usually manage to work a few additional hours if necessary. It was suggested that direct payment users were more likely to require smaller care packages which would better suit a part time workforce. Full time workers were valued, given staff recruitment problems, but the need to keep them fully occupied gave rise to more pressure on managers to ensure sufficient client hours; full time care workers were also more difficult to replace if they left the agency.

Unsurprisingly permanent workers were prized over temporary ones because, as well as providing a better return on the investment in relation to staff development and training, they also provide clients with continuity of care which was regarded as very important, whether or not clients are personalised budget holders. However, it was noted that as more people began to use personalised budgets, there might be increased competition for care workers. Managers suggested that this could lead to much more movement in the home care workforce as carers shifted between different agencies, and between agencies and direct employment.

The overriding message from agency managers in relation to the workforce was the shortage of domiciliary care staff generally. This was seen to be a key issue in the wider home care market, as demand for home care increases as people live longer and remain in their own homes rather than nursing or residential care homes.

#### **6.6.4 The costs of delivering services**

With the growth in personalised budget holders, most managers felt that the costs of delivering home care services would increase across the home care market as a whole. Various reasons were given, including 'bad debts' and the additional administrative costs involved in trying to recover these, and increased travelling expenses as service users opted for shorter periods of support. Care workers' pay would also need to be increased, not only in response to expected increases in the national minimum wage, but also in compensation for poor working conditions such as lack of job security and the higher level of flexibility demanded from staff. With the increase in the use of personalised budgets it is likely that there will be more demands for flexible working hours. However there was also a view from some managers that costs would go down in response to greater competition between

agencies for clients and fewer top down rules and regulations. Additionally, some managers predicted that, unlike LA contract payments, charges to personalised budget holders would more accurately reflect the true cost of care through the inclusion of overhead charges for the hidden costs of public liability insurance, CRB checks, training, mileage allowance and holiday pay.

### **6.6.5 Differential pricing**

The overwhelming response from service managers when asked if the growth in personalised budgets would lead to differential pricing was that differential pricing was already in operation. LA charges were agreed through tendering processes but it was up to agencies how much they charged private clients. Increasing the price charged to private clients was one way of recovering increased costs generally and to bridge the gap left by low levels of funding by central government in particular. Managers reported that private service users (including direct payment users) typically paid more per hour than LA service users and in this way were subsidising LA clients. As one manager said:

‘unless [central government] are going to make funding available so that we can pay our care staff a reasonable rate, then to enable us to recruit and retain and to train staff, the money has to come from somewhere, and the money will end up having to come once again from [the] private sector.’  
[ID129].

Conversely, and not typically, a manager from another agency reported that private service users paid two or three pounds less per hour than the LA. With a shortfall between the hourly direct payment rate set by some local authorities and the rate agencies charged for home care, some managers expected to have to engage in negotiations with personalised budget holders over how much they were charged. It was noted, for example, that someone might be awarded a direct payment for 12 hours of care a week but the payment would be sufficient for only 11 hours. One agency charged private service users and direct payment users different rates; direct payment users were charged an all-inclusive price to include, for example, bank holiday cover, whereas private payers were charged double time for bank holidays.

### **6.6.6 Changes in the skill mix of care workers**

In terms of the home care workforce as a whole, agency managers noted that care work risks becoming de-skilled if personalised budget holders chose carers ‘off the street’ [ID79] that had not undergone any training rather than agency care workers who are trained and receive updates regularly. For many agencies, pay rates were based on staff skills and experience. Managers recognised that with more use of personalised budgets, the demand for home care services other than personal care, such as shopping, domestic work, independent living skills and social support, would increase. Although some forms of care were considered to be less skilled, other

specialist health care-related roles, such as assisting with peg feeding, were seen as requiring additional specialist training. As a result, there were views expressed that agencies might have to charge different rates to service users according to the different skills required for support, and in addition might have to introduce different rates of pay for the different types of staff.

#### **6.6.7 Changes in the quality of care**

Managers had serious concerns about the quality of home care provision with any growth in the numbers of personalised budget holders. There was widespread unease about personalised budget holders purchasing care from unqualified carers when the home care market as a whole was being increasingly subject to regulations in order to protect clients and staff. There were fears that vulnerable service users may be exploited in a home environment that was neither monitored or regulated, and that, unprotected by social services, service users would have no recourse for complaint if their standard of care was unsatisfactory. In relation to the quality of care provided by agencies with more personalised budget holders, if price was king, quality was likely to be eroded, in part because personalised budget holders would focus more on price than quality. Maintaining quality was seen as a function of local authorities and regulatory bodies like CSCI. Finally it was noted that CSCI was downsizing at a time when more monitoring was required as more agencies were entering the market. Managers felt this would negatively impact in the quality of home care provision.



## **7. Summary and Discussion**

### **7.1 Summary of the research**

The aim of this study was to examine, from the perspective of domiciliary care agencies, the perceived threats of, barriers to and opportunities for responding to increases in user choice, exercised through mechanisms such as direct payments, other personalised budgets and private purchase.

We analysed existing survey data to identify any differences in characteristics of domiciliary care agencies with high and low proportions of privately paying clients, using the proportion of privately paying clients (in the context of the relatively low take-up of direct payments) as an indicator of experience of self-directed support packages. The findings were used to inform the sample selection and content of interviews in the second stage of the study.

The second (and main) stage of the study involved interviews with commissioning managers in four local authorities and subsequent interviews with managers of 32 agencies from these four local authorities. We aimed to relate the findings to differences in the characteristics of four local authorities and the agencies themselves; however, there were no clear patterns. The main factors at play in each LA were similar – zone-based providers, financial pressures and local labour market concerns. Local authorities were also similar in their concentration on the provision of home care for social services-funded rather than private clients and in their general commitment to moving towards the greater use of personalised budgets. However, three local authorities were tied into block or cost and volume contracts, and the fourth was considering introducing a guaranteed element into provider contracts, suggesting that progress may be slow. The findings have, therefore, been reported for all agencies together.

### **7.2 Strengths and limitations**

The local authorities and home care agencies taking part in this research were selected purposively to reflect a wide range of experiences with personalised services. Thus, local authorities with different purchasing environments were selected: in urban and rural settings; with different levels of deprivation; and with different levels of take-up of direct payments. The secondary analysis undertaken in the early phase of the research had shown agency size to be related to the percentage of private clients. Therefore home care agencies from within the local authorities were selected as far as possible to give a range of sizes and sources of funding (LA or private purchase), as well as numbers of direct payment users and types of services provided. The agencies taking part in this research were therefore

not a representative national sample, but more importantly for this study they had a variety of experiences necessary to portray a full range of views about the impact of a future expansion in the use of personalised budgets.

Almost all agencies had experience with direct payment users. For many, however, the number of direct payment users was limited. This is not surprising given the low take-up rate, particularly by older people. Two agencies had no experience with direct payment users or private purchasers; these two were specialist agencies - one for carers and the other for supported living. However, the majority of agency managers were able to use their experiences so far with direct payment users and private purchasers as a basis for speculation about the future impact of an expansion in the use of personalised budgets.

Furthermore, the interviews for this research were undertaken between June and December 2007. Thus the interviews with commissioning managers and the majority of those with agency managers were undertaken prior to the government concordat committing to roll personalised budgets out across the whole of adult social care (HM Government, 2007). The fact that direct payments had not impacted on agencies in a big way had led some agency managers to believe that personalised budgets would have little impact either; these views may now have changed.

### **7.3 Discussion of the findings**

We laid out in the introduction a number of expectations. These were based on using the lens of principal-agent theory to look at the reactions of agencies to increased numbers of people using personalised budgets. Specifically, we viewed agencies as the principals to care workers but the agents for clients, as resources passed from either the LA or the client to the agency, and then from the agency to the care worker. We now consider these expectations again in the light of our findings and also present other implications from our research.

We expected that an increase in the number of personalised budget holders would result in fewer and smaller LA contracts with domiciliary care agencies, and that agencies would have to compensate for this loss in income by entering into contracts with personalised budget holders. Agencies would thus face a stronger market logic than previously. For the majority (21/32) of agencies interviewed, LA contracts formed the main source of funding. One would expect that these agencies would be concerned about losing at least some of this funding in the future. In fact, this did not appear to be a major concern; agencies based their thoughts on the future on their experiences of the past, and had seen little uptake of or impact from direct payments, thus they expected little impact from personalised budgets. In addition, many had won LA zone contracts and were thus protected from reductions in volume for a number of years, at least until the agreed contract period ended. However, the security for agencies of being tied into long term contracts introduces related

problems for local authorities. They too were tied into these contracts. The consequence is that it is unlikely that these local authorities will be able to shift quickly from a care managed system of purchasing support to one that is driven by personalised budget holders. The one LA in this study that did not guarantee any hours to zone providers, and thus had the freedom to move more quickly towards personalised budgets, was in fact considering introducing some guaranteed hours into contracts.

With regard to marketing services to potential clients with personalised budgets, we were interested in a number of issues. First we wanted to find out how agencies did or planned to identify these clients. Our findings show that agencies do not know how to identify and thus target personalised budget holders. Managers were planning to rely on networking, word of mouth and a good reputation to attract new clients with personalised budgets. Some felt that advertising via a LA personalised budget welcome pack would be helpful, but were not aware such packs existed.

Second, we wanted to know if agencies were trying to attract new clients by persuading LA clients currently served by other agencies to opt for direct payments in order to transfer to them. There was no evidence of this. However, local authorities were leading an exchange of clients between agencies; when contract zones were introduced or zone boundaries altered, local authorities often offered all clients the option of receiving direct payments as a method of retaining their current provider rather than transferring to the new zone provider. Most of the agencies' direct payment users had been gained in this way. In addition, there was some limited evidence of agencies trying to retain clients by making them aware of the opportunity to use direct payments. One concern that agencies had was that most service users did not know what direct payments were or how they could be used. This made it difficult for agencies to advertise their services to potential direct payment users without first explaining direct payments. Agencies did not feel that this was their role, nor did they have sufficient advertising space or funds to do so. This finding suggests that all LA-funded service users may need to be provided with information about personalised budgets and how they can be used if they are to be able to make informed choices about their care. Once service users are aware of the opportunities available to them, they will be able to weigh up the benefits of different agencies or, indeed, private care workers.

Our third area of interest in relation to marketing was in how agencies managed to deal with many individual purchasers at the same time as managing LA contractual commitments. The majority of agencies already managed private purchasers alongside LA contracts, but, for most, the LA contracts were the biggest income generators. Despite gaining some direct payment users as a result of the changes in zones described above, the situation had not yet arisen whereby any agencies had had to adjust to a greater reliance on individual purchasers. As a result, agencies were not concerned about it in the future. When prompted, a handful of agencies did



show concern about increased administration costs associated with large numbers of individual purchasers. In contrast, some believed that the greater administrative burden would be offset by a reduction in the administration associated with LA contracts which were renowned for their intensive monitoring requirements.

We wanted also to find out what domiciliary care agencies were doing to become more responsive both to clients purchasing support individually and to those covered by LA contracts. On the whole, the care that clients were provided with was reported to be the same whether they were purchasing care privately, through a direct payment or were included in a LA contract. The policies and procedures for LA contracts tended to govern policies and procedures for all clients. However, it was generally accepted that agreeing changes in the content of care packages with private clients was easier than for service users within a LA contract. This was because agency managers could communicate directly with private service users whereas within a LA contract there was a chain of command with all negotiations having to go through a care manager, who, in the language of principal-agent theory, played a principal-cum-agent role, acting as a principal for agencies but an agent to service users. For all service users, however, one of the main restrictions on providing truly flexible support was staff; support could be provided only if staff were available and willing to work at the requested times. It is not clear how this restriction could be overcome on a larger scale.

Given the incentives for carers and direct payment users to contract with each other directly, we were interested in what kinds of incentives or controls agencies used to retain both care workers and clients. Methods of retaining clients included giving positive messages, mainly about reliability and quality, but also some fear marketing which involved pointing out the risks of employing a care worker privately. Private, and in one case LA, clients were often asked to sign a contract that stated they would pay a 'finder's fee' if they employed privately a care worker within a set number of months of that worker leaving the agency. This type of clause acted to prevent both clients and care workers leaving. Similar clauses were included in care worker contracts but the main control for care workers was to insist that they pay back training and other costs if they left an agency within a certain period of time. Non-financial incentives for a care worker to stay with an agency were reported to include back office support, secure hours of work and training. Some financial rewards such as pay increments for long term employment and higher level training were also offered. It remains to be seen whether these incentives and controls are sufficient to retain clients and care workers in the future; there was some evidence of both leaving agencies but returning after experiencing difficulties managing private arrangements.

We expected that agencies might try to contract with direct payment users or private purchasers for long periods of time in order to avoid repeated set up and other transaction costs and also to reduce the risk of losing clients to other providers.

Agency managers did not talk about the risk of losing clients to other providers; in general the view was that service users preferred continuity and were unlikely to change provider. Whilst continuity of care worker was probably the most important factor, clients were believed also to prefer a continuous relationship with a particular agency; some were reported to have been with the same agency for many years and even with a serious break down in a relationship, it was likely that a different care worker would be agreed from the same provider. This is an important finding as it questions the alleged value to personalised budget holders of choice of provider. There was no evidence of agencies setting long contracts with direct payment users. This may be due to the limited experience so far. However, one of the complaints about direct payment users from a few agencies was that they had a very short notice period enabling them to withdraw from an agency with as little as 48 hours notice. It is not clear whether this is a LA stipulated rule or something that direct payment users negotiate.

We supposed that agencies might compile information about the activities of their carers in relation to individual clients, in part to monitor responsiveness and to set prices for services, but also perhaps to reduce the risk of a carer leaving to work privately for a client by ensuring that clients were not supported by a single care worker only. In general, support provided to service users who formed part of the LA contract was monitored for the LA on the basis of tasks undertaken. Services for private clients were priced according to time, not activities. However, there was some talk of a future where different types of support might be undertaken by different types of support worker, for example, domestic or companion workers, perhaps at different prices. Also, while many agencies did ensure that clients were not supported by a single care worker only, one of the main reasons for this was to cover care worker absences due to leave or sickness with other workers that were familiar to the clients. An additional reason for some agencies was to retain a professional distance between care workers and clients, and to provide care workers with experience in a variety of support skills. None was providing services from several workers to each client because of trying to reduce the risk of care workers leaving to contract directly with clients on a private basis.

Finally, and related to the point above, we thought agencies might set contracts with care workers they perceived as a threat (in terms of setting up privately in competition) differently to those not perceived as a threat. This was not the case. However, some agencies had introduced restrictive covenants into their care workers' contracts to stop them setting up in competition within a specified number of miles, and others were considering this for the future.

In addition to the findings related to our propositions, we discuss below the implications of our findings for choice and flexibility for personalised budget holders, care worker supply and local authorities' roles respectively.

### **7.3.1 Choice and flexibility for personalised budget holders**

One of the driving forces behind personalised budgets is to increase the amount of choice and control that service users have over their support. Personalised budget holders should therefore have a choice of which agency (or private care worker) provides support, what support is provided, and when.

At the very basic level of choosing between agencies, our findings show that this choice may well be restricted as a result of the implications of LA zoning. Travel out of a core geographical area of work was not considered cost effective for a short visit to one client. Thus, personalised budget holders may be left with no choice but to employ a care worker from the local zone agency or to employ someone privately. Prior to the introduction of zones, agencies travelled to clients in a wider area and also employed care workers who lived across a wider area. Choice of agency, and thus care worker, may therefore be restricted through zoning. However, this may change as more people opt to use personalised budgets and local authorities begin to commission services for fewer people; the importance of funding from zone-based contracts relative to income from personalised budget holders may decrease, leaving agencies more willing or, perhaps, with no option but to travel outside their zones in order to retain business.

Many agencies appeared to be willing to offer a variety of types of support (for example, personal care, domestic support, and companion workers). However, there was a common view also that agencies should focus first on their strengths, that is, providing personal care; providing new services that were of a poor quality could result in suddenly losing a reputation that had taken years to build. Fears such as these could dampen any diversity in the provision of services. A number of other concerns were raised that might hamper diversity. Agency managers believed that people not yet receiving direct payments were not fully aware of how flexible they could be, for example, some people may not realise that agencies offered alternatives to the standard LA-funded morning, lunchtime and evening calls. In order to realise the potential of direct payments or other personalised budgets, it might be useful for agencies to advertise these services, for example, to advertise that their care workers could take a client shopping or do their shopping for them. However, agencies used the same literature to advertise their services to all potential clients, whether private, personalised budget holders or LA clients. In order to avoid raising the expectations of LA clients who could receive only those services assessed and purchased by the care managers, agencies tended to focus their advertising on the most common service, that is, personal care. Thus LA contracting now and in the future may risk depressing diversity for all service users by inadvertently limiting service users' knowledge of the support on offer by agencies.

Agencies highlighted the demanding nature of some direct payment users and how in some cases their levels of expectations had been raised by social workers. What we

do not know is whether the demands made by direct payment users were in fact unrealistic and not achievable by agencies, given their workforce limitations; or whether these demands were reasonable but agencies were not willing or able to adapt. Generally, direct payment users were reported to be treated no differently to other users. What they were able to do, however, was to terminate their support with an agency if they were not satisfied with it. This is something that is not easy for a service user provided for under a LA contract. In effect, direct payment users were able to express active 'choice' (that is, exit) rather than just 'voice' their dissatisfaction through routine LA complaints procedures (Hirschman, 1970). However, as discussed already, the impact of LA zones may impede these processes through limiting the choice of alternative providers. In addition, also discussed above, direct payment users may choose to exit from a relationship with a particular care worker if that relationship breaks down, but choose to continue purchasing care from the same agency, thus voicing their dissatisfaction but not ending the relationship.

Further restrictions on the type of support that agencies might be able to offer personalised budget holders were insurance requirements and the skills held by care workers. Certainly for LA clients, agency care workers were not insured to undertake any activity that was not listed on the care plan. For other clients there were some restrictions also, such as all travel having to be undertaken on public transport. Care workers in some agencies were insured to drive mobility vehicles, but the point remains that if personalised budget holders are to have a choice of agencies, and want support that involves being driven to certain events, agencies will need to consider the insurance implications, and if most do not cover travel in private vehicles, choice will be reduced for service users. Choice might be reduced also through a lack of appropriate skills held by care workers. Until a sufficient proportion of care workers are trained in providing the types of support personalised budget holders want, which may range from social support to specialist health care-related roles, choice will be limited. It is not clear who might fund appropriate training.

### **7.3.2 Care worker supply**

Care worker recruitment and retention has been a common theme throughout this research. However, the pattern of care worker supply could change as a result of more people using personalised budgets. First, the number of people willing to be an agency-employed care worker may reduce. With or without the roll out of personalised budgets, agencies believed that the level of LA funding being given to them through contracts meant that offering wage rises to care workers was almost impossible. Thus, the size of the pool of people willing to undertake care work through an agency might decrease as people leave for employment in alternative sectors. In addition, the pressures on agency care workers to be trained to at least NVQ level 2 were also perceived to be encouraging some care workers to leave

agency employment, possibly to work privately, and therefore avoid the requirement for formal training.

This leads us to the second point, that care workers might not leave the sector but instead leave employment in an agency to become a self-employed, private care worker. One factor that might encourage such a move is the reported fact that the hourly rate that direct payment users received to purchase care was in some cases lower than the hourly rate charged to them by agencies. This has been found to be the case also for most local authorities in a national survey of direct payments (Davey *et al.*, 2007, p57). The effects could be twofold. One effect is that direct payment users may be tempted to avoid agency overheads by purchasing support privately at a cheaper hourly rate, indeed, they may have no choice but to do so. This would reduce demand for agency care, resulting in agencies finding it increasingly difficult to keep care workers fully occupied, again leading to care workers leaving. The other effect could be that some care workers may be attracted to working privately where they could receive more than the minimum wage that is all that many agencies can afford to pay. There are of course other non-pecuniary benefits to be gained from working for an agency which may influence care workers' decisions on who to work for and counteract the financial incentives.

A third reason why there might be changing patterns of care worker supply is that new people might be attracted to join the existing pool of care workers. Some of the agency managers we interviewed believed that there could be a shift in demand towards less specialised support, such as companion workers or help with shopping (and perhaps an increase in the demand for male care workers), as personalised budget holders choose the type of support most appropriate for their desired lifestyles. If these new roles require less formal training than is required for the delivery of personal care, then people who have been put off care work because of the growing training regime may join the industry and perhaps some of those who have left because they wanted only to be home helps may be tempted back. Currently, all newly appointed care workers delivering personal care are required to register for NVQ level 2 or level 3 in the first six months of employment if they do not already hold a relevant qualification (Department of Health, 2003).

Whether these shifts have a positive or negative effect on recruitment and retention by agencies depends in part on where the pool of workers originated, how flexible agencies can be in terms of staff training requirements, and whether they are able to attract a wider range of staff than previously. If the pool of private care workers merely transfers from working for an agency to working privately, then the overall pool will not have increased in size and agencies will find it harder to recruit. However, if care workers are re-entering the care worker market after having left because of the training requirements, or if they are transferring from other service sectors, then the pool of potential care workers will increase, perhaps relieving some of the recruitment problems. Agencies, however, would be able to take full

advantage of this increase only if some of the training requirements for care workers providing personal care could be relaxed for someone wishing to be, for example, a domestic or companion worker only.

### **7.3.3 Local authorities' roles**

Local authorities are likely to retain a large role in commissioning social care in the near future. This is in part because of the inevitably long timescales needed to roll out personalised budgets. In addition, providers with LA contracts to cover geographical zones in this study had the luxury of secure LA income for up to another three years from the time of the interviews. This means that they were somewhat protected from needing to develop their services to meet new requirements for support from personalised budget holders. Conversely, local authorities retain all the risk; their funds are tied into domiciliary care contracts no matter how many service users opt for other forms of provision. Given claims by agency managers that LA contract policies and procedures tended to govern all care provided by agencies, no matter how it was being funded, we might expect agencies without LA contracts to develop new services appropriate for personalised budget holders more quickly than those with. Smaller agencies that were unable to win block contracts and agencies that were unhappy with undertaking 15 minute visits for local authorities might be the first to take this opportunity.

A further effect of the move by LAs to geographical zone-based contracts is that personalised budget holders may be faced with a limited choice of care providers. One reason that commissioning managers gave for introducing zones was to create community-orientated home care agencies that employed local workers to provide care to local people and that were aware of local issues; in effect, they have created local monopolies. While it is likely that using zone providers has achieved a reduction in agency travel costs and stopped the practice of two or more agencies providing care in the same street, a possibly unforeseen consequence is that residents in a zone who opt for personalised budgets or who purchase care privately now have reduced choice of provider. Many agencies reported that they were not willing to incur the additional travel costs of providing support to a service user outside their zone area; private clients or personalised budget holders may therefore have the choice only of using the zone provider or purchasing support from a self-employed care worker. Certainly if personalised budget holders continue to purchase short visits (not dissimilar from the LA-purchased 15 to 30 minute slots) rather than longer periods of support that might make travel by agencies more financially viable, their choice of provider will be limited.

Whilst local authorities will retain a commissioning role, their wider activities in relation to domiciliary care may change. As the number of people using personalised budgets increases, the amount of direct involvement by local authorities in purchasing home care will fall. One of the new roles of local authorities could be to

help develop capacity – capacity in terms of suitable options for service users to choose from and sufficient care workers to deliver support, whether from agencies or through direct employment of personal assistants.

In relation to suitable options for service users to choose from, commissioning managers interviewed for this study had a limited awareness of the private market in their areas. It follows that LA commissioning teams will have limited knowledge about the types and patterns of support demanded by service users not included in LA contracts. This is not surprising as the role of commissioning teams generally has been to procure services for defined groups of people that did not include private purchasers. Generally, there is little information available about the market for privately purchased home care (Poole, 2006). However, LA commissioners and care managers will be relinquishing to a large extent their current roles in commissioning and contracting services. Thus in order to ensure that providers provide the types of support demanded, local authorities may need to learn more about what personalised budget holders want and to encourage providers to deliver these new style services.

To deliver services, agencies need sufficient numbers of care workers. One of the problems reported by agencies was that they were recruiting and investing in training care workers only to see some of them leave to work privately. A new role for local authorities could be to assume a degree of responsibility for training care workers. This might be through funding training, perhaps by commissioning existing agencies to act as training bodies for the wider care workforce. Certainly, if it is the case that hourly personalised budget rates are less than agency charges, few personalised budget holders will be able to purchase agency support and the capacity for agencies to maintain training levels could suffer. If agencies charge higher rates for more highly qualified care workers, personalised budget holders could also find the cost of purchasing support from highly trained care workers through an agency prohibitive, and may thus be forced into purchasing support from less well trained agency care workers or from the private care workforce.

Some agencies in addition suggested that local authorities should act as a 'buffer', chasing poor payers and using their greater 'clout' to deal with the perceived over-expectations of clients. Linked to these suggestions, there is an important role that local authorities could play by engaging in a dialogue with providers about personalised budgets and the changing nature of the market for home care services, including the different types of demands that personalised budget holders might reasonably make. It was clear from the managers we spoke to that non-specialist domiciliary care agencies had limited experience of direct payment users and knew little about individual or personalised budgets. Many agencies were waiting to see what would happen with regard to demand for services and felt unable to act in advance by employing additional or different types of care worker in case changes in demand did not materialise. There is an argument here for some form of LA

transitional support for agencies to act quickly and develop new forms of support when needed.

Finally, there was no clear view from agency managers about the longer term costs of delivering home care services. Some believed they might decrease due to greater competition and less exposure to local authority contracting regulations. Others were concerned about increases as a result of additional administrative costs, for example, to recover debts, and the likelihood of increased charges to personalised budget holders relative to LA block contracts as agencies begin to charge more realistic levels for covering overhead costs. Any increase in the cost of delivering home care is concerning, particularly in relation to the Gershon efficiency targets for public sector spending (Gershon, 2004).





# Appendix 1

The following sections give the characteristics of each LA area, describe the ways in which local authorities have influenced agencies and summarise the main local issues for each authority. The data are taken from the interviews with LA commissioning managers and those with agency managers.

## LA A

### Characteristics and background

LA A was a two-tier authority with a relatively high take-up of direct payments and a low level of deprivation in a predominantly rural area.

LA A made a decision around the year 2000 to reduce their in-house provision of domiciliary care and expand their use of the independent sector. The decision was based in the main on costs; overheads associated with the in-house service made it relatively expensive. This decision coincided with the transfer of some commissioning responsibilities to the local PCTs and a desire to reduce delayed discharges and prevent hospital admissions. Thus the in-house domiciliary care service now provides only intermediate care for six weeks post hospital discharge and a rapid response and prevention service to help prevent hospital admissions. After six weeks of intermediate care, people needing ongoing domiciliary care are transferred to the independent sector.

The independent sector providers that are commissioned by LA A consist of 33 agencies on a select list. The authority also has a list of specialist providers that provide more of an enabling service in addition to these 33 agencies that provide generalist domiciliary care. Generalist domiciliary care agencies do provide complex packages of care, including to a young man with head injuries and on a ventilator, and continuing care, palliative care and double visits.

Of the 33 general agencies, 17 have contracts comprised of a small block element that provides a guaranteed number of hours (albeit very small compared with total hours each provides) and a larger proportion of spot purchasing. The other 16 have spot contracts only. The LA does use a zoning system but providers are expected to provide support anywhere in the LA area if requested, for example, to help if there are capacity problems elsewhere.

The small block contracts were decided on through negotiation between the LA and the providers. The LA wanted to use block contracts to secure some guaranteed hours of care but the providers did not want large block contracts that they couldn't

always meet if they had staff recruitment problems. The use of small block contracts was the compromise. About three-quarters of the 33 independent agencies have been on the LA select list since about 1999. Although there are a couple of large agencies the authority prefers to 'grow' small and medium sized enterprises.

Contracts were tendered for in 1999 and then again in 2002. The LA agreed that those providers that had shown a willingness to develop and to help the authority when needed would be exempt from the re-tendering. This agreement meant the LA did not risk losing providers with whom they had built up good relations. Those (17) providers were rewarded by being given the small block contracts and the remaining contracts went out for tender.

In addition to standard domiciliary care services, some providers have won contracts to provide late night and early morning weekend visits in city areas. For these services, a driver and three care workers travel together. This enables some flexibility for service users, for example a care worker can leave and come back later if a service user wants more time before being helped to bed. It also means that care workers do not have to travel around the city areas late at night alone. Six or seven agencies also run 'double-up cars'; this system involves two care workers travelling together to service users who need two people for moving. The service helps to stop delays resulting from one care worker being late due to traffic.

Although national statistics showed this authority to have a relatively high take-up of direct payments, the commissioning managers considered it to be low and to have had little impact. Since the tendering of a support agency to help people with arranging and managing the use of their direct payments, take-up had increased. The authority at the time of the interview had 16 or 17 people using an in-Control personal budget and a waiting list of more people interested. Plans for the future include introducing personal budgets for 50 per cent of all service users by 2010. This plan was in its very early stages; a project group had just been set up to discuss issues including how to get providers on board and what to do with existing contracts.

LA A is a special case in that in 2001 the commissioning and delivery of domiciliary care services for older people were transferred to the local PCT, with a budget pooled from health and social care. However, the LA continues with procurement, contract monitoring and management of these services. The LA commissions and delivers services (including some health services) to adults under 65 years old (again, from a pooled budget). In practice this means that all high level strategic planning is undertaken jointly by the LA and the PCT, but care management staff and care assessment functions for older people are operated by the PCT.

Independent providers in LA A can be involved in two groups. Both groups are run by the LA and are only for providers that provide to the LA; providers dealing solely with private service users are not included. One group is known as an independent

sector consultative group with a membership comprising one person nominated from each locality. The group meets quarterly and deals with strategic level issues; it aims to ensure that the market can cope with any decisions made. The other groups are locality-based groups that meet monthly or bi-monthly. These groups include commissioning teams and members of the PCT as well as domiciliary care agencies. They deal with issues pertinent to the locality at that time.

There was no consistent view from the domiciliary care managers about the role of the LA in shaping their businesses. However, the 1993 Community Care Act and subsequent incentives for independent providers to develop home care services were influential to some agencies. Agencies used spot contracts as a pathway to building up good relations with the LA and eventually winning block contracts. Block contracts were seen as offering a degree of security and thus opportunities to invest in, for example, staff training. The policies and procedures governing block contracts generally governed all other contracts held by agencies, including individual contracts with private purchasers. Staff pay rises were also linked to increases in funding for LA contracts. A living-in care agency had made the positive decision after the 1993 Community Care Act to develop as a nationwide business based on both LA and private purchasers, in part to ensure that the agency could not be 'held to ransom' by any single LA.

## **Big local issues**

### ***LA/Contract issues***

A big issue for domiciliary care managers in LA A was cutbacks in funding following the partnership arrangements of the LA and the PCT regarding domiciliary care services for older people. It was also suggested that social care funding from central government is inadequate. In particular, LA cutbacks have meant there is no extra money available to enable agencies to offer pay rises to their care staff which in turn impacts on recruitment and retention. Cutbacks are also threatening the future of specialist 'double up car teams' operating in the area, where two carers are needed for moving and handling reasons and therefore share transport. As a result of financial pressures, there is reluctance to fund any more of these relatively expensive care packages despite high demand and waiting lists for this type of care.

There was also some concern that the level of support agencies receive from LA care managers was diminishing. Domiciliary care managers found it difficult to get hold of care managers now contact with them has to be routed through a 'direct call centre'. This problem was exacerbated in areas where care managers are in short supply and in cases where responsibility for a service user has passed after six weeks from an allocated care manager to a duty manager.

LA block contracts were highly valued in providing intensive care packages in LA A. After block contracts are awarded, spot contracts are issued to agencies on the

preferred list alphabetically. Those not immediately picked up are put on a waiting list for other agencies to take-up. However these remaining spot contracts are often difficult to service because they are in remote rural areas, require double-ups, and so on. This makes it difficult for agencies to profit from them, which in turn makes it difficult for agencies to build up enough trade in an area to make it cost effective to operate there. Block contracts were seen as both a threat and an opportunity for providers of specialist care such as 24 hour live-in care or home care support for people with challenging behavioural needs. It was a threat in that by their very nature these agencies are not set up to win generic social care contracts and also an opportunity for specialist agencies to become the LA's lead provider in their particular field.

### ***Private/DP users***

With regard to competition between agencies for private clients or direct payment users, domiciliary care managers in LA A did not see this as a big local issue. Their view was there was plenty of private work available in the home care market, with some agencies holding waiting lists of private clients seeking care services. Split packages were common, where service users 'topped up' their LA care packages with additional care, such as domestic services, funded privately. However it was noted that some agencies undercut others by initially reducing their charges for services in order to 'win' private home care clients, and then raising them once their custom is secured. Another issue locally was service users wanting to keep their care packages 'open' whilst in respite or hospital or for some other reason. In this situation, agencies continued to receive revenue from their contracts with LA service users, but not from privately funded service users. For this reason agencies were thinking of introducing 'retainer' fees in their contracts with private clients.

### ***Labour market/workforce issues***

One of the big local issues discussed by the commissioning managers was the labour market. The select list of the 33 providers the LA commissions care from has been frozen due to concerns by the authority about the limited supply of care workers. The LA was concerned that as the number of agencies grew, the supply of care workers would become insufficient and the good quality agencies already on the select list may be compromised. Some care workers 'do the circuit', working for one agency after another. The workforce problems arise from a limited number of people being prepared to do care work; the area is a high-tech and affluent. Some agencies try to combat recruitment problems by looking overseas.

In common with commissioning managers, domiciliary care managers in LA A cited labour market pressures as a key issue locally. With a highly successful high-tech research and manufacturing base in the region, both wage rates and the cost of living are high. Unemployment is low and whilst there is a large population of economic migrants many do not have the necessary language skills needed for care work. Domiciliary care agencies are competing for staff not only with each other but also

with other major employers in the area. Supermarkets were singled out as major competitors, particularly since they can offer flexible shift working at higher rates of pay than home care agencies. Other competitors included a mental health hospital and a residential school for young people with physical and/or learning disabilities. In one district, five home care agencies were competing with each other for staff and consequently care workers were able to 'play the field'. However agencies do try to work together, and have carried out mapping exercises to identify recruitment areas for different agencies. Staff recruitment is particularly difficult in the south of the county where it is more rural and, in response, some agencies have resorted to paying higher wages to recruit staff from this area. Recruitment is also more difficult in parts of the region where three local authorities border each other. This is because a carer can earn more working for one authority than another due to differences in the amount of LA funding.

To help address both these problems the LA has introduced different levels of business. They pay a higher premium if two care workers are needed at one time; these care workers are required to be qualified to a higher level (NVQ 3) and get paid slightly more in return. Working in these small teams of two has helped with care worker retention. Additionally, in some hard to reach rural areas staff are paid on a salaried basis rather than an hourly wage. This also helps retention. Both these initiatives have originated from the providers rather than the authority.

### ***Other local issues***

The rural location of LA A, with service users sometimes 15 or 20 miles apart, impacted on domiciliary agencies in several ways. Primarily it affected transport costs and travelling time costs which were often not recognised in LA contracts. Informally this financial shortfall is sometimes met by carers including travel time as well as care time on their time sheet records. This can upset service users who feel they are being cheated when records do not accurately reflect the time their carer has spent with them. The associated risks of car travel in rural areas, particularly at night on hazardous roads were noted. Recruitment was also affected by the rural location of LA A in that there was a smaller population to draw on across a much wider area.

## **LA B**

### **Characteristics and background**

LA B was a two-tier authority with an average level of take-up of direct payments and a low level of deprivation in a predominantly rural area.

LA B introduced an in-house re-ablement service in 2002/2003. Every new service user is referred to the re-ablement service and, where capacity allows, is assessed and receives the service for six weeks. After six weeks service users are referred to

one of the independent sector zone providers. One of the advantages of using zone providers rather than spot contracts is that the re-ablement service know in advance which provider will take the care package and thus preparations for handing over packages can begin early in the process.

Since 1993 there has been a gradual shift from the use of in-house to independent providers. Ten independent preferred providers are contracted to provide domiciliary care to the LA zone areas. There are an additional six agencies that are supplementary providers based in areas where insufficient capacity to provide support may become an issue. If none of these 16 agencies has capacity, spot contracts are agreed with providers on an additional list of agencies with pre-service agreements that specify standards.

The LA area was divided into zones in 2003. All new care packages are contracted to 'preferred' providers unless they have no capacity in which case they are passed to a supplementary provider in certain zones and spot providers where there is no supplementary provider.

The preferred providers are guaranteed all new referrals in their zones, but not hours of care which vary according to the number of referrals. The number of hours is difficult to predict; for some providers this meant more work than providers initially expected and for others less. Zones were introduced in part to save money on travel costs by using and encouraging locally-based providers and in part to stop the escalation of prices charged by agencies. Previously, under a spot contracting system, new agencies had destabilised the local market by offering higher wages to care workers and charging higher prices to the LA. Incumbent agencies that paid their staff lower rates lost some staff and were no longer able to meet the LA's capacity requirements. The LA then had no choice but to spot purchase with the higher priced agencies.

Current zone contracts expire in March 2008. They were for three years with a two year extension. The commissioning manager expected that they would continue with a zone system in the future and they are considering guaranteeing some hours. LA B also commissions a preventative service (which includes shopping, cleaning and gardening) which is supplied by Age Concern. Some specialist packages such as those for people with learning difficulties, mental health problems and specialist brain injuries are commissioned separately.

Although national statistics show this authority has a middle level take-up of direct payments, the commissioning manager perceives there has been little impact from direct payments to date. The authority does have targets for self-directed support and care managers do give service users the choice of using direct payments. Direct payments support is provided by a voluntary organisation through a contract with the LA.

There is a local voluntary organisation of independent providers that the LA liaises with. However, neither members of this organisation nor other domiciliary care providers are formally involved in the commissioning and planning of services; the authority feels that some providers would be given an unfair advantage in tendering processes if they were involved and others not.

Agency managers perceived some influences on them from the LA were negative, for example keeping wages low or not giving many referrals to zone providers but others influences were more positive – some agencies had developed by initially taking on difficult spot contract packages, building relations and then becoming a zone provider. New providers still aimed to gain zone status.

## **Big local issues**

### ***LA/Contract issues***

Competition for LA contracts in LA B was not a big local issue since zone providers, as long as they had the capacity, serviced all the packages within their given zone. There were some concerns that not all zone providers were able to supply all the cover in their area, but it was felt that this would be rectified through the re-tendering process by appointing two providers in some areas. It was also noted that the majority of social workers were unaware of the zone boundaries in LA B.

However a major concern for both commissioning and domiciliary care managers was that social services were funding fewer care packages in LA B. Pressures on the social care budget meant that the LA weekly co-ordination panel had been approving fewer care packages. People's care needs were being prioritised, with lower priority clients having to wait longer for care. The result was less work for the domiciliary care agencies. This was particularly hard for zone providers who were geared up to meet a higher level of demand for care. One agency reported a decline in LA work of 27.5 per cent in six months; at one time it accounted for 90 per cent of the agency's work. This was attributed to a LA budget overspend resulting from drastic cuts in central government funding, and agencies were being encouraged by campaigning organisations to lobby parliament for change. Furthermore agencies with LA contracts were not receiving an annual rise in their rates to cover increasing agency costs, such as a higher holiday allowance for staff. There was also an insufficient supply of care workers caused in part by a high demand for care from increasing numbers of elderly people moving into the area. A problem was also noted that the LA's re-ablement team were acting in some cases like a generic domiciliary care agency and were 'cherry picking' the best elements of care packages for themselves and contracting out the more difficult evening and weekend calls to zone providers. Zone providers are paid one price for a package regardless of weekend working or mileage, so it does not pay them to share packages in this way. Finally with regard to LA contracting in area B, there was a view that block contracts make it virtually impossible for small providers to break into the market.



### ***Private/DP users***

Domiciliary care managers in LA B did not see competition for private or direct payment users as a big issue locally. The local population was relatively affluent and ageing rapidly. It was felt that future service users were therefore more likely to come from the private as opposed to the social sector. Many agencies picked up private work on recommendation from social services, and direct payments had not been 'pushed' locally. Besides it was felt that younger people were more likely to take-up direct payments and the majority of people referred by social services were elderly or physically disabled.

### ***Labour market/workforce issues***

Recruitment was one of the big issues for commissioning managers in LA B, particularly in the very rural areas. The commissioning manager described staff shortages, added to by sickness or holidays, that can lead to a downward spiral; a shortage of workers results in an agency being able to take fewer new referrals which means there is a lower workload resulting in more staff leaving. The LA holds regular zone meetings and provider forums to discuss these issues. Ultimately, these discussions can lead to a change in zone providers.

Carer supply is also a major concern for domiciliary care managers in LA B to the extent that some fear the home care market is on the brink of collapse. Low wage rates in the care sector attract transient workers and make it difficult for agencies to compete with other local employers. The changing nature of home care, with more carers taking on nursing as opposed to domestic responsibilities, has not been matched by an increase in either wages or status and affects carer morale. Last minute cancellations of jobs due to unplanned hospital admission or delayed discharges can leave carers out of pocket because agencies cannot afford to compensate them. The financial impact of staff leaving to work for other agencies or to set up an agency themselves, is forcing some agencies to introduce restrictive covenants to staff contracts as a deterrent.

### ***Other local issues***

Costs associated with travel in a rural location were cited as a big local issue for domiciliary care managers in LA B, with some service users inaccessible without four wheel drive vehicles to negotiate farm tracks. These costs were more easily recovered from private clients by charging a mileage rate on top of the care service cost and passing these on to carers through a mileage allowance. However staff do not always get reimbursed for time spent travelling to and between jobs. Additionally recruitment is a bigger issue in rural areas because of there is a smaller population to draw on.

## **LA C**

### **Characteristics and background**

LA C was a unitary authority with an average level of take-up of direct payments and a high level of deprivation in a predominantly urban area.

In-house domiciliary services in LA C are currently being reconfigured. The high cost of the in-house service means that it provides little generic domiciliary care; instead the service concentrates on providing special services such as short term interventions, rehabilitation and services for people with dementia. The in-house service also undertakes consultancy work with independent providers, for example, management training.

The LA contracts with 11 independent providers on a cost and volume basis and from a preferred list of 15 providers using spot contracts. The 11 main providers service 21 contracts, each contract covering one zone. Seven of these providers held cost and volume contracts previously, two held spot contracts and two are providing services for the LA for the first time (but are not new providers). All of the main providers provide generic home care services for people of all ages and with a range of impairments. Services include high level packages such as 24 hour care, overnight services and double-up visits. The 15 preferred providers receive little or no LA work unless they are a specialist provider, for example, for people with autism or brain injury.

Part of the reason behind introducing zone-based contracts was to reduce costs. The LA used to do a lot of spot purchasing which inevitably cost more. Another reason was to introduce sustainable procurement; the LA wished to cut down on travel costs, stop more than one provider working at the same time in the same street, and create community-based providers that should be aware of local issues such as employment. In certain areas that are more rural or where recruitment is a particular problem the LA are aware that they may have to pay a higher price for services.

Current zone contracts expire March 2010 but have the possibility of a two year extension.

The take-up rate of direct payments in LA C is average according to national statistics. Future growth in the use of direct payments was taken into account when structuring the new zone contracts. The LA uses a voluntary organisation support agency to help DP users find and employ a personal assistant or agency worker. There have been examples of domiciliary care agencies asking the LA to pay 'introduction fees' to compensate providers for training care workers and providing them with experience only to find the service user they've been working for begins to use DPs and employs the care worker privately. At the time of the interview the

authority had recently appointed a self-directed support project manager to take personalised budgets forward.

For the 26 independent providers with LA contracts, there is a bi-monthly meeting with the authority to discuss any issue, from payment issues to national policy documents. In addition, the LA held short consultations with existing providers when preparing the new tenders and sessions where the providers gave the LA information or came to find out what they wanted from the new system. Agencies that provide only to private service users are not included in any of these meetings. The LA has, however, provided some training opportunities to the whole of the independent sector, not just commissioned agencies.

Large block contracts based on zones played a role in the recent development of many of the agencies interviewed in LA C. Where block contracts were held, the same policies and procedures were used for all agency clients, whether or not they were funded through the LA contract. As in other areas, there were examples of agencies building up experience with spot contracts and eventually gaining block or zone contracts. For one agency this opportunity arose when another was unable to meet their contracted capacity; since taking this opportunity the agency had developed into a 'low margin, high volume' business with a number of zone contracts throughout the city. However, a minority view among agency managers was to avoid block contracts on the grounds that the spare staff capacity required to fulfil them was too great, and that the pressure within block contracts was to provide short drop-in calls which not all agencies were comfortable with.

## **Big local issues**

### ***LA/Contract issues***

Prior to the recent introduction of zones, agencies in LA C believed mistakenly, according to the commissioning manager, that providing services to people with physical disabilities was more costly than providing services to older people. As a result there was reluctance among agencies to provide services to the full range of service users. This misconception has now been resolved and all agencies provide support to people of all ages. The LA is now working towards using outcomes-based contracts but is not using them yet.

With the introduction of zones in LA C, some domiciliary care managers have found themselves under more pressure. In the tendering process, once a quality 'benchmark' was reached, zone contracts were awarded to the cheapest bidders. Unable to afford to pay their staff adequately, some agencies could not recruit or retain sufficient staff to service all the packages in their zone. This has meant that there have been lots of spot contracts for other agencies to pick up, so in this respect there is plenty of home care work available locally. However, the LA zoning policy, in terms of its aim to reduce competition between providers in any one area, has been

compromised. Zone providers also note that the LA has been putting pressure on them to make more short calls. However no allowances have been made for the extra travel involved in taking on more clients, and this in turn puts extra pressure on staff and on costs. Specialist providers on the other hand report plenty of work, with one agency supporting young adults with learning difficulties experiencing a threefold increase over the last few years.

A view from the commissioning manager was that although there are sufficient providers in the area as a whole, demand tends to change from one area of the city to another. This can result in capacity issues after contracts have been agreed. However, most zone providers are not small; small agencies are not able to win the zone area cost and volume contracts because the LA looks for providers with sufficient capacity and experience. Small providers are successful instead in getting on the preferred provider lists.

Another big local issue was a recent increase in user charges for services. This resulted in some people choosing not to carry on receiving services through the LA. LA investigations into the reasons why people made this choice showed it was usually more to do with a poor service than the price rise itself.

#### ***Private/DP users***

Competition for private or direct payments was not an issue in LA C since there was plenty of home care work available from the LA. Also local forums help to foster a culture of cooperation between agencies. LA contracts provided the big care packages with guaranteed payment, whereas private or direct payment users typically wanted much smaller care packages and were seen as a greater financial risk.

#### ***Labour market/workforce issues***

Domiciliary care managers regarded staff recruitment and retention as a major issue in LA C and a barrier to expansion. Low wages in the care sector and an abundant supply of unskilled work in this city environment added to the problem of recruiting and then retaining 'good' staff. However, important sources of labour in LA C were students, particularly those on health related courses (physiotherapy, occupational therapy, and so on) seeking relevant work experience; migrant workers where there can sometimes be cultural and language barriers; and workers previously employed by heavy industries. Furthermore, managers highlighted the importance of an agency's reputation in recruiting staff.

## **LA D**

### **Characteristics and background**

LA D was a unitary authority with a low level of take-up of direct payments and a moderate level of deprivation in a predominantly urban area.

In LA D the in-house domiciliary care service provides specialist support including elderly mentally infirm (EMI), an overnight service, high dependency services, functional mental health and rapid response. Some EMI services are commissioned also from an independent sector provider. After a successful pilot of a re-ablement service, the LA has introduced an in-house service to promote independence. All new referrals are assessed by care managers and forwarded to one of the re-ablement teams for a six week service. After a maximum of six weeks and if on-going care services are required, the service user will receive on-going domiciliary care from an independent zone provider.

There is an intermediate care service which is jointly commissioned by social services and health services. The LA is responsible for managing and monitoring intermediate care contracts but the referral point is via health care.

LA D commissions domiciliary care from four independent agencies through block contracts. Each block contract covers one zone. Prior to 2006, care was commissioned through spot contracts from 35 accredited providers.

In addition to the block contract providers, there is a list of accredited providers that have a pre-purchase agreement. This means that they have signed up to the LA's terms and conditions and undertaken an extensive evaluation process. During the early stages of the move to four block contracted providers, these accredited providers received some referrals from the LA; however, once the move had had time to settle down, the commissioning team for domiciliary care did not expect to commission any care outside the block contracts. The learning disabilities and mental health teams do commission accredited agencies on a spot contract basis but this is a very small proportion of total home care.

There is a further exception to the block contracts; service users who receive Independent Living Fund support are not included. This is because the LA is responsible only for the first £200 of their services (up to April 2008) and did not feel it was appropriate to alter people's support arrangements.

Current block contracts expire in 2009.

When the commissioning system changed in 2006 to four zone providers, all LA-funded service users were given the option of direct payments so they could keep the

same carer rather than transfer to a new agency. There was a big increase in the numbers taking DPs as more people opted for them than expected. At the time of selection into this study, the take-up rate of direct payments was below the national average, but increasing. *Independent Living Schemes* provides a support service to direct payment users, including managing payments on their behalf. The LA provides free CRB checks to any service user who wants to employ their own staff. All but one local provider has agreed to accept the same hourly rate from people on direct payments as the average the LA pays in its four zone contracts.

There is an independent care group which is the representative body for all local providers; it is open to all providers whether or not the LA commissions any care from them. There is also a LA-initiated provider forum to help keep providers abreast of developments such as *in-Control* and other LA developments. Domiciliary care providers were consulted throughout the home care services review which ultimately resulted in the use of the four block contracted providers.

For many agencies in the study, the LA was the main purchaser. One agency with no LA D contracts was hoping to gain some spot contracts soon. Another had not been influenced by LA contracts and concentrated mainly on private purchasers; they felt more able to maintain high standards without the pressure to reduce costs to meet LA or direct payment user's budgets.

## **Big local issues**

### ***LA/Contract issues***

The introduction of contract zones in LA D was a major local issue for domiciliary care managers. With this re-organisation of the home care market, staff wages immediately dropped because carers were no longer paid by visit but by the amount of time spent on a visit, and also because agencies had gone in as low as possible when bidding for their contract so finance for wages was stretched. When zones were launched, the plan was for staff contracts to be transferred under TUPE to the zone provider in their home locality. However this did not happen in all cases and for one agency staff shortages meant they had to drop their contracted number of hours with the LA from 1200 to 400 hours of care. Furthermore quality was compromised as agencies struggled to meet the sudden demand for carers in their newly allocated zone. The disparity between the ethos of choice characterised by personalised budgets and the prescriptive nature of zoning was noted by some domiciliary care managers. It was also noted that block contracts and preferred provider lists for spot contracts were prohibitive to new providers entering the home care market.

Competitive tendering for specialist care contracts in LA D was planned in the near future. One agency specialising in supporting people with learning difficulties and/or physical or sensory impairments in their own homes was working proactively with the LA to develop their service to meet local needs. Another agency, providing the ILF

funded element of specialist care packages, noted how these split packages can mean multiple agencies working with one service user. Personalised budget holders were unlikely to purchase this agency's services because they were relatively expensive.

### ***Private/DP users***

In LA D domiciliary care managers noted that the cost of their services would put off a lot of privately funded clients because they included deductions, for example, for training, registrations and insurance. Carers were paid the national minimum wage which is insufficient for many seeking work. Personal recommendation was recognised as an important source of new service users.

### ***Labour market/workforce issues***

The biggest local issue in LA D according to the commissioning managers is recruitment. Both in-house and independent agencies find it difficult to recruit staff – this is an issue particularly for the specialist in-house services. Wage levels in the local area are good and for home care workers the commissioning managers believe the rates are the same whether a care worker is working for an agency or a private purchaser.

Workforce issues were a big issue for domiciliary care managers in LA D with carer shortages preventing agencies from fulfilling contracts and expanding. Low unemployment and new care agencies entering the market, has increased competition for workers. Barriers to recruitment included low pay and no guarantee of hours due to, for example, unplanned hospital admissions, and also the low status of care work, despite the increasing responsibilities of carers and the training they are often required to undertake.

### ***Other local issues***

A local issue raised in LA D was the increasing number of enquiries from private clients living in rural areas. Many agencies reject clients living in remote rural areas because of the travel costs involved, particularly if they require several calls in one day. Unless an agency is established in an area with sufficient clients and carers, it is often not worth their while to take these rural packages on because of the punitive travel costs involved both in terms of transport and time. Finally, the distance between clients in rural areas mean agencies operating in these areas need to employ carers that can drive.





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