

Vision and Values

The Commission for Social Care Inspection aims to:

- put the people who use social care first;
- improve services and stamp out bad practice;
- be an expert voice on social care; and
- practise what we preach in our own organisation.

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Time to Care?

An overview of home care services for older people in
England, 2006

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Chair's foreword



Enabling people to live as independently as possible in their own home is a key theme of current public policy and central to achieving the vision set out in the White Paper *Our Health, Our Care, Our Say*. Without good quality home care services, this vision will not be realised.

At its best, social care can transform lives – making a difference to people's lives is what social care is all about. Home care therefore has a vital role to play in helping people to live their life as far as possible as they wish, where they wish, with the people they want to be with.

This report offers an overview of the current state of the domiciliary care market. It also sets out the views and expectations of people who use and rely on home care services. It provides a guide to current trends in home care, identifies how well this sector is performing against national minimum standards, and highlights the gap that exists in many areas between services as they currently operate and the aspirations of the White Paper.

The report paints a mixed picture of the quality of home care. It is critical to listen to what people say they want to see in their home care service and to judge services on that basis. We know that people value services that offer them independence, choice and control over their lives. They want care that is flexible to respond to their needs, while also being consistent and safe.

People who receive home care are frequently not satisfied with the way that services are currently provided. Many are very dissatisfied with the '15 minute slot' model of service, which they experience as undignified and unsafe. Many find the task-based approach of the majority of councils insensitive to their needs, requiring particular activities regardless of whether people want them done that day or at all. People tell us that this inflexible approach means that services are more accountable to councils than to them. It is also unsatisfactory for those who provide care and support, as it inhibits the proper relationships that should develop between care workers and the people they care for. Care workers who have earned a National

Vocational Qualification (NVQ) do not find a task based, '15 minute slot' model of service satisfying work nor does the model make the best use of their hard earned skills.

This failure to listen to what people really need, and to respond to their wishes and aspirations, is of real concern. It results in missed opportunities to promote independence and to help people live full and rewarding lives. At worst, it can also result in services that do not respect people's rights and dignity. Commissioners need to examine how they can contract services differently, so that they respond to the qualities that people value.

Home care services are currently very constrained. Providers struggle to recruit appropriately trained staff. Preventive services that would help people remain living in their own homes for as long as possible are under-developed. Councils cut simple practical services. High eligibility thresholds result in services that concentrate only on those people who need more intensive packages of care. It is thus becoming clear that the service needs more resources. Nonetheless, commissioners and service providers should look for opportunities to reshape the service to support people in more effective ways, which meet their aspirations and those of policy makers. Just doing more of the same will not deliver better personalised care services.

The majority of service providers have responded constructively to their first experience of regulation and have achieved some improvements over the last three years. However, it is clear that the existing framework of national minimum standards for domiciliary care needs to be reformed to focus much more strongly on outcomes for people who use those services. In light of this, we recommend that the Government bring forward its planned review of national minimum standards without further delay.



Dame Denise Platt DBE

Chair, Commission for Social Care Inspection

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Introduction

Summary

Home care is an essential service, which is enabling thousands of older people to remain safely at home when they may otherwise be unable to cope. Older people who use services, and their carers, usually stress that they would be unable to carry on normally without this support.

This report provides many examples of the relationship between the individual and their care worker being inspirational and rewarding for both sides. Excellent outcomes are being achieved, ranging (at individual level) to an increase in people's health, confidence and quality of life to (at strategic level) thousands of people being helped to live quite independently without recourse to more expensive interventions.

However, there is evidence that the current arrangements for commissioning and providing home care are likely to be unsustainable, for a number of reasons.

Firstly, the tight targeting of statutory support towards those with critical levels of need has resulted in a gradual reduction in the numbers of older people receiving state-funded home care, to the extent that the proportion of older people receiving this kind of support is low by international standards. This pattern of 'intensification' of home care is resulting in missed opportunities to prevent crises and to promote the well-being of older people living in the community. The recent Department of Health White Paper – *Our Health, Our Care, Our Say* – places a new emphasis on early intervention, but there is no sign that councils' expenditure on social care for adults is shifting in this direction. More thought will need to be given to how this aspect of Government policy can be resourced and implemented.

Secondly, the sector itself is a fragile one, that is struggling already to provide services of sufficiently high quality for those who need them now. There are concerns that the sector may find it difficult to rise to the challenge to expand and improve from here. At the heart of the problem is the challenge to recruit, train and develop care workers both to replace the older workers who are leaving the sector, and to meet new demands and ways of working.

Thirdly, the system has to date given councils responsibility for arranging services on behalf of older people – even where people themselves are contributing financially. A gap appears to be developing between what people themselves want and need, and what is on offer from statutory services. During this study, we found that many older people were asking questions about whether the current arrangements offer value for money. It is likely that these questions will continue to be asked. Older people – particularly those paying substantially towards the cost of their own care – are beginning to press for more choice and control.

Many councils and service providers are engaged in positive work to transform home care. The report ends by illustrating some of the innovative work that is taking

◇ ***The targeting of home care:***

Most councils are targeting their services to those whose needs are defined as 'substantial' or 'critical' and who need more intensive support. The actual number of households supported fell from 528,500 in 1992 to 354,500 in 2005, and the proportion is now low by international standards.

This tight targeting of services in most areas means that some people with significant needs are not receiving home care. (This problem is exacerbated by the fact that people do not always know where to go for help, or find the assessment process off-putting). During this study, CSCI found examples of people 'slipping through the net', and some instances where people's safety and well-being were compromised by inadequate support.

◇ ***The home care market:***

Since the 1990s, councils have steadily increased the proportion of home care purchased from independent sector providers, and the independent sector has grown exponentially. The percentage of home care hours delivered by the independent sector increased from 2% in 1992 to more than 73% in 2005. By March 2006 there were 4,622 registered domiciliary care agencies, 80% of which were in the private or voluntary sectors.

Most of the home care sector has the characteristics of a 'cottage industry' with many small, inexperienced providers delivering (on average) 500 hours/week of care. There was a large amount of movement in the market during 2005-06; for example, CSCI deregistered 416 agencies and processed 905 new registrations. However, there are signs that the sector is beginning to consolidate, as a result of councils' decisions to purchase from fewer providers and the competitive tendering processes they use.

◇ ***The quality of home care services:***

2005-06 was the first full year of statutory inspections for this sector. On average, 74% of inspected domiciliary care agencies complied with each of the national minimum standards in 2005-06. This is broadly comparable with performance for the residential care sector.

The areas most often commended by CSCI inspectors concern particular aspects of personal care, associated with the usually respectful, caring and helpful attitudes of staff. One of the areas of most concern is the handling of medication, where there is a need to improve both procedures and training. Another is the level of supervision, support and training offered to care workers more generally.

◇ ***Older people's experience of home care:***

Surveys of older people usually demonstrate high levels of overall satisfaction with home care. This evidence suggests that most older people are grateful for the service, and value the relationship they have with their care workers.

More detailed interviews and groups discussion tend to elicit more critical feedback. This study found that the appreciation expressed towards individual workers is often tempered by concerns, usually associated with a perception that care workers are 'rushed'. We found widespread problems in relation to the shortness of visits, the timing of visits, and reliability (associated with care workers rushing between visits and turning up late). The experience of many of the older people interviewed during this study was that services were short-staffed.

◇ ***Care management:***

Most councils restrict the help they will offer to a list of prescribed activities. Care managers draw up individual care plans that tightly specify both the tasks to be undertaken and the time to be devoted to these tasks. During this study, people using services, their families and their care workers told us that it could be difficult to carry out the required tasks in the time available. They also expressed frustration with the inflexibility of this system, and said there were often problems in getting plans reviewed as their circumstances changed.

◇ ***The home care workforce:***

At least 163,000 people are employed as care workers. This is broadly equivalent to the numbers of people employed in the hotel industry.

In many parts of the country, there are significant problems recruiting and retaining care workers. These appear to be associated not only with the low pay in this sector, but also with terms and conditions that often do not compare well with other sectors (such as the retail trade).

Where hard-pressed agencies have particular staff shortages, there is evidence that they can 'cut corners' in their selection and recruitment practices. Statutory requirements relating to the selection and recruitment of staff are not sufficiently well adhered to. Thirty nine per cent of inspected agencies are not complying with the national minimum standard in this area, often because they cannot demonstrate to inspectors that they have carried out the necessary checks before the person starts work.

◇ **Strategic commissioning:**

Home care has already made an important contribution to the delivery of a range of government targets. For example, the number of delayed transfers from hospital almost halved between 2002-03 and 2004-05, and the number of people entering residential care reduced by 14% over the same period.

Home care is likely to continue to play a critical role in the delivery of strategies to promote the economic and social well-being of local communities.

◇ **Improving commissioning processes:**

A key finding of this report is that in many areas, home care services are now over-stretched. There is an urgent need to secure existing levels of service for people, in the face of supply shortages and rising demand.

The relative fragility and uncertain quality of some parts of the home care sector is, at least in part, a consequence of some short-sighted and ineffective approaches adopted to strategic planning and commissioning to date. A common problem is that relationships between councils and service providers are dominated by discussions about fees and/or characterised by a mutual lack of trust. This can hamper local dialogue, and results in lost opportunities to work together – at both individual and strategic level – to improve services for people.

◇ **The importance of innovation:**

Some councils and their partners are already exploring creative and innovative ways of developing home care, including approaches that focus on enablement, or that give older people more ‘purchasing power’ or more control over their services. A number of examples are included at the end of this report, all of which can demonstrate improvements in user satisfaction or in the quality or efficiency of home care services. A characteristic of all these developments is that they have required considerable cultural change across all the agencies involved.

Conclusions

There is ongoing debate about the future priorities for social care, and how these should be resourced. An important conclusion of this report is that the debate should not just focus on how we will fund more of the same services for the same groups of people. Radical changes are needed to the way services are commissioned and delivered.

The evidence in this report broadly supports the conclusion reached by the Wanless review team¹ – that social care services for older people have become too narrowly

targeted, and should be extended to a wider group of older people in the community. This would also be in keeping with the renewed emphasis in the Department of Health's White Paper – *Our Health, Our Care, Our Say* – on the importance of preventing problems and promoting well-being.

To achieve this, councils and their partners will need to find new ways of harnessing the different kinds of support available to people within communities. A definition of 'home care' that limits state-funded support to a prescribed list of tasks, delivered by a certain type of agency, does not make practical sense to older people and their families. A more flexible and holistic response is needed, that is more closely attuned to what people actually want and need. The provision of extra help for informal carers is likely to be a high priority.

Most importantly, future models for planning and delivering services must ensure that older people can choose what kind of help they receive, when they receive it, and who provides it. This implies a profound cultural shift – towards thinking of the individual as the 'customer' rather than leaving the purchasing power with councils. In many cases it will also involve the actual transfer of budgets to older people so they can purchase their own support.

Further work is now needed to consider new ways of commissioning and providing home care in the medium term, and to evaluate the models that are currently being piloted. Pending this, this report also contains some more immediate lessons for councils, service providers and CSCI as the regulator. These are set out below.

Lessons for councils and their partners

- Home care can be developed in a number of different ways, in tandem with the development of local health and housing strategies, and also taking new technologies into account. Councils and their partners (including service providers) should therefore establish a vision and clear objectives for their home care services.
- Some councils need to work to create the conditions in which more constructive dialogue can take place with independent sector providers, and their expertise can be used to the full.
- It is also critically important to involve older people in strategic planning and in all aspects of the commissioning, monitoring and evaluation processes. In this context, better ways need to be found to elicit the views of older people, including those who find it hard to engage in formal processes.
- Care plans that tightly specify the tasks to be undertaken by care workers, and the time they will take, are hard to reconcile with an emphasis on giving people choice and control. Commissioners' thinking needs to shift away from a focus on inputs towards the outcomes that older people themselves are looking for.

- Services that offer reablement – an approach that aims to restore people’s capacity to do things for themselves rather than doing things for them – have been successful in several parts of the country. They offer a model that other councils might wish to learn from.
- In the short-term, urgent steps are needed in many places to address supply shortfalls. Councils should use the evidence available (including the market information provided by CSCI) to check their comparative performance both in terms of the numbers of older people they are supporting, and the quality of their local domiciliary care services. CSCI intends to challenge councils whose performance appears poor in either respect.
- Social care workforce strategies should be developed across agencies, and seen as a vital part of local economic development strategies. Commissioners should be prepared to specify standards relating to the home care workforce – including levels of wages, expenses and other conditions of service.

Lessons for domiciliary care agencies

- In the early stages of the regulation of this sector, CSCI has concentrated on ensuring that domiciliary care agencies meet registration standards and comply with statutory regulations. On the whole, there has so far been good compliance with the requirements made by inspectors.
- In the next phase of regulation, domiciliary care agencies will be asked to produce self-assessments which demonstrate that they are monitoring their own current performance and have credible plans to achieve improvement.
- In this context, many agencies will need to develop their own quality assurance arrangements, including the methods they use to ascertain user satisfaction.
- The specific areas for improvement vary from one agency to the next. However, there are some issues that are of concern across large parts of the sector. In particular, CSCI expects to see an overall improvement in relation to:
 - processes for recruiting and selecting care workers, and the supervision and support offered to them;
 - procedures and training in relation to the handling of medication.

Lessons for the regulator

CSCI is currently consulting on the next phase of its proposals to modernise regulation and arrangements for assessing the performance of councils. The Department of Health also plans a review of the national minimum standards for domiciliary care. Feedback obtained during this study, as set out in Chapter 7 of this report, will be taken into account in the new arrangements. These will include:

- the introduction of 'quality ratings' to all registered services including domiciliary care agencies.
- developing work to ensure that councils are held to account for their role in commissioning good quality domiciliary care services.

In both these aspects of its work, CSCI is putting an increasing emphasis on the experience of the people who use services and on the outcomes being achieved for them.

1 Introduction



1.1 Purpose of this report

This report summarises evidence about the current performance of home care services in England, presents conclusions about the current state of this sector, and makes suggestions about how it might improve and develop.

The report draws upon a range of evidence collected by CSCI over the last two years, including evidence from our engagement with people who use social care, our regulation of domiciliary care agencies and our performance assessment of councils' social care services.

1.2 Policy context

For at least the last fifteen years, Government policy has been to support older people to remain in their own homes wherever possible and appropriate, by developing community-based alternatives to residential care. As a consequence, there has been considerable expansion of home care services, to the extent that the amount of home care funded by councils more than doubled between 1992 and 2004.² Most of this expansion has taken place in the private sector.

More recent Government initiatives have confirmed the strategic direction of social care, and emphasised the need for services to respond to changing attitudes and expectations, as well as demographic change. For example, the cross-government strategy – *Opportunity Age: Meeting the Challenges of Ageing in the 21st century*³ – stresses the contribution that the growing numbers of older people can make within society. It underlines the importance of supporting them to play a full and active role, and removing the barriers to their participation. The 2006 Department of Health White Paper – *Our Health, Our Care, Our Say* – also sets out a vision to enable older people to live more independently, to exercise choice, and to take more control of their health and care.⁴

These and other policy frameworks (including the *National Service Framework for Older People*, published in 2001) imply the need for further expansion of the range of services for older people in the community.

On the other hand, Sir Derek Wanless is amongst those who have drawn attention to the need to make informed decisions about what kinds of intervention are most effective, and about how scarce resources should be deployed as the numbers of older people increase. In his major review of how much it will cost to provide social care for older people in England in 20 years time, he argues for a new debate about the future shape of social care services and about how these should be funded:

² Source: Department of Health annual return HH1.
³ Department of Work and Pensions (2005).
⁴ Department of Health (2006).

“(There) should be a debate about what social care will do in the future. How will it help people? What outcomes should it aim to achieve? Who should it help? Once its purpose is understood and specified, important decisions can then be made about the range and type of services, the size and composition of the workforce, the implications for housing, the use of technology to assist people to live with more control, and the extent of preventative action required to avoid or delay need.”⁵

This report aims to contribute to this debate, by setting out some of the evidence that will help policy makers and commissioners make decisions about what home care services should be offered to whom, and what form they should take.

1.3 The role of home care

Good quality, flexible home care services are considered by older people themselves to be critically important, and are likely to be an essential component in the range of services that will together help to deliver Government policies. There is little doubt that these services can contribute significantly to the outcomes envisaged in *Our Health, Our Care, Our Say* and to the achievement of a number of specific objectives. For example:

- Helping people maintain their independence, including their links with their local networks of family, friends and volunteer helpers;
- Reducing the social isolation and anxiety associated with physical or mental ill-health;
- Contributing to the safety and well-being of people who might otherwise struggle to look after themselves. (This may include helping to manage the risks for confused older people in their own home surroundings);
- Offering support to informal carers, either by helping them regularly with some tasks or by providing periodic breaks from caring;
- Getting the best from other services, by checking people’s needs (including changes in their health status) and helping them to access other forms of help where appropriate;
- Preventing or delaying admissions to care homes, by offering up to the equivalent level of support to people in their own homes;
- Helping to prevent unnecessary hospital admissions; and
- Facilitating effective discharge from hospital, and helping people to get back on their feet after surgery or an episode of ill health.

Wanless confirms that investment in home care services could bring a range of benefits. However, he also argues that any investment should be accompanied by “a commitment to re-configure services, demonstrating value for money and fairness.”⁶ These issues are explored throughout this report.

5 Kings Fund (2006).

6 Kings Fund (2006).

1.4 The scope of this report

1.4.1 Defining 'home care'

'Home care' must be viewed as part of a whole system of services available to people in the community, including those provided by health and housing agencies. Defining it is not easy, as there are grey areas associated with the different forms of accommodation and different forms of support that people use.

In this report we take the home care setting as a 'self-contained dwelling' (excluding institutions such as care homes). The range covers those living in their own homes or flats, to those living with their families, to more formally monitored locations such as sheltered and 'extra care' housing. The latter may or may not be located close to a care home and include communal facilities and 24-hour on-site staff.

The type of care delivered can also be wide-ranging in scope, from help with practical tasks (such as DIY jobs and gardening) through to more personal care (including washing and dressing) and health care support (such as dressing wounds and managing insulin levels).

Care is available to people from a number of different sources. Most help is provided by spouses, family members and friends – to the extent that over 5 million people are known to provide unpaid care in Britain, many for 50 or more hours per week. Many older people pay for a bit of extra help – perhaps by making a private arrangement with someone who will do 'odd jobs' or look after the garden. Many receive extra help from local voluntary organisations, and a relative minority from statutory social care and health agencies. So, at any given time people may be receiving complex combinations of services, delivered by a number of agencies and involving different combinations of public and private funding.

This report does not attempt to offer a new way of categorising home care – since the creation of artificial boundaries between tasks and between services is often problematic for people themselves (see Chapter 3). Equally, the report attempts to analyse trends in the sector as a whole, regardless of funding streams and the complex system of eligibility for statutory funding.

However, data collection and information sources tend to be fairly tightly focused on those elements that are commissioned (and sometimes provided) by councils with social services responsibilities. Equally, CSCI's data about home care agencies is restricted to those registered under the Care Standards Act 2000. For these reasons, the report's main focus is on the role played by councils and registered domiciliary care agencies.

1.4.2 Access to social services' home care in England

Under the *NHS and Community Care Act 1990* councils are required to assess people who have a need for community care services, and to decide on the services they will arrange to meet those needs. Councils must publish eligibility criteria, as a transparent way of managing the numbers of people who can receive a service and of controlling total expenditure.

The Department of Health's *Fair Access to Care Services* policy guidance (2002b) introduced a more consistent eligibility framework which recognises four categories of risk: critical, substantial, moderate and low. Councils are expected to make a decision about which levels of risk they will address. Within this, councils must also assess individuals' presenting needs, and prioritise their 'eligible needs' by considering what might happen if this particular need were not met.

As discussed throughout this report, many councils have been tightening their criteria, often to the extent that only people with critical levels of need are offered a service following assessment. Furthermore, most councils prioritise tasks defined as 'personal care' (such as intimate help with bathing and dressing), and have refocused home care services away from the provision of domestic and practical help. Most paid care workers have changed their job titles from 'home help' to 'home carer' to reflect the more demanding nature of their new responsibilities.

Councils are also entitled to charge for these services on the basis of a means test, and in practice almost all councils do charge individuals up to the full cost of the care package. In total, councils recoup around 11% of their expenditure on home care through fees, although this varies substantially from one council to the next.⁷

A consequence of this restricted access to statutory support is that many people make their own care arrangements. In doing so, they may buy services directly from the same agencies used by councils, or from different sources altogether. The large numbers of private and informal transactions are an important feature of this sector; however, as discussed throughout this report, the actual scale and nature of this privately funded activity is very difficult to judge.

1.4.3 Registration of domiciliary care

In 2000, the Government's decision to regulate domiciliary care necessitated some further thinking about how to categorise the services offered to people at home. The Department of Health proposed four types of 'personal care':

⁷ Source: Department of Health PSS EX1 return, 2004-05. See Table 21 in the Appendix.

- 1 assistance with bodily functions (feeding, bathing, toileting)
- 2 care involving physical and intimate touching (eg bathing, dressing)
- 3 non-physical care (eg advice, encouragement and supervision)
- 4 emotional and psychological support, including the promotion of social functioning, behaviour management and assistance with cognitive functions.⁸

Agencies providing personal care under the first two of these headings (but not the other two) are subject to registration under the Care Standards Act (2000). Individuals not employed by an agency do not have to register to be able to provide this care.⁹ This means that the data available about registered agencies gives an incomplete picture of the sector as a whole.

The provisions of the Care Standards Act have been applied to domiciliary care agencies since 2003, with 2005-06 being the first full year of statutory inspections of these agencies. Chapter 4 gives an overview of the findings from these inspections.

1.5 Methodology for this report

This report seeks to provide an overview of the current state of home care in England, using the range of available evidence. In particular, it makes use of data obtained by CSCI in delivering its statutory functions including:

- Inspections and reviews of councils' social care services;
- Registration and inspection of domiciliary care agencies; and
- Performance assessment of councils with social services responsibilities.¹⁰

An overview of the methods used is as follows.

- **Review of relevant data and literature.** CSCI commissioned a review of relevant data and literature in February/March 2006. This formed the basis of a 'scoping paper' that was tested and discussed with individuals and groups with particular expertise. In particular, 12 individuals representing partner agencies, government departments, councils, user-led organisations and independent sector agencies were interviewed about the current state of home care, and about what would contribute to improvement.
- **Analysis of the views of people who use home care services.** CSCI's findings from different types of engagement with people using services over the last two years were analysed. In particular, we undertook secondary analysis of the group discussions and individual interviews carried out in the course of our joint review of

8 Department of Health (2002b). See also Section 4 (3) of the Care Standards Act 2000.

9 The General Social Care Council (GSCC) has submitted proposals to Ministers about the next phase of its work to register different parts of the social care workforce. Domiciliary care workers employed by registered agencies are amongst the proposed priority groups for the next phase of individual registration. However, this would still not affect people not employed by registered agencies.

10 CSCI's statutory duties and functions derive from the Health and Social Care (Community Health and Standards) Act 2003.

the implementation of the *National Service Framework*, published in March 2006.¹¹ The group discussions involved around 1,800 older people across ten locations, and interviews were carried out with an additional 120 older people. [See Chapter 3].

- **Analysis of regulatory inspection reports.** A stratified sample of 137 inspection reports was analysed, as a way of investigating the factors that explain the overall performance of domiciliary care agencies in 2005-06. (See Chapter 4).
- **Expert seminars.** Three expert seminars were convened in June 2006, to explore the issues facing the sector and to discuss examples of good practice. These were attended – respectively – by a group of key stakeholder agencies, local user-led organisations, and service providers. A total of 45 people attended these seminars, representing 35 agencies. In addition, a seminar was held for a mixed group of 14 CSCI staff (including inspectors and business relationship managers) from 7 different CSCI regions.
- **Site visits.** Visits were made to nine councils and three service providers in August 2006. The councils were selected on the basis that they were engaged in innovative practice that had been commended either by CSCI's local staff or by CSCI's partner agencies. (They also represented a cross-section of types of authority and geographical locations). At each site, the research team interviewed a range of different people, including commissioners, managers and care workers. People using services were interviewed or individually visited at most of the sites.

Specific aspects of the methodology are described in more detail in the chapters that follow. A full list of the individuals and agencies that contributed to the report is set out in the acknowledgements on page 151.

2 Setting the scene



This chapter sets the context for the rest of the report. It summarises key trends in the home care market, including the main factors affecting the demand and supply of services. The chapter uses the most recent available data and draws upon the work of a number of independent commentators, including those who attended our expert seminars in June 2006.

Key findings

- The demand for home care services is certain to rise significantly over the next 20 years.
- The changing aspirations of older people – especially their wish to exert more control over the services they receive – are likely to drive changes in the way services are organised.
- The amount of home care funded by councils has almost doubled over the last decade. However, the trend has been to provide more intensive services to fewer people.
- The increasingly tight targeting of home care is not in keeping with the Government's emphasis on early intervention, and may be resulting in missed opportunities to prevent or reduce the usage of more expensive social care and health services.
- There is significant and unexplained variation between councils in the number of people they support.
- Expenditure on home care rose by 7% in real terms in 2004-05, to £1.7 billion. However, the proportions of social care budgets that are spent on residential services and home care services have remained constant for several years.
- In March 2006 there were 4,622 agencies registered as domiciliary care agencies – an increase compared with the previous year. 80% of these were in the private and voluntary sectors. There are a large number of entries and exits from the market each year, suggesting that the market is in a state of flux.
- Much of the home care sector has the characteristics of a 'cottage industry' with many small, inexperienced providers. However, there are signs it is beginning to consolidate.
- Overall, councils account for 80% of the business of registered domiciliary care providers, and therefore have considerable leverage in this sector.
- There are serious problems in most places in recruiting and retaining care workers. These relate both to low wage levels and to uncompetitive terms and conditions.
- If the current trends continue, the sector may not have the capacity to respond to the challenges of an ageing population and the Government's vision for older people's services.

2.1 The changing demand for services

The ageing of the population structure over the next 25 years is well documented. As well as an increase in the overall population, there will be a large increase in the relative size of the most elderly population aged 75+ or 85+, who are the largest consumers of home care. The population aged over 85 is projected to nearly double, with steady growth of 2 – 3% per annum throughout that period.¹²

However, we are currently coming to the end of a period of a few years where the number of very elderly people (aged 85+) has changed very little, largely as a result of a drop in the birth rate after World War I.¹³ This implies that the underlying growth in demand from this group has been less in recent years than can be expected in future.

Apart from overall numbers, the following additional demographic factors are likely to impact on the demand.

- The number of older men will increase faster than women. An important implication is that older men are usually still alive with partners. This may require support to be tailored more for couples at home.
- There will be an increase in levels of disability and ill-health, with the number of disabled people projected to rise significantly in the next 20 years.
- This will include a rise in the incidence of dementia, including that caused by Alzheimer's disease.
- There may be local 'concentrating' effects of migration. (For example, older people moving to popular retirement areas and younger people moving away from certain urban areas).
- There will be a greater ethnic mix in the older population in the future. This will be especially significant in localities with higher minority ethnic populations.
- The composition of households will change, with a rise in the number of older people living alone. Changes in the patterns of working and family life, and the attitudes of people towards care responsibilities, may also impact on the number of people available to care for their relatives. The stability and age structure of informal care support is also likely to change, with fewer younger people to care for older relatives.

In addition, the following factors are likely to have significant consequences:

- *The changing aspirations of older people* – particularly their wish to exercise control and choice over their own lives.
- *The commissioning strategies of statutory agencies.* As councils are by far the largest purchasers of domiciliary care, their spending decisions have been the main driver of local home care markets in recent years. Councils' eligibility criteria and charging policies have also had a significant impact.

¹² See Table 2 in the Appendix.

¹³ See Table 1 in the Appendix.

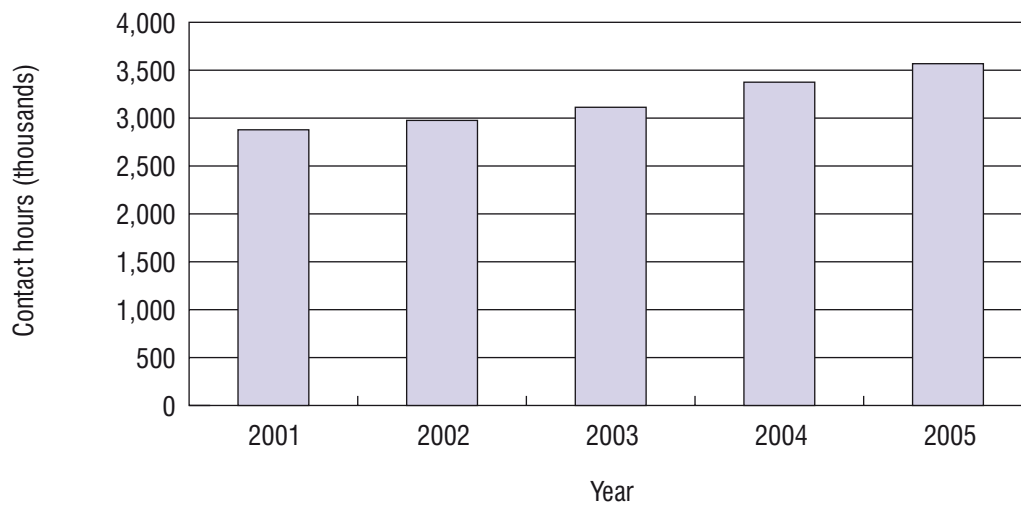
- *The existing pattern of local services, and the 'culture' of their utilisation.* The availability and usage of bed-based resources will be particularly important, as the number of residential beds has been found to be a significant determinant of the numbers of older people helped to live at home.¹⁴ However, the development of other services (such as home adaptations and different forms of supported housing) and the use of new technology will also impact on the demand for 'mainstream' home care services.
- *The possible impact of direct payments and individual budgets.* These could give older people greater 'purchasing power' and significantly influence the way markets develop (see Chapter 6).

2.2 Trends in the provision of home care

Over the last few years there has been a steady fall in the number of permanent admissions to residential and nursing home care (see Table 11 in the Appendix). Because residents in care homes stay on average around three years, the full effect of reduced admissions has not yet been seen; the total number of supported residents only began to fall in 2004-05 (see Table 12 in the Appendix). There is likely to be a further reduction in the numbers of supported care home residents, potentially releasing revenue that could be re-invested in home care and related services.

In line with Government policy, these changes have been accompanied by a significant rise in the numbers supported to live at home. The most recently available data indicates the following:

- Just over a million adults had completed community care assessments in 2004-05, of whom around 75% were older people aged 65+.¹⁵
- Altogether, over 1.2 million older people were receiving residential or community-based services following assessments in 2004-05. Of these, 484,000 received home care during that year. (367,700 were receiving home care in September 2005 – the point in time when the Department of Health's HH1 returns are collected).¹⁶
-

Figure 1: Home care contact hours (all sectors): England 2001-05

The significant increase in the overall volume of home care masks changes in the numbers and types of households receiving care. Over time, all councils have deliberately targeted services towards those with higher levels of need, but have achieved this by reducing the amount of ‘low level’ support to the larger number of households with fewer immediate needs.¹⁹ As a result:

- The number of households receiving home care funded by councils fell from 381,700 in 2001 to 354,500 in 2005 (see Figure 2, below).²⁰ This is an extension of a trend that started at least 14 years ago; in 1992, over 500,000 households received funded home care.
- The average number of hours provided to each household per week increased to 10.1 in 2005, compared with 3.2 in 1992.²¹
- The proportion of households receiving six or more visits and more than 10 hours per week rose to an average of 24% in 2005 (see Figure 3, below)²²

This trend has been encouraged by the Government, to the extent that in the 2004 Spending Review, it set a new Public Service Agreement (PSA) target for councils to increase the proportion of intensive home care to 34% by 2008 whilst also increasing the numbers of older people helped to live at home.

19 See Chapter 1, paragraph 1.4 above.

20 Source: Department of Health annual return HH1. See also Table 4 in the Appendix.

21 See Table 8 in the Appendix.

22 See also Table 7 in the Appendix.

Figure 2: Number of households and clients receiving supported home care

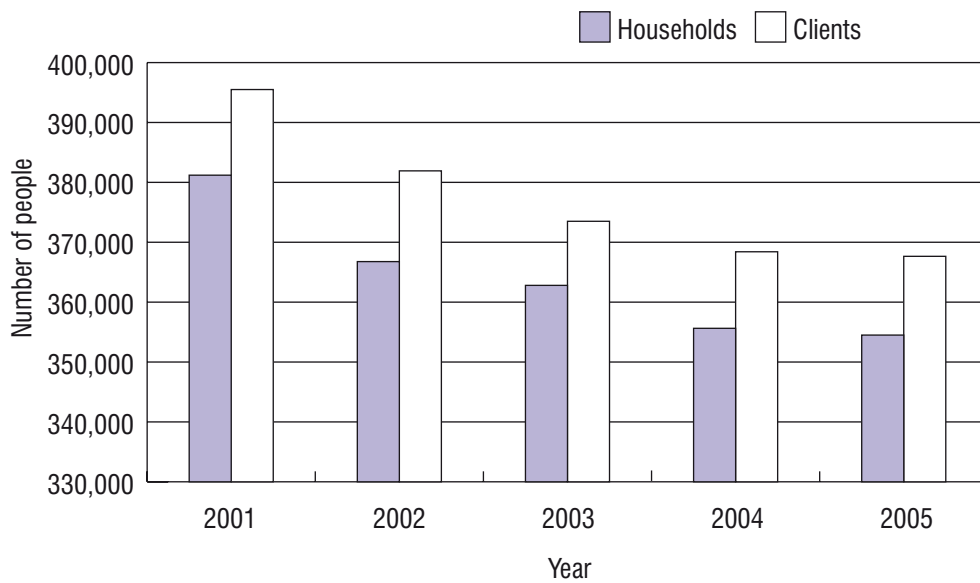
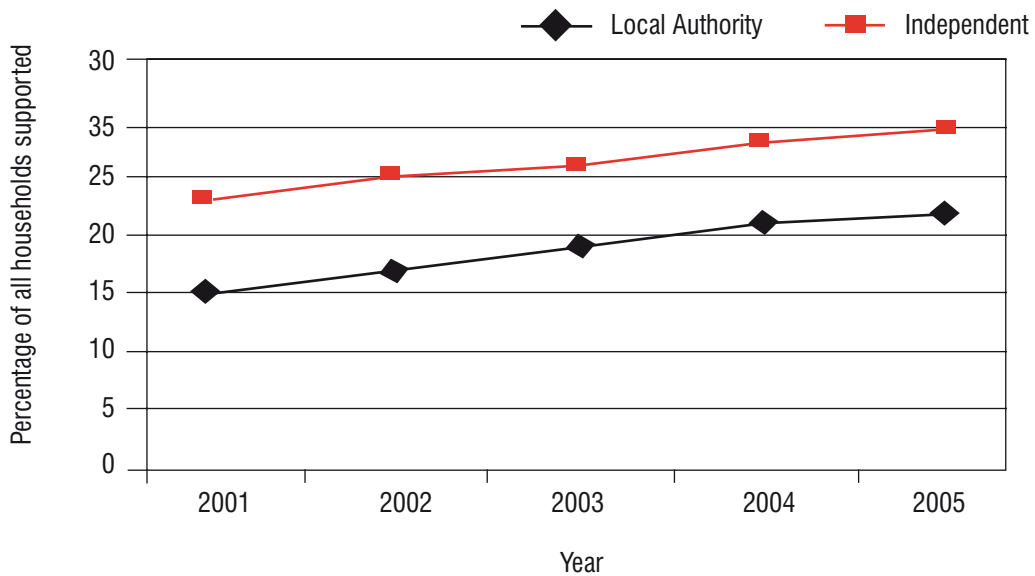


Figure 3: Households receiving intensive home care (10+ hrs/wk) as a proportion of all households receiving domiciliary care



The data collected by the Department of Health are known to understate the amount of ‘low level’ and preventative work funded by councils. (For example, the figures currently exclude people offered direct payments and also exclude those who benefit from grant-funded voluntary sector services whose take-up is not quantified).²³ On the other hand, as demonstrated in the following chapter, there is evidence of disquiet amongst older people and their representatives about rising eligibility thresholds, which may be preventing some people from receiving the help they need.

²³ Evidence about the lower level provision funded by councils – often through service level agreements with voluntary organisations – was collected by CSCI in 2005-06 and will be presented in forthcoming reports on councils’ overall performance.

Wanless concludes that there is ‘significant evidence of unmet need’ and that the proportion of all people in their own homes who have care needs and who have those needs met is low compared with other European countries and has been falling.²⁴

2.3 Privately purchased home care

Relatively little is known about privately purchased home care in terms of volume or expenditure. One estimate puts privately purchased home care as equivalent to 854,000 hours per week at a cost of £417 million per year.²⁵ However, this is for home care from registered providers only, and excludes care purchased through informal arrangements with individual care workers, and care purchased using direct payments.

Older people meeting eligibility criteria related to disability (but not income) can claim Attendance Allowance (AA). The payment is intended to help towards costs which could include home care – although this is not a requirement of the award. The number of AA awards has been rising steadily, with the growth being mostly in the higher rate category.²⁶ These payments (combined with other relevant benefits such as Disability Living Allowance for people aged 65+) totalled £3.7 billion 2004-05. Sir Derek Wanless reviewed the evidence about how these benefits are being spent; he concluded that there is currently less impact on the formal home care sector than might be expected.²⁷

There is some uncertainty amongst commentators about whether the volume of privately purchased home care is growing or declining. Home care providers surveyed by Laing and Buisson (2005) suggest the former, while the United Kingdom Home Care Association (UKHCA) consider that there has been a decline in the number of privately purchased hours of home care in England.²⁸ As discussed elsewhere in this report, there are indications that the growth in the supply of registered home care is not always keeping up with the demand. As providers prioritise their contracts with councils (see paragraph 2.5, below), there may not be enough ‘spare’ capacity in some parts of the country for those who wish to pay for themselves. However, there is insufficient data for reliable conclusions to be drawn at the present time.

2.4 Trends in expenditure on home care

Gross expenditure on home care for older people amounted to £1.7 billion in 2004-05 (excluding capital charges) – an increase of 11% over the previous year, and a real terms increase of nearly 7%.²⁹ This accounted for around 21% of councils’ expenditure on older people’s services in 2004-05 (compared with 56% spent on residential and nursing home care). These proportions have changed very little over a number of years, demonstrating that expenditure is not actually shifting from one form of provision to the other.

24 Kings Fund (2006).

25 Laing and Buisson (2005a).

26 See Table 23 in the Appendix.

27 Kings Fund (2006).

28 McClimont and Grove (2004).

29 Source: Department of Health PSS EX1. See Table 19 in the Appendix.

The figures are partly explained by the fact that fee increases to care home providers have so far outweighed the impact of the reducing numbers of people admitted.³⁰ Whilst there have been equivalent increases for home care (see Figure 4, below), the smaller size of this sector lessens the impact on overall budgets. (See also Table 20 in the Appendix). Wanless cites one study of the basis for these increases over time, which concluded that price changes for the residential and nursing home sector had kept below those expected from increases in costs.³¹ Key drivers – across social care services – have been the increasing dependency of the people supported, required increases in the standards of provision, the introduction of the minimum wage in 1999 and subsequent above-inflation wage increases, linked to significant recruitment problems and wage competition from other sectors.

Figure 4: Fee increases for domiciliary care, 2004-05

- Three councils did not raise fees at all.
- Eighty-two councils raised fees by up to 3%
- Forty-four councils raised fees by between 4% and 9%
- Eleven councils raised fees by 10% or more.

Source: CSCI (2005d)

Councils raised around £190 million in income from charging for home care in 2004-05, to recoup around 11% of their gross expenditure. This income has been relatively static over the last five years, whilst councils' income from fees for residential care has started to fall (see Table 21 in the Appendix).

Investment in home care services, including a lowering of thresholds to encompass more people with lower levels of need, is likely to produce a range of benefits. Wanless makes an economic case for this, by citing research that shows that home care can delay entry to a care home environment by around six months using care packages costing around £100 per week (compared with £300-£400 per week net in a care home placement).³² There is also international evidence that increased home care can reduce the need for more expensive health care – for example, by reducing the length of stay in hospital. Wanless draws the following conclusion:

“The potential of helping vulnerable dependent people is justification for directing scarce and limited public funds to social care. But social care can also facilitate health care objectives and cost savings,

30 Fee increases are reflected in the average unit cost, collected as part of the Department of Health's Performance Assessment Framework. See Table 22 in the Appendix.

31 Darton et al (2003) cited in Kings Fund (2006).

32 Davies et al (2000) cited in Kings Fund (2006).

such as reducing inappropriate hospital admissions and facilitating timely discharges to the community”.³³

The clear implication is that a ‘whole systems approach’ is needed, whereby the impact of one type of service on another is better understood and taken into account in commissioning decisions (see Chapter 5).

If councils’ existing social care budgets are to be used to finance increases in home care, then this could possibly be achieved by realising the savings from the sustained reductions in permanent supported admissions to residential and nursing homes for older people. Alternative options (including the potential role of non means-tested benefits such as AA, as well as more radical changes to the way services are funded) are explored in depth in the Wanless review. However, changes to the existing welfare benefits system would be controversial, especially for the many disabled people who rely on this form of support, and for whom the flexibility to use these benefits as they choose is very important.

2.5 Trends in the supply of home care

In March 2006 there were 4,622 home care agencies registered in England.

Eighty per cent of these are based in the independent sector.³⁴ This is symptomatic of the major changes achieved since the early 1990s, when councils themselves were by far the dominant supplier of home care. In 1992, only around 2% of home care hours were delivered by the independent sector. By 2005 this had increased to more than 73%.

The market can be described as both fragmented and unstable. There is a large number of types of organisation and considerable diversity in ownership including:

- Local authority in-house home care teams (which may include joint health/social services funded teams);
- Voluntary or not-for-profit organisations (which are often small, local and specialist);
- Social enterprises (ie business with primarily social objectives, whose surpluses are reinvested for that purpose);
- Sole proprietors, partnerships and franchises (with turnover of between £150,000 and £500,000); and
- Limited companies, which can range from single branches to large national organisations.

According to Laing and Buisson, an ‘average’ independent sector home care agency provides around 500 hours of care per week, although this figure masks huge variation. Whilst there are a few very large providers (with at least one delivering

33 Kings Fund (2006).

34 See Chapter 4, paragraph 4.1.

over 36,000 hours per week), most are very small, with the smallest registered agency delivering only 14 hours per week.³⁵ Overall, most of the industry still has the characteristics of a ‘cottage industry’ dominated by small providers, many of whom are relatively inexperienced in running their own businesses. A recent survey by the UKHCA concluded that 39% were delivering fewer than 500 hours of home care per week.

Most commentators agree that the market is in a state of flux, with a large number of entries and exits each year. In 2005-06, CSCI deregistered 416 agencies; this is around one tenth of the number registered at the start of the year. It processed 905 new registrations, and this accounts for one fifth of the agencies registered at the end of the year. This last figure includes some re-registrations of agencies that previously operated under another name, and a number of registrations of established providers such as care home operators that are beginning to diversify. Even so, these figures suggest a large amount of ‘churn’ in the market.

Laing and Buisson are amongst those who suggest that the market is beginning to consolidate overall, with larger providers increasingly winning contracts and acquiring some of the smaller businesses. (The growth in the number of agencies registered with CSCI may mask this effect, since large providers are required to register all their local services, including franchised services, separately). A pattern of consolidation would be consistent with the commissioning strategies of many councils, that are deliberately reducing the number of ‘preferred providers’ with whom they do business (see Chapter 5). Pressures on costs, and fierce price competition,³⁶ may be disadvantaging smaller providers. The requirements of the new regulatory regime – such as the standards relating to staff training, quality assurance systems and robust administrative arrangements – may also have presented insurmountable challenges to some of the most inexperienced providers. Some of the implications of this are discussed in Chapter 4.

789 registered domiciliary care agencies (17% of the total) are managed by councils themselves. They tend to be larger than average, and are more likely to play a specialist role; for example, councils increasingly focus their in-house services on assessment, reablement, short-term help for people leaving hospital, rapid response in a crisis, or support for people with dementia.³⁷

The unit cost per hour of providing home care varies around the country and depends on what cost components are included. For example, a UKHCA survey in 2004 concluded that the range varied from £7 to £29 per hour, with the average cost being £15 per hour.³⁸

35 Laing and Buisson (2005a).

36 Netten et al (2005). They cite Forder et al (2004).

37 A pattern whereby councils are not only reducing but also refocusing their in-house services has been observed in CSCI’s recent inspections of councils’ older people’s services, and in the fieldwork for this report – see Chapters 5 and 6.

38 Mathew (2004).

The average price for a weekday, daytime hour of home care in the independent sector was £11.45 in 2004.³⁹ Prices paid by local authorities to the agencies that took part in the UKHCA survey in the same year ranged from £5 to £14. The unit cost of councils' in-house provision has always been higher. For 2005-06 councils have reported their unit costs to be in the range of £13-£16.50, with an England average of £14.80.⁴⁰

Of all the factors affecting income to the sector and market stability, the purchasing policies of councils are the most important. Councils are by far the most significant purchaser of home care, accounting for approximately 80% of the hours provided by registered agencies.⁴¹ (This is different from the residential care sector, where the private market is believed to account for at least 30% of placements). The proportion funded by councils may even be increasing, according to the UKHCA – who also found that 60% of the providers were reliant on councils for more than three quarters of their business, and 14.5% worked exclusively for councils.⁴² The approaches adopted by councils, and their impact, are discussed further in Chapter 5.

2.6 The home care workforce

The home care workforce is largely comprised of relatively low paid, part-time older female workers. Estimates of the numbers of people employed in the sector vary, but the UKHCA's most recent estimate is 163,000, of whom 65% are employed in the independent sector.⁴³ This is around one fifth of those employed in social care, and is broadly equivalent to the numbers employed in the hotel industry.

People from black and minority ethnic backgrounds are over-represented in the home care workforce and their numbers are believed to be increasing. For example, Patmore (2003) found independent agencies in London where 80% of the staff were from ethnic minorities.

There is some evidence that the growth in the numbers of hours provided has been achieved by increases in the number of hours worked by each person, rather than by an increase in the number of workers. (The UKHCA reports that the number

of people employed as care workers may even have fallen in the period between 2000 and 2004).⁴⁴ Care workers now work an average of 30 hours a week each, but with significant variation.⁴⁵ Patmore (2003) found that care workers in inner London worked longer hours than average – often over 40 a week.

The skill levels of care workers are increasing from a very low base (see Chapter 4). CSCI data suggest that around 5,200 care staff were on training courses in 2003-04, including those leading to the NVQ2 qualification.

Providers report significant problems in both recruiting and retaining staff, although the nature of the industry and its employment practices mean that it is almost impossible to quantify the shortfall. As the UKHCA points out:

39 Laing and Buisson (2005a).

40 Source: PAF B17, reported in the 2005-06 Delivery and Improvement Statements.

41 Laing and Buisson (2005a).

42 See McClimont and Grove (2004).

43 McClimont and Grove (2004).

44 McClimont and Grove (2004).

45 McClimont and Grove (2004).

“In home care provision there is no fixed number of workers needed and the concept of a ‘vacancy’ is largely meaningless. Providers recruit on a continuous basis to get as many workers as possible, especially when the labour market is so restricted. They utilise all their available workers.”⁴⁶

Turnover is also high, with estimates ranging from 26% to 36% per annum.⁴⁷

In an independent sector workforce survey carried out in 2001, 76% of homecare agencies reported pay to be the main reason for the recruitment and retention problems.⁴⁸ In another survey carried out in 2003, the UKHCA found rates of pay ranging from £4.50 (then the national minimum wage) to £7.00 an hour, with an average rate of £5.50 for weekday work. Netten et al (2005) make the following observation about wage levels:

“As in the care home market, local authorities have used their purchasing power to keep prices down...Pressures on providers are increased by the widespread practice of local authorities paying on a per hour rate and then commissioning care for half hour periods or less. The pressure on prices does not appear to drive providers out of the market but rather to affect employment conditions for care workers...”⁴⁹

Another constraint on recruitment is the daytime pattern of the need for care workers; the demand peaks in the morning, just at the time when women may be managing their own family situations including taking their children to school. Terms and conditions of service are also, in general, uncompetitive, with many care workers employed on a casual basis with no guarantee of work and no possibility of career development. Travel time and travel expenses are not always paid, even though this work by definition involves travelling between people’s homes.⁵⁰ Whilst many care workers derive considerable satisfaction from their work with older people, others experience a sense of isolation, with little daily interaction with other members of the team. These factors mean that the home care industry is now struggling to compete for low-paid workers with the retail and catering industries.

2.7 Conclusion

This chapter has presented evidence that by and large, the home care sector is a fragile one, still reliant on small private providers and in a prolonged state of flux. In most places, agencies are competing with other parts of the ‘low wage economy’ (for example, the retail sector) for potential care workers. Both wages and other aspects of care workers’ terms and conditions are often uncompetitive.

Wanless (2006) finds that the evidence about the likely future supply of care staff is mixed, and that the factors affecting this will be complex.

46 McClimont and Grove (2004).

47 Laing and Buisson (2005a).

48 Social and Health Care Workforce Group, December 2002.

49 Kings Fund (2005).

50 Francis and Netten (2003), cited in Netten et al (2005).

Overall, however, he expresses concerns about potential shortfalls in the supply of services, making the point that *“even if (...) extra funding were made available in the near future, the required response on the supply side would take a number of years.”*⁵¹

The evidence about the funding needs of the sector is also very complex, as the Wanless review has confirmed. This chapter suggests there is room for some optimism about the potential for financial ‘shifts’ to be achieved, away from long-term residential care placements for older people, towards services in the community. However, fee increases in the residential care sector are amongst the factors that have prevented this so far.

This is an issue that will need addressing across agencies, in the context of the development of ‘whole systems’ strategies that address the pattern of provision (including health and housing provision) overall. An important conclusion of this report is that these strategies should address concerns about the capacity of the home care sector to respond to the challenges presented by an ageing population, and the Government’s ambitious agenda for older people’s services.

3 Older people's experience of home care



This chapter explores what older people want from their home care services, and their views on the services they receive. It uses evidence from CSCI's engagements with older people over the last 18 months, particularly consultations carried out in 2004-05 as part of a joint review of the implementation of the National Service Framework for older people. Wherever possible, CSCI's evidence is triangulated with wider evidence from other studies and from recent academic literature on this subject.

Key findings

- Traditional ways of categorising services and tasks means little to older people themselves. Older people are often bewildered by the rules concerning what statutory services will and will not provide.
- The processes adopted by councils to assess needs and to determine eligibility can cause frustration.
- Many people struggle to find out what help they are entitled to and what services are available. CSCI has found evidence of people 'slipping through the net'. Problems are particularly acute for those facing language or cultural barriers.
- The findings of national surveys about home care are somewhat hard to interpret. Home care is hugely important, and usually highly valued, by those who receive it and most express satisfaction with their services overall. However there are significant problems with their quality, timing and reliability.
- Most older people speak very highly of their own care workers, and blame problems on 'the system' rather than the workers themselves. In particular, there is a widespread perception that staff's work schedules are too tight, with too little time allowed for visits.
- Older people perceive that home care services are short-staffed, sometimes linking this problem to low pay.
- Older people appear to give careful consideration to what constitutes 'value for money'. Some people decline a service because of the level of the charges, and others appear to make alternative (sometimes cheaper) arrangements.
- Whilst most people regard their care workers as willing and able, there are also concerns about the competence of some workers. Training is considered very important.
- Older people may be reluctant to complain, and it can be hard to find out what they are really experiencing. More thought needs to be given to effective ways of ascertaining user satisfaction.
- At present, councils – not people themselves – play the role of 'customer' in the home care market. New ways must be found of giving people control over the services they receive.

3.1 Sources of evidence for this chapter

Joint review of the implementation of the National Service Framework for Older People, 2004-05

Most of the material in this chapter is drawn from an extensive series of consultations with older people in 10 local authority areas in England, carried out from the end of 2004 until summer 2005. These consultations informed the joint review of the implementation of the National Service Framework for Older People ('the *Living Well* review') undertaken by the Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Audit Commission.⁵²

A total of 1,839 older people responded to invitations to participate in public listening events and group meetings (which included people from voluntary and community sector groups) and 120 were interviewed individually. The discussions focused on people's perceptions of health and social care in each locality: had services got better or worse? what were the most important factors for them in service provision? what other services impinged on health and social care?

Although home care was not the specific focus of the review, it is not surprising that there were frequent references to it. So, for this report, secondary analysis was undertaken of the interviewers' notes; the key messages, including verbatim notes of interviews with older people, are summarised throughout this chapter.⁵³

Other sources of evidence

The findings from the 2004-05 review have been compared with findings from several other CSCI sources:

a. Inspections of domiciliary care agencies

At the beginning of each inspection of a domiciliary care agency, a number of people using the service, their relatives, care workers and other professionals are asked to comment on the quality of service provided by the agency, via comment cards or questionnaires. The material here is drawn from inspections of 118 agencies conducted between June 2004 and February 2005. Analysis was undertaken of the responses received, encompassing 1,037 people in receipt of domiciliary care services and 493 relatives, carers or friends.

Because this material was gathered in the early stages of the new regulatory arrangements for the sector, there were inconsistencies in the methods used to obtain the comments, and also some doubts as to the representativeness of the sample. However, material from this analysis is used where it appears to triangulate with other evidence and to shed further light on people's experience.

52 The findings of this review were published in *Living Well in Later Life: a review of progress against the National Service Framework for Older People*. Healthcare Commission (March 2006).

53 Quotes from older people interviewed for the 2004-05 *Living Well* review are annotated 'LW' in this chapter.

b. Complaints

CSCI received complaints from 684 people about domiciliary care in 2005-06, covering 1,458 complaints issues.⁵⁴ Whilst extensive analysis of these has not been possible, the topics covered (which have remained consistent over 2 years) give some indication of what is important to people.

c. Seminar with representatives of local user-led organisations, June 2006

15 people representing 9 locally-based agencies from different parts of the country attended this half day seminar, which was designed to test some hypotheses for this study with a group of older people. Discussion focused on the broad question: 'What would help the home care sector to expand, improve and develop?'

d. Site visits to nine councils

As reported in Chapter 6 of this report, nine councils were visited in the context of this report, in an exercise designed to explore 'what works' from the perspectives of different stakeholders. An additional 24 older people were interviewed in this part of the study.⁵⁵

Finally, it was considered important to take account of wider research findings. This chapter therefore makes use of the growing body of academic literature and studies relating to older people's views of the sorts of support they need, and on the quality of the services they receive. Deliberately, these references are kept brief, as there are other overviews of what older people want in later life and, specifically, of what is wanted from home care. On the other hand, where there are apparent discrepancies in the evidence overall – including differences between CSCI's evidence and other evidence – this is pointed out.

3.2 What do older people want from services?

Many of the recent studies of the help older people want have ended up focusing not just on home care, but on a wide variety of examples of 'good services' ranging from voluntary schemes to helpful responses in supermarkets. It is typical for these studies to generate a list of what people require, that goes well beyond what is normally delivered by 'social care' services.

For example, the Audit Commission (2004) looked at people's understanding of independence and well-being:

"Older people value having choice and control over how they live their lives. Interdependence is a central component of older people's well-being; to contribute to the life of the community and for that contribution to be valued and recognised. They require comfortable, secure homes, safe neighbourhoods, friendships and opportunities

54 See Tables 29 and 30 in the Appendix.

55 In this chapter, where material from inspections is used, this is annotated as 'I'. Where material from the June 2006 seminar is used, this is annotated as 'S'. Where material from the site visits is used, this is annotated as 'SV'.

for learning and leisure, the ability to get out and about, an adequate income, good, relevant information and the ability to keep active and healthy.⁵⁶

Whilst the role of social care must inevitably be focused on specific aspects of people's lives, there are lessons from these studies for those commissioning and providing home care. Wistow (2005), as part of SCIE's review of social care, also uses the term 'interdependence' in his discussion of people's needs for social connections.⁵⁷ Clough and colleagues, in a report for the Joseph Rowntree Foundation (2006, forthcoming), reporting on what older people want, state that older people talk about lives not services:

"Thus someone may talk about the joys of seeing children and grandchildren, and yet feeling lonely, not bothering much with meals since the death of a partner; alongside this, they may have problems with practicalities: the payment of bills, getting the rubbish out in the proper recycling bins or putting drops in their eyes. 'We all want ordinary living', as one person commented...

Significantly also, older people are only too aware of the intermeshing of their lives inside their houses with the worlds outside, factors to which service providers find it hard to respond. Social care services have tended to focus on personal services within the home. Yet changes to the environment – post offices closing, bus services changing, more expensive adult education classes, pavements that seem unsafe because of cyclists or closures of public lavatories – may mean that older people go out less, exercise less, socialise less and feel less good about themselves. Moreover they may be less able to contribute to family or other social networks. There is strong evidence that people's feelings about themselves and the worlds in which they live, affect their sense of well-being and quality of life, which in turn affects their health".⁵⁸

The same tendency to view services broadly – and to emphasise 'getting out' as well as 'staying in' – has been evident in all of CSCI's engagements with older people including the June 2006 seminar. Even where the focus of the discussion was on care at home, people wanted also to talk, for example, about transport, getting to the day centre, and joining clubs.

So, the traditional 'categorisation' of home care tasks, such as that set out in page 15 of this report, appears to mean little to older people themselves. When asked to talk specifically about home care, the rules about what statutory services can and cannot do are often mentioned with bewilderment:

"They do the Hoovering, sink, toilet. They will open cans, which is a big help. They will not dust." [LW]

"Home carers won't clean – it's not allowed." [LW]

56 Audit Commission (2004a). See also Raynes et al (eds) (2006).

57 Wistow G (2005).

58 Clough et al (forthcoming).

“They couldn’t do this, they couldn’t do that – nothing above this level, nothing below that. In the end I told them ‘is it worth your while coming? Because it’s certainly not a lot of good to me’.” [LW]

“They [volunteers] do all the things that paid carers can’t or won’t do... The big difference is that the carers come and do what someone else has decided I need, and the volunteers come and ask what I want.” [LW]

The literature suggests not only that people's needs tend to defy categorisation, but also that they vary according to their personal circumstances, and may also change from day to day and over time. The following are amongst the factors that impact on people's needs and wishes:

- Life experience, and historical patterns of daily living (including how many hobbies, visits and outings people are used to);
- Personal standards and expectations (including whether individuals are used to having tidy gardens and homes);
- Levels and types of support offered by family and friends;
- The factors which created the need in the first place – for example, whether a short-term difficulty or long-term condition; and
- The person's level of dependency – for example, whether they need help as a 'fall back' when they cannot cope with certain tasks, or whether they are reliant on the same help every day.

Patmore contends that there is far more variation in what matters to people than is usually recognised. He concludes that it would be better to invest efforts “in whatever areas matter most to each individual, rather than achieving for everyone some common standards which for some people may have little importance.”⁵⁹

This may suggest the need for a radical approach, which emphasises outcomes for people, and their own expressed wishes, rather than standard processes and inputs. The implications of this are discussed throughout this report, and especially in Chapter 6.

3.3 Levels of satisfaction with home care

National surveys: Various attempts have been made, at national and more local levels, to assess overall levels of satisfaction with home care services. This includes a national survey commissioned by the Department of Health in 2002-03, and due to be repeated in 2005-06.

The last national survey – which revealed that 57% of respondents across England

were 'extremely' or 'very' satisfied with home care – was followed up by an extension study involving 20,000 people in 34 councils, carried out by the PSSRU.⁶⁰ In this study, just over half the sample had assistance in completing the questionnaire from someone other than their care worker. The latter group generally reported lower levels of satisfaction and quality – confirming a well-known pattern whereby older people are either particularly grateful for the help they receive, or reluctant to express reservations unless prompted.

Netten et al conclude that beneath a 'surface' picture of reasonably high satisfaction, there is reason to be concerned about aspects of individuals' experiences. Some of their concerns chime with those expressed during the 2004-05 *Living Well* review and reported later in this chapter:

"The vast majority [90%] felt that they received sufficient visits and three-quarters felt they had the things done that they wanted but, in practice, almost a third felt that at least on occasions less time was spent with them than they were entitled to. Linked to this, over half of the respondents reported that, at least sometimes, care workers were in a rush, and a fifth that care workers were only sometimes or even less often on time, with 5% never knowing when the care worker was going to arrive."

CSCI inspection findings: The responses collected by CSCI in the course of its regulatory inspections are, overall, even more positive than the last national survey. Of the 963 in our sample people who answered a question about satisfaction, all but 15 reported that they were pleased with the service. The comments below give a flavour of some of the positive feedback.

"The care we receive is of the highest quality and we are delighted that such a service exists. The carer's input, during her weekly visit, is of great help as she is always cheerful and converses with me, despite my deafness, etc. The office regularly contacts us with information and we are confident of their continued help." [1]

"Both my carers are friends and I look forward to their visits. They are like part of the family. Their visits are like a lifeline to me." [1]

On the other hand, as reported later in this chapter, the same group of respondents gave more equivocal answers to specific questions, such as those relating to care workers' punctuality, reliability, and staying the right length of time.

The 2004-05 'Living Well' review: Many of those interviewed for this review were immensely appreciative, rating highly the quality of the work undertaken. Indeed, in one area the review team noted that in nearly every sector (voluntary, statutory, health, social services) some people spoke very appreciatively of those who provided a service, but it was home care workers who were mentioned most often.

However, criticisms were far more frequent than praise – most often of timing, competence, consistency and getting access to information and services. Frequently the blame was put on the system, rather than the individual: too much paperwork; not enough staff; no slack to cover illness. There were many comments though from those who, in all sectors, spoke of impersonal treatment, a brusque approach and lack of sensitivity. So the remainder of this chapter covers the shortfalls as well as the strengths of home care.

3.4 Aspects of people's experience of home care

3.4.1 The importance of home care in people's lives

What emerges first from this study – and reinforced to us by those attending the expert seminars – is the sheer importance attached by people to their home care services.

"I would be lost without them." [LW]

"Home care support is a key service." [S]

The older people attending our expert seminar linked this to the need to safeguard those they regarded as most vulnerable, including people with dementia and frail older people living alone. (Their frequent references to high profile cases where people had been seriously neglected, abused, or died alone, suggested some degree of fearfulness for themselves and for those in their communities).⁶¹ The seminar group of older people was, therefore, much more preoccupied than the other seminars with security issues (like the vetting of staff) and they also asked for more thorough inspections. What is clear is that for many people, home care is an essential service rather than an optional one.

3.4.2 Getting access to services

A succession of reports by CSCI and its predecessors have drawn attention to the problems people experience in finding out about their entitlements, and about the services available.⁶² This was again a recurrent theme during the 2004-05 *Living Well* review and during other work undertaken for this report.

On the one hand, the review team noted examples of where the system had worked well. For example, they heard praise of social workers and housing scheme workers, and recorded instances where general practitioners had given helpful advice. They were given at least two accounts of what could be described as a 'textbook' response:

61 The voluntary organisation, 'Action on Elder Abuse' has reported that 67% of calls received by its helpline concern incidents in people's own homes. This compares with 22% relating to nursing homes and residential care settings. See House of Commons Health Select Committee (2004).

62 For example, see SSI (2004), CSCI (2005a) and CSCI (2006e).

The voluntary and private agencies were associated with the provision of help, even though it may well be funded by the council.

The following case study illustrates how people from different communities may have particular difficulties understanding what 'social care' means and how the system works.



CASE STUDY 1

In a group discussion with people from the Yemeni community, the facilitator asked whether people wanted or got help with daily living. Immediately it became apparent that there was little understanding of what 'help with daily living' might mean. People replied that it was more straightforward to understand 'health'. 'You have a headache, you go to the GP, and you get medication.' Someone thought the facilitator was asking rather about what they could do to help each other and replied: 'Why don't you tell us what sort of services you can provide?' Another person added: 'We need services just like the rest of the community, perhaps help with walking.'

Overall, the processes adopted by social services to assess need and determine eligibility were regarded as frustrating and – at worst – alarming.

"It's silly. They said, 'Can you wash and dress?' and I said 'Yes'. They said, 'Oh, you don't qualify for help'. But I don't want someone to help me wash and dress – I want someone to help me with housework. I don't like to depend on my family." [LW]

"I'm terrified of social services – they want to know too much – I struggle on – it's just the fear of not being well..." [Carer, LW].

The user representatives who attended the expert seminar were also preoccupied with this issue, advising us that having an assessment could feel like having to pass a test:

"The targeting system is introducing a league table attitude and is undermining the quality of care." [S]

3.4.3 Timing and reliability of services

People's concerns about the reliability of services, often linked to the punctuality of workers and the timing of their visits, feature in much of the literature on this subject. Francis and Netten (2003) list 'reliability' as one of the three aspects of quality that were most often mentioned by people in their study – 'staff attitudes' and 'flexibility' being the others.⁶⁴

In the *Living Well* review, timing – and time-keeping – were recurrent themes, often with recognition that care workers were asked to fit in more than was possible, and with insufficient time allowed for travel. These problems could be more acute in rural areas where travel between people's homes inevitably took longer.

"The carers are very good but the managers change the times that the carers are due to call without telling us." [LW]

"The main problem was always that they didn't have time to get from one person to the next, so 30 minute visits often became 20. I only wanted help with washing Mum." [LW]

"Sometimes I wait until 8pm for someone to come... They should come at five or six – they don't ring me to say what's happened..." [LW]

The irregularity of the visits, coupled with poor communication about what to expect, was one of the factors that gave some people a sense of loss of control. Shortages of staff, and very tight schedules, often meant that the time allotted for certain tasks seemed too short, or that people had little choice about when they were visited. In several of the group discussions during the review, there were also stories of people suffering when care workers had not turned up; for example, one person described having to wait all morning to have a drink, and another could not dress properly because only 15 minutes was allowed for her morning routine. Carers worried that their relatives were not taking their medication at the required intervals.

"We are individuals, and some people need more time." [LW]

"I have a carer morning and night – but when she's off sick you get five or six strangers and get put to bed at 5.45pm." [LW]

"It's abuse when home carers don't turn up." [LW]

The large amount of criticism recorded about these issues does not negate the widespread appreciation expressed towards home care services. However, the survey evidence seems to confirm that there is considerable cause for concern that services are overstretched, and that this is impacting on the time available for individuals and on the quality of service they receive. In our sample of inspections, the responses are very similar to those recorded by Netten et al (2004). For example:

- Only 60% of older people in our sample stated that their care workers arrived punctually, with another 24% saying their care workers 'usually' did so.
- 78% of people said their care workers never failed to turn up, leaving a fifth saying their care workers sometimes failed to turn up.
- Most people (84%) said their care workers stayed the length of time intended, but a substantial number said this only happened 'sometimes'.

3.4.4 The impact of charging policies

In spite of the issuing of Government guidance, there is evidence that councils' charging regimes impact unevenly across the country.⁶⁵ In our expert seminar, it was the issue of fairness that people most wanted to discuss, with some arguing that there should be a uniform charge across the country (or that social care should be free to everyone). Others argued that this would be impractical.

People felt there may be a generational divide, so that the current older generation do not seek or accept help if they believe they cannot afford it. It was widely agreed that the next generation might have a different attitude, as well as higher levels of disposable income.

Both the seminar and the *Living Well* review produced some evidence that charging regimes were deterring people from using services, plus limited evidence of informal arrangements, whereby people pay others small amounts of cash, in return for help with certain tasks. As discussed in Chapter 2, little is known about the nature and extent of this aspect of the economy.

“When they put up the charges at the local lunch club my brother-in-law couldn't afford to go out. All social life stopped.” [S]

“No home care. I couldn't afford them. My friend has just paid £2?? for home care for a month. It's nearly £9 an hour. I've got a neighbour who I pay to help with the cleaning.” [LW]

“I think the Government ought to pay.” [LW]

A conclusion might be that, even with the take-up of direct payments being low,⁶⁶ people are clearly giving a lot of consideration to where their money is going and what constitutes 'value for money'. They also appear to have higher expectations when they are paying for themselves.

“They say they are not allowed to do this or that – well what are they allowed to do? I'm paying for it after all!” [LW]

“Sometimes you end up paying more than you would a private cleaner. When you're ill, if the house is dirty, it's a worry. You want someone to do what you need.” [LW]

“Social services can't cope, they are so short-staffed. They pay a pittance – £5 an hour, but charge us £9. Until there is a proper salary...” [LW]

3.4.5 Staff attitudes and communication

'Staff attitudes' were the second factor identified by Francis and Netten in 2003

65 See Kings Fund (2006)

66 See Table 10 in the Appendix, and paragraph 6.2 in Chapter 6.

as being important to people. In the more recent major PSSRU study, positive and negative care worker characteristics were found to correlate very closely with overall satisfaction. It is therefore unsurprising that in CSCI's engagements with people about home care, and in the formal complaints we receive, the calibre of staff is one of the issues most often raised.

The interviews, discussions and expert seminars elicited sometimes effusive praise both for individual workers and for care workers generally.

"Always on time, always smiling, always friendly. Just helpful." [SV]

"They'll do almost anything for you." [SV]

"Care assistants are very special people and we need to value them." [S]

Staff attitudes – including overall willingness to help, as well as respect – were mentioned as frequently as their actual competence. When asked about the qualities of a good care worker, one very satisfied older person expressed it as follows:

"A bit of respect for my home and be on time. A bit of respect for me personally...They've really got to listen...and they've got to be able to have a joke!" [SV]

The *Living Well* review found some concerns about communication problems between people and their care workers, sometimes linked to language difficulties and/or cultural differences. For example the review team talked to women and men from a Somali community, who thought it would be important to recruit more people from "our own culture and religion". Another person had contact with a couple of older Greek speakers – and said that in her area there were no suitable interpreting services so there were problems in providing services. With 170 languages spoken in this borough, resources did not match diversity. There were other examples of language difficulties apparently being overcome:

included 206 of the staffing issues.

There was a very similar pattern in the previous year, when a total of 1,529 complaints issues were received, 32.4% of which concerned staffing issues. 624 (41%) were upheld in that year including 216 of those concerned with staff.

3.4.6 Staff competence and training

“The only thing is, I get annoyed if they send someone who hasn't got a clue – but that doesn't happen often.” [LW]

This statement typifies many concerns about the quality of staff providing services, and what people described as a lack of training. Such criticisms of staff are often accompanied both by recognition of the high level of skill sometimes required, and by sympathy with those staff who are out of their depth.

“My husband isn't the man I knew. He can refuse help but this carer is trained to know what to do and how to persuade him to do things like take a bath.” [LW]

“One girl in the (agency) I have used was just given a jacket and a list. She was nearly in tears. She said she was sorry but she didn't know what to do. I sat her down on the settee and told her and went through the list.” [LW]

Even so, frustrations associated with having to explain things to care workers, often exacerbated by very high turnover and constant changes of staff, were mentioned by many interviewed for this study. The strain of having to 'train' new staff was perhaps the most important reason why people valued continuity – and the chance to build a relationship with the same care worker (or small group of care workers) over time.

“I had five different carers in 10 days. I have to explain things in detail. One brought me cold water to wash all over. I had to say there are two taps...” [LW]

“There should be a central point for carers training. We have to learn to lift and to care for our relatives because we don't have any other choice. I had to teach the carers how to use a hoist and how to lift a person... This problem needs urgent attention.” [LW]

“The good thing now is most agencies are requiring NVQs.” [LW]

3.5 Conclusions

3.5.1 Listening to people

One conclusion from this chapter is that it can be quite hard to gauge what older people are experiencing, either at an individual level or across whole services. High satisfaction levels – especially when measured through simplistic questionnaires – may mask people's reluctance to complain, perhaps due to a fear of being penalised or losing the service altogether.⁶⁹ People's answers also vary according to the way a question is phrased, who is with them when they reply, what they perceive is wanted from the question and what they want to convey. Due to these and other factors, the evidence from surveys can be hard to interpret. The conclusion here is that alongside apparently high levels of satisfaction with home care in England there is a considerable amount of dissatisfaction.

Patmore (2002) suggests that focusing on specific measures may miss key aspects of home care delivery:

“Broad, open-ended questions need to be at the heart of instruments and procedures for discovering older people's values and preferences. This is essential to reach concerns which an interviewer has not conceived of.”⁷⁰

There may be implications here not only for regulators, but also for those monitoring contracts and for service providers who are responsible for assuring the quality of their services.

3.5.2 Who is in control?

In spite of the reservations expressed about the capacity of some care workers, the older people representatives who attended our seminar were very positive about the contribution they could make. A good relationship between the older person and their care worker appears to be one of the keys to success, suggesting that the 'matching' of older people to workers should be given careful thought and consideration. Those attending the seminar thought that, once a relationship was established, there could be negotiation (and, perhaps, frequent re-negotiation) about the tasks to be undertaken. This could take the form of a regular dialogue rather than a formal 'care planning' process. This might require greater delegation to the care worker.

“It's the bond that develops between the care worker and the user that makes it all work.” [S]

Above all, however, it seems to require more control being given to older people themselves. The evidence in this chapter suggests that the existing service culture gives the 'purchasing power' to the council rather than to the person receiving the service, even where they may be paying all or part of the cost of their care.

69 Of 684 complaints received by CSCI in 2005-06, only 18% were directly from the service user. 42% were from relatives or carers, and the remainder from a variety of other sources. See Table 29 in the Appendix.

70 Patmore (2002).

"The council is the customer, rather than the user." [S]

The potential for more budgets to be transferred to older people for them to spend themselves is discussed elsewhere in this report, but the evidence here suggests that these systems changes will need to be underpinned by attitudinal change, both towards older people and towards those providing their care. As one of the older people who attended our seminar concluded:

"It's my home so respect my needs and my standards and my expectations!" [S]

4 The quality of registered domiciliary care services



The aim of this chapter is to present an overview of the current performance of registered domiciliary care agencies, highlighting particular strengths and areas for future development. The chapter draws its evidence from the statutory inspections carried out in 2005-06.

Key findings

- On average, 74% of agencies complied with each of the national minimum standards in 2005-06. Levels of compliance differed between standards, the range being from 52% to 94%. This overall performance is comparable to the residential care sector (where the equivalent figure is 76%).
- There is considerable and unexplained variation between local authority areas. CSCI is discussing its concerns with councils, especially where the overall quality appears low.
- There is good performance against some of the important standards relating to 'personal care'. For examples, CSCI inspectors report that people's privacy and dignity is respected, and they are able to express their individual wishes. Both of these standards appear related to the perceived sensitive and caring attitudes of staff.
- There is relatively poor performance in the 'managers and staff' domain. Too many organisations fail to achieve satisfactory standards in relation to supervision, support and training for staff. Nearly 39% are not conforming with basic requirements for the selection and recruitment of staff.
- There are significant concerns in relation to medication practice, with a need to improve both procedures and training.
- 188 statutory enforcement notices were issued to domiciliary care agencies in 2005-06, and overall there was good compliance once problems had been highlighted. However, there was one urgent cancellation of an agency's registration where this was not the case.
- When the national minimum standards for home care are reviewed by the Department of Health, revisions will be needed to reflect changing priorities and expectations. In particular the standards over-emphasise plans and record-keeping, and under-emphasise the importance of promoting independence and of listening and responding to people's changing needs and aspirations.

4.1. Introduction

4.1.1 Regulating Domiciliary Care Agencies

Care in people's homes is by its nature private; there are rarely other people around to see what takes place. Regulation was introduced to domiciliary care in 2003 in recognition of the importance of this activity in people's lives. The purpose is both to ensure compliance with a set of national minimum standards (NMS) and to encourage improvement across the sector.

In this chapter we look at the information that is available from inspections in 2005-06, which was the first full year of inspections. It is not possible at this stage to report on trends, and nor are there obvious benchmarks with which to compare performance. However, it is worth noting that in residential care (which has been regulated since 1948) only around 76% of agencies on average meet each national minimum standard; this led CSCI to expect that there would not be full compliance across the domiciliary care sector in the early stages. It is also relevant that, as described throughout this report, this is a less well-established sector, where providers are typically small and often have limited infrastructure and under-developed management systems. The findings reported in this chapter need to be viewed in this context.

Reflections on the National Minimum Standards

The framework for each inspection is set out in the Care Standards Act (2000) and associated regulations. Where there is a breach of the regulations, CSCI has powers to take enforcement action. In 2002, the Government also devised NMS for domiciliary care agencies, and these must be taken into account during inspections.⁷¹ So, as explained below, every inspection involves an assessment of the agency's performance against some or all of the NMS (see Figure 5 below).

Our early experience of inspecting against the NMS has given us (as well all our stakeholders) many opportunities to reflect on whether the standards do provide a good framework, and how they could be improved. The Department of Health has announced its intention to review them, and to start implementing changes in 2007-08. This review will take account of what has been learnt so far.

The NMS all deal with important aspects of management and care practice, and give a good indication of the characteristics of well-run domiciliary care organisations. However, because they tend to deal with the procedures to be followed, rather than with the outcomes achieved for people, they can lead to a preoccupation with paperwork. Furthermore, the standards give equal emphasis to all the documentation, whereas in practice there are some instances where it is essential to record an incident or transaction, and other instances where this is less useful.

(For example, 'care plans' may be a helpful way of recording what the service is aiming to achieve, but they become unhelpful when they are

⁷¹ Department of Health (2002b): Domiciliary Care National Minimum Standards Regulations.

overly prescriptive and detailed, or try to record all the minutiae of a person's daily routine). All the evidence – including the evidence in the previous chapter of this report – suggests that a responsive and sensitive care service depends on building a good relationship between the care worker and the person receiving the service, rather than just relying on a detailed record. CSCI believes it will be important to reflect this in any new version of the NMS.

Our inspectors are required during every inspection to engage with the people using the service and to concentrate on what is important to them. (The staff representatives who attended our seminar were very preoccupied with how to do this well, and the user representative organisations also thought this was a very important issue for the whole domiciliary care sector). However, the imperative to assess performance against each of the NMS can distort the priorities and the focus of inspections and reports.

Pending the Department of Health's review of the NMS, we have therefore decided to introduce a new way of reporting our findings so we are more directly addressing the outcomes being achieved for people as opposed to the standards themselves. (Our proposals are explained in paragraph 7.2.2, Chapter 7). In doing so, we are proposing to give particular weight to the following three areas:

- Improved health and well-being
- Personal dignity and respect
- Leadership and management

The importance we attach to these three areas is very much based upon the feedback we have received from people who use services, including that summarised in the previous chapter.

people who use services (TJ4T/T18992(s)11(e)22(r)-35(vi)11(c)11(

Figure 5: The National Minimum Standards(NMS) for Domiciliary Care Agencies

User focused services

1. Users have comprehensive information so that they can make an informed choice as to whether the agency can meet their needs.
2. The care needs of individual service users, and of family members where appropriate, are assessed before a service is offered.
3. Users know that the agency has the skills and competence required.
4. Each individual user has a written individual contract.
5. Confidentiality is maintained.
6. Users receive a responsive, flexible, consistent and reliable service.

Personal care

7. The needs, wishes, preferences and personal goals for each user are recorded in a personal service user plan.
8. Users feel that they are treated with respect and valued, and their privacy is upheld.
9. Users are helped to make their own decisions, control their own lives and are supported in maintaining independence.
10. There are safe procedures for medication, with users keeping control where possible.

Protection

11. There are safe working practices, protecting users and staff.
12. The risk of accidents and harm for users and staff is minimised.
13. Users' money and property are protected.
14. Users are protected from abuse, neglect and self-harm.
15. The security of users' homes is maintained.
16. Records are kept in the users' homes to safeguard their rights and best interests.

Managers and staff

17. There are rigorous recruitment and selection procedures.
18. Staff are clear as to their roles and responsibilities.
19. Staff are appropriately trained.
20. Personal care is provided by qualified and competent staff.
21. Staff are supervised and appraised.

Organisation and running of the business

22. The business operates from permanent premises and there is a management structure in place to support effective service delivery.
23. There are sound financial procedures and records.
24. There are accurate and up-to-date records.
25. There are robust policies and procedures that are implemented and monitored.
26. There is an accessible, easily understood complaints procedure.
27. A quality assurance system is in place, to set and monitor standards.

Background

In the first two years of the new regulatory arrangements, all agencies were required to register with CSCI, and initial inspections were carried out. (In some cases where the registration requirements were not fully met, registration was made conditional on the outcome of the first inspection). By March 2005, 4,120 agencies had registered with CSCI and had their registration confirmed.

In 2005-06 the process of maintaining the register continued, and by the end of the year the number of registered agencies had increased to 4,622. These were of the following types:

Table 1: Number of registered agencies at 31 March 2006, by type

Agency type	Number	Percentage
Council:	789	17%
Private:	3285	71%
Voluntary:	402	9%
NHS	43	1%
Other	103	2%
TOTAL	4,622	100%

A full programme of inspections was carried out, comprising an announced inspection of every agency and unannounced follow-up inspections in some cases. There were 6,133 inspections altogether. This chapter summarises the findings for every inspected agency in 2005-06; where an agency was inspected more than once, we have used the data from its last inspection in that year.

Methodology for regulatory inspections

CSCI's inspections of domiciliary care agencies use a range of types of evidence. These include:

- The views of a range of stakeholders including people using the service (see Chapter 3);
- The agency's self-assessment;
- Documentation and records held about the service; and
- Case tracking (usually of 3-6 individual cases per agency) and observation of care workers at work.

Each inspection (including the planning, fieldwork and reporting) takes one inspector three days.

Making judgements

CSCI inspectors make judgements about the performance of an organisation against each inspected standard, scoring performance from 1 to 4:

1. Standard not met (major shortfalls)
2. Standard almost met (minor shortfalls)
3. Standard met (no shortfalls)
4. Standard exceeded (commendable)

In any one period CSCI declares that it will give special attention to particular “key” standards, and some inspections only cover the selected few. Table 28 in the Appendix shows how many times each standard was inspected in 2005-06; the following were adopted as key standards and were therefore inspected more often than the others: 2, 8, 10, 11, 12, 14, 17, 19, 21, 22, and 26.

4.2 Overall performance against the national minimum standards

Table 28 in the Appendix gives the percentage of agencies achieving each of the standards, and also shows how many were inspected against each one. This overall performance is also illustrated in Figure 6 (below). On average, each of the 27 standards is met or exceeded by 74% of agencies. (For the group of 11 key standards the average performance drops to 71%).

There is some variation between types of agency. For the second year running, CSCI found that voluntary sector agencies were performing rather better on average than the other types (see Table 2, below – which covers the key standards only). However, this must be seen in the context of the differences in the numbers of agencies of each type; for example, there are around eight times more private agencies than voluntary sector agencies in this sector (see Table 1, above).

Table 2: Average percentage of agencies meeting or exceeding the key standards – by type of provider

Agency type	Percentage
Council:	71.7
Private:	69.7
Voluntary:	76.6
NHS	80.4
Other	76.5
TOTAL	70.9%

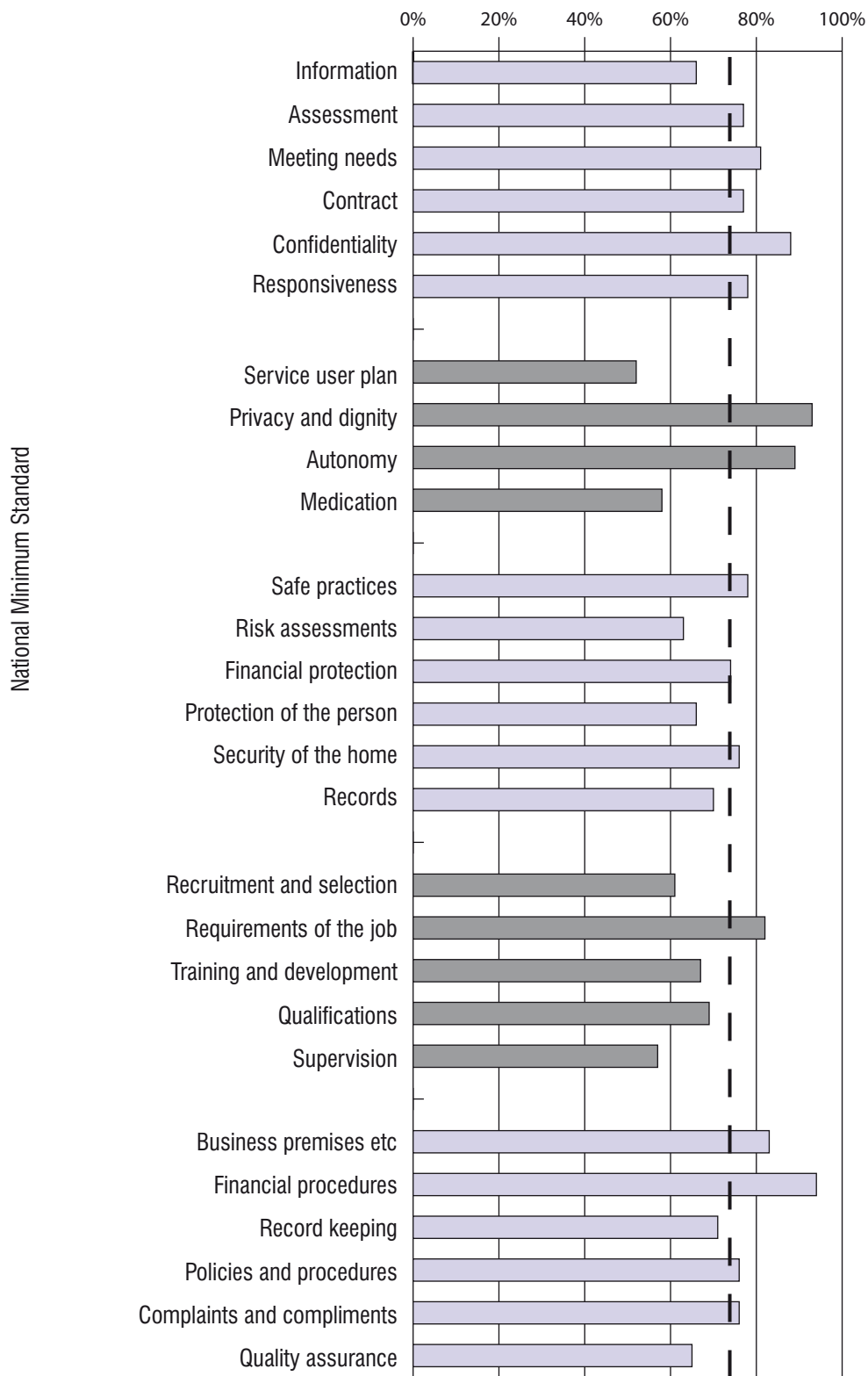
Overall, there are particularly high levels of compliance with the following standards:

- Standard 23 – “There are sound financial procedures and records” (94%);
- Standard 8 – “Users feel they are treated with respect and valued, and their privacy is upheld.” (93%);
- Standard 9 – “Users are helped to make their own decisions, control their own lives and are supported in maintaining independence” (89%);
- Standard 5 – “Confidentiality is maintained” (88%); and
- Standard 22 – “The business operates from permanent premises and there is a management structure in place to support effective service delivery” (83%).

The standards where compliance is lowest are:

- Standard 7 – “The needs, wishes, preferences and personal goals for each user are recorded in a personal service user plan” (52%);
- Standard 21 – “Staff are supervised and appraised” (57%);
- Standard 10 – “There are safe procedures for medication, with users keeping control where possible” (58%);
- Standard 17 – “There are rigorous recruitment and selection procedures” (61%); and
- Standard 12 – “The risk of accidents for users and staff is minimised” (63%).

Figure 6: Performance of domiciliary care agencies 2005-06



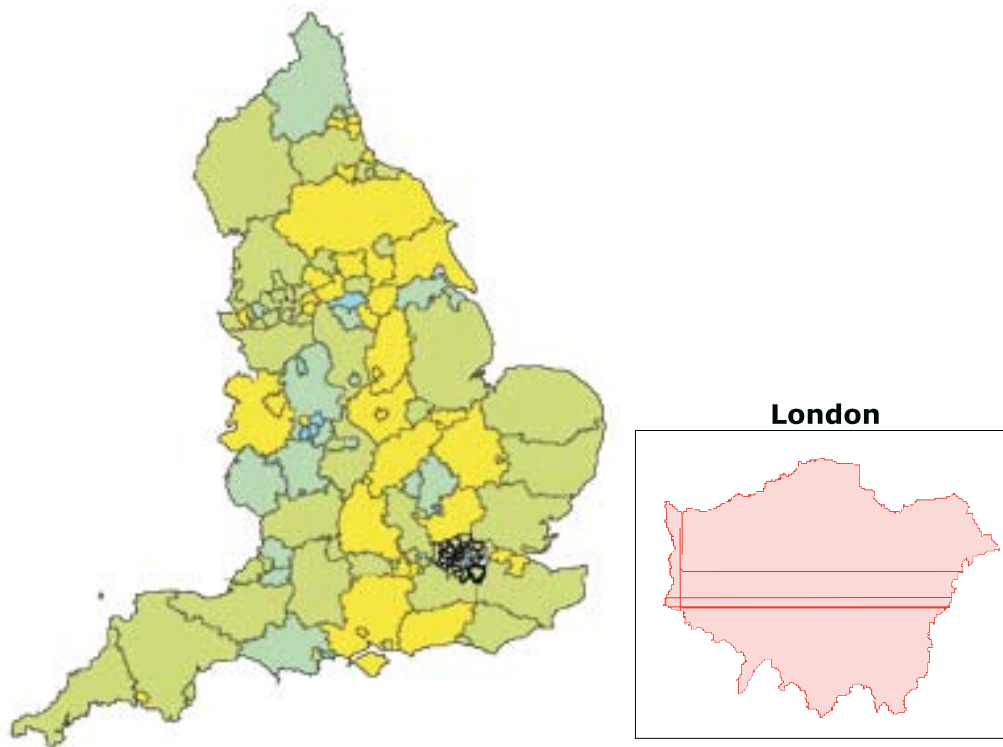
Percentage of agencies meeting the standard, 2005-06

4.3 Variation between councils

There is considerable unexplained variation between councils.

Figure 7 (below) uses a slightly different kind of analysis to illustrate this; it aggregates the average number of the 11 key standards met or exceeded by agencies within each council area. Across England there are 4 councils where on average domiciliary care agencies meet fewer than 5 of the key standards. In 47 councils, agencies within their boundaries meet on average 9 or more.

Figure 7: Average number of key standards met by domiciliary care agencies in English councils



4.4 Analysis of performance – by standard

4.4.1 Introduction

The purpose of this section is to illuminate some of the factors that underlie the

'headline' story of performance set out above, and where possible to explore the impact for people using services.

The qualitative information in this section comes from analysis of a sample of 137 reports, from inspections carried out in the last six months of 2005-06. The sample was weighted to provide a cross section of (a) owner types, (b) council types, as shown in Table 3. There were also some agencies from each of CSCI's nine regions.

Table 3: Details of the sample of inspection reports used for the analysis in this chapter

LA Type	Private	Local Authority	NHS	Other	Voluntary	Grand Total
Inner London	19	4		1	3	27
Met Districts	21	5		1	2	29
Outer London	14	5			10	29
Shire Council	17	2	1	1	3	24
Unitary Authority	18	5			5	28
Grand Total	89	21	1	3	23	137

The representativeness of the sample was checked by comparing the overall performance for the sample with the national averages; we found broad similarities between the sample and the rest. (For example, whereas agencies across the country met 74% of all standards, the equivalent figure for our sample was 75%; five of the 'top six' and five of the 'bottom six' standards in our sample are the same as for the national picture).

The evidence behind each standard was sorted and then analysed.

A separate analysis was also undertaken of the 'requirements' section of each report, where the inspector records the actions that must be taken to correct shortfalls (see paragraph 4.5 and Table 31 in the Appendix). The findings were compared with the written account of our staff seminar, as a way of checking whether our analysis captured the issues raised by our inspectors and managers in regions. Finally, the conclusions were also triangulated with evidence from complaints received by CSCI over the last two years (see Tables 30a and 30b in the Appendix).

4.4.2 User focused services

This section deals with standards 1–6. These are concerned with: the quality of the information available to people, and whether this allows them to make an informed

choice; whether an assessment is undertaken before a service is provided; whether staff are reliable, flexible and maintain confidentiality.

Standard 1: Information

The national minimum standards include detailed guidance on what should be contained in a *statement of purpose* and *service user’s guide*. The purpose is to allow older people and their relatives access to information that makes it clear what they can expect from the service and what they will have to pay. (This is important to allow people to make an informed choice between potential providers). The guide should also contain essential details such as how to contact the agency if there is a problem, and how to complain.

66% of agencies achieved this standard

Our sample suggests that some agencies did not have the necessary documentation in place when they were first registered. By the second inspection, most agencies had rectified this – but the quality is sometimes uncertain. In particular the documents are often not sufficiently comprehensive, clear or accessible.

	Good practice		Areas for development
↗	Well-presented and accessible user guides.	↘	Ensuring people actually get the information
↗	Clear information about what kind of support can be offered and how this will be provided	↘	Presenting the information simply and in plain English
↗	Information about how to complain, and contact details for local advocacy services.	↘	Ensuring translation and interpretation services for people whose first language is not English
		↘	Providing details about the charges for services.

Standard 2: Care needs assessment

This standard looks at whether people using the service have a needs assessment prior to the commencement of the service. The assessment may be undertaken by the local authority or (in the case of self-funders) by a competent manager within the agency itself.

77% of agencies achieved this standard in 2005-06

Assessments are usually carried out, but it is not always evident that people are properly re-assessed when their needs or circumstances change. Where the statutory referral agency holds the budget for the service, it is imperative that they remain in touch and respond to the triggers that suggest a re-assessment

is needed. (This issue, and associated problems for people using services and the agencies providing their care are discussed further in paragraph 5.3 in Chapter 5).

	Good practice		Areas for development
↗	At least one visit carried out prior to the service starting, so the individual can decide whether they want to use the agency and the agency can be sure it has the capacity to provide a service.	↘	Better communication between social care professionals and domiciliary care agencies
↗	People participating fully in the process for planning their care.	↘	Documentation that encourages the recording of what is important to the person receiving the service, including the outcomes to be achieved
↗	Effective referral processes involving collaborative working between health and social services professionals.	↘	More frequent and more robust reviews and re-assessments when the individual's needs change – for example, after a stay in hospital.

Standard 3: Meeting needs

This standard examines the extent to which the organisation has the capacity to meet the needs, including any special needs, of individuals to whom services are provided.

81% of organisations achieved this standard in 2005-06

This standard was not one selected for particular focus in this round of inspections. (Our sample of reports suggests that this standard should perhaps be clarified or expressed differently in future, as inspectors seem unsure about which of their findings are most relevant here.)

Standard 4: Contract

The standard requires that a satisfactory written contract be in place within seven days of a service starting. The wording of the standard appears to apply exclusively to those funding their own care. (However, CSCI regards it as good practice for all people to receive a copy of their contract, regardless of the source of funding).

77% of agencies achieved this standard in 2005-06

Contracts are usually drawn up, but there is variable practice in ensuring these are accessible and transparent, and sharing them with the person receiving the service so they can exercise their rights.

Standard 5: Confidentiality

The desired outcome is that people will feel confident that their personal information is handled appropriately and that their personal confidences are respected.

88% of agencies achieved this standard in 2005-06

There is good overall compliance with this standard, with far more positive practice than areas for concern.

Standard 6: Responsive services

This standard is concerned with whether people receive a flexible, consistent and reliable care service.

78% of organisations achieved this standard in 2005-06

Three areas for concern are highlighted in inspection reports, often linked together:

- reliability: staff turning up regularly; being on time; staying the correct time;
- flexibility: staff being prepared to do additional jobs when required;
- consistency: users knowing staff and feeling comfortable with them.

These are also recurrent themes in consultations with people who use home care services (see Chapter 3).

	Good practice		Areas for development
↗	Rapid arrangements for setting up a service	↘	Frequent changes of care worker, so people have to keep explaining their requirements to a new person.
↗	Sound planning, with packages tailored to individuals' needs and requirements.	↘	Inadequate out of hours contact systems
		↘	Inadequate time allowed for travel, putting pressure on time slots
		↘	Agencies changing the times of visits without consultation with the person using the service
		↘	Visits being missed, with no explanation given

4.4.3 Personal care

This section covers standards 7–10, and is concerned with whether people have a satisfactory care plan; whether they feel they are treated with respect and have their privacy upheld; whether they are supported to be independent and to have control; and whether there are robust policies and procedures in relation to medication.

Standard 7: Service user plan

The desired outcome is that the care needs, wishes, preferences and personal goals for each individual service user are recorded in their personal service user plan.

52% of agencies achieved this standard in 2005-06

Our inspection reports suggest that care plans often do not give care workers the kind of information they need about the individual's situation, their aspirations and goals, and their personal requirements. There are also problems associated with care plans actually being available in the person's home, and read and adhered to by new care workers.

The poor compliance with this standard is of concern, but it is not CSCI's intention that agencies should seek to rectify this by producing more detailed plans that set out instructions for care workers in minute detail. There is no particular evidence that this kind of documentation actually improves the quality of the service or is welcomed by people using the service. Agencies are advised to concentrate instead on ensuring that care workers listen and develop a relationship with the older person, as this is the best way of ensuring a sensitive and responsive service.

Standard 8: Privacy and dignity

The desired outcome is that older people feel they are treated with respect and valued as people, and that their right to privacy is upheld.

93% of agencies achieved this standard in 2005-06

This is one of the most important standards and it is therefore very positive that performance is so high. Inspectors usually interpret this standard as being concerned with staff attitudes and with user satisfaction. Overwhelmingly older people tend to speak well of their individual workers and do consider they are treated with respect. Where there are reservations, these concern the occasional employment of staff who are too inexperienced to cope, or whose attitudes are not considered satisfactory.

Standard 9: Autonomy and independence

The desired outcome is that people are assisted to make their own decisions and control their own lives, and are supported in maintaining their independence.

89% of agencies achieved this standard in 2005-06

Staff use this standard to record their findings about whether care workers listen to the person receiving the service, and allow them to direct the work that is

done as far as possible. The overall picture is one where staff are perceived by inspectors – and described by older people and their carers – as ready to listen and respond.

However, a detailed reading of the inspection reports suggests that most agencies focus on maintaining people’s current levels of independence, rather than helping them to regain their strength or confidence. As described in Chapter 6 of this report, some of the most innovative work in this sector has been concerned with how to promote reablement; this usually involves spending much more time with people in the early stages after an illness or accident, to explore their motivation and goals and to see whether their earlier independence can be restored. At present, only a minority of councils are using this approach on a wide scale; the tradition of most ‘mainstream’ home care is that care workers do things for people instead of helping them do things for themselves.

	Good practice		Area for development
↗	Care workers trained to respect individuals’ wishes.	↘	Insufficient attention being paid to the potential to promote or increase the individual’s independence.

Standard 10: Medication and health related activities

This standard is concerned with whether the agency’s policies and procedures protect people and assist them to maintain responsibility for their own medication and to remain in their own home – even if they are unable to administer their medication themselves.

58% of agencies achieved this standard in 2005-06

Many people do rely on domiciliary care workers either to give them their medicines, or to ensure they are taking them at the appointed times. The relatively poor performance against this standard relates to inadequate written policies, levels of staff training, and record-keeping. The concerns in this sector are very similar to those in residential care, reported by CSCI in February 2006,⁷² with the additional problem that it is even more difficult to monitor practice when care workers are working alone in dispersed settings. (Because of its concerns in this area, CSCI has issued professional advice to inspectors that is also available on the CSCI internet site, and provides support through its team of pharmacists based in each Region).⁷³

72 See CSCI (2006a).
73 CSCI (2006b).

	Good practice		Areas for development
↗	Good liaison with primary care trusts in relation to risk assessment and monitoring	↘	Robust policies and procedures being in place.
		↘	Staff training in the handling of medication
		↘	Monitoring sheets being filled in.

4.4.4 Protection

This section covers standards 11–16. It is concerned with the safety of usual working practices; the management of risk both to people using services and to care workers; arrangements to safeguard people from financial and other kinds of abuse and self-harm; and the keeping of accurate records.

Standard 11: Safe work practices

This standard is concerned with whether the health, safety and welfare of older people and care staff are promoted and protected.

78% of agencies achieved this standard in 2005-06

Inspection reports stress the importance of compliance with health and safety legislation. Shortcomings usually relate to the need to have suitable policies and procedures in place. There are also some issues about the safety of care workers themselves, especially when working alone late at night in remote areas; it is good practice for employers to issue mobile phones or personal alarms in these circumstances.

Standard 12: Risk assessments

Potential risks to older people and to their care workers are to be assessed and updated annually.

63% of agencies achieved this standard in 2005-06

Inspectors' concerns are often related not to high-level policies, but to the completion of robust risk assessments in individual cases. Risk assessments for individuals are sometimes not kept updated when people's needs change, and not recorded in a way that would allow care workers to adapt their practices (such as the use of hoists or other lifting techniques) to the individual's situation, taking the person's own preferences into account. However, there were no examples in the sample of reports where individuals had come to harm as a result of these issues.

Standard 13: Financial protection

The aim is for the money and property of older people to be protected.

74% of agencies achieved this standard in 2005-06

Where there are shortfalls, these usually relate to lapses in recording; for example, staff may carry out a financial transaction on the person’s behalf but not record this. This is a potentially serious issue, but the reports in the sample contain no instances where systems to protect people’s money and property have actually failed.

Standard 14: Protection of the person

This standard is about people being protected from harm. The agency is to have robust procedures in place for responding to suspicion of abuse. This is an area where good inter-agency working is very important; protocols are required to be in place in all areas, with the local authority expected to play a co-ordinating role.

66% of agencies achieved this standard in 2005-06.

Most agencies are judged to have satisfactory procedures in place. Those that fall short seem to have failed to understand locally agreed procedures, to have developed policies or to have trained staff.

	Good practice		Areas for development
↗	Agreements in place in relation to the Protection of Vulnerable Adults (POVA)	↘	Training for staff, especially in POVA arrangements, so they know where to report suspected or alleged cases of abuse.
		↘	Whistle-blowing procedures, made accessible to all staff.

Standard 15: Security of the home

This standard refers to people’s homes being kept secure when workers are providing care. It requires protocols for: going into the house; holding keys; confidentiality of entry codes; and discovery of an accident.

76% of agencies achieved this standard in 2005-06

Several reports note good systems for identity cards and sound protocols: others record inadequacies in both areas.

Standard 16: Records kept in the home

People should have access to records about the service they are receiving, and these should be kept in their homes.

69% of agencies achieved this standard in 2005-06

Records are usually available in people's homes. The weaknesses are in ensuring these are used and kept up to date. Inspectors also highlight the need for these to be periodically checked by managers.

4.4.5 Managers and staff

This section covers standards 17–21. The standards relate to rigorous recruitment procedures; clear expectations of staff; and training, development and supervision of staff.

Standard 17: Recruitment and selection

This standard is concerned with compliance with relevant legislation, including the need for all care workers in registered agencies to have an enhanced Criminal Records Bureau (CRB) check before being employed. The guidance also stresses the importance of references and medical checks.

61% of agencies achieved this standard in 2005-06

This is a key topic. There has been substantial evidence in all fields of social care that often selection practices have been poor. If this has been the case in residential care – where regulation has been in place for far longer than in domiciliary care – perhaps it is not surprising to find this proportion of agencies failing to reach minimum standards. Nevertheless it is very concerning.

It is a statutory requirement to carry out checks – including Criminal Records Bureau (CRB) checks – on all staff before they are employed. Our inspections too frequently found that managers were cutting corners. There was evidence of the full range of checks either not being carried out or not being well documented: a typical observation from the inspections reports is: *“not possible to identify that full and satisfactory information was obtained”*.

	Good practice		Area for development
↗	Arrangements to vet staff before recruitment, in line with statutory requirements, usually in place	↘	Full set of checks, including CRB checks, carried out on staff before they start work.

Standard 18: Requirements of the job

This standard is concerned with whether staff are aware of their responsibilities and accountabilities, including the limits or boundaries to their work activity.

82% of agencies achieved this standard in 2005-06

In general, staff appear to be clear about their roles. There are, however, some references to the need to improve staff handbooks and to ensure staff are clear about their terms and conditions.

Standards 19: Staff development and training

The standard relates to the importance of training, including induction training, for all staff and stipulates that care workers should not be asked to undertake activities for which they are not competent.

67% of agencies achieved this standard in 2005-06

There is a pattern whereby a range of courses, including statutory courses, are on offer. (These include a) protection of adults; b) risk assessment; c) moving and handling; d) recording; e) food hygiene; f) medication handling). Most agencies are also developing general training programmes encompassing induction and core training. The best have undertaken training audits and created training plans for all staff. However, actual participation by staff is variable, with too many reporting that they have not been trained in some of the basics. Many report that the volume of care work, including pressures very soon after they join the agency, mean there is not enough time allowed for training.

	Good practice		Areas for development
↗	Agencies having training audits and training plans for all staff.	↘	Robust and comprehensive induction arrangements for new staff.
		↘	Ensuring that all staff have training, including statutory training, in core skills.
		↘	Ensuring that staff are given time (and are paid) to attend those training sessions that are planned.
		↘	Training for managers, assessors and administrators.

Standard 20: Qualifications

The standard is designed to ensure that staff are competent and trained for the work that they are undertaking. It covers compliance with the target that by April 2008, 50% of all personal care should be provided by workers who are qualified with either NVQ II or NVQ III in care.

69% of agencies achieved this standard in 2005-06

There are records of the endeavours of many organisations to improve the numbers of staff and managers accredited with NVQs at appropriate levels. However, there appears to be a need for further expansion of these initiatives.

Standard 21: Supervision

This standard covers the supervision and support offered to care workers, individually and in groups.

57% of agencies achieved this standard in 2005-06

Supervision is a comparatively new area of practice for some domiciliary care agencies, so it is concerning but not surprising to see the big shortfall. Some inspection reports note the development of formal supervision and, to a lesser extent, of appraisal. There are also comments about the holding of team meetings and equivalent opportunities for care workers to get together and learn from others. However, it is still the case that care workers operate in relative isolation and their work is rarely observed by anyone except the person receiving the service.

	Good practice		Areas for development
↗	A range of methods to provide supervision and support	↘	Observation of care workers at work, including spot checks.
		↘	Regular supervision and adequate support for all care workers.
		↘	Team meetings and group learning opportunities for care workers.

4.4.6 Organisation and running of the business

This section covers standards 22–27. It deals with the need for agencies to have a sound business base; a manager who has been assessed by CSCI as being suitable to be registered; satisfactory financial procedures and records; a full range of formal procedures including complaints procedures; and systems for setting and monitoring standards.

Standard 22: Business premises, management and planning

This standard is concerned with the agency having 'fit for purpose' office accommodation and management systems (including a management structure) in place.

83% of agencies achieved this standard in 2005-06

There are instances where new managers do not register with CSCI within the specified timescales, or where CSCI are not notified quickly enough of changes. There are also occasional concerns about overall management cover, and shortages of administrative support, both of which may help to explain other observed weaknesses such as poor record-keeping (see below). There are some references to new computer systems and the ways in which these make it easier for hard-pressed office staff.

Standard 23: Financial procedures

This standard aims to ensure that systems are efficient and that the organisation has continued financial viability.

94% of agencies achieved this standard in 2005-06

Most agencies appear to be financially viable and most have adequate insurance to protect the agency, its staff and those receiving the service.

Standard 24: Record keeping

This standard aims to ensure that the rights and best interests of those using the service are safeguarded by the agency keeping accurate and up-to-date records.

71% of agencies achieved this standard in 2005-06

Very frequently, inspectors are faced with statements about practice that cannot be corroborated from records. Some of the most important areas for improvement are the recording of complaints; staff checks including CRB checks; the administration of medication; and records of financial transactions using older people's money. In our seminar with user representative organisations, there were also worrying references to staff time sheets being completed inaccurately, including instances where people were asked to sign false accounts of the time spent with them.

Standard 25: Policies and procedures

This standard concerns both the existence of policies and procedures, and the implementation of them. The guidance explicitly emphasises that they need not be lengthy documents.

76% of agencies achieved this standard in 2005-06

Our sample suggests that most agencies have updated their policies as a result of the regulation process, and that there has been good compliance with requirements and recommendations made in this area. However, there are some concerns about the quality of the documentation and also about the extent to which procedures are followed.

Standard 26: Complaints and compliments

This standard covers the need for clear and accessible complaints procedures that are well adhered to.

76% of agencies achieved this standard in 2005-06

Two aspects are mentioned most frequently in our sample of reports: is there a clear enough protocol? Do older people and, separately, their relatives know how to access the system? A third area, commented on less, is whether the recording of complaints is satisfactory. Finally, in some reports there is a comment on the actions taken in response to complaints, with some positive examples of managers taking action such as offering the person a new care worker.

	Good practice		Areas for development
↗	Complaints procedures usually satisfactory.	↘	Ensuring people know whom to contact when concerned about the quality of a service, and feel encouraged to communicate when they have a problem.
		↘	Ensuring people can easily get through to a manager on the phone.
		↘	Ensuring the outcomes of complaints are recorded on file.
		↘	Ensuring that all staff are aware and trained to use the procedures.

Standard 27: Quality Assurance

The requirement is that standards and indicators are set and then monitored.

65% of agencies achieved this standard in 2005-06

Given the recent regulation of domiciliary care this seems another area where it is not surprising that there has been limited development. However, CSCI considers that in order to improve, agencies must have a very good understanding of how they are currently performing – and this understanding must be based on the expressed views of those using the service. Agencies will in future be required to complete a self-assessment demonstrating (inter alia) that they have systems in place to obtain and respond to feedback.

	Good practice		Areas for development
↗	Newsletters for users and staff – eg publicising a summary of questionnaires.	↘	Quality assurance systems, including effective ways of obtaining feedback from those using the service.
↗	Techniques involving the canvassing of independent professionals about service quality.	↘	Few written quality assurance reports.
↗	Regular quality audits		

4.5 Enforcing standards

The Domiciliary Care Agencies Regulations (2002) came into force in April 2003. Registration is contingent on agencies complying with these regulations and CSCI has powers to enforce their implementation. (There are no equivalent powers in relation to the NMS, although they must be taken into account during inspections).

Many agencies were registered 'conditionally' during the first year, and their registered status was confirmed or otherwise on the basis of follow-up inspection during 2004-05. During the first phase of regulatory activity, many agencies therefore worked hard to improve their performance, to meet all statutory requirements, and to have this confirmed.

The inspectors who attended our staff seminar confirmed a pattern of good compliance once shortfalls were pointed out. This is also confirmed in our sample of inspection reports, which contain relatively few examples of requirements from a previous inspection still not being met when followed up. The case studies below are illustrative of activity across the country over the last two years.

However, inspectors also gave a few examples of agencies which had decided not to proceed with registration once they realised what would be involved. In all those cases discussed at our seminar, the inspectors reported this as a positive outcome, since the small number of agencies that decided not to register or who left the sector as a result of the new requirements did not have the capacity to run home care services well.

In 2005-06, there were 189 recorded enforcement actions across the country, ranging (in order of seriousness) from the issuing of a requirement notice to urgent cancellation of a service (see Table 4). No domiciliary care agencies were prosecuted during the year.



CASE STUDY 1

An agency in CSCI's East Region had its first inspection in December 2005. The inspector had a number of serious concerns, about such issues as the inadequacy of care plans and risk assessments, weaknesses in training and lack of supervision for staff. There were many signs of poor management; it transpired that the manager had recently been down-graded to a carer's post and no replacement had been found. The service was assessed as Level 1 (red/high risk) and a number of requirements were recorded in the inspection report.

After the report was finalised, the inspector contacted the "responsible individual" in the organisation; this person expressed alarm at the poor report, submitted a time-based action plan and undertook to make rapid changes.

At a second inspection five months later, every undertaking in the action plan had been met. Service users and relatives surveyed stated they were happy with the care received and commented on the improvements to their service. The service was re-classified as Level 3 (green).



CASE STUDY 2

An agency in CSCI's South East Region applied for registration on 31 March 2003 and had already been operating prior to this date. The site visit and application details revealed that the provider could not demonstrate adequate fitness to manage the service, and substantial improvement was required.

It was agreed with the provider that if an appropriate manager were appointed and other regulations were fully met within a specified period, registration would be approved. The agency met these conditions and was registered in January 2004.

However, in October 2004 CSCI became aware that the manager had resigned. There were new concerns about financial irregularities, lack of vetting of staff and lack of appropriate staff training. CSCI took enforcement action by way of a proposal notice to cancel the registration of the agency. At this stage CSCI also became aware that the agency had changed its business status and become a limited company without notifying CSCI. On legal advice, it was agreed the agency should submit a full application to be registered as the new limited company.

The agency brought in a new Director to raise the standards; the agency was registered with this person as the responsible individual and with certain conditions attached. By April 2006 this agency had raised its standards substantially, and was rated at Level 3 (green).

Table 4: Enforcement actions for domiciliary care agencies between 1 April 2005 and 31 March 2006⁷⁴

Requirement notices issued	Statutory notices issued	Urgent cancellations	Prosecutions
182	6	1	0

Our analysis of the sample gave some indications as to what issues were most frequently of serious concern. The sample did not include any of the agencies that had been subject to formal enforcement activity. However, many reports contain a list of 'requirements' which, if they entail a breach of regulations and are not complied with within a reasonable timescale, are likely to result in the issuing of a formal 'requirement notice'. Table 31 in the Appendix shows what topics the requirements in our sample covered; unsurprisingly, most address the kinds of issues highlighted through this chapter, with the following being the most common: lack of staff supervision; inadequate care plans; inadequate training in 'protection of vulnerable adult' arrangements; insufficient training generally; risk assessments (especially for people who need help to be lifted or moved); inadequate or poorly documented recruitment and selection arrangements.

Only one service had its registration cancelled. This concerned an agency in the Midlands that was served with five statutory notices in July 2005, dealing with a number of areas for concern. CSCI convened a meeting with the Directors of the company in October 2005, but there was no evidence of satisfactory plans for meeting people's needs. CSCI took the view that there could be a serious risk to people's life, health or well-being; this view was shared by the local authority commissioning the service. CSCI proceeded with urgent closure of the business in accordance with Section 10 of the Care Standards Act (2000). The Order was granted by the Magistrates' court on the same day as the application. CSCI worked with the local authority to ensure that a new manager was put in place to oversee the service, and new arrangements were made immediately for all the older people affected.

⁷⁴ Source: CSCI R&I database as at August 2006.

5 Commissioning and procuring home care



This chapter summarises the evidence about how councils commission home care, including their contractual arrangements with providers. It draws on evidence obtained during CSCI's 19 inspections of councils' services for older people in 2005-06 (which included 6 'Living Well' joint reviews), its work to assess the performance of all councils in 2005-06, and the site visits conducted for this study. It also uses feedback obtained during three of the expert seminars held in June 2006, and secondary sources.

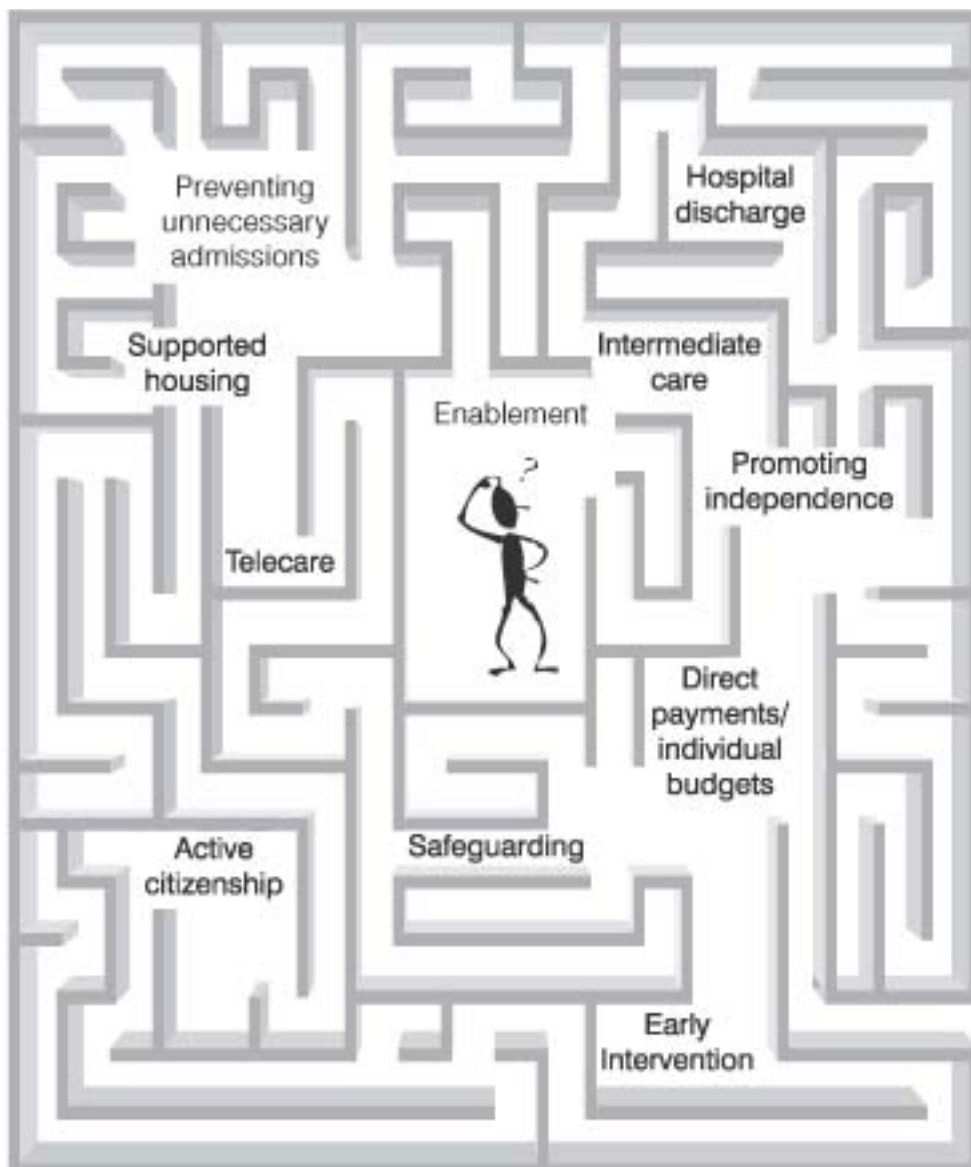
Key findings

- A reliable range of good quality home care services will be key to the delivery of the Government's agenda for older people.
- New approaches to commissioning must be found, to ensure that services are more responsive, flexible, and suited to individual needs.
- The range of organisations involved in local strategic partnerships have a stake in home care, and should be actively involved in shaping these services.
- Home care has the potential to be developed in a number of different ways, which may vary from place to place. Councils and their partners should be clear about their local vision and priorities.
- It is critically important to involve older people in this objective setting and in all aspects of the commissioning and contracting processes.
- In many areas, the immediate priority is to secure existing levels of service for people, in the face of severe staff shortages and rising demand.
- There is considerable scope for improvement in the way services are commissioned. Councils and their partners need to grasp the 'big picture' and plan for the medium term.
- Whilst some councils have developed constructive partnerships with independent sector providers, many do not engage well enough. Better results could be achieved through stronger collaboration that makes the most of providers' experience and expertise.
- Social care workforce strategies should be developed across agencies, and seen as a vital part of local economic development. Councils should be prepared to specify standards relating to the home care workforce, including levels of wages, expenses and other conditions of service.
- Councils should commission realistic and adequate time for care workers to carry out their job without rushing.
- Care plans which tightly specify the tasks to be undertaken for people, and the time to be devoted to these tasks, are hard to reconcile with the imperative to give people greater choice and control.

5.1 Strategic commissioning

As described in the introduction to this report, home care services are likely to be key to the delivery of a number of inter-connected Government priorities (see Figure 8). Home care can also take many forms, and can ‘overlap’ with other types of provision including – for example – supported housing and intermediate care. It is likely to be fundamental to the delivery of strategies to promote the economic and social well-being of local areas, and to developing social capital and community cohesion.⁷⁵ This means that several of the agencies involved in local strategic partnerships have a strong stake in home care services, and should be actively involved in shaping them.

Figure 8: Home care and the policy maze



The setting of Government ‘stretch targets’ in this area⁷⁶ has already resulted in concerted work to increase the volume and intensity of home care in most locations.

⁷⁵ See Lyons (2006).

⁷⁶ See paragraph 2.2. in Chapter 2.

At the same time, the imperative to reduce delayed discharges from hospital (and associated ring-fenced grants) has acted as another driver; home care appears to have played an important part in reducing the number of delayed transfers from a high of more than 7,000 people in 2001, to 2,570 in March 2005 (see Tables 16 and 17 in the Appendix).⁷⁷ As reported in Chapter 6, home care has also contributed to positive developments in relation to reablement, intermediate care, support for people with dementia, and other national and local priorities.

However, the evidence in this report suggests that this success has been uneven. There is now unacceptable variation both in the numbers receiving home care and in the quality and reliability of the services they achieve. Commissioners should therefore give more thought to the objectives they are trying to achieve, being clear about the overall vision, where home care sits in relation to other social care and health services, and about the actual priorities for their local area.

Figure 9 sets out a number of possible options. They are all likely to be important, but the relative priority given to each one will vary from place to place, and, in the context of resource shortfalls, hard decisions may need to be made about where to invest and disinvest. In many areas, councils and their partners should be alert to the growing capacity problems in the sector – associated with both immediate recruitment and retention difficulties and the ageing of the home care workforce. There appears to be a priority need to secure existing levels of supply, even before the sector can expand, develop, and respond to the new policy context.

“The commissioners want outcome-based care and we’re asked to go in for five minutes to get someone out of bed.” [S]

Grappling with these issues, and engaging partners in finding creative ways of realigning services, will be a fundamental part of the new responsibilities of Directors of Adults Social Services, as described in the White Paper, *Our Health, Our Care, Our Say*.^{78 79}

Figure 9: Developing home care: examples of local priorities

- Making home care more accessible, by improving information and signposting services.
- Finding ways of giving people more choice, and putting them more in control of the services they receive.
- Reducing waiting times, especially to guarantee a fast response for those experiencing a crisis and for those leaving hospital.
- Securing the supply of home care by investing in recruitment and retention initiatives, including those that target school leavers.
- Raising the quality of services, both by tackling workforce shortages, addressing disadvantageous terms and conditions for care workers, and by investing in training and development.
- Ensuring more consistent coverage – for example, for people in rural areas – and better out-of-hours services.
- Addressing gaps in specialist provision, including more culturally sensitive services for people from BME communities and better services for older people with dementia.
- Increasing the numbers of people receiving support, perhaps as part of an overall early intervention strategy.
- Assessing the potential of other council services (such as transport, leisure and adult education) to contribute more to the well-being of older people as part of an overall strategy.
- Offering ‘reablement’ services to ensure that people have every opportunity to regain their independence after an episode of ill-health.
- Developing new models of service that integrate health and social care, perhaps creating different roles such as community healthcare assistants and rehabilitation officers.
- Exploring the potential for efficiency gains, such as cutting down the paperwork associated with the contracting process and/or using electronic monitoring techniques.
- Making better use of new technology, including ‘telecare’ and ‘telemedicine’ to support people at home.
- Laying down the conditions for long-term development – for example, by investing in the relationship with local providers and exploring the potential for more active collaboration.

When we asked what would help the home care sector to improve, the agencies that attended our expert seminars underlined the importance of the following:

- **Consulting with, and listening to, the local population**, including the ‘hard to reach’ older people who are receiving home care.⁸² Almost by definition, these people may struggle to participate in mainstream consultation exercises and may also find it hard to express criticisms (see Chapter 3).
- **Having strategies for a range of older people’s services**, so that home care’s contribution to wider objectives is understood and planned.⁸³ This will require a better understanding of how the availability of one form of service (such as a care home or intermediate care bed) might impact on another part of the market.⁸⁴ (In most cases, this will require improvements in the type and quality of data collected and more sophisticated analysis across agencies⁸⁵).
- **Planning for the medium to long term (eg the next ten or fifteen years)**, so that the significant changes in demography and in social expectations, and new service delivery models, are anticipated and addressed.
- **Developing collaborative relationships with service providers**, to make the most of their expertise and willingness to innovate.
- **Developing workforce strategies**, ‘owned’ across all parts of the council and with other sectors including voluntary and private organisations and other related social care and health agencies. These need to be backed up by action to improve recruitment, to offer real incentives to work in social care, and to provide training and development.

The last two points were particularly stressed by many of our interviewees, and are explored further below.

5.1.1 Collaborative commissioning

The providers who attended our seminar described wide variation in the relationships they had established with their purchasers. (The same variation was noted in CSCI’s service inspections during 2005-06; some inspectors concluded that relationships were productive, whilst others found providers being excluded from relevant discussions about commissioning and provision). From our seminar, there were reports of thriving ‘partnership forums’ where purchasers and providers would come together regularly for discussion. Where these were held regularly, were properly resourced, involved real dialogue, and addressed wide-ranging issues rather than just fee levels, providers reported an increase in trust.⁸⁶ This was regarded as an essential prerequisite to building mature contractual partnerships.

By contrast, other respondents talked of continuing adversarial

82 An example of good practice in this area is set out in paragraph 6.7, Chapter 6.

83 An example of good practice in this area is set out in paragraph 6.11, Chapter 6.

84 See paragraph 2.1 in Chapter 2, and CSCI [2005a].

85 In Kings Fund [2006], Sir Derek Wanless reports that his inquiry was hampered by a paucity of good evidence and inadequate information about what social care does now.

86 Examples of good practice in this area are set out in Chapter 6.

relationships with their local councils, dominated by sometimes acrimonious arguments about fee levels.

*“An annual arm-wrestling over price, and that’s your contract management.”
[S]*

The national evidence (including economic studies) about contractual relationships in this sector is somewhat concerning. For example, Kendall et al found very low morale amongst the home care providers they interviewed, often attributed to the harsh competitive environment in which they operated, and failure by councils to engage constructively with the home care providers in their localities.

“Just under half of the providers that we examined could be characterised as either disabled by a sense of ambivalence in terms of opportunities purchasers have put in place, or in a small number of cases, seriously marginalised and frustrated.”⁸⁷

Providers perceived that many of the problems were due to a lack of understanding on the part of commissioners of what was involved in running home care. (For example, did they understand the impact for an agency of being faced with five new referrals in one day, all to start the next morning? There was no slack in the system, so it was very difficult to maintain a consistently good service with all the unexpected variations that occur). Our respondents thought that councils’ contract units and finance teams often had a particularly poor understanding of the distinctive characteristics of the social care sector, and that it would be better for social care professionals to be given the lead responsibility for drawing up contracts. Their sentiments seem to echo the views of the chief executive of a Centre for Independent Living, who attended a CSCI seminar on commissioning in May 2006:

“Commissioning social care is not the same as buying any other commodity. It is not the same as purchasing office supplies, for example. It should be about changing people’s lives for the better, which means it requires a different approach to ordering a thousand reams of photocopying paper.”⁸⁸

When asked about the essential attributes of good commissioners, our providers produced the list at Figure 10 (opposite).

5.1.2 Developing workforce strategies

Many of the older people, providers, CSCI staff and other agencies who attended our seminars or were interviewed during site visits talked about the poor terms and conditions experienced by care workers.

“The staff will be out at 10pm at night in the lashing rain, on their own and they’re only paid minimum wage.” [S]

87 Kendall, J et al (2002).

88 CSCI (2006c).

Figure 10: Attributes of good commissioning – according to service providers**Knowledge**

- Understanding the business – for example knowing about costs and about how budgets actually operate in an independent provider organisation
- Experience of having worked in the sector

Attitude

- Acknowledging providers' expertise and showing respect. (In some cases this requires a marked change in the tone of the relationship).

Practice

- Sharing information, for example about market trends
- Adopting a 'preferred providers' approach
- Having a consistent approach to tendering across councils
- Being transparent about commissioning practice and ensuring this is monitored
- Paying realistic inflation increases
- Sharing risk, and being as explicit as possible about the risks to everyone involved in the contract
- Auditing all paperwork with an emphasis on reducing the bureaucracy

These comments were often accompanied by real concerns about the sustainability of the current situation, whereby people were depending for their care on large numbers of largely untrained care workers, who usually did not have secure contracts or guaranteed hours, and often moved on quickly when more attractive options became available.

Our interviewees noted that care work was still a vocation for many workers; this was borne out by our discussions with care workers during site visits, where many care workers spoke movingly of the rewards they experienced from this work. So, our respondents thought it likely that retention (as well as recruitment) would be enhanced by paying attention to the factors that enhanced job satisfaction as well as to financial incentives. The following were all considered important:

- Longer slots of time to do the work, and to build relationships with people;
- More discussion about the concept of 'professional boundaries' – thinking again about the 'no personal relationship or contact' rule;
- A culture of good working relationships with professional staff including social workers – especially clarity about people's contributions to ongoing assessment and review;

- Spare time in the rota to allow for sickness/absence;
- Guaranteed hours of work;
- Adequate time being allowed for travel – and payment for travel time and travel expenses;
- Locality-based work, with opportunities to interact with a team;
- Proper induction training;
- A career structure – with senior care worker posts and further opportunities for career development including the development of specialist skills; and
- Good supervision and support, from skilled managers.

On balance, staff appear to become prouder of their roles and more committed once they achieve qualifications – although the UKHCA (and our evidence) suggests some resistance to attending courses, especially amongst more established care workers.⁸⁹

Overall, those attending our seminars argued for the need for workforce development strategies linked to local economic development strategies, encompassing more basic training as well as training leading to qualifications. (For example, given the prime importance of good communication, English language and cultural orientation may be particularly important in this sector). A lack of educational facilities, and lack of priority given to training people to work with older people, were identified as key obstacles; contrasts were drawn with the opportunities available for school leavers to train for careers in childcare.

5.2 Procuring home care

Successive studies have stressed the importance of councils' purchasing arrangements on the overall shape and quality of this sector. For example, Forder et al, in their study of the arrangements being used by councils and the implications of contract choices, conclude that 'institutional arrangements' have a profound effect on agencies' performance.⁹⁰ Unsurprisingly, this was also a recurrent theme during our expert seminars, especially the seminar for service providers. Some of the evidence is set out below.

5.2.1 Types of contract

Two discrete surveys of providers carried out in 2003-04 produced similar findings about the types of contract then in use. Both explored the use of the three most common types of contract: 'spot', 'block' and 'cost-volume'.⁹¹ Laing and Buisson (2005) found that overall, 54% of home care funded by councils was spot purchased with the figure rising to 66% for for-profit agencies. The UKHCA's survey found that 61% of hours in the independent sector were spot purchased.

89 McClimont and Grove (2004).

90 Forder et al (2004).

91 A helpful explanation of these is set out in the Kings Fund (2005) working paper.

Providers understandably argue that this pattern of purchasing hampers their ability to plan ahead, and leads to insecurity, since they have no guaranteed business on which to build. Most providers 'share' this insecurity with their staff, by employing them on a casual or temporary basis rather than offering them permanent contracts. Spot contracts are also often regarded as inefficient, since they generate larger numbers of invoices.

CSCI's evidence seems to confirm the above picture for 2004-05, but suggests that the use of block contracts (including cost-volume contracts) increased in 2005-06 (see Table 5).⁹²

Table 5. Contract types for adults receiving home care

	2004-05	2005-06
Block contracts	27%	32%
Spot contracts	43%	40%
In-house services	30%	28%

This pattern seems to have been accompanied in many places both by measures to reduce the number of contracted providers and to build more mature relationships with those with 'preferred' status. For example, it is becoming more common for councils to divide their areas into 'zones' and to give a level of guaranteed business to one or more preferred providers in each zone. This system is believed to carry the advantage of retaining a competitive market and a sufficient range of services to ensure people have a choice, whilst also allowing providers to develop a relationship with people in their locality, offer more continuity to people using services, and cut down travel time.

These approaches caused considerable debate at our expert seminars. Most understood why councils might wish to contract with fewer 'preferred providers', and certainly supported the notion of a strong focus on localities. However, there was consensus that the reduction of the number of contracted providers could disadvantage smaller providers, particularly where the tendering process itself was overly complex and bureaucratic. In some areas, agencies that lost contracts went out of business very quickly, as there were no alternatives to the council contract and insufficient private business to enable them to stay afloat. Examples were given of valued small businesses – including one catering for an African community – closing down after it lost a contract. Other examples were given of older people being distressed by sometimes abrupt changes in local arrangements, causing discontinuity to their care.⁹³

92 Source: CSCI, Delivery and Improvement Statements, Spring 2006.

93 Paragraph 6.2 in Chapter 6 includes the story of some older people who opted to start using direct payments, so they could contract directly with the care worker they were used to.

5.2.2 The time allowed for visits

For providers, block and cost-volume contracts carry the advantage of guaranteeing a level of business, but usually they must still log the time they spend with people, counting every 15 minute block – and sometimes every minute. Providers attending our seminars reported instances where – in apparent breach of statutory guidance – commissioners required arbitrary cuts in the lengths of visits in response to budget crises, and made these cuts without re-assessing people’s needs.

Such practices exacerbated a situation where visits were already quite short. In the recent UKHCA survey, 58% of independent providers and 43% of local authority providers reported that more than half their visits were half an hour or less. 40% of independent providers and 73% of in-house providers reported taking on some visits of 15 minutes or less.⁹⁴ Independent providers with block contracts were more likely to take on these visits than providers with spot purchase contracts.

“They’re asking more and more for the time you came in, the time you went, so they pay by the minute.” [S]

“From the point of view of the staff going in, it’s so demoralising. It makes a mockery of the NVQ!” [S]

“I’ve been a home carer for four years. Some old people live on their own and it’s appalling. Three months ago I was asked to help out over the weekend. The first lady was given half an hour but needed one hour. I was told by the agency it was up to social services. I felt awfully guilty – the house was filthy, appalling, disgusting. And the next person I went to should have had two people as she was on a hoist.” [JR]

The evidence from our seminars suggests that councils should give attention to the following:

- Involving people who use services in the contracting process, including the drawing up of specifications, the evaluation of bids, and the monitoring and evaluation of services.
- Getting the balance right between having a few preferred providers, and nurturing valued small – including specialist – agencies.
- Where geographical areas are divided into zones, getting the size of each zone right, so there is competition but also enough business for each provider to ensure viability and economies of scale.
- Commissioning realistic and adequate time for care workers to carry out their job without rushing.
- Being clear about the true costs of providing a service, and having mature discussion with providers about this issue.
- Giving attention to quality as well as cost, finding better ways of measuring and specifying quality, and finding ways of linking the two.⁹⁵

⁹⁴ Mathew (2004).

⁹⁵ See Chapter 6 paragraph 6.7 for an example.

- Having regard to the impact of low fees on care workers' wages and terms and conditions, and to the impact of this for people using services. (In particular, being concerned with how workers' travel costs and travel time will be funded).
- Being prepared to specify standards relating to the workforce.
- Ensuring that any new arrangements continue to offer choice to older people, including the option of using a direct payment or individual budget to purchase from a different provider.⁹⁶

5.3 The role of care managers

Since the 1990s, the culture across older people's social care services has very much emphasised the role of the care manager in purchasing services 'on behalf of' the person who needs care.⁹⁷ This process almost invariably involves the drawing up of a care plan, specifying both the times of home care visits and the tasks that will be undertaken.

Care managers operate under budget constraints, and whilst they may have significant discretion over smaller home care packages, there is usually a ceiling to the amount they can spend and a special process for approving more expensive packages. Depending on local arrangements, care managers may or may not actually negotiate the package with the provider; often, some form of centralised system is in place to 'broker' the individual contract. Equally, arrangements for reviewing individual plans vary from place to place.

In our expert seminars, the care management role was mentioned more often than other aspects of the purchasing process. Care plans that focus on inputs – the time and the task – are often at the root of people's complaints about the inflexibility of home care and the rushed visits.

"It's less important whether it's block or spot – it's time and task based." [S]

CSCI's inspectors had especially strong views about the constraints this placed on people, who found their care workers were 'not allowed' to do certain things or did not have the time. As discussed in the previous chapter, they are often critical of the quality of the care plans – both those drawn up by care managers and those developed by providers themselves – because they often shed little light on what is important to the person receiving the service.

During the seminars, there were also complaints that it was difficult to change plans once they were drawn up. Providers have very little scope to amend the actual time spent with people, and usually need permission from a care manager to increase the package.⁹⁸ Yet it can be difficult to get access to a care manager once they have closed the case, and budget constraints can make them reluctant to change the care plan. The data

96 Evidence from the schemes that are piloting individual budgets is included in Chapter 6. See Audit Commission (2004b).

97 The care management role is described in detail in the NHS and Community Act 1990 and associated guidance.

98 This pattern was also observed by Patmore (2003).

about councils' performance in reviewing care packages lends credence to the view that care plans are developed at a moment in time rather than being dynamic and variable. In 2005-06 only 67% of people receiving community care services had a review during the year. This represents an improvement over previous years, but still fits with the evidence from the 2002-03 PSS survey, which gave cause for concern about people's ability to get their care packages changed (see Figure 11).

"You can never find someone to talk to when the needs change." [S]

"They always say we'll review it after three months or six months... They never ever do." [S]

Figure 11: Extracts from the PSS Survey of home care users in England aged 65 or over, 2002-03

In answer to the question: If you asked for changes in the help you were given, were those changes made?

- 65% of respondents in England said changes were 'always' made when asked for.

In answer to the question: Did anyone contact you from social services to check that you are satisfied with the home care you receive?

- 55% of respondents in England said 'yes'

[DH Statistical Bulletin 2003/26, pub. Dec 2003]

One commissioner interviewed during our site visits – who had past experience as a care worker and manager of care services – agreed that ways needed to be found of achieving more flexibility.

"It's getting a care plan that moves with you all the time, because your tastes and your needs change." [SV]

This respondent thought the solution might lie in developing closer relationships of trust between care managers and home care staff. After a basic assessment, perhaps the details of the care plan should be left entirely to the care worker and older person:

"It's getting the social worker to accept what the domiciliary carer is saying, because they're the one doing the work day by day."

Our expert seminars produced at least one example of such techniques being tried. In one service based on a sheltered housing scheme, providers were allocated a block

of time to spend flexibly with a named group of people, allowing regular negotiation with the individuals about the help they would receive in the course of each week.

On the other hand, some of those attending the expert seminar thought that even more radical solutions, such as more extensive provision of direct payments and individual budgets, might be the only solution to the current power imbalance between the people needing care, and the agencies who commission and provide it.

5.4 Conclusion

Focusing on outcomes

This chapter began by suggesting that councils and their partners – through engagement with local communities – should give more thought to their strategic objectives for older people's services, and to the role to be played by home care overall.

It ends with evidence that at the individual level, rigid care plans that focus on inputs – the time and the task – often provide an unsatisfactory basis for arranging people's care. These aspects may be much easier for commissioners (and indeed policy makers and regulators) to measure, but they result in a focus on the volume of a service rather than its effectiveness.

Our consultation for this report has provided evidence that good outcomes for people may be complex, long-term and not directly attributable to any particular set of inputs or any one organisation. The challenge for commissioners is to find ways of arranging services that are flexible enough to respond to people's dynamic and very individual needs, whilst still meeting demanding budget targets.

The next chapter presents examples of the new approaches being developed by some councils, including early examples of outcome-based commissioning.

6 Commissioning for improvement



This chapter provides examples of innovative practice, identified during visits to nine councils and three providers whose work was recommended either by CSCI local staff or by a partner agency. (In one additional case – Trafford council – we undertook a telephone interview and a study of documentary evidence in lieu of a visit). Although seven of the councils have three star status overall, the sample includes some that are improving their older people’s services from a lower base.

Most visits involved one of the study team and lasted either one or two days. At each site, individual or small group interviews were held with a range of stakeholders; this usually included commissioners, providers, care workers and people using home care services. (Altogether over 100 people were interviewed, including 24 older people). It was not possible to undertake formal evaluation but the views of the different stakeholders were sought about “what works”. Some of the councils emphasised to us that their innovative work was at an early stage and should be presented in this report as ‘pilot’ activity.

6.1 Introduction

Chapter 5 began by suggesting that councils will need to work with their partners and older people themselves to establish a clear vision for their home care services, and creative ways of expanding and developing these services.

There is ongoing debate about how any expansion should be resourced, but CSCI agrees with other commentators who suggest that the debate cannot focus on how we will fund more of the same services for the same groups of people.⁹⁹

CSCI’s seminar on commissioning held in May 2006 supported the need for radical change and concluded that this was urgent. As one senior manager put it:

“If what people choose is not what councils offer, councils and independent providers may not survive. The lesson is change or die.”¹⁰⁰

The councils featured in this chapter share a willingness to take risks and try doing things differently, even where some of the changes are so far on a modest scale. Between them, these councils appear to be tackling the kinds of challenges set out in the previous chapter, although the emphasis and relative prioritisation varies from place to place. All emphasised to us the importance of cultural change; one senior manager described the need to change the philosophy from ‘we don’t do that’ to ‘how can we do that?’

All the councils are also grappling with the issue of whether their innovations offer value for money. In doing so, they face the same problems experienced by the Wanless review team – of a lack of data and agreed methodology for making such judgements (see paragraph 5.1 above).^{101 102}

99 See CSCI (2006c) and Kings Fund (2006).

100 CSCI (2006c).

101 See also Rankin (2005). She concludes, for example: “At present there is no robust evidence available that would lead to the conclusion that individual budgets on a large scale will be cheaper, more expensive or cost the same compared to existing provision”.

102 Several of the initiatives being undertaken by the Department of Health’s Care Services Efficiency Delivery Programme are also beginning to shed light on issues raised in this report, including the value of reablement schemes and the benefits that can be achieved from using new technology. See the Programme’s website: www.csed.csip.org.uk

In some cases the changes have required extra investment, but in all cases the results have been improvements in one or more of the following areas:

- Increased choice and control for people, resulting in increased satisfaction;
- Increased quality, measured by an improvement in standards;
- Increased staff motivation – sometimes leading to demonstrable improvements in recruitment and retention;
- Reduced demand for home care over time;
- Reduced admissions to residential care;
- Reduced delayed transfers from hospital; and
- Increased efficiencies.

The resources available for this study did not allow formal evaluations to be carried out. Where evaluations have been undertaken by the councils themselves, or where attempts have been made to quantify the costs and benefits, these are reported below using the councils' own data.

6.2 Putting people in control

Oldham's *In Control* pilot for older people

In November 2005 Oldham became one of the 13 pilot sites for the Individual Budgets Pilot Programme and over the last six months they have been developing and implementing a whole system change throughout their adult services. The main principle of the new model is that each individual must have the maximum possible choice and control over any support they receive.

The process

Once an individual has been referred and is assessed as eligible for services they are asked to complete a self-assessment form (the Resource Allocation System (RAS)) either independently, with a carer, or with a care manager. The RAS asks questions similar to those in standard assessment tools, but also scores the answers given to the questions. The resulting score converts into an amount of money that the individual is then eligible for, to be paid from the council's community care budget. This becomes the 'Individual Budget' for that person. However, the RAS (and the financial assessment that is also completed) may also trigger eligibility for other benefits or grants, such as the Independent Living Fund, Attendance Allowance and Disabled Facilities Grants.

Once the person's Individual Budget has been agreed, the individual is asked to plan how they wish to use the money to ensure their needs are met. They may do this independently, with help from a friend or a care manager, or perhaps using a

'broker' to help them to consider their options. The main aim at this stage is that the individual is able to think as creatively and personally as they can about how they would wish to improve their own situation. Previously, at this care planning stage the individual would be heavily reliant on whatever services or support the council was able to provide. In this model, the planning is more likely to involve ideas involving the family or community resources outside of the traditional social services remit.

The individual's support plan is then considered at a resource allocation panel. In the majority of cases it is agreed, an Individual Budget Agreement is signed between the person and the council, and the payment is made to enable the individual to start arranging their support. The situation is normally reviewed annually to ensure the RAS amount is still appropriate and the person's needs are still being met.

Although this new model has only been up and running for six months in Oldham, there are currently over 200 adults involved (including 15 older people). Our reviewer was shown some positive examples where people have been able to arrange support in a more appropriate and individual way than would have been possible under the traditional system.

The council is working in very close partnership with the local voluntary and private sectors to raise awareness of the new system. The council and voluntary sector alike believe that any progress towards self-directed support can only be properly achieved and sustained with diversification of the market and a growth in the capacity of small, independent local organisations. The local Age Concern branch is very enthusiastic that this empowerment of older people could improve the level of preventative support on offer and they have recently extended their services to include a shopping service, one of many examples of the type of support that individuals may choose to purchase.



CASE EXAMPLE 1

Mr A & Mr B are both in their early 60s and have lived together as partners for many years. Mr

A was diagnosed with dementia and the illness progressed quickly. Both men desperately wanted to remain living together at home and Mr B was considering giving up his paid employment in order to care for his partner. They were both wary of receiving home care support through the council as they felt that a stream of different carers would not only be disruptive for Mr A owing to his confusion and forgetfulness, but would also be an invasion of their private lives at home.

When they received an Individual Budget, they were able to organise support and care from a personal assistant of their choosing – someone who respected and valued their private life without any judgement or prejudice. It has enabled Mr A to remain at home, and Mr B has been able to continue working during the day.

direct payments by 31 March 2004. This figure has significantly increased, with 628 older people in receipt of direct payments by 31 March 2006. The council's work to increase the take-up by older people provides an interesting example of a 'problem' being turned into an 'opportunity'. The triggers for the increase are described below.

Essex undertook a Best Value Review for its older people's services in 2002, and identified a need to improve the capacity of the independent sector, by offering more stability and longer term security to suppliers. The county had been regularly spot purchasing with up to 100 providers; like other councils, it decided to introduce block contracts to a smaller number of preferred providers.

The council was convinced that there would be many benefits from the new approach over the medium term. However, older people using the service faced the prospect of losing their existing care workers and being offered alternative services provided by a different agency. Naturally, many of these people reacted negatively to the proposed change and voiced their concerns at the lack of continuity and the potential disruption of their longstanding relationships with particular care workers.

Essex opted to deal with this situation in a positive and proactive way. Offering direct payments appeared to be one way of ensuring older people could keep their existing care workers, if the workers themselves were in agreement.

To achieve this, the council had to review why there had been relatively low take-up by older people, and to find ways of making this option more accessible and user-friendly. Although the council stresses that they do not treat older people any differently from other adult service user groups, certain revisions were made to the system.

- a) A new enhanced agency rate for direct payments was put in place on 1 April 2005 so that people could continue to purchase their existing care package from their familiar agency. The new direct payment hourly rate of £11.53 was higher than that previously paid by the council, but lower than the rate sometimes paid by private payers. The council encouraged local agencies to sign up to this agreement. However, not all agencies have agreed to this and, therefore, some people have had to make the choice as to whether to 'top up' their direct payment in order to maintain their existing care package.
- b) Essex has developed several support mechanisms in order to alleviate people's concerns about using direct payments. Funded by the council, the Essex Coalition of Disabled People runs a Personal Assistance Support Service (PASS), which can provide payroll services, payment facilities, assistance with the quarterly returns, advertising and training for personal assistants. There is also a local Direct Payments Users Network, where people can share their experiences, offer peer support and advice, and provide feedback to the council. In addition,

Independent Living Advocacy Essex provides a direct payment support service and offers independent formal advocacy.

- c) The council's finance department has also addressed certain practical obstacles that older people, in particular, have raised as barriers to accessing direct payments. People can now agree to the payments being paid into a third party's bank account to be administered by a relative, rather than having to deal with payments and paperwork themselves. If an older person would benefit from the use of direct payments but they are unable to consent to the process, perhaps owing to lack of mental capacity, a Trust can be set up and managed by three signatories who will act as the employers for that person's care.
- d) The council has introduced a comprehensive training programme for its staff in order to increase their awareness of direct payments and how to encourage all people in receipt of services, but particularly older people, to access them if they so wish. (Research has highlighted that training for care managers is one of the most important factors in the successful take-up of direct payments).

6.3 Advice and signposting for self-funders

The MAYSI project in Shropshire

"MAYSI" – which stands for Mayfair Supporting Independence – is based at the Mayfair Community Centre in a small town in Shropshire. The project is funded by Community Services as part of the county's preventative strategy. It employs one part-time co-ordinator and two volunteers, whose role is to support people who are either not eligible for assistance from social services or who do not wish to engage with social services.

The co-ordinator's motto is "*if you're struggling to maintain your independence, for whatever reason, contact me and I'll try to help.*" She then visits and carries out a simple assessment and arranges support for people in a whole range of areas including help with shopping and jobs around the house, Benefits advice, the installation of personal alarms, applications for a Blue Badge, help with mobility aids, support for carers, and regular domiciliary care. The project's emphasis is on mobilising whatever support is available in the local area, including help from volunteers. To achieve this, the project tries to encourage people to visit the Mayfair Centre itself, since the centre provides opportunities to socialise with people of all ages, as well as ready access to health services such as chiropopdy, audiology, exercise classes, a community café, and organised leisure activities. The co-ordinator says "*you just come into Mayfair and you're OK. People are here to help.*"

MAYSI has strong links with local domiciliary care providers. Two years ago the centre was aware of self funders, including those leaving hospital, who were given no help

except a list of local care agencies to phone. Often, these agencies had no spare capacity. MAYSI was proactive in contacting suitable care agencies and encouraging them to increase the provision of care in the area. One agency in particular has worked on recruitment and now has a reasonable size staff which is catering for many older people in the locality. This agency holds its staff team meetings in the Mayfair centre and MAYSI is able to feed back to them about any problems they hear about.

Shropshire sees MAYSI as a successful model, and is now considering how to extend it to other parts of the county.

6.4 Outcome-focused commissioning

Thurrock's pilot scheme

Thurrock is developing an 'outcome-based' approach to the commissioning of home care, on the basis of a recent pilot project involving both in-house and independent providers.

Seventy older people were involved in the pilot; these included some people who were looking for short-term rehabilitation following discharge from hospital, and some who needed a longer-term package. A social worker gave an initial assessment

Hartlepool's outcome-based approach

Hartlepool's 'outcome based' approach has been in place for about two years, but was being developed for several years prior to that and is still being worked upon. It applies both to the in-house service (which mainly deals with rapid response and intermediate care work) and to the three independent agencies which operate on a locality basis. There has been a major emphasis on getting the quality standards and procedures right and agreed by everybody; a trusting and open relationship with providers is said to be crucial.

The system works in a similar way to that piloted by Thurrock. A social worker provides an assessment (using the Department of Health's Single Assessment Process) and agrees a care plan with the person that specifies the number of hours to which they are entitled. The plan is constructed from a menu which examines:

- What does the person want to happen?
- What do they want to change?
- What are the key issues for the person in relation to how the service is to be delivered?
- How can they be achieved?

There is then a flexible approach to the implementation and amendment of the care plan. Home care workers from one of the independent providers told us:

"We used to always have to follow the care plan. We now do person centred care...if it's slightly different to the care plan it's not a problem."

"It's a lot easier now we're alongside the social work teams...you work with the same social worker all the time. They treat us as professionals – they trust our judgement now."

Temporary upward adjustments in hours can be made by the home carer with agreement from her manager; permanent adjustments need the approval of the social worker.

Hartlepool prioritises investment in training (including assistant OT skills) and this is shared across in-house and independent providers. Social care traineeships have been introduced to attract young staff; three 18-24 year olds have been recruited for three years and three more are about to begin. Recent developments have included the provision of good out-of-hours support with 24 hour cover, and improvements in the service's ability to respond rapidly in a crisis. Inspections show that the agencies in Hartlepool collectively score well above average in their compliance with the NMS.

6.5 Focusing on reablement

Shropshire's START team

Shropshire's in-house home care team has been refocused, to place more emphasis on promoting independence.

START stands for the short-term assessment and reablement team. In Shropshire, anyone assessed as needing home care, and as being eligible for statutory funding, is first referred to the service.

The team provides a service for the initial six weeks, which is sometimes extended up to twelve weeks. During this time, the team build up a relationship with the individual and get to understand their personal wishes and goals. A care plan is developed over the six weeks, and usually changes over the time that START is involved.

The team has been trained in 'reablement' techniques, their approach being to encourage individuals to do things for themselves rather than doing things for them. This may result in more time being spent with people at first – but it is common for the package to be reduced over the six weeks, or even stopped altogether.

Each of the five locality teams monitors the difference between the initial allocation of hours to each individual, and the allocation at the end of START's involvement. The difference is regarded as a 'saving'. Using this technique, START calculates that 1,402 hours/week were 'saved' in the period between October 2005 and March 2006. START also monitor people's destinations at the end of their period in the service. During the first three months of 2005-06, these were as follows:

Destinations of people leaving START	Total	Percentage
No ongoing care needs	88	48%
Referred to another agency for ongoing care	61	33%
Admitted to hospital	19	10%
Moved into residential care	7	4%
Died	10	5%

Although no comparator figures are available for the time before START was established, the percentage needing no further help is believed to be higher than in the past.

Our reviewer visited two people who were receiving the service, and interviewed a group of care workers. In both cases, levels of motivation were high.

"It's been absolutely brilliant. It's built my confidence up..." (Service user)

"There's much more job satisfaction. With home care we were there for years sometimes. We made people dependent on us!" (Care worker)

HART (Home Care Assessment and Reablement Team) in Leicestershire

In Leicestershire, a number of specialist in-house home care teams have been developed. In each of the six localities there is a specialist HART team as well as specialist dementia and child care teams.

Each HART service comprises a number of home care assistants, an occupational therapist (OT) and a review officer as well as a team manager. Referrals are made by the adult social work teams as well as by the intermediate care teams (which are managed by PCTs and are considered as particularly important partners in the community). An outline care plan is provided which is discussed with the individual and any adjustments made (within the scope of the overall plan).

HART's objectives are very similar to those of Shropshire's START. The whole approach is based on a dialogue with the person, helping them to decide what they need within a short term contract.

“Reablement is about doing what’s absolutely right for that person – so the package can increase or decrease as necessary.” (Service Manager)

The notion of ongoing assessment has become important. Any concerns are referred back to commissioning colleagues and the trust and confidence between the two parts of the system are seen as crucial:

“We worked really hard at removing the elitism (of the split between qualified and non qualified staff).” (Service Manager)

Another important feature of HART is that managers and senior home care assistants have been trained to assess for and order minor aids and adaptations. They are now receiving more advanced training that will enable them to order such items as bathing hoists, portable ramps, steps, gallop rails and mattress raisers. The OT within the team can provide back-up advice and intervention in more complex situations, and the team can also refer into the mainstream locality OT teams.

Recruitment to the team has been seen as crucial to its success – getting people with the right attitudes and skills to work *with* people, not do things *to* them. There have been some recruitment difficulties but these have not been a major problem; this may be partly due to the more rewarding conditions offered by the team, including flexible hours, a career structure, strong emphasis on team working and good support and supervision.

Because of these factors, and the extra infrastructure needed to run this service, the costs are inevitably higher than those of mainstream home care. However, a Best Value Review in 1999 confirmed that whilst unit costs were higher, the costs for individuals became lower as their needs reduced. These findings were backed up by an independent review by De Montfort University in 2000. Its conclusions were quite similar to Shropshire's findings about its START team:

- Packages of care for the HART team's users were far more likely to be discontinued at first review compared to a matched group of users (62% to 5%) and twice as likely to be decreased (26% to 13%)
- Packages of care were far less likely at first review to be increased compared to the matched group (2% to 11%) and also far less likely to be maintained (10% to 71%).
- Qualitative analysis confirmed the pilot scheme as “distinctively different” from traditional home care services in terms of its underpinning principles and how it put these into practice.

Current managers point to evidence gathered on a daily basis that demonstrates the links between inputted hours and the achievement of personal outcomes. Our team visited one person who was being helped by the HART team to rebuild her life at home after spells in hospital and in a nursing home. She told us:

“I couldn't be here without them, I'd still be sitting in that nursing home paying out loads and loads of money.”

Leicestershire's dementia teams

The county also has some teams that specialise in providing home care for older people with dementia. Referrals are made by the social work teams, the community mental health teams and other home care agencies. The specialist service is considered appropriate in situations where a person's mental health needs have become so great that the other home care services cannot cope. It can be provided over a longer period of time than HART. It aims to enable people to stay in their own homes; to support their carers; to monitor the situation and to report back to the team manager who ensures that the plan remains appropriate. Staff receive specific training (eg in dementia awareness) although much is said to depend upon the personal empathy of the care workers and the relationship they build with older people and their families. Links with community psychiatric nurses are also important and a number of home care assistants are also doing nursing training. Leicestershire report that they do not yet have the same 'hard evidence' of success as for the HART team. As people's mental health needs often increase, and they can stay in the service for a long time, there is not the same 'numbers argument' – but there are a lot of individual narratives that demonstrate that this is delivering quality outcomes.

6.6 Making good use of new technology

Telecare In Sandwell

'Telecare' is the name given to the use of innovative technologies to help people in their own homes.

The role and profile of telecare in Sandwell has grown steadily over recent years. This goes beyond community alarm systems to a much wider range of equipment

and technologies. Our reviewer met a number of people who were benefiting from different kinds of telecare.

All of these people also receive home care support from care workers for personal care tasks, but the additional technology support has enabled those workers to be more effectively used (for example, reducing the number of short visits required).



CASE EXAMPLE (1)

For one woman in her eighties, living on her own with mild dementia problems and with a risk of falling, telecare has meant the installation of a pressure mat under her mattress timed to come on at night. If she gets out of bed lights automatically come on guiding her to the kitchen and bathroom and, if she has not returned to bed after a length of time, the community alarm centre is alerted and an operator rings to check she is alright. This has been operating now for over six weeks following a hospital admission:

“Oh, I much prefer to be at home. I can see where I’m going – I’m not going to fall over any more.”



CASE EXAMPLE (2)

Telecare can be equally beneficial for informal carers. One man, whose mother had dementia, but was physically active and prone to wandering from the house, was given a pager activated by magnetic contacts on the porch door and linked to a radio transmitter – alerting him if his mother went into the front garden. Prior to this he had to be constantly checking whether she was at home or not. Importantly, he had also been given a choice in the type of technology.

“The alarm system could have automatically rung my mobile phone, but I preferred to have a pager so I knew at once what the alert was about... It’s been brilliant; it really has helped. I doubt I could have coped without the system.”



CASE EXAMPLE (3)

Another man in his mid-eighties, with his wife as carer, has found the community alarm system provided by the council together with additional household security equipment he has had installed gives him *“great peace of mind... and that’s 90% of your care.”* As an active participant in the voluntary sector he has also been an enthusiastic ‘tester’ of equipment in his own home for the council and has given valuable insight to the telecare team, as well as being an enthusiastic campaigner for the concept in the local community.



CASE EXAMPLE (4)

A timed medication dispenser is ‘genuinely wonderful’ according to an elderly male client who, although living with family, is usually alone during the day when they are working. He can be forgetful, and this reminds him to take medicine at lunchtime:

“I don’t have to think about it, it ties in with my food!”

From a service point of view this saves a daily visit from a home care worker who might just need to check on whether medication has been taken.

A structured database is being maintained, in which assessment staff are asked to record what service might be used if telecare were not available and to give a deliberately conservative estimate of how much resource is being saved or diverted. The data suggest that across 69 clients tracked over the past year, more than 2,500 home care visits have been saved. Telecare may also be helping people to remain at home for longer, and even preventing some hospital admissions.

So, although telecare has required some investment, including investment in the training of assessment staff, Sandwell and its partners are committed to developing the approach further. Funding for telecare has been jointly supported by health and social services and is recognised as having a major role to play in enabling local health service reconfiguration plans over the next three years. The telecare initiative has also embraced other local agencies with responsibilities for community safety including police and fire services and local ‘third sector’ community and voluntary groups. Future plans envisage a ‘telecare centre’ where clients and professionals can share access to education, training and hands-on trialling of equipment and discuss the implications of the service required to support it.

6.7 Engaging with older people to improve the quality of services

Trafford’s ‘performance-related commissioning’

Some years ago, Trafford realised that improvements were needed in the quality of its home care services. It established a network of ‘service improvement forums’, which together oversee Trafford’s three year service improvement plan. The forums include:

- A service improvement partnership, for service providers
- A home care user reference group

The user reference group includes people who were initially recruited as a result of complaints they had made about their home care. It meets every six weeks and

has been developed over time; for example, they have received briefings about the sector and training to enable them to participate in reviews of services. The group uses a range of media to publicise its activities, and is now planning to hold an annual service user conference and a consultation week. Their other projects include the development of minimum standards for providers on consultation with people receiving services, and an 'inclusive consultation' strategy that addresses 'hard to reach' groups such as the deaf/blind community.

A conference was held in December 2005 to reflect upon the previous year. Workshops were also held about how services should develop in future; these generated an interesting list of development goals, ranging from 'more culturally appropriate services' to 'personal budgets' and 'internet shopping'.

Trafford has designed a Quality Assurance Framework (QAF), broadly based upon the national minimum standards. The council regularly measures performance against these standards, as well as being rigorous in collecting other information – for example, about complaints. The council can demonstrate consistent improvement over a number of years albeit from a rather low base.

The development of robust quality assurance arrangements has enabled Trafford to make more evidence-based decisions about the balance between cost and quality. Unusually, the council has used the QAF to introduce 'performance-related commissioning' for home care, whereby a premium is paid to providers who undertake to:

- Provide a high quality service, as measured through the QAF;
- Improve the recruitment and retention of staff, by taking steps to introduce permanent contracts and career paths for care workers.

Of the 13 providers who have contracts with Trafford, four have been rewarded with an increased premium or the commissioning of additional hours.

6.8 Offering culturally sensitive services

Mushkil Aasaan

Mushkil Aasaan provides a range of different services to people of Asian origin in Wandsworth. The charity was established in 1993, by a group of Asian women who got together to help each other cope, in what was for them an unfamiliar environment. In its early stages the organisation received development support from L.B. Wandsworth. It eventually entered into a formal home care contract with the borough, and then won the tender to become the accredited provider for specialist domiciliary care services for Asian people. The agency now has 200 clients and employs 100 domiciliary care workers; it is registered with CSCI and has performed well in its inspections so far.

Mushkil Aasaan has an office in a prominent position, accessible to local Asian communities, and has become well known in the area. It supports whole families including both older people and children, regardless of country of origin, religion and culture. In practice this means that the agency serves several diverse communities and its staff speak a variety of languages. The care workers are carefully matched with the people they visit, so they are not only of the same gender but also share the same language and culture.

The agency's managers told us that one of the challenges in providing domiciliary care to Asian elders is that the concept of a 'paid care worker' may be unfamiliar in their culture. Also, rules about when care workers can come, how long they can stay, and what they are allowed to do seem even more anachronistic in situations where the older person is in a position of authority within the community, and the younger care worker must show them particular respect. So, Mushkil Aasaan has worked hard over time to introduce the concept of domiciliary care and to adapt the system to make it work for local families.

Very importantly, Mushkil Aasaan has established a whole range of 'back-up' services, including some funded separately via grant aid from the council. For example, there is a social work consultant and support workers (funded from grant aid), who undertake counselling, crisis intervention work and other kinds of support for families. The agency also offers respite for carers, a welfare rights service, advocacy, volunteer transport, self-help support groups and social and cultural activities. These enable the agency to meet people's needs in a holistic way that might not be possible if it only followed the council's care plan. So, if a person needs help with shopping and cooking, but this is not covered in the care plan, this can be provided using the back-up volunteer support.

Mushkil Aasaan has also worked to make the job of 'care worker' acceptable and attractive within the local community, to the extent that it believes it has created employment opportunities for people who might otherwise not have found paid work. This has meant – for example – adapting the conditions of service to allow people to observe their religion at the required times. There is a strong emphasis on training (beginning with literacy skills in English), to the extent that some local women now see becoming a care worker as a real opportunity to gain a qualification, as well as serving their community. The agency has twice won the 'Investors in People' award. One obstacle, however, is the lack of NVQ II courses delivered in local languages; managers told us that some of their staff already have degrees in their own language but struggle with English. Their solution so far has been to use European Social Fund money to provide English language classes to their staff as the first step towards an NVQ. However, they are also seeking funding to translate the NVQ modules into local languages.

6.9 A community enterprise scheme

Sunderland Home Care Associates

Sunderland Home Care Associates is an employee-owned social enterprise, where staff are given shares in the company after six months service and have the opportunity to take part in democratic general meetings to make decisions on aspects of the business, including budgets, pay and conditions, and training. There is also an Employee Beneficiary Trust in place so that any profits get handed on to staff or go back into the running of the business. Just over 175 staff members now own the business.

The agency has a block contract with Sunderland Council and about 95% of recipients of their services are referred by the council, as Sunderland is a relatively low-income area. This amounts to about 2,600 hours per week. The rest of those receiving services are split between self-funders, those on direct payments, students funded through the local education authority who access the agency's academic support workers, and some funded through the Independent Living Fund. The agency tries to ensure continuity of care for all packages by rotating a small team of perhaps three care workers to each client. In this way, there is less disruption when care staff take holiday or sick leave.

The agency generally has a steady, secure business, although when the council recently took on another five new agencies, their business did go down significantly for a while. This situation has levelled out again now.

The agency is able to pay staff a very competitive wage, compared to most other local independent sector agencies, as all of its profits and finances are kept internal to the company. Payments are not made to external stakeholders or shareholders. In addition, since the agency has expanded in size, the unit costs have started to go down, improving the company's income. Staff wages are second only to the in-house council provider agencies. Travel expenses are also paid.

There is also an internal staff award held every year – the Robert Oakshott Award, with everyone having a say about who should be rewarded. Winners usually win a trip away for a few days to visit another social enterprise scheme. The last winners had a few days away in Scotland.

The manager told us that the majority of staff tend to stay with the agency for a long period of time. Those who have left have tended to leave for 'positive' reasons, such as pursuing full time education in social care or nursing.

Care workers told us that owning shares in your work place was a real bonus. They are allocated shares after six months service and every year they can cash some in if they want to. One staff member said it really helped with all those little things you need to buy. For instance, she cashed some in to purchase a washing machine she really needed, but has got enough shares left as a "little nest egg". Other staff

talked about the feeling of having a stake in the organisation:

“Here, we can suggest training we want to do, come up with new ideas for how to run things. You feel like you can really do it, that you will be listened to, you get taken seriously here.”

“You turn up to the meetings and really have your say. The majority vote wins out. You always feel like your really being listened to, not like most places where I’ve worked.”

The founder and manager is now part of Care and Share Associates (CASA), an organisation that exists to help support and advise others who wish to set up a similar model of employee-owned social enterprise in their local area. This model is spreading in the north east, and new independent home care agencies have started to open for business in Newcastle, North Tyneside and Manchester.

6.10 Investing in workforce development

Recruitment, Retention and Training In Southampton

Southampton’s service providers are, on average, providing high quality services according to CSCI’s inspection evidence. The council also reports fewer recruitment problems than in many places, and their retention of care workers is improving.

In common with other councils, Southampton receives central government funding to promote training in the home care sector with voluntary and independent providers. Although this funding is not ring-fenced, Southampton spends all of it (about £676k) on training and also tops up the fund to bring the total training budget to £1.5m. They run a joint steering group with providers to decide what is needed and this is supported by a dedicated support manager:

“It’s an open process with good high-level representation and support from the council and good links between health, social services and housing.”
[Director of an independent sector agency]

“Partnership working is genuine here.”
[Regional manager of a national independent provider]

Another key factor is engagement with care workers over what is required of them and where the gaps are. Most of the money is used to provide supported places on national NVQ training schemes, but some is put aside to fund specific short and specialist courses. These cover a range of personal care skills (including dementia and behavioural training) as well as more general management training. The possibility for new courses and extending their reach – for example, to include informal carers – is always being explored. From the commissioners’ perspective

the quality and competence of individual managers amongst provider organisations has proved time and again to be crucial to their operating success.

Senior management involvement in the training process appears to lend weight to the seriousness with which it is taken and viewed by providers. One independent agency spends nearly 10% of its contract revenue on training. The in-house provider operates a system whereby once signed up for training, staff cannot be withdrawn from it to meet short-term operational difficulties elsewhere.

Attitudes to recruitment have also changed and, in the independent sector, it has become increasingly common practice to guarantee a certain number of hours of work to care workers to cover circumstances when, for example, clients go into hospital and workers would otherwise not have any contact hours (and pay).

For the purposes of this study, discussions were held with several care workers – some recent entrants, others who had worked for nearly 20 years in the sector – about what motivated them. They were in general agreement that the availability of training, and the feeling that their organisations listened and responded to their needs were key characteristics:

“There’s loads of training and support available which strengthens my confidence as well as my skills. The council’s been very flexible with arrangements and supportive to my family circumstances.”

“If I need support, I’ll get it quickly and there’s always advice on the end of the phone if I need it. You feel there’s plenty of back-up available.”

“The three days ‘shadowing’ experience for new recruits prior to their induction training is a great way to see whether you like what the job has to offer.”

6.11 A multi-agency approach to planning

Salford’s strategy for older people’s services

The important feature about how home care is commissioned and delivered in Salford is that it is part of a strategic approach that looks at needs and issues across communities. The council and the Primary Care NHS Trust have a joint strategy for older people’s well-being – *Growing Older in Salford* – that was written in partnership with older people from across the city. The strategy encompasses the work of other public, voluntary and private sector agencies, and will make use of the resources available to Salford from the national ‘LinkAge Plus’ initiative. The stated priorities are:

- Feeling safe and secure
- Combating ageism and enabling older people to continue to be involved in the life of the community
- Appropriate transport
- Being healthy and active
- Access to information
- Health, social care and housing
- An adequate income
- Increasing the involvement of older people.

Partnership working is already quite well established in Salford, and *Growing Older in Salford* is the most recent manifestation of this. Since 2001 there has been an Older People's Development Board overseeing work to implement the National Service Framework. This has contributed to a very positive overall performance against national targets, including very high numbers of older people being supported at home, relatively few older people moving into residential care, large numbers of extra care housing tenancies, good progress on intermediate care, and significant increases in the take-up of direct payments by older people.

According to the council, an important aspect of the shift toward more flexible services in the community has been the influence of older people themselves. They are meaningfully involved in the Older People Partnership Board and Development Board, and will play a key role in monitoring the well-being strategy. Increasing emphasis is also given to the scrutiny role of older people; the Salford Forum of Older People helps to 'age proof' the council's policies, reporting formally to the council's Overview and Scrutiny Committee.

Two members of the Partnership Board, who were interviewed for this report, spoke positively about the role they were enabled to play and about the importance of ensuring older people have good access to a range of services:

"Older people here generally don't want to use services but when they do it should be easy to do so."

Home care is seen as critical to the delivery of the overall strategy; both private and voluntary sector providers have been part of the shared vision. The private sector delivers the 'mainstream service' based on four localities. The council's in-house service (the intermediate home support service) is free to older people and concentrates on short term 'enabling' work. It takes referrals directly from health as well as social care professionals, and often works alongside health colleagues (including one secondment to the PCT's intermediate care team) in delivering the service.

There is also a cleaning and shopping service that is 'pay as you go' (the council meets the infrastructure costs of the local organisation that runs it) and a handy

person scheme run by a community enterprise commissioned through the housing service. Local extra care housing units have their own on-site care and support provided by an independent agency.

A key feature of all these components of home care in Salford is a culture that encourages managers and staff to make wider connections: with the ambulance service for training on lifting, with the fire service for the fitting of smoke detectors, with local benefits agencies to pursue individual claims, with the adult safeguarding team to be mindful of the vulnerable position that some older people (especially those with dementia) may be in. A senior manager told us:

“There’s no quick fix... you can’t just change home care without looking at the whole system. There isn’t one service – there’s a spectrum.”

7 The role of the regulator



The purpose of this chapter is to explore the implications of this report for the way we regulate domiciliary care services and assess the performance of councils in commissioning them. The chapter summarises CSCI's plans to promote improvement in this area from 2006 onwards.

7.1 Feedback on the role of CSCI

This study provided many opportunities to discuss with stakeholders the impact of regulation on the home care sector, and how CSCI should develop its role. In particular, all those who attended the expert seminars were asked their views. A range of different views were expressed, but a summary of the main messages is as follows.

- ***It is very important that this sector is regulated.*** This view was expressed most strongly by the user representative organisations, but there was no dissent from the other groups. The consensus was that older people were potentially at risk from poor standards or unscrupulous care providers, and these risks increased in settings (such as people's own homes) where care workers' activities could not easily be monitored.
- ***CSCI should engage as much as possible with people using services, and base its judgements on their experience.*** The user representatives thought it particularly important for inspectors to visit older people at home, and thought most people would not see this as 'intrusive'. CSCI staff were preoccupied with the challenge of fi 0 0 1id nt fo12{t}2 1S0{t o}16{l}22{d}17{e}22{r p}14{e}14{o}15{p}16{l}17{e ris

- ***There may be a mismatch between what is currently regulated, and the government's expectations that services should diversify.*** Council representatives, in particular, were interested in how to assess councils' progress in offering direct payments, individual budgets, and various new models of care. There were concerns that the existing performance indicators were sometimes measuring the wrong thing, or could result in perverse incentives. Questions were asked, in particular, about (a) whether early intervention and preventative services were taken sufficiently into account in the current performance assessment framework, and (b) whether the unit cost indicators 'rewarded' costs that were too low, and/or diverted the focus away from quality and value for money.
- ***CSCI should challenge 'ageist' service provision.*** All our seminar groups were concerned with the apparently low per capita expenditure on social care for older people, and associated low standards of care. They asked CSCI to reflect this back to policy makers and commissioners. Their particular challenge was for us to pay more attention to older people's quality of life and rights as citizens, as opposed to just their health and safety.
- ***Home care should not be seen as 'just a social care service'.*** A range of services – such as health, housing, transport and leisure – also need to be in place for people to be supported well in the community. So, regulators should look at the whole picture rather than just one part in isolation.

7.2 CSCI's developing methodologies

The feedback summarised above resonates with the findings of CSCI's consultations since April 2004. We have been taking these into account in our phased programmes to improve both our regulatory work and our performance assessment of councils. This section briefly outlines CSCI future plans, including some proposals that are currently the subject of consultation.

7.2.1 User involvement

This is a major priority area for CSCI. Our annual report¹⁰¹ for 2005-06 includes an account of how we have developed techniques for engaging people across the range of our activities. At present, inspectors are required in every domiciliary care inspection to: to meet people using the service either through individual visits or group discussion; to undertake a 'case tracking' exercise in relation to 3-6 people, and to survey around 10% of the people using the service using postal and/or telephone questionnaires. We plan to extend and develop these techniques in 2006-07, including the increased use of people who are 'experts by experience' to interview people using services, an improved and standardised survey questionnaire with

simpler questions, and guidance for staff on the range of methods they can use. An important feature of this work will be the introduction of new ways of engaging with people who have difficulties communicating. We will also be exploring user views on quality issues relating to cultural diversity; we are introducing surveys in different languages and formats from this year.

In a self-assessment (to be introduced later in 2006-07) service providers will be required to tell us how they are engaging with the people who use their service, as part of their own quality assurance arrangements. Our approach – in this and other aspects of our work – will be to minimise duplication and to ensure there is clarity about the respective roles of councils, providers and the regulator in improving standards.

7.2.2 Regulation of domiciliary care

Registration:

CSCI simplified the registration process in 2005, to make it less bureaucratic. For domiciliary care, we have also changed the definition of ‘small agency’ – which was previously based on the number of staff employed – to reflect the pattern of extensive part-time work in this sector. The outcome will be that more small providers will be offered fee concessions in line with Regulations.

CSCI recognises that the guidelines on what types of service should be registered will need to be kept under constant review, as domiciliary care continues to diversify and new models are introduced. During 2006 CSCI issued revised guidance to staff on registering and inspecting a variety of schemes that support people who use direct payments. Some arrangements (such as independent living trusts) fall outside the scope of regulation. Others (such as user-managed agencies) are registrable. However, inspectors are encouraged to take account of the role played by users in setting policies (for example, on staff training) when assessing these services against the minimum standards.

We are in dialogue with independent living organisations about the future regulation of support arrangements related to the piloting of individual budgets. Informal systems for sharing staff, brokerage schemes, on-call support schemes and similar initiatives all work to non-standard patterns and may require a new approach to regulation.

Inspection:

The government is undertaking a review of the national minimum standards, with any significant changes expected to take effect from 2008-09.

Pending this, CSCI improved its inspection reports in April 2005 and 2006 to make them easier for people to read and also to include basic information about the provider’s fees.

CSCI now intends to make further improvements so that the reports deal more directly with the seven social care outcomes set out in *Our Health, Our Care, Our Say*¹⁰² rather than with each national minimum standard and associated domains. [See Figure 12].

Figure 12: Social Care Outcomes

- Quality of life
- Exercising choice and control
- Making a positive contribution
- Personal dignity and respect
- Freedom from discrimination and harassment
- Improved health and emotional well-being
- Economic well-being

Source: Department of Health (2006)

In addition, we propose to report under an additional heading covering 'leadership and management'.

From April 2007, every inspection report will include an 'outcomes graph' that reports performance in each of these areas on a four point scale. From 2007-08 onwards, we will then introduce a published 'quality rating' for every service, so the public can easily see how well a service is performing compared with others. The quality rating (and all other information about the service) will be reviewed annually. The frequency of key inspections in any year will depend on the rating given to the service, with the best having one every three years and the poorest services being inspected twice a year or more.

Our detailed proposals are set out in a consultation document: *Inspecting for Better Lives: A Quality Future*, published in August 2006 and available on our website: Quality.RatingsQPM@csci.gsi.gov.uk. Feedback can be sent by post or to our mailbox by 14 November 2006.

7.2.3 Performance assessment of councils

Phased changes are planned to the way we assess the performance of councils, leading up to the creation of a new social care and health inspectorate in 2008. The *Our Health, Our Care, Our Say* White Paper requires CSCI and the Healthcare Commission to work together and the two frameworks should be aligned by 2009. At the same time we are working with other local government regulators to streamline and co-ordinate our activity in anticipation of the creation of a new local government inspectorate, and a White Paper on the role of local government later in 2006.

Central to this task will be an emphasis on how councils with adult social services responsibilities achieve the outcomes set out above. We intend to assess councils' performance against the outcomes (replacing the existing set of national standards and criteria) from 2007. Again, we intend to add measures relating to how services are led and managed, how they are commissioned, and how resources are used. The 'success factors' set out in the consultation document (see below) relate very closely to those described throughout Chapter 5 of this report. For example, we and our partner regulators will look at:

- Councils' analysis of the needs of the whole population including self-funders;
- Councils' understanding of local markets;
- How local people contribute to planning, monitoring and evaluating services;
- The quality of local multi-agency plans;
- The existence of systematic long-term financial plans;
- Partnership working with the private and voluntary sectors, as well as statutory partners; and
- Finding innovative and creative solutions to longstanding challenges.

We will also systematically focus on the quality of the regulated services commissioned and purchased by councils – so that the data from our regulatory work (described above) is used to hold councils to account.

A feature of our new approach will be a commitment to reducing any unnecessary data collection. We plan to consult separately on which data items (over and above the Department of Health's indicators) are most helpful and which need changing. We are working with our colleagues in the Healthcare Commission on the development of joint performance measures, that will allow us to hold health and social care commissioners jointly to account where appropriate.

Details of our proposals can be found in: *A new outcomes framework for performance assessment of adult social care 2006-07* published in July 2006 and available on our website. The final date for submission of responses was 6 October 2006.

Appendix



Introduction

This appendix contains the most recent data available from a variety of sources that illuminate the state of the home care sector.

The majority of the data are available online from a published sources, including the NHS Information Centre, Department of Health, Department of Work and Pensions, and the Office for National Statistics.

Data relating to registration, enforcements and complaints originate from CSCI databases.

NB: Please note that all data referring to PAF indicators for the year 2005-06 are provisional estimates only.

Definitions of principal data sources:

- HH1 – Home Help and Home Care Services for Adults return, Department of Health. This holds data recorded over one week in mid-September each year by all councils. Includes data on supported service provision by all sectors for all adults (age breakdown unavailable).
- Delivery and Improvement Statement (DIS) – A wide range of data collected from councils and collated annually for CSCI.
- HES – Hospital Episode Statistics, Department of Health. Annual return providing information about the admitted patient treatment delivered by NHS hospitals in England.
- PSSEX1 – Personal Social Services Expenditure, Health & Social Care Information Centre. Annually collected expenditure returns.
- Attendance Allowance – Department for Work and Pensions. Quarterly data collection.
- ONS – Office for National Statistics. Population data including trends and projections.

In addition, other data sources are referenced as required.

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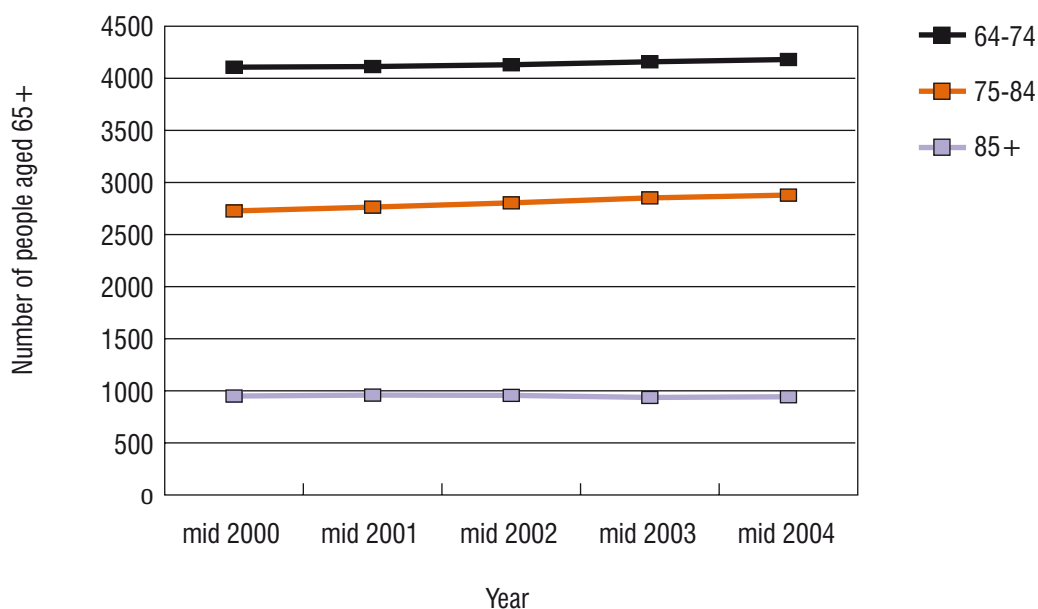
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Population Estimates

Table 1: Mid-year population estimates, England residents (thousands)

	mid2000	mid2001	mid2002	mid2003	mid2004
65	41,449.9	41,614.1	41,756.2	41,908.7	42,090.8
65-74	4,106.8	4,113.0	4,130.2	4,158.6	4,180.6
75-84	2,726.7	2,763.7	2,804.3	2,852.0	2,879.0
85+	949.9	958.9	956.2	936.4	942.7

Source: ONS published mid-year quinary estimates for England resident population

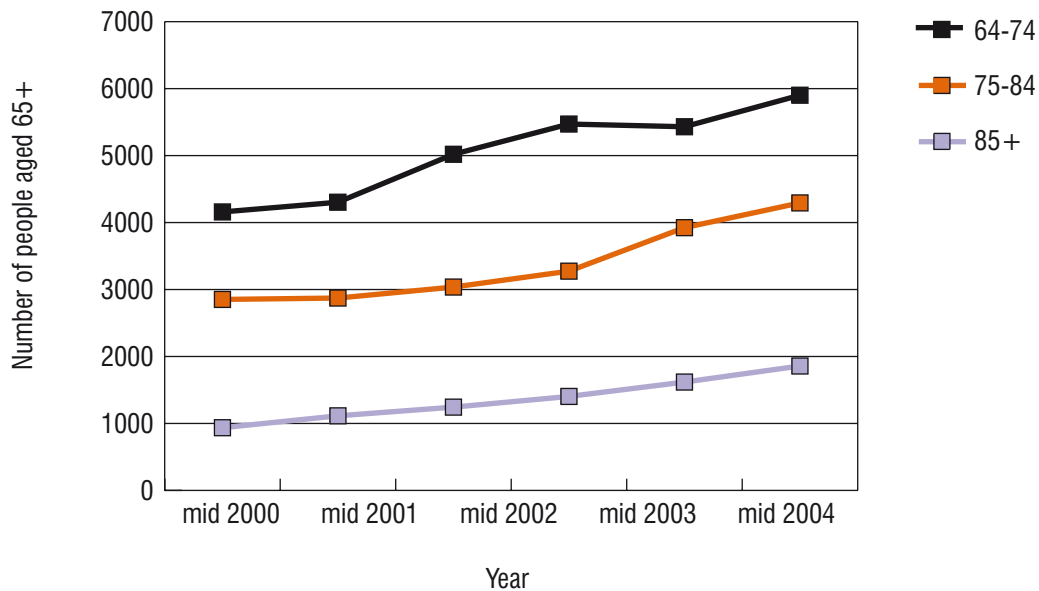


Over the past five years the 65-74 population has risen slightly and the 75-84 age group rather more. A surprising fact is that the numbers aged 85+ have declined very slightly over the time period; this is probably a reflection of low fertility in the 1920s.

Table 2: 2003-based population projections, England (thousands)

	2003	2008	2013	2018	2023	2028
65-74	4,158.6	4,303.6	5,019.5	5,471.0	5,430.9	5,901.5
75-84	2,852.0	2,872.6	3,036.8	3,274.2	3,923.8	4,293.3
85+	936.3	1,113.8	1,243.7	1,403.4	1,618.1	1,857.9
AGES 65+	7,946.9	8,290.0	9,300.0	10,148.6	10,972.8	12,052.7
AGES 75+	3,788.3	3,986.4	4,280.5	4,677.6	5,541.9	6,151.2

Source: DIS 2005-06, CSCI



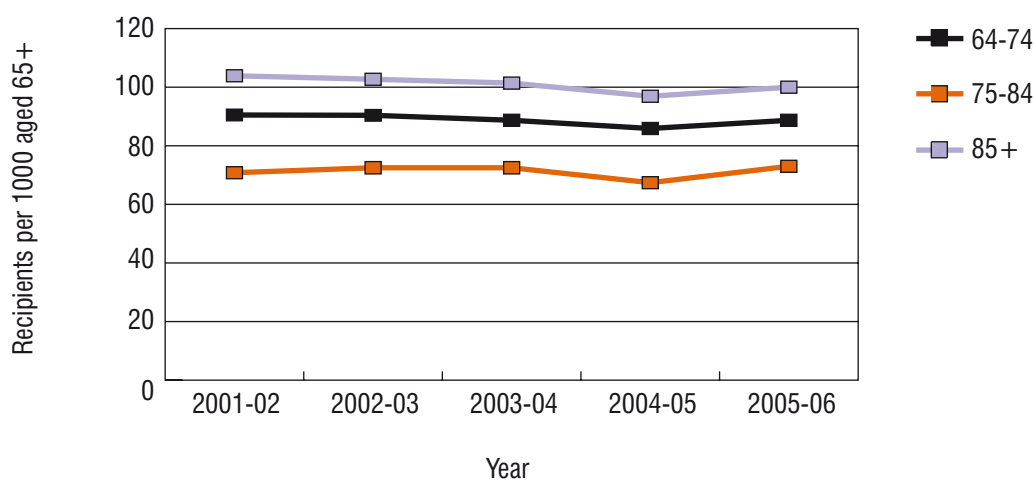
Although the numbers in the very elderly population (aged 85+) have been stable in recent years, this is set to change to an increase over the next 20 years or so.

Provision of home care

Table 3: Older People helped to live at home with support from social services, per thousand aged 65+ (PAF C32)

	2001-02	2002-03	2003-04	2004-05	2005-06
England	90.5	90.4	88.7	85.9	88.7
Lower Quartile	70.8	72.5	72.5	67.4	73.0
Upper Quartile	103.9	102.7	101.4	96.9	100.0

Source: DIS 2005-06, CSCI



Note: The recent dip in the figures is the effect of a restatement of guidance on the definition of the data. Prior to this some councils had included data that overstated their position.

The proportion of older people helped to live at home has remained rather stable for several years, with a switch of resources to more intensive care packages.

Table 4: Number of households and clients (all ages) receiving supported home care and number of contact hours delivered

Year	Households	Clients	Contact hours
2001	381,700	395,500	2,878,300
2002	366,500	381,920	2,975,800
2003	363,000	373,500	3,113,100
2004	355,800	368,410	3,375,490
2005	354,500	367,700	3,567,550

Source: HH1 return, Department of Health.

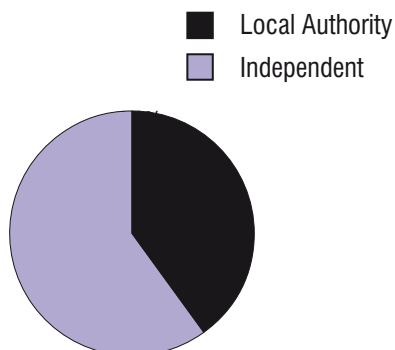
Over the past five years initiatives have increasingly focused on people with higher-level support requirements. So, while the total number of supported contact hours has *increased* by 8% (see Table 5), the overall number of households and clients supported over the same time has *decreased* by 7% (see Table 4).

Table 5: Contact hours by sector of provision

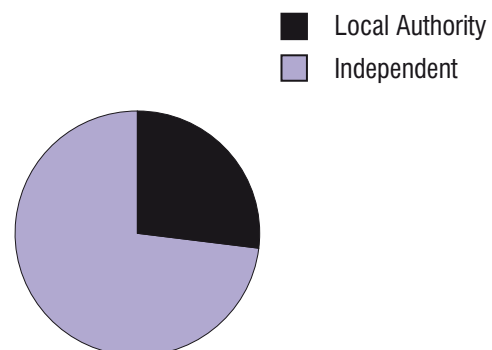
Year	All sectors	Local Authority	Independent
2001	2,878,300	1,161,400	1,716,900
2002	2,975,800	1,078,430	1,897,370
2003	3,113,100	1,043,200	2,069,800
2004	3,375,490	1,036,820	2,338,670
2005	3,567,550	948,600	2,618,950

Source: HH1 return, Department of Health.

Proportion of supported contact hours by sector 2001



Proportion of supported contact hours by sector 2005



The proportion of supported contact hours provided by the independent sector (as opposed to local authority providers) has increased from 60% to 73% between 2001 and 2005.

Table 6: Number of households receiving supported home care by sector

Year	All sectors	Local Authority	Independent
2001	381,200	194,300	205,300
2002	366,770	167,850	216,200
2003	362,800	149,500	226,500
2004	355,630	134,080	235,830
2005	354,500	119,680	250,220

Source: HH1 return, Department of Health.

The number of households receiving supported home care from the independent sector (as opposed to local authority providers) increased by 22% between 2001 and 2005. This represents an increase in the proportion across all such households from 54% to 70%.

Table 7: Growth in supported intensive home care (10+ hrs/wk)

Year	Local Authority	Independent
2001	15%	23%
2002	17%	25%
2003	19%	26%
2004	21%	28%
2005	22%	29%

Source: HH1 return, Department of Health.

Across all the households receiving support, there has been a steady increase in the proportion receiving very intensive care packages (10 hours or more per week, with or without overnight care).

Table 8: Contact hours per client

Year	Households	Hrs/household
2001	381,200	7.6
2002	366,770	8.1
2003	362,800	8.6
2004	355,630	9.5
2005	354,500	10.1

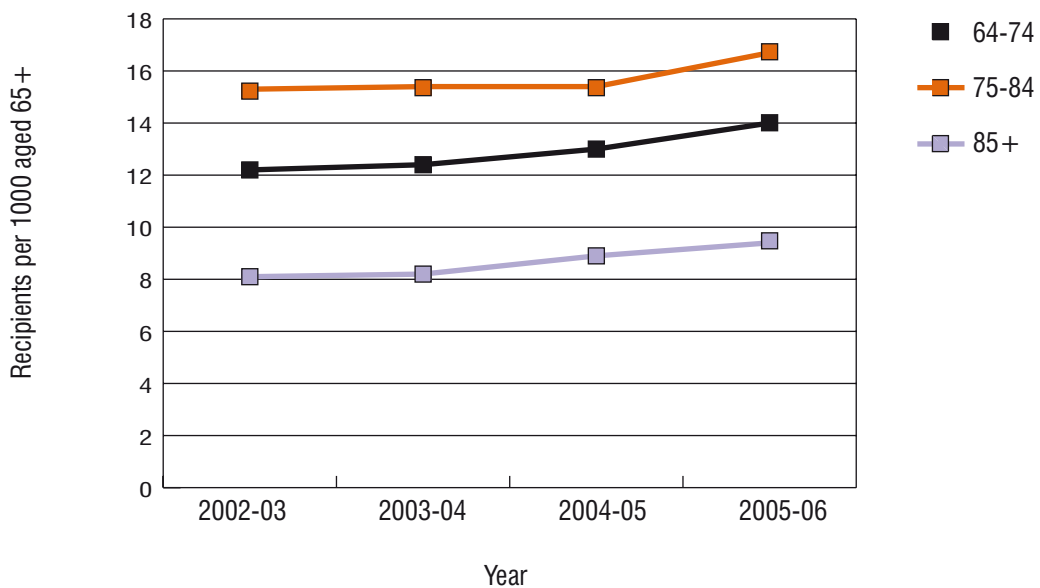
Source: HH1 return, Department of Health.

The intensification of services is also reflected in the average number of contact hours per household, which has risen to 10.1 hours in 2005, compared with 7.6 hours in 2001.

Table 9: PAF C28: Intensive Home Care (per thousand aged 65 and over)

	2002-03	2003-04	2004-05	2005-06
England	12.2	12.4	13.0	14.0
Lower Quartile	8.1	8.2	8.9	9.4
Upper Quartile	15.3	15.4	15.4	16.7

Source: DIS 2005-06, CSCI



Note: this PAF indicator is calculated with the assumption that the share of intensive home care going to older people (as opposed to younger adults) is proportional to the overall share of home care going to older people (about 82%). With effect from September 2006 data on the age of recipients will be collated as part of the routine HH1 return.

The growth in 'intensive' home care has been 14% over three years, adding approximately 14,000 more recipients.

Direct Payments

Table 10: Estimated number of people aged 65+ receiving Direct Payments and net expenditure

	Number of people aged 65+	Net expenditure (£000)
2002-03	2,000	10,234
2003-04	4,000	20,818
2004-05	7,000	38,663

Source: RAP and PSSEX1 returns, DH and Health & Social Care Information Centre

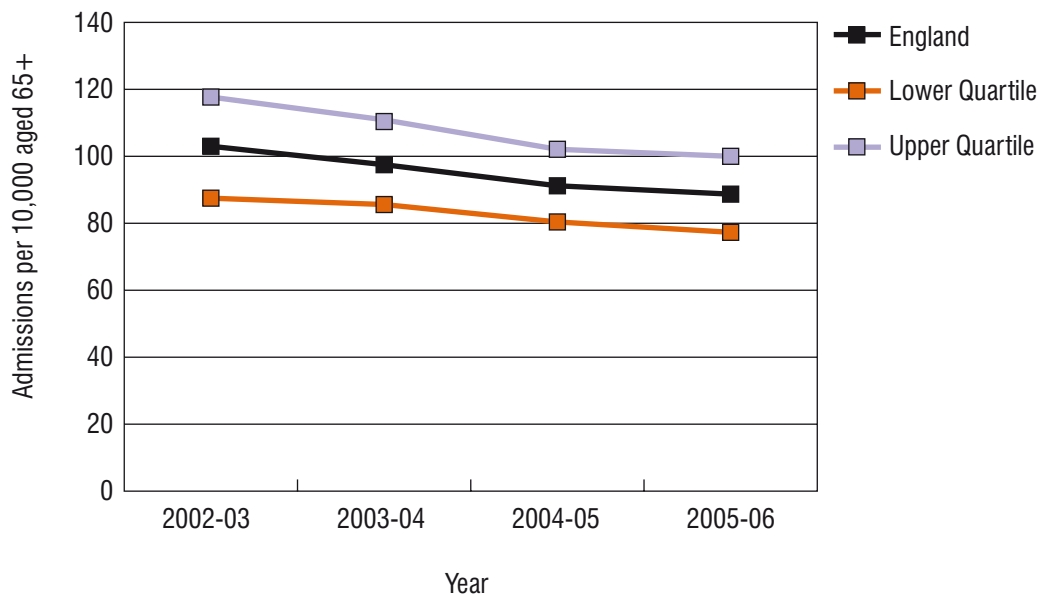
Direct Payments were extended to people aged 65+ in 2000. The number of older recipients has been growing steadily with a concomitant increase in net expenditure.

Supported admissions to residential care

Table 11: PAF C26: Admissions of supported residents aged 65 or over to residential / nursing care

	2002-03	2003-04	2004-05	2005-06
England	103.0	97.5	91.2	88.7
Lower Quartile	87.5	85.6	80.4	77.3
Upper Quartile	117.7	110.9	102.1	100.0

Source: DIS 2005-06, CSCI



The growth of domiciliary care has also contributed to a reduction in the numbers of people being permanently admitted to care homes with support from councils. There has been a reduction of 14% over the past three years, equivalent to approximately 12,000 fewer admissions per annum. The increased number of clients receiving intensive domiciliary care support is close to the decrease in supported residential placements.

Table 12: Council supported residents at 31 March (people aged 65+)

Note: These data include both permanent and temporary residents. From 2003 the

*data include clients who (s)11(e)14(b)2(f)15(r)en/8(s)inberwip12(t) frse 22(nr-325v)12(e)24(d)rd
upward 31(t)19(e)22(m)pc)24(1)125(d)22(g)14(e)15)32(n)se*

Provision of intermediate care

Table 13: Number of places funded by councils in non-residential intermediate care schemes per 100,000 people aged 65 and over

	2002-03	2003-04	2004-05	2005-06
England	40.0	60.0	67.0	79.0
Lower Quartile	11.0	25.0	41.0	46.0
Upper Quartile	104.0	140.0	171.0	150.0

Source: DIS 2005-06, CSCI

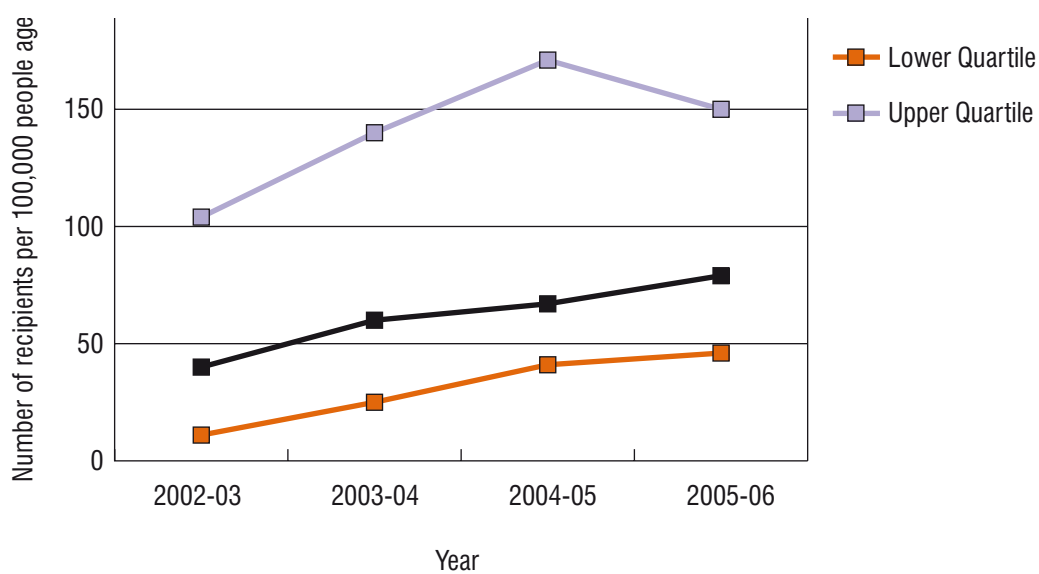


Table 14: Number of people funded by councils receiving non-residential intermediate care to prevent hospital admission, per 100,000 people aged 65 and over

	2002-03	2003-04	2004-05	2005-06
England	289.1	341.9	431.2	506.1
Lower Quartile	70.5	87.5	111.8	130.3
Upper Quartile	364.8	397.5	534.0	716.5

Source: DIS 2005-06, CSCI

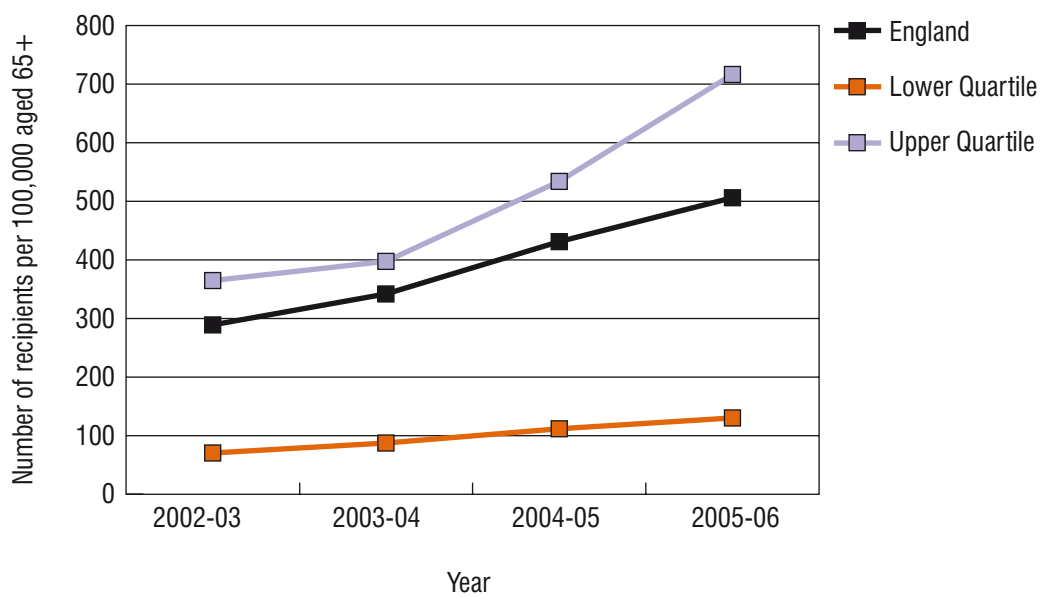
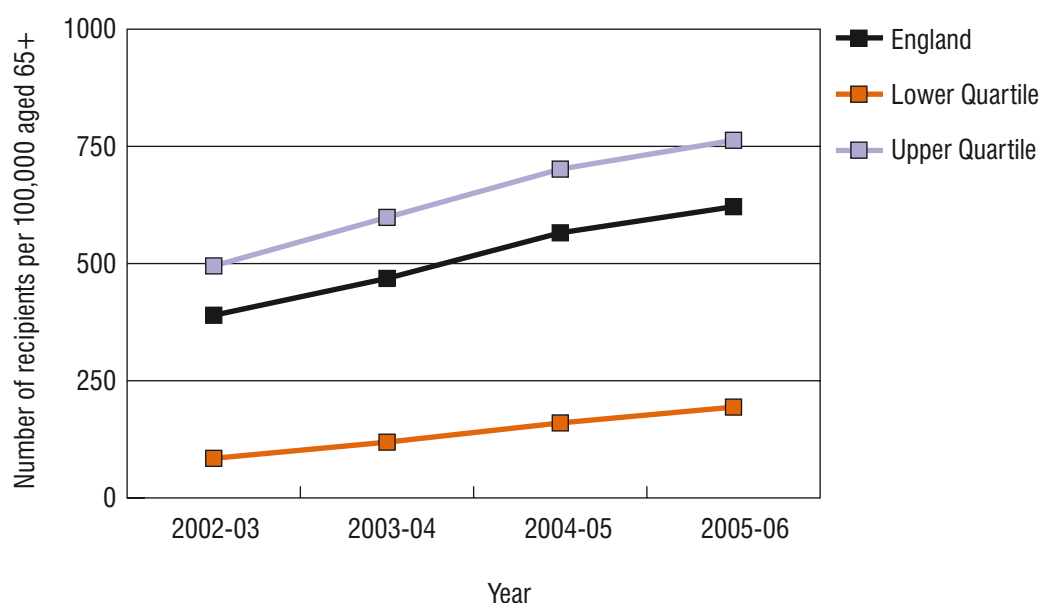


Table 15: Number of people funded by councils receiving non-residential intermediate care to facilitate timely hospital discharge and/or effective rehabilitation, per 100,000 people aged 65 and over

	2002-03	2003-04	2004-05	2005-06
England	389.7	468.3	565.6	621.4
Lower Quartile	84.5	119.0	160.0	193.8
Upper Quartile	495.0	598.5	701.5	763.0

Source: DIS 2005-06, CSCI



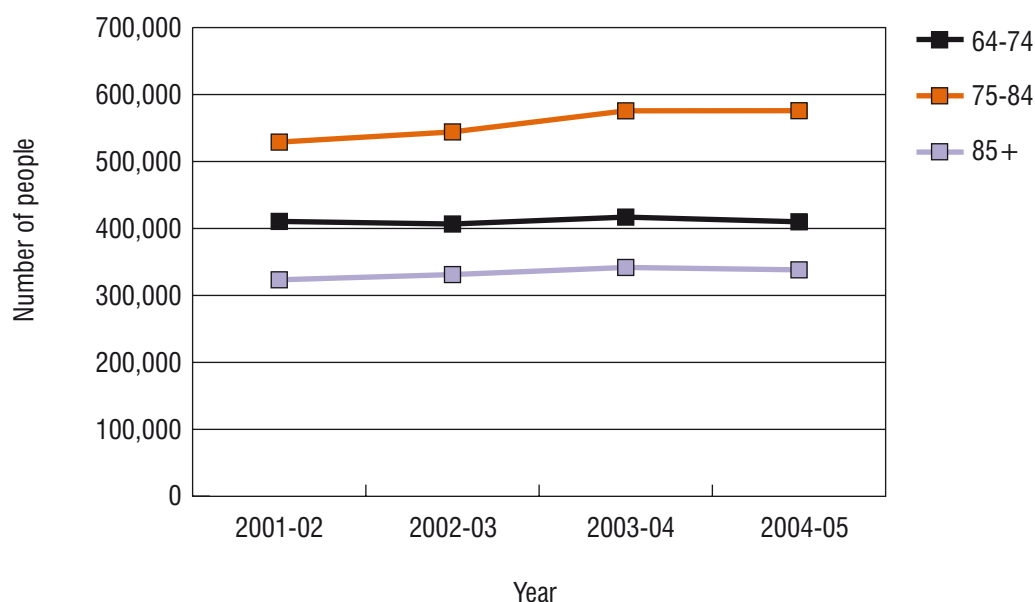
The growth in domiciliary care has also supported the development of non-residential intermediate care with the number of places funded by councils having doubled over the past three years. There has been substantial growth in the numbers receiving care to prevent hospital admission (up 75%) and to facilitate hospital discharge (up 60%).

Delayed transfers from hospital

Table 16: Number of finished spells in (discharges from) general and acute specialties with length of stay greater than one day

	2001-02	2002-03	2003-04	2004-05
65-74	410,541	406,660	416,971	409,968
75-84	528,983	544,186	575,689	575,877
85+	323,353	331,162	341,780	338,201
Total	1,262,877	1,282,008	1,334,440	1,324,046

Source: HES, Department of Health



Source: HES, Department of Health

It is difficult to assess the consequences of enhanced home care and the related developments of intermediate care on acute hospital demand. Changing practice has, for example, greatly increased the numbers of older people admitted for a day or less for medical assessment.

Overall the number of emergency admissions of older people who stayed longer than one day fell slightly across England in 2004-05 after rising in previous years.

Table 17: Percentage of patients whose transfer of care from hospital was delayed (by PCT)

	2002-03	2003-04	2004-05
Lower Quartile	2.70%	1.80%	1.20%
Median	4.10%	3.00%	2.20%
Upper Quartile	6.80%	4.80%	3.40%

Source: Healthcare Commission, Performance Indicator Ratings 2005

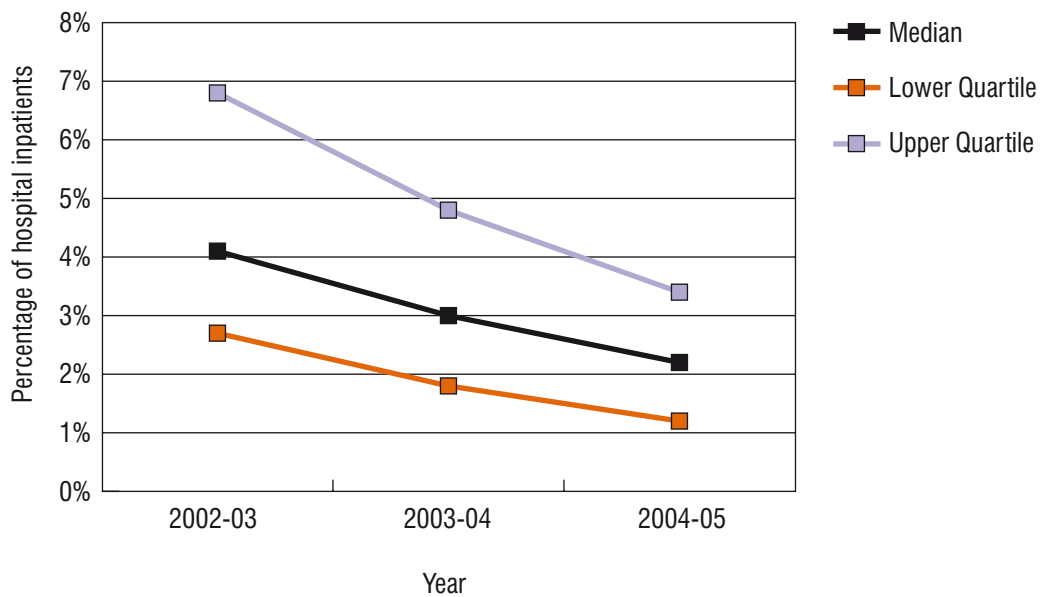
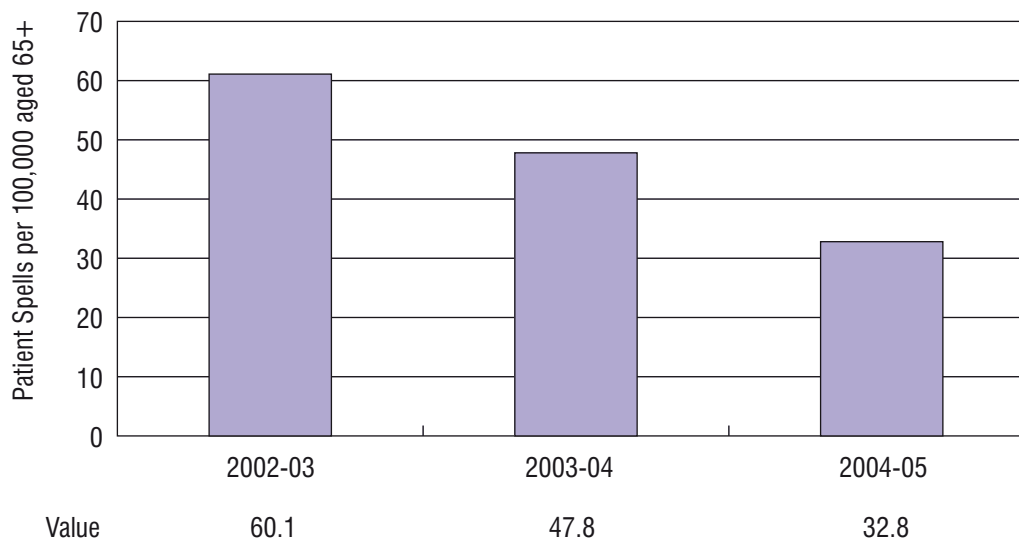


Table 18: Delayed Transfers of Care per 100,000 people aged 65 and over



Source: PAF D41

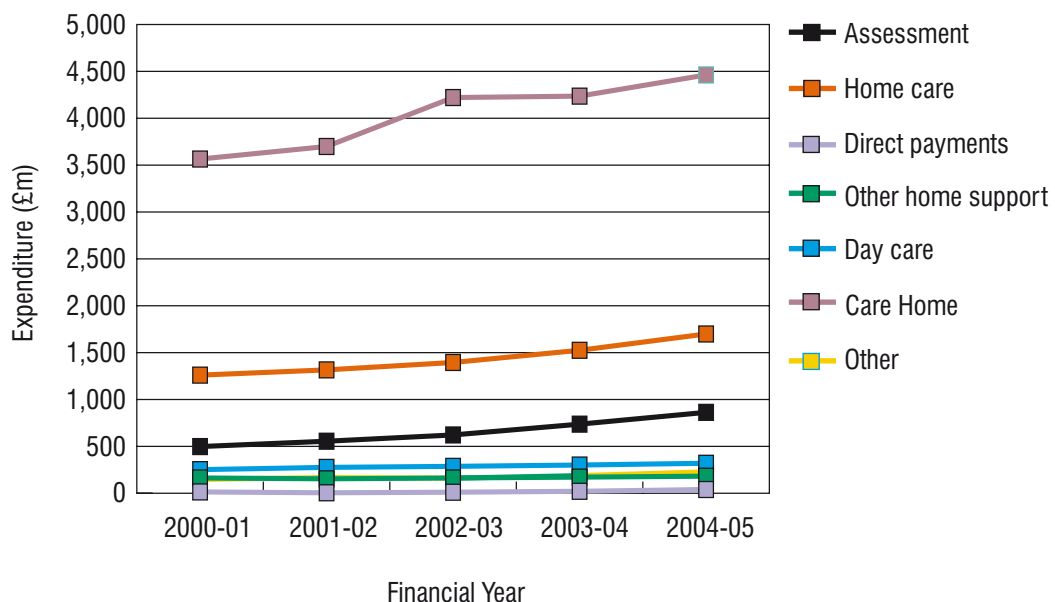
Improved availability of home care is one of the factors that have contributed to a decline in delayed transfers of care. Relative to the population, the numbers of delayed transfers of care in 2004-05 were just over half that two years earlier. Most patients who are delayed in this way are older people.

Financial Data

Table 19: Gross expenditure on people aged 65 years and older (£m)

	2000-01	2001-02	2002-03	2003-04	2004-05
Assessment	498	555	622	737	863
Home care	1,260	1,316	1,395	1,525	1,699
Direct payments	14	5	11	21	40
Other home support	163	154	163	172	182
Day care	252	276	287	301	320
Care Home	3,565	3,699	4,221	4,236	4,462
Other	148	168	161	188	228

Source: PSSEX1 Health and Social Care Information Centre



Note: these figures exclude capital charges.

Overall gross social services expenditure rose by 32% between 2000-01 and 2004-05. The share of this growth on home care was proportionate at 35%. Home care has accounted for a constant proportion of overall expenditure on older people's services, with the figure remaining at 21-22% between 2001 and 2005.

Table 20: Net expenditure on people aged 65 years and older (£m)

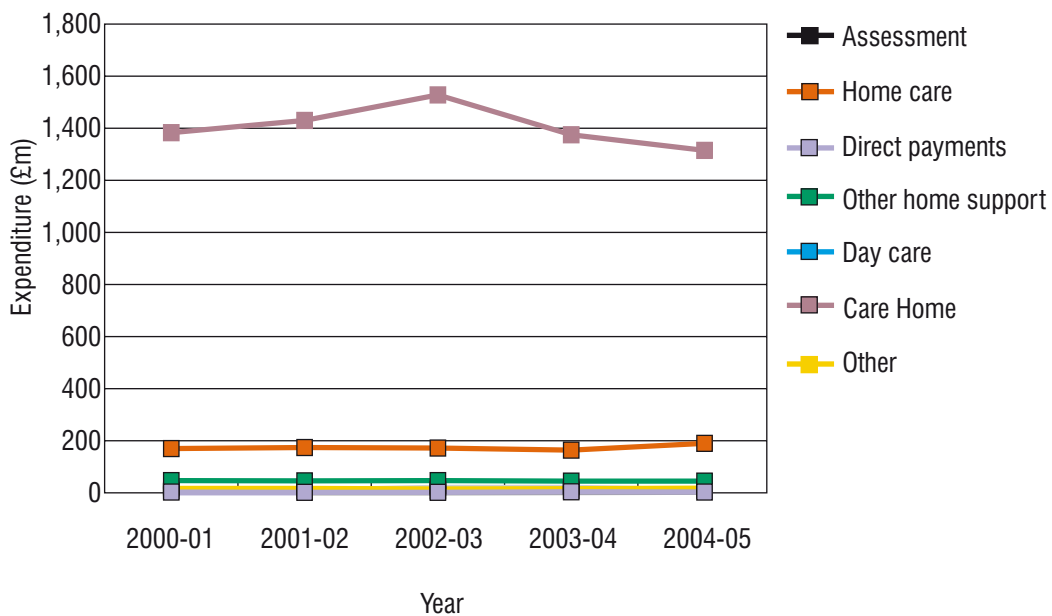
	2000-01	2001-02	2002-03	2003-04	2004-05
Assessment	495	553	620	733	860
Home care	1,090	1,142	1,223	1,360	1,509
Direct payments	14	5	10	21	39
Other home support	116	108	116	127	137
Day care	235	259	272	285	302
Care Home	2,182	2,269	2,692	2,552	2,750
					1,450

Expenditure net of income from fees and charges paid by clients grew by 46% over the same time period. Net expenditure on care home placements increased noticeably more than gross expenditure. This reflects an increasing share of care home costs being paid for from public funds through higher fees to care home operators paid by councils. It may in part also result from the growth in residential intermediate care placements paid for by councils.

Table 21: Income from fees and charges etc. for older people (£m)

	2000-01	2001-02	2002-03	2003-04	2004-05
Assessment	3	2	2	4	3
Home care	170	174	172	164	190
Direct payments	0	0	0	1	2
Other home support	47	46	47	45	45
Day care	17	17	15	16	18
Care Home	1,383	1,430	1,528	1,375	1,315
Other	12	11	21	21	12

Source: PSSEX1 Health and Social Care Information Centre

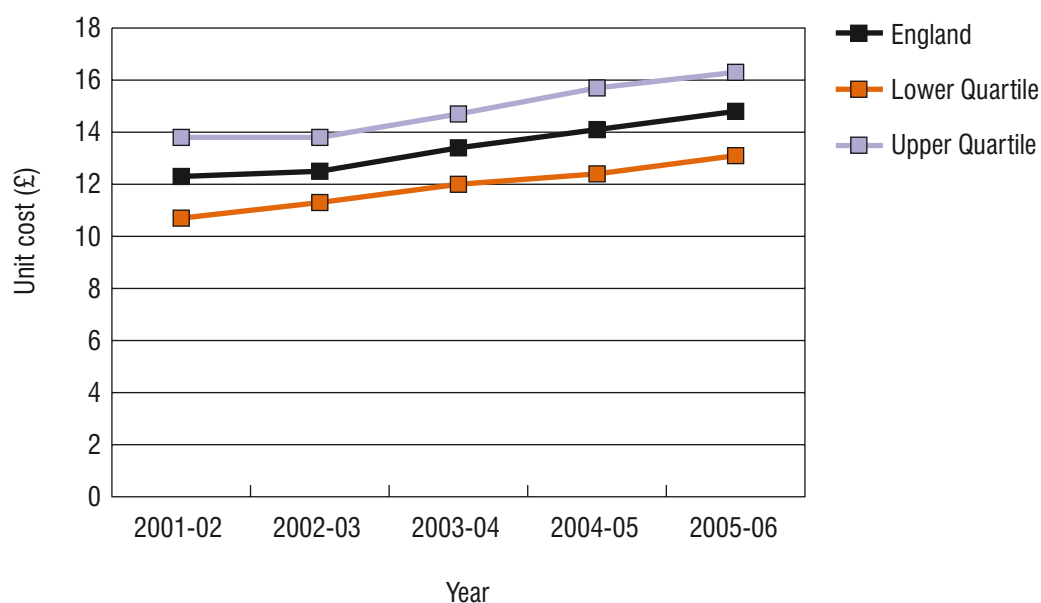


Income from care home residents fell and that for home care remained static over the period 2001 – 2005. This suggests a decreasing contribution from individuals for their care in real terms. Different arrangements for funding some types of service provision (including some intermediate and respite care) may affect the numbers from whom charges are levied.

Table 22: PAF B17: Unit cost of home care for adults and older people (£ per hour)

	2001-02	2002-03	2003-04	2004-05	2005-06
England	12.30	12.50	13.40	14.10	14.80
Lower Quartile	10.70	11.30	12.00	12.40	13.10
Upper Quartile	13.80	13.80	14.70	15.70	16.30

Source: DIS 2005-06, CSCI

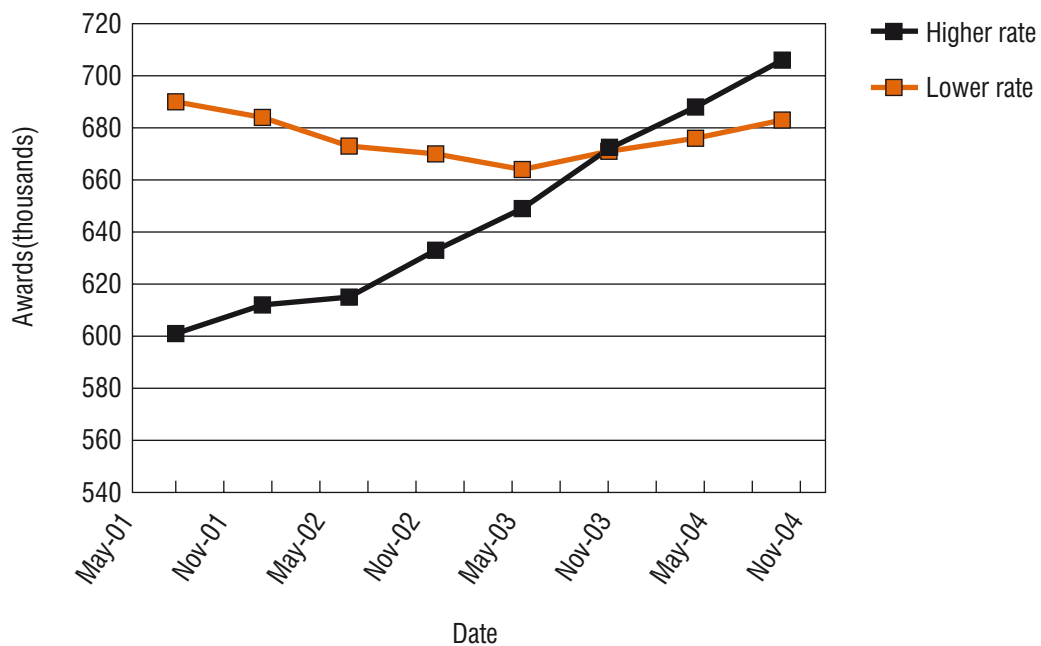


Unit costs of home care nationally have risen from an average of £12.30 per hour to £14.80 per hour – an increase of about 5% per annum in cash terms, equivalent to about 2% each year in real terms.

Table 23: Attendance Allowances current on the last day of the month shown (thousands)

Year	Higher rate	Lower rate	All awards
May-01	601	690	1,290
Nov-01	612	684	1,295
May-02	615	673	1,288
Nov-02	633	670	1,303
May-03	649	664	1,313
Nov-03	672	671	1,344
May-04	688	676	1,365
Nov-04	706	683	1,389

Source: Department for Work and Pensions, quarterly data collection



Note: data shown relate to all adults, not only people aged 65 years and older.

The graph shows the total number receiving Attendance Allowance at the end of the month shown: there was an increase of 105,000 (17%) in the numbers receiving the higher rate between May 2001 and November 2004.

Waiting times for assessments and services

Table 24: PAF D55 (part ii): Percentage of assessments of older people completed within 4 weeks

	2003-04	2004-05	2005-06
England	65.7	69.7	75.7
Lower Quartile	54.8	60.9	67.6
Upper Quartile	75.8	77.8	84.6

Source: DIS 2005-06, CSCI

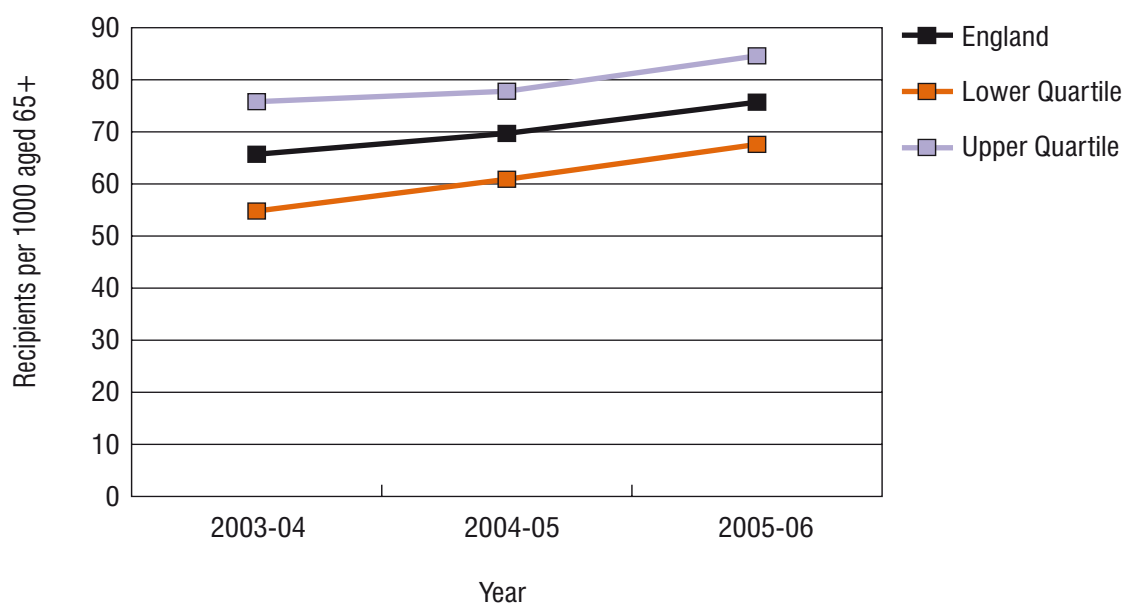
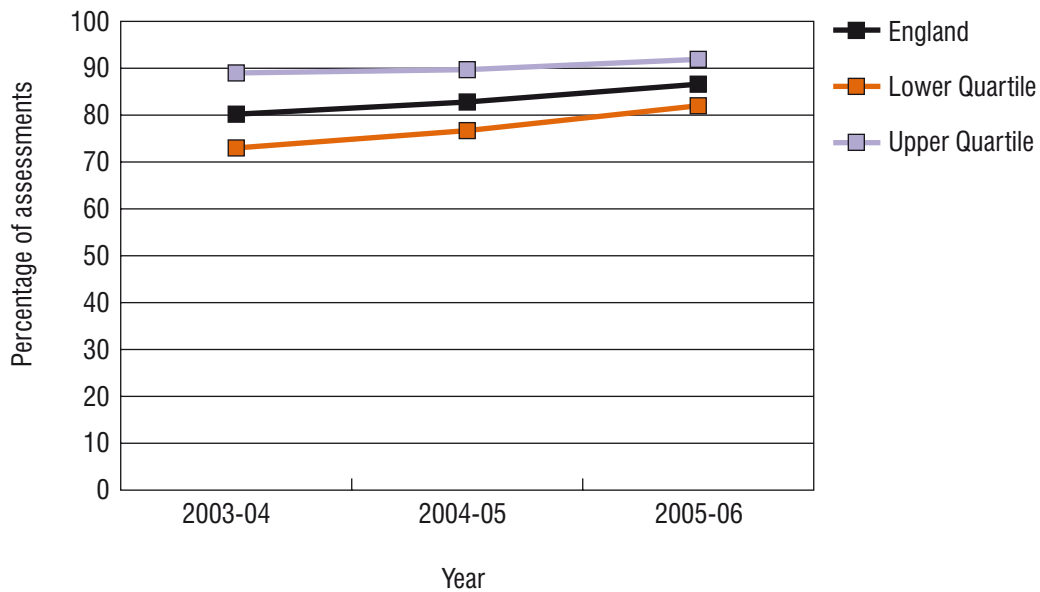


Table 25: PAF D56: Percentage of social services for older people provided within 4 weeks following assessment

	2003-04	2004-05	2005-06
England	80.2	82.8	86.6
Lower Quartile	73.0	76.7	82.0
Upper Quartile	89.0	89.7	91.9

Source: DIS 2005-06, CSCI



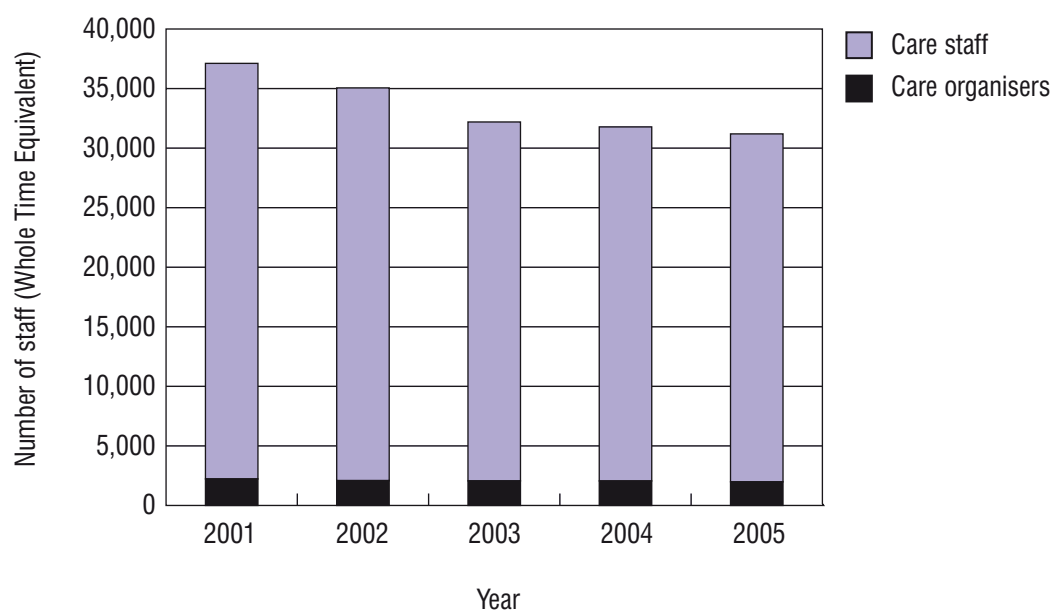
There has been an increase in expenditure on assessment activity (see Table 20). This is one of the factors that may have contributed to a reduction in the waiting times for assessments. The numbers receiving a service within four weeks after assessment has also increased.

Local authority home care workforce

Table 26: Local authority home care workforce

	Care organisers	Care staff
2001	2,230	34,885
2002	2,090	32,965
2003	2,065	30,130
2004	2,060	29,720
2005	1,985	29,210

Source: SSDSS01, NHS Health and Social Care Information Centre



Note. These data apply to all adults, including people aged 54+

In line with a decreasing proportion of home care being provided by local authority in-house teams, the home care workforce (measured in Whole Time Equivalents) has decreased over recent years.

Regulation of Domiciliary Care Agencies

Table 27: Number of registrations and de-registrations of Domiciliary Care Agencies (1 April 2005 – 31 March 2006)

Region	Registrations	De-registrations
North East	45	24
East Midlands	134	35
South West	96	70
West Midlands	93	32
North West	127	41
London	105	48
South East	131	76
Eastern	102	55
Yorkshire & Humber	72	35
England	905	416

Data Source: CSCI registration database (extracted 1 July 2006)

Table 28: Percentages of all inspected domiciliary care agencies meeting specific standards, 2005-06

Standard	No of times inspected	Description	1	2	3	4	Total met or exceeded
			Standard not met	Standard almost met	Standard met	Standard exceeded	(3 + 4)
User focused services							
1	3063	Information	3%	31%	64%	2%	66%
2	3441	Care needs assessment	4%	19%	74%	3%	77%
3	2675	Meeting needs	3%	16%	78%	4%	81%
4	2393	Contract	4%	19%	76%	1%	77%
5	2603	Confidentiality	1%	11%	87%	1%	88%
6	2924	Responsive services	3%	19%	71%	7%	78%
Average percentage meeting standards 1-6			3%	19%	75%	3%	

Standard	No of times inspected	Description	1	2	3	4	Total met or exceeded
			Standard not met	Standard almost met	Standard met	Standard exceeded	(3 + 4)
Personal care							
7	3208	Service user plan	8%	40%	48%	4%	52%
8	3412	Privacy and dignity	1%	6%	88%	6%	93%
9	2456	Autonomy and independence	1%	10%	85%	4%	89%
10	3393	Medication and health related activities	8%	33%	57%	1%	58%
Average percentage meeting standards 7-10			4%	22%	70%	3%	
Protection							
11	3432	Safe work practices	4%	19%	76%	2%	78%
12	3427	Risk assessments	6%	31%	61%	2%	63%
13	2436	Financial protection	3%	23%	73%	1%	74%
14	3430	Protection of the person	4%	30%	65%	1%	66%
15	2407	Security of the home	2%	22%	75%	1%	76%
16	2596	Records kept in the home	4%	27%	69%	1%	70%
Average percentage meeting standards 11-16			4%	25%	70%	1%	
Managers and staff							
17	3452	Recruitment and selection	8%	31%	58%	3%	61%
18	2368	Requirements of the job	2%	16%	81%	2%	82%
19	3417	Development and training	4%	29%	59%	8%	67%
20	2607	Qualifications	2%	29%	64%	5%	69%
21	3398	Supervision	7%	36%	53%	4%	57%
Average percentage meeting standards 17-21			5%	28%	63%	4%	

Organisation and running of the business							
22	3398	Business premises, management and planning	3%	14%	78%	5%	83%
23	1979	Financial procedures	0%	6%	93%	1%	94%
24	2513	Records keeping	3%	26%	70%	1%	71%
25	2503	Policies and procedures	2%	22%	73%	3%	76%
26	3438	Complaints and compliments	2%	22%	75%	2%	76%
27	2721	Quality Assurance	5%	31%	60%	5%	65%
Average percentage meeting standards 22-27			3%	20%	75%	4%	

Table 29: Complaints received by CSCI concerning Domiciliary Care Agencies in 2004-05 and 2005-06, by person making the complain

Person Making Complaint	2004-005		2005-006	
	Number of Complaints	%	Number of Complaints	%
Anonymous	20	3.2%	22	3.2%
Current Staff Member	27	4.3%	52	7.6%
Former Staff Member	36	5.8%	45	6.6%
Health Professional	8	1.3%	11	1.6%
Member of Public	9	1.4%	14	2.0%
Not Known	71	11.4%	71	10.4%
Other	39	6.3%	23	3.4%
Other Service User	0	0.0%	1	0.1%
Relative or Other Carer	263	42.4%	288	42.1%
Self (ie the Service User)	95	15.3%	120	17.5%
Social Worker or Placing Officer	53	8.5%	37	5.4%
Total	621	100%	684	100%

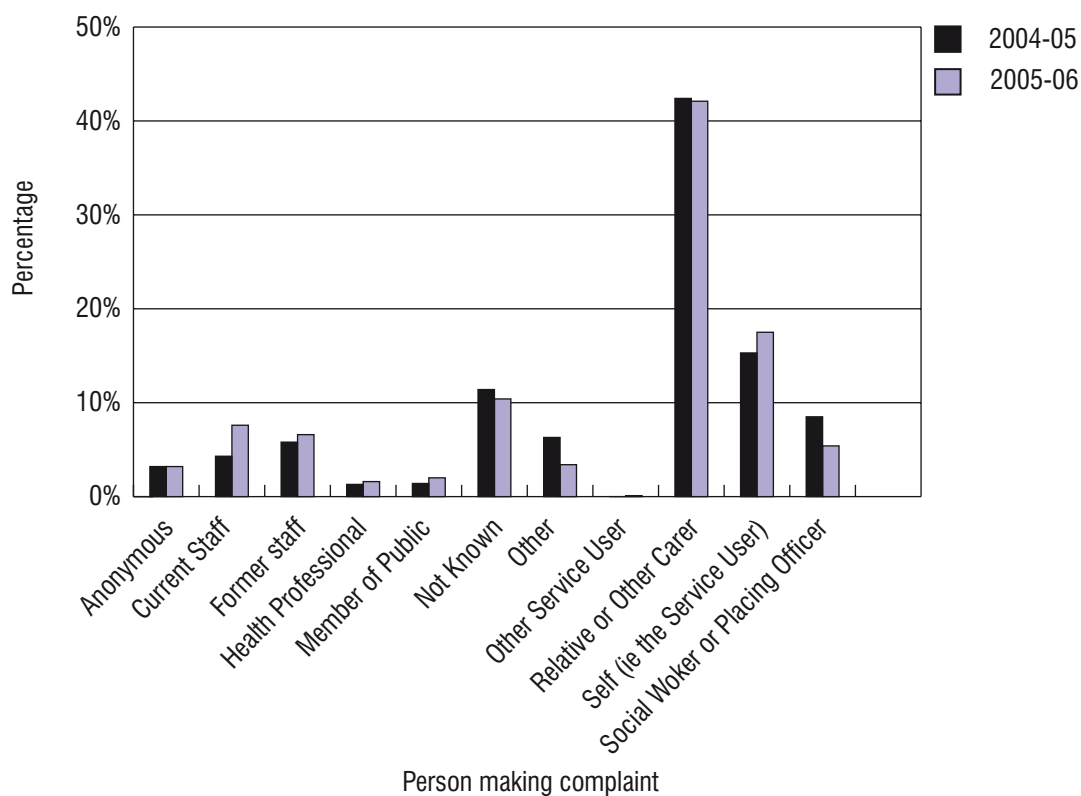
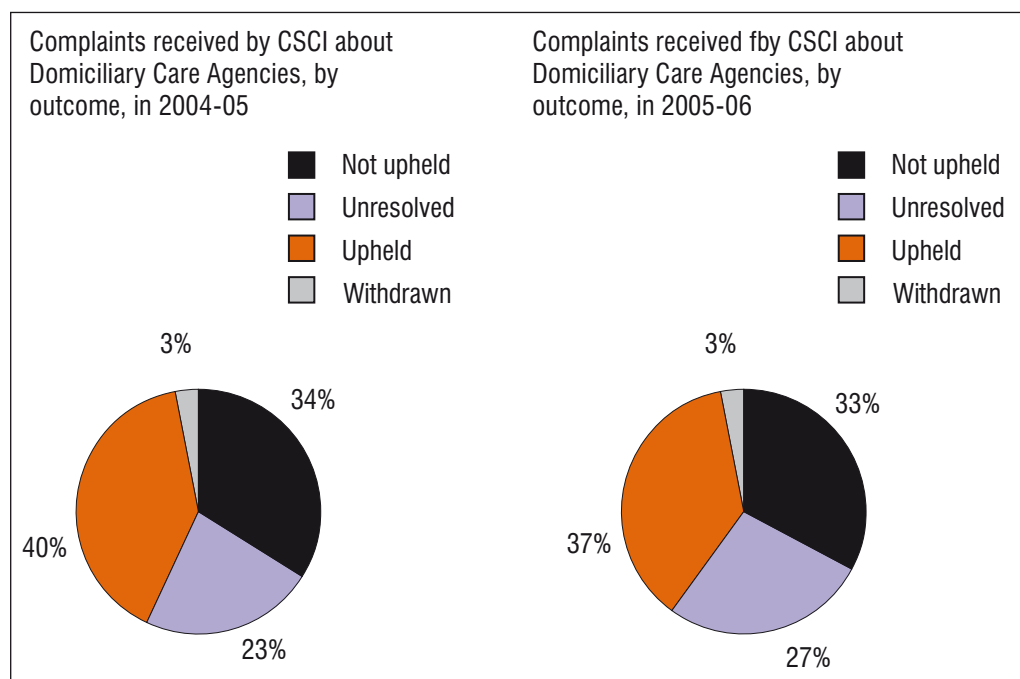


Table 30a: Complaints Received for Domiciliary Care Agencies, by outcome, in 2004-005 and 2005-006

Where a complainant is concerned about more than one issue, these are logged as separate complaints. So, whilst 684 people complained to CSCI about domiciliary care in 2005-06 (see Table 29), the number of complaints was 1,458 (see Table 30a). The overall numbers and underlying patterns were broadly similar in the previous year.

Category	2004-005					
	Not upheld	Un-resolved	Upheld	With-drawn	Total	%
Abuse	63	60	56	8	187	12.2%
Access	12	7	16	0	35	2.3%
Activity	2	2	0	0	4	0.3%
Admission	5	5	4	0	14	0.9%
Care Practice	81	59	119	4	263	17.2%
Facilities	1	0	0	0	1	0.1%
Food	6	9	9	1	25	1.6%
H&S	36	17	19	3	75	4.9%
Incidents	7	6	5	1	19	1.2%
Other	29	25	69	4	127	8.3%
Premises	5	2	3	0	10	0.7%
Registration	100	53	108	13	274	17.9%
Staffing	171	100	216	8	495	32.4%
Total	518	345	624	42	1,529	100.0%
%	33.9%	22.6%	40.8%	2.7%	100.0%	

Category	2005-006					
	Not upheld	Un-resolved	Upheld	With-drawn	Total	%
Abuse	60	70	45	8	183	12.6%
Access	10	9	17	1	37	2.5%
Activity	1	2	0	0	3	0.2%
Admission	7	4	5	1	17	1.2%
Care Practice	90	61	125	8	284	19.5%
Facilities	4	6	0	0	10	0.7%
Food	5	9	2	0	16	1.1%
H&S	10	22	23	0	55	3.8%
Incidents	4	3	6	0	13	0.9%
Other	48	33	57	8	146	10.0%
Premises	5	11	6	0	22	1.5%
Registration	67	28	47	5	147	10.1%
Staffing	175	133	206	11	525	36.0%
Total	486	391	539	42	1,458	100.0%
%	33.3%	26.8%	37.0%	2.9%	100.0%	



Source: CSCI Complaints Database

Table 30b: Breakdown of most frequently recurring complaints topics (1 April 2005 – 31 March 2006)

Complaint Description	
Abuse	183
Abuse	11
Bullying	5
Discriminatory	2
Emotional/Psychological	10
Financial	63
Neglect & Acts of Omission	72
Physical	11
Sexual	9
Care Practice	284
Care Planning	77
Care Practice	77
Health	4
Medication issues	38
Nursing	1
Personal Care	77
Privacy	10
Registration	147
Management/Organisation - Manager	98
Management/Organisation - Provider	48
Registration Categories	1
Staffing	525
Attitude	157
Competence	163
Facilities	10
Numbers	106
Qualifications/Skills	26
Training	63

Source: CSCI Complaints Database

This Table provides further breakdown of the most frequently recurring complaints topics, as set out in Table 30a.

16	Records in the home	10	Records to be kept of key events and of the work carried out and of changes affecting the care plan. Also, accident logs to be maintained.
17	Recruitment and selection	14	Recruitment processes to be made more rigorous, in line with Domiciliary Care Regulation 12 Schedule 3. To include two written references for all staff and confirmation of immigration status.
18	Requirements of the job	2	Better staff handbooks to be produced, explaining care workers' rights and responsibilities.
19	Training	19	Training programmes to be developed for all staff, in line with statutory requirements and standards set by the Training Organisation for Personal Social Services (TOPSS).
20	Qualifications	5	Achievement of NVQ2 qualifications in line with the Government target that 50% of the workforce should have this qualification by 2008. Also, achievement of the target that registered managers should have the NVQ level 4 qualification or equivalent by 2007.
21	Supervision	23	Structured programmes of supervision to be developed for all staff – which should happen no less than every 3 months. This to include some observation of the care worker's work.
22	Business premises etc	11	New managers to register with CSCI within specified timescales. CSCI to be informed if the manager is absent for more than one month.
23	Financial procedures	3	Records to reflect the amount of time truly spent with people, so that invoicing is fair.
24	Record keeping	2	Adequate staffing records to be maintained (eg employment history, photographs, statements of fitness).
25	Policies and procedures	2	Policies and procedures, especially those relating to users' rights, health and best interests, to be reviewed
26	Complaints and compliments	7	Records about the complaints received and the action taken to be kept - and to include accurate information.
27	Quality Assurance	9	Better QA systems to be introduced, to ensure that the views of users and carers are sought. T

Many inspections result in 'requirements' being made of the provider within a reasonable timescale, which is usually specified. For data collection purposes, current practice is to code these according to the national minimum standard (NMS) they most closely relate to, although it should be noted that CSCI's enforcement powers relate to the Domiciliary Care Standards Regulations (2002) rather than to the NMS. (In practice there is little difference, as most of the NMS are underpinned by statutory regulations). If requirements are not acted upon, and if this entails a breach of the regulations, then more formal enforcement action can be taken, starting with the issuing of a written 'requirement notice' (see Chapter 4, paragraph 4.8).

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Care UK

Carewatch

Choice Support

Coalition for Social Enterprise

Cottage & Rural Enterprises Ltd

Department of Health Equality and Human Rights Group

Enfield Borough Over 50s Forum

England Community Care Association (ECCA)

Essex Coalition of Disabled People

Essex County Council

Extra Care Charitable Trust

Hartlepool Borough Council

Healthcare Commission

HICA Group
Homecare Partnership
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Principle Home Care
Royal Mencap
Salford City Council
Sandwell Metropolitan Borough Council
Sandwell Primary Care Trust
SCA Community Care Services
See Ability
Shropshire Association of Senior Citizens Forums
Shropshire County Council
Skills for Care
Social Care Association
Southampton City Council
Sunderland Home Care Associates
Surrey Service Users Network
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Watford Senior Citizens Forum
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