

Home care in England

Views from commissioners and providers

Editor: Simon Bottery

**Authors: Laura Jefferson,
Laura Bennett, Patrick
Hall, Julia Cream, Veronica
Dale, Matthew Honeyman,
Yvonne Birks, Karen Bloor,
Richard Murray**

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1 Beyond time and task: introduction

Traditionally, home care has been commissioned and delivered on a 'time and task' model. This prioritises procedure and amount of time spent on care over meeting the needs of individual people.

(National Institute for Health and Care Excellence (NICE) 2015)

Home care (also known as domiciliary care) is the 'front line' of social care delivery. In 2015, more than 350,000 older people in England were estimated to use home care services, 257,000 of whom had their care paid for by their local authority. A further 76,300 younger people with learning disabilities, physical disabilities or mental health problems were also estimated to be using publicly funded home care (Wittenberg and Hu 2015).

The term 'home care' covers a wide range of activities. The provision of personal care (help with washing, dressing and eating) to people with long-term care needs is the core service provided by most local authorities, but home care also extends to reablement services for people leaving hospital or receiving crisis interventions to avoid hospital attendance in the first place. The term can also include help with household tasks – the 'mopping and shopping' activities that many people may need to live independently. However, under the eligibility guidelines applied in England, the requirement for these latter activities alone would not entitle people to local authority help and, in most cases, would need to be paid for privately. Some home care is also provided on a 'live-in' basis.

The United Kingdom Homecare Association (UKHCA) estimates that around 249 million hours of home care are delivered in England each year (Holmes 2016). As a service, it is critical to the longstanding strategic intention to enable people to 'age in place' and to deliver care as close as possible to people's homes. It is, or should be, central to the NHS strategic driver of 'helping frail and older people stay healthy and independent, avoiding hospital stays where possible' (NHS England 2017b). It is



also an essential component of care that responds to the priorities of those using it, which can be summarised as:

... the ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a 'burden' to their own families and that they can continue their own role as caregivers.

([Oliver et al 2014](#))

Commissioning and delivering home care of the highest quality, connected as closely as possible with health and housing services, and with the best outcomes and greatest efficiency, should be a significant objective for our health and social care system. Yet the future of home care is uncertain and the market is fragile. A survey of directors of adult social services in 2017 found that 39 per cent had experienced home care providers ceasing to trade in the previous six months and 37 per cent had experienced contracts handed back ([Association of Directors of Adult Social Services 2017](#)). In the past two years, three of the biggest national providers of home care (Saga, Care UK and Housing & Care 21) have withdrawn from the publicly funded home care market, while two others (Mears and Mitie) reported losses in their home care divisions. Mitie subsequently sold its home care business for £2 ([BBC News 2017](#)).

The market from which they are withdrawing is large and diverse. The Care Quality Commission (CQC), which inspects and regulates home care providers, says there were around 8,500 domiciliary care services in 2016/17. It notes 'substantial churn', with around 500 agencies registering each quarter and 400 de-registering ([Care Quality Commission 2017](#)). More agencies are de-registering before having provided any services which, according to the CQC, adds to uncertainty in the sector and concerns about lack of care continuity.

Home care agencies employ around 680,000 people (similar to the numbers employed in residential care), of whom the vast majority do 'direct care' as care workers ([Skills for Care 2018](#)). These numbers are likely to need to increase significantly in the coming years to cater for growing need, yet the care sector struggles to recruit even the number of staff it currently needs (there are around



110,000 vacancies at any one time). Over half of home care workers are employed on zero-hours contracts – more than in any other sector of social care – and turnover is also highest for domiciliary care, with a third of staff leaving their role within the previous year and the turnover of care workers running at over 4 in 10.

Quality of care is far from uniform: of the 5,788 agencies inspected by the CQC, 81 per cent were good and 3 per cent outstanding; 16 per cent required improvement and 1 per cent were inadequate. These are similar ratios to residential care homes and most other community social care services. And as with other care services, smaller providers were more likely to be rated as good (85 per cent compared to 73 per cent of services for more than 100 people).

Under the [Care Act 2014](#), local authorities have a statutory duty to ‘shape’ this market – to ensure that there are sufficient services of a sufficiently high quality to meet needs. An indication that this is not the case comes from the increasing wait for home care packages for people ready to leave NHS hospitals. This is now the single biggest reason for delayed discharge, rising from 12,777 bed days lost in August 2010 to 33,520 in March 2018 ([NHS England 2017a](#)). However, the length of wait varies significantly, highlighting a key theme of this report – that the market being ‘shaped’ differs significantly from area to area.

How councils respond to these differing local circumstances is at least in part driven by the state of their budgets. The Local Government Association (LGA) says that, by the end of this decade, English councils will have had a £16 billion reduction in government grant funding since 2010, at a time when there are increasing numbers of ageing and disabled people ([Local Government Association 2017](#)). Councils are therefore caught in the crossfire between rising demand and reduced funding. As a consequence, control of expenditure on social care has been vital, and one key factor in this is the rate they pay to private providers for commissioned home care. Since their local situations vary significantly, in practice this means that different councils may pay very different rates.

My colleague in Gloucestershire pays £26 an hour [to buy home care services], my colleague in Oxfordshire pays £22, I pay £16.80 and there are colleagues at less than £14. In the main, those are sustainable figures because, in different parts of the country, the labour costs are very different.

Glen Garrod, Association of Directors of Adult Social Services (ADASS), giving oral evidence (House of Commons Public Accounts Committee 2018)



Others, however, argue that the market is not sustainable and point to the number of provider withdrawals as evidence. This concern may be responsible for a recent year-on-year increase in the rates councils pay for externally commissioned home care – up by over 7 per cent from £14.46 in 2015/16 to £15.52 in 2016/17 (NHS Digital 2017). It may be that the drive to lower rates has finally bottomed in the face of market realities.

This report aims to understand the key trends and challenges facing the home care sector, based on discussions with commissioners, providers and national social care organisations. It draws on work carried out between 2016 and 2018, when The King's Fund produced three linked pieces of research into issues affecting the home care market in England, in collaboration with the University of York.

- *Adult social care: local authority commissioning behaviours*, which examined the factors driving commissioning of adult social care (including care homes) in England (Jefferson *et al* 2017). It explored the factors that either constrain or support commissioners to use their purchasing powers to shape the market. In total, 23 participants from 20 organisations – local authorities and national stakeholders – were interviewed.
- *Understanding domiciliary care in England*, which aimed to improve understanding of the mechanisms of purchasing and delivery of home care, including the current state of supply and demand and key drivers of market dynamics (Hall *et al* 2017). It drew on the report into local authority commissioning behaviours, but also used the following analysis:
 - a literature review of reports, articles and reviews published in the previous five years
 - national data analysis, drawing on samples of the labour force data supplied by Skills for Care from the National Minimum Data Set for Social Care (NMDS-SC) and data on registered providers of care from the CQC, along with data on expenditure and activity from NHS Digital. Other data sources included the Relative Needs Formula for adult social care, which estimates need to guide local funding; data on delayed transfer of care; and contextual data from the Indices of Deprivation and the Annual Survey of Hours and Earnings
 - 20 qualitative interviews with providers and commissioners in six locations across England, as well as interviews with a number of national stakeholders, including the CQC.



- *New models of home care*, which involved a literature review and 10 interviews with innovative providers and commissioners (Bennett et al 2018). It explored alternatives to traditional ‘time-and-task’ models of delivering care at home, highlighting a wide range of emerging models of care:
 - technology and digital, including assistive technology and in-home monitoring
 - co-ordinated care planning
 - new approaches to recruitment in home care, including values-based recruitment
 - autonomous team working, including the Buurtzorg model and wellbeing team
 - alternative approaches to commissioning, including outcomes-based models
 - personalisation, including personal budgets and integrated service funds
 - integrated care approaches
 - community asset or connections models, including Community Circles
 - family-based support and community living models such as Shared Lives and Homeshare.

This report is based largely on these three pieces of work. It uses the original research, analysis and interviews from all three and combines them to further define and explore key trends and challenges, to form a narrative about the state of the home care market in England. It should be noted that the report, and the original material on which it draws, record the stated opinions of the participants, whether commissioners, providers or other stakeholders. These views give insight into why participants behave as they do in the home care market – why, for example, commissioners believe it is reasonable to focus on driving down the price they pay for home care – but do not necessarily explore the evidence for these beliefs or their consequences.

The report also includes references to other publications by The King’s Fund that touch on the subject of home care, in particular *Reimagining community services: making the most of our assets* (Charles et al 2018) and *Understanding quality in district nursing services: learning from patients, carers and staff* (Maybin et al 2016).



2 Findings

Staffing remains a fundamental challenge

Securing an adequate workforce is one of the greatest challenges facing domiciliary care. Many of the providers and commissioners we spoke to¹ identified difficulties in recruiting and retaining an adequate workforce, fuelled by a perceived unattractiveness and low status of care work, which in turn related to poor pay levels and job security.

Interviewees suggested that providers' ability to recruit and retain appropriate staff was a central driver in local domiciliary care markets, with one large national provider reporting staff turnover as high as 48 per cent. However, our analysis of national data from the NMDS-SC found that, while some local authority areas have an average turnover rate of more than 40 per cent between 2014 and 2016, for others the figure is as low as 10 per cent.

Competition for labour, both within and outside the health and care sector, were key issues, largely because of low pay but also due to public perceptions of care work as low status work. Care workers are attracted to work in settings such as residential homes or the NHS due to greater security in contracted hours, less anti-social hours, and the pull of working indoors in care homes as the weather worsens. Meanwhile, other low-pay sectors, such as supermarket chains, can offer higher wages and greater predictability.

If a supermarket opens up [locally] everybody wants to become a till operator because they can say, 'you've got work between 6am and 3pm and 3pm and 10pm'. So, they can sit in one location, they've got one venue and they get paid a slightly higher rate than care work.

Local provider (Hall et al 2017)

1. Unless otherwise indicated, all quotations were part of original research for the three publications listed on p 5.



Some interviewees observed that seasonal conditions affected labour supply for home care providers.

As it gets a bit colder, there is evidence that people go and take jobs 'cause the pay is virtually the same. You know, you're not outside knocking about from door-to-door. All these things are a factor. The competition is really very, very difficult.

Local authority (Hall et al 2017)

In more affluent areas, it could also be difficult to recruit staff in domiciliary care.

There are some more affluent parts of the borough where you can't get carers to work – as many as we would like anyway – and therefore, we have to... do spot purchases because there isn't enough of a workforce to support some of the more affluent areas where people need home care.

Local authority (Jefferson et al 2017)

Several commissioners described competition within the domiciliary care sector, with even small fluctuations in pay rates drawing employees to work for competing firms.

Because what you find quite pivotal is that carers will move to another provider for pennies literally. It's that kind of a market. You could walk out of one agency and go to another one in the afternoon. Call it fickle, but that's the way we are, that's the way it works.

Local authority (Hall et al 2017)

There's a lot of benchmarking in home care and that's simply because the workforce starts to move. If people know that you can get more money in [a neighbouring local authority area], well, we'll go and work [there], so you end up with that workforce shift that's problematic as well. So we're quite conscious that we've got to make sure that we're paying fees that are in line with elsewhere, so we're not then... causing lots of staff to go and say, 'well, I'll go and work for somebody else.'

Local authority (Jefferson et al 2017)

Our research found concerns that rates of pay in some parts of the home care industry are below the minimums set by the National Living Wage (or National



Minimum Wage for workers under 25 years of age). Interviews highlighted the complexity of care worker payments – in particular, payments for travel time, which can create confusion and at least the potential for workers to be paid below these minimum levels.²

One commissioner (and some providers when talking about competitors) raised concerns that this was difficult to police:

In terms of whether the providers were doing the right checks? I think you get a lot of it... It's very difficult to ensure from a commissioner's perspective... This isn't just here, it's happened in other local authorities where the rights to work is really difficult to establish.

Local authority ([Hall et al 2017](#))

A further complication was payment for mileage costs. Some providers paid at a rate of £0.45/mile while others paid less, requiring workers to offset additional costs against their annual tax allowance.³

If somebody's got 10 visits on a shift – that might be mornings and lunches, five morning calls and five lunch calls – that travelling in between those properties isn't paid for. Now, yes, the government does provide mileage that you can claim back at the end of the year [from tax allowance]. It still doesn't help staff today putting petrol in their cars, paying their insurance monthly, weekly, whatever it is.

Local provider ([Hall et al 2017](#))

The low-wage nature of home care work brought with it some additional difficulties for providers. Some had to place restrictions on the number of hours

2. Overall, workers must receive at least the National Living (or Minimum) Wage (at the time the interviews were conducted, this was set at £7.20 for workers aged over 25 years and now £7.83) for all working time, including travel between appointments (though not to and from the worker's home at the start and end of the day). Compliance with the legislation is judged on the average figure over a specified 'pay reference period', which is the frequency that the worker is paid (or one month, whichever is shorter). In practice, this typically means either paying the minimum wage for all hours or paying a rate above the national minimum wage for only the time spent with clients, but ensuring that the average pay for all working time is at or above the minimum legal level. This latter method requires employers (and employees) to check that, in practice, this ensured compliance over the pay reference period.

3. Reimbursement of mileage costs is not a requirement of the National Minimum Wage Regulations but, where employers do not make a reasonable reimbursement of these costs and other out-of-pocket expenses, HM Revenue & Customs (HMRC) can take this into account when assessing total pay.



employees could work, as some employees were willing to work 80–90 hours per week to increase their income. According to national data from the NMDS-SC, approximately 13 per cent of all staff in direct care roles were working more than 37.5 hours each week (average across all three years). Interviewees identified concerns around safety where employees were working such long hours, and also discussed greater costs associated with staff sickness that may arise due to poor work–life balance. Indeed, NMDS-SC data shows that almost 7 per cent of all staff in direct care roles took over 20 days off sick per year on average (March 2015 and 2016).

You will find staff that are reliant on quite a number of high hours a week, just to pay the bills, because the wage isn't the greatest.

National provider (Hall et al 2017)

Meanwhile, at the other end of the scale, some employees were limiting their hours to below 16 per week to maintain entitlement to certain benefits. This led to higher costs for these providers due to employing greater numbers of carers to meet need, but also concerns around continuity of care. According to the NMDS-SC data, approximately 7 per cent of all direct care staff work less than 16 hours per week (average across all three years of data).

It's drummed into you: consistency, continuity of care. You can't do that if you've got a workforce that only works 16 hours a week because they lose benefits if they don't.

Local provider (Hall et al 2017)

Attempts to reduce turnover of care workers have led some home care providers to adopt innovative approaches to recruitment, aiming to maximise retention by more careful approaches to recruiting the right people. Values-based recruitment considers the extent to which candidates demonstrate values linked to caring roles (such as compassion), alongside the candidates' skills-based experience. Other approaches look to improve terms and conditions for care workers, including addressing issues of training, stability, pay and autonomy.



Interviewees outlined the importance of valuing staff contribution and the impact of that, in turn, on service users.

Don't treat them like a commodity because they're doing something very tough and very hard. They're not cleaners. And if you don't give them the right skills and training and remunerate them well enough, they're not going to do a very good job.

Provider (Bennett et al 2018)

So, we take our care workers' wellbeing extremely seriously and we try to do what we can to ensure that they are satisfied, which, in turn, is why we have a very high satisfaction rate from them...

Provider (Bennett et al 2018)

Location is key

Recruitment of staff, though a critical aspect, was not the only challenge facing home care providers, and nor was it experienced to the same degree in all areas. There was a complex relationship between issues such as rurality, diversity and deprivation, which had an impact on recruitment of staff but also on the wider cost of providing home care services. Local political factors also played a part.

Rurality is a key factor. In the *Understanding home care in England* research, rurality was identified as one of five predictors of problems relating to home care supply (Hall et al 2017). Rural areas generally have lower rates of unemployment and lower rates of income deprivation affecting older people. We found that home care providers in rural areas were smaller, but provided better quality care (a higher proportion were rated good or outstanding by the CQC). They received higher fee rates from local authorities and paid higher hourly rates to their workers (both of which may reflect supply challenges).

The rurality of a provider's location creates financial pressure on domiciliary care companies because of the additional travel time that needs to be paid to care workers – something that was confirmed in qualitative interviews. Commissioners whose administrative areas covered both rural and urban areas spoke about the difficulty of contracting for these different markets and allowing for the costs of rural provision to be factored into the pricing structure.



In rural and urban areas, supply of labour's very different. Qualifications are very different. Turnover's very different. The other thing is the rural urban space we have – again, big, big problems getting coverage in rural areas.

Local authority (Hall et al 2017)

In some instances, home care providers had deliberately moved out of rural locations due to the unsustainable costs associated with paying staff travel time, which were not sufficiently reimbursed by local authority contracts.

I think consciously we've, sort of, moved away from some of the more rural locations... Clearly when you get into rural locations and you're having to pay disproportionately more for non-contact time, as it were, then that creates that whole issue in terms of viability again that, you know, when you're paying a lot for travelling time, but you're not recovering that from the commissioner... It's difficult.

National provider (Hall et al 2017)

Rurality was not the only factor affecting recruitment and/or cost, however. Providers also described how ethnically diverse areas created pressures financially and strategically, as there was a need to either provide translators or bilingual carers. At times, it could also be difficult to place these types of carers on other calls if their level of English was insufficient.

[It] is a very multicultural area... We don't have the means to provide services for some of that population... They may be non-English speaking, they may need care staff from the same cultures, social background. To a company such as ours, that means that we may have to employ staff to meet that person's cultural need, as in the language. What we have to be careful of is that that person is not going to be employed only to go to people from that background. They're still going to have to go to your average white British person. So, their communication needs to be bilingual at least, good reading, writing, understanding of English.

Local provider (Hall et al 2017)

In deprived areas and areas with high crime, multiple carers may be required to double up on appointments. This adds to the cost of providing care but also has implications for managing resource as it can be more difficult to plan visits if the two carers are not required for the next visit.



The challenges that we find round here is we have some really, really rough areas... There's gangs of youths with drug use and everything... Care workers refuse because of safety reasons... The main thing that we do round here is we'd put it to a two-carer package, so that there's two carers going to that client. We wouldn't allow them to go on a single call... and we supply the carers with alarms and everything. Attack alarms.

National provider (Hall et al 2017)

Furthermore, deprived areas may be associated with higher costs of providing care because service users may have more complex needs, as one provider explained.

[There is] a higher proportion of co-morbidities in lower-income areas, because people haven't been living healthy lives and things like that, and so what you're seeing is, by the time they get to 50, 60, you've got that accumulation of issues.

National provider (Hall et al 2017)

Some local authorities discussed how political decisions had influenced funding and the cost of social care either in their own area or in neighbouring boroughs. For example, one local authority described their political motivation to raise rates in line with the London Living Wage, but although they had been an early adopter of this, which had led to greater labour supply at the time, supply had declined gradually as other neighbouring authorities began to offer the same. Other authorities described their local Labour-led political agendas as having accelerated the uptake of the London Living Wage.

Our council is Labour-led, and has been for some years, and it was a huge aspiration for members to move to London Living Wage. So, they were less concerned about the market, the impact on the market, and more concerned about what's that doing to individuals as well.

Local authority (Jefferson et al 2017)

Councils have held down fees

In these differing market situations, commissioners adopted different strategies depending on their specific situation. The overriding approach – fuelled by declining overall council funding – was to hold down the price paid for care. But in some



areas of low supply (often rural areas), local authorities are forced into paying higher rates simply to secure sufficient supply: they are 'price-takers', not 'price-makers'. Where councils had a much wider supply, they were able to drive down the rate they paid for home care – often to levels that some research participants (nationally and locally) thought were unsustainable.

In areas of lower supply, local authorities were reacting to what providers asked for and described being 'effectively held to ransom' as they said they had to alter prices according to what providers dictated and did not feel able to negotiate due to lack of supply in the market.

We have come under huge amounts of pressure from providers this year to increase rates. We don't have the luxury, necessarily, of playing hard ball, 'no, we're not going to negotiate with you at all', and risk them handing back hundreds of packages to us, which we just simply would not have the capacity to replace.

Local authority (Jefferson et al 2017)

Lack of supply could, in turn, raise issues around quality.

We were only able to secure three providers and all of them have had quality problems over the last three years... So, the issue for us there is there are quite a small number of providers. So, there's not very much flexibility, limited choice for people living here, but also when there are quality issues, that's really problematic for us because we've got, you know, a significant proportion of our suppliers, which is really quite vulnerable providers.

Local authority (Jefferson et al 2017)

By contrast, many commissioners in urban and deprived areas remain confident that providers, often new market entrants, will respond to their tenders, despite the advertised rate being lower than even the most conservative estimates of the costs of delivering good care.

In these areas, where there was a steady supply of providers, commissioners often offered one set price to the whole of the market.



People are in the market. So when people say we can't afford to provide it, you're in the market though. And actually our neighbours pay 50 quid a week less and you're in the market there as well, so you can afford to provide it. It's market management; you're either in the market or you're not in the market. If you can't afford it, then exit the market. Because some people can afford it.

Local authority (Jefferson et al 2017)

Not surprisingly, providers in these areas saw the situation very differently. They commonly felt that they were being placed under greater pressure as a result of what they considered to be 'unrealistic' fees set out in contracts with local authorities.

Providers described how other companies bid for contracts on a lowest-fee basis, but then exited the local market when they found they could not deliver care under these tight margins, which left remaining providers struggling to continue on already unrealistic council fees.

It's absolutely a race to the bottom [price] with a number of local authorities... [commissioning is] still far too skewed towards price, massively towards price.

National provider (Hall et al 2017)

Many providers suggested that councils had not increased fees following the introduction of the National Living Wage, resulting in providers' margins being squeezed or needing them to react by changing their business strategy. For example, some described limiting call-outs to a minimum length of time, in order to protect already tight profit margins, as longer call times balanced the proportion of call time to travel time, which was a hidden cost not paid by local authorities:

What we have done to try and compensate the increase in labour cost is that we've gone around and said we no longer do 15-minute calls and, in actual fact, we shouldn't do half an hour calls. Our minimum call-out should be for an hour. And at the moment if you do the calls at an hour then that's still okay for us, but if you go to 30 minutes it's very hit and miss whether you should stay in business and continue providing the service.

Local provider (Hall et al 2017)



There were widely differing views among interviewees about the sustainability of the home care market. Crucially, many local authorities were still successfully procuring home care, often with a good response to tenders from providers. While market exit and instability is a concern for some, it does not appear to have driven a wholesale change in commissioning. Some areas facing shortages in supply do appear to have responded by raising fees, but these tend to be in specific local (most noticeably rural) areas.

Nonetheless, several commissioners were concerned about larger, national chains handing back work. None described this as having a significant impact on supply, but most were worried that it represented a trend.

They handed us back about 4 million quid's worth of work, which is getting on for about 4 per cent of the market. So it's not catastrophic, but it is significant, especially because they had a high geographical concentration.

Local authority (Hall et al 2017)

To meet the challenges being faced in supply and market instability, commissioners discussed how they had needed to adapt over the past six or seven years, in light of budget restrictions. Several local authority areas were undertaking (or about to undertake) re-commissioning of domiciliary care. It was hoped that this would consolidate fragmented provision through establishing and maintaining a single contractual framework, but the fragility and shifting nature of the market made these tasks difficult. In many cases, commissioners had found that these frameworks quickly proved inadequate and they had to rely on 'spot purchasing' – that is, negotiating individual packages of care with providers outside of a framework or contract.

National stakeholders echoed concerns about long-term stability.

Given the feel of closures and the number of contracts handed back, councils by and large are trying to sustain the market, hold it up, stop it falling over and focusing on a different kind of sustainability – which is about getting good enough quality.

National stakeholder (Jefferson et al 2017)



Interviewees also described very different strategies from providers in the face of price-driven local authorities: withdrawing from rural areas, withdrawing from certain local authority contracts and – conversely – not pursuing the private paying market to focus on the larger volumes that local authority contracts could provide.

Views differ on whether rates have affected quality

There were widely differing views between commissioners and providers about whether quality of home care had declined in recent years and, if it had, the role of fees in that process.

Providers were more willing than local authorities to accept that quality might have declined. While several providers felt that councils had responded to pressure for increasing the duration of calls, some providers were still being commissioned to deliver 15-minute calls – something they described as ‘not viable’.

To further reduce costs, providers suggested that commissioners had reassessed service users’ needs – described by commissioners as ‘demand management’⁴ – and this also led to concerns around quality. Meanwhile, concerns were also raised that working conditions in domiciliary care (wages, job insecurity, etc) could lead to an unskilled and unmotivated workforce, with resulting quality implications.

The quality has certainly deteriorated. Again, in 2009, we were providing visits at, say, 45 minutes to somebody. By 2012 that had been cut back to 30 minutes and in some lunchtime calls they were eliminated, so if you had a morning call, a lunchtime call, an evening call and a night call, the lunchtime calls were generally done away with. And as part of your morning call you were asked to put a glass of water and make a sandwich ready for lunchtime. So that’s, again, how the local authority has managed to cut their budgets in going through it but they’ve just had six years... seven years of doing that, and there’s no more fat left and demand has increased.

Local provider (Hall et al 2017)

4. Demand management can include not just reassessment but a number of different measures to reduce demand for formal services (Bolton and Provenzano 2017).



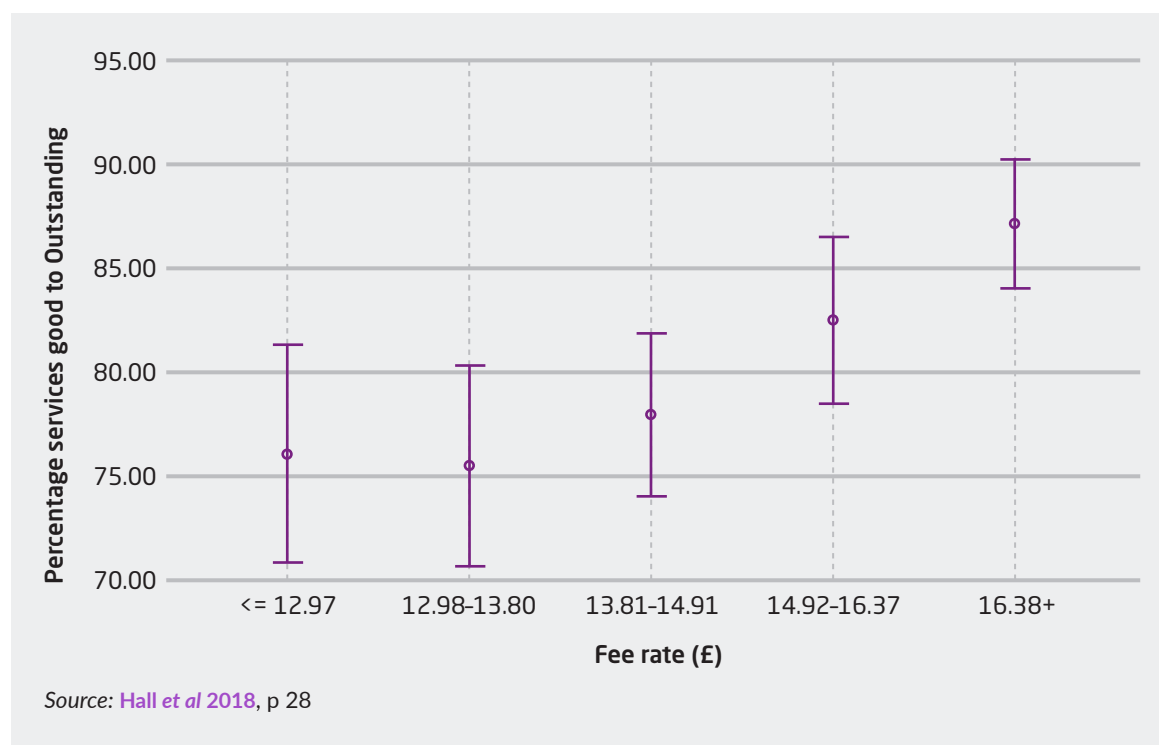
However, many local authorities did not accept any direct relationship between fees and declining quality, commenting on the variation in levels of providers' CQC quality ratings, despite similar or equal fee rates. In fact, our statistical analysis did find a positive association between fees and CQC ratings (see Figure 1) though this correlation cannot, of course, demonstrate causality. Also, as we have seen, higher fees were typically paid as a response to lack of supply in the market rather than as a deliberate strategy to raise quality.

National stakeholders appear more willing to acknowledge that 'there's a level below which you don't get quality'. This view was clearly linked to insufficient staffing levels. They also argued that providers had a responsibility to price care at a rate that could guarantee quality.

[Providers] have got a responsibility for not putting in tender proposals that aren't sustainable. Some providers are operating across multiple authorities – and they pick and choose which tenders to keep in.

National stakeholder (Jefferson et al 2017)

Figure 1 Relationship between fee rate and quality





The focus used to be on high fees, and a drive for low unit costs. Now the problem is really that providers are bidding too low. Providers say that commissioners are paying for care that's too low. But we'd argue that the way to correct the market is for providers to not put in tenders that can't be delivered – they'll do anything to say they can meet the spec. That's the only way to change.

National stakeholder (Jefferson et al 2017)

As we have seen, while fees paid for home care represent one main tool of influence, there were differing approaches to how they were used. This in turn was influenced by differing commissioning beliefs, particularly about the impact of fees paid on recruitment, staff pay and care quality.

It was not universally agreed that there is a direct link between fees and care worker wages. Some local authorities were sceptical about whether higher fees translate into higher wages for staff or, more widely, into better quality care.

Research we've been doing... has highlighted actually how little of the extra investment that goes into providers actually translates into either more people on the ground or more pay in people's pockets... I don't think we have much confidence that if we paid higher rates it would do anything other than increase profit margins.

Local authority (Jefferson et al 2017)

In one instance, however, a local authority had built a requirement on pay into its re-tender process to ensure that an increase in fees led to an increase in wages for home care staff.

One local authority commented on wider issues within the profession that could not be solved through increased fees alone

I think there are more fundamentals to be changed than just the cost per hour in terms of the significance of the profession... The investment in the profession as a brand is something that people could see as these are great careers that are fulfilling... It's a bit cynical but... essentially to put 10p an hour on somebody's pay packet will cost me 30p an hour to the provider.

Local authority (Jefferson et al 2017)



Most commissioners attempted to establish a clear pricing framework but were sceptical that a national approach like the one provided by the United Kingdom Homecare Association (see [Angel 2018](#)), which represents home care providers, was fit for purpose.

In interviews, most commissioners said they discussed the challenges of establishing a clear local pricing framework that could be agreed with providers, and described the tense negotiating atmosphere that resulted. Fees, particularly when being set at a fixed amount, tended to dominate conversations between commissioners and providers.

Several local authorities argued that their rates were low as a reflection of the local labour market, which did not require higher rates of pay to attract sufficient workforce into the social care sector. Many had benchmarked their rates against other local authorities within their region and were confident that they could offer a competitive rate, both for providers and the workforce. Many also commented on there being a north–south divide, with benchmarking against the national distribution irrelevant as it does not reflect local market dynamics.

Time-and-task commissioning remains the dominant approach

Providers described being frustrated with being commissioned on a time-and-task basis, with little emphasis on measuring longer-term costs or outcomes.

How many hospital bed days per year does provider A end up with versus provider B? What percentage of provider A's residents end up in residential care? It's not difficult. But not one of [the local authorities] actually measures... They measure their cost per hour, but surely you should measure what impact... Compare your providers on the ability to reduce long-term care costs.

National provider ([Hall et al 2017](#))

Others thought it had contributed to market instability.

We've commissioned on a time-and-task basis and in many ways that's contributed to the significant problems we've had. We've been very successful using that model to drive down what home care costs us. But that's also then got us to a point in the



market which is flat. We just can't place work and we've got an increase in the level of unmet need.

Local authority (Hall et al 2017)

As a result, a small number of commissioners were attempting to move away from a largely fee-based commissioning process towards one based on outcomes. This would remove the focus of payment linked to tasks and units of time or processes to be followed, and instead direct it towards expected outcomes (Billings and de Weger 2015). The premise is that this will enable more flexible and person-centred approaches to care, delivering better quality and more efficient care.

So rather than it be like, we get paid on an hourly rate per client... the local authority gives us an annual budget... for this zoned area, this is the budget that you're allocated, and how you distribute those hours. So, as a provider, it gives you a bit more control [to plan visits and workforce]... by giving us an annual budget, it gives us a bit more stability on the money that's coming in, so then we can offer staff a bit more stability, because it is difficult for the staff, just things like annual leave.

National provider (Hall et al 2017)

Commissioners and providers were attracted to the related concept of Individual Service Funds. These involve establishing a notional amount to meet the needs of each individual service user, which is paid directly to the provider either in full or partly conditional on outcomes. This notional amount would then be used to fund a flexible package, negotiated with the service user and their family. For providers, this offered an opportunity to reduce administrative burden and to control a larger budget, with potential for greater strategic planning and job security for staff.

It's another frustration that all of these individual tasks that we do at the moment end up with an invoice, thousands of invoices... in [location]... We are just given a budget per service user... the administration burden is hugely reduced. So we went from 13,500 invoices in a quarter to 1.

National provider (Hall et al 2017)

However, most of these approaches were either new or still being piloted and would require local authorities to collect and monitor outcomes data.



Some commissioners doubted whether providers had sufficient infrastructure to implement this. An additional concern identified in the research is that outcomes-based approaches could lead providers to cherry-pick individuals who will provide good outcomes (Bolton and Mellors 2016).

To be blunt, I think commissioning got pushed to one side in the bid to secure the savings. So, we're now in a position whereby we needed to stabilise the market, develop the market, shape it and then we need to bring in some initiatives – for example, Payment by Results, but we're too... immature, I think, at the moment to bring that on board.

Local authority (Jefferson et al 2017)

Adopting new approaches was particularly challenging where some local authority teams had either shrunk or gone through organisational change. Problems were seen to stem from failures in the system – for example, social workers still reviewing users on a time-and-task basis rather than an outcome basis.

We had the intention of doing outcomes-based commissioning and [it] was foiled completely by the fact that our social work teams were not doing outcomes-based assessments... bluntly fell at the first hurdle because the assessments weren't done... And what we still have an issue with is actually even if you did an assessment, how do we capture that series of outcomes that you want the provider to deliver and how do you transmit that to them? So technically, what's your information recording system so that you can have a baseline of where you started and where you end up to see if the outcome was achieved?

Local authority (Jefferson et al 2017)

One other outcomes-based approach that has attracted attention recently is the Buurtzorg model in the Netherlands, which uses self-managed teams led by nurses to provide care. Key to its success is the integration of health and social care to provide a holistic, person-centred approach, whereby one professional meets all of a person's needs. A core part of the original model also involves connections to community assets (discussed on page 6). The Buurtzorg approach is based on the expectation that investing nursing time upfront saves on care needs and time required later, as well as deriving savings from fewer professionals having to make visits and lower back-office costs.



So traditionally, dom care makes people dependent on the care, and we like to... we celebrate when people cut their care down, because that means that they are becoming more independent again.

Provider ([Bennett et al 2018](#))

However, it is unclear whether place-based models in England inspired by the Buurtzorg approach but limited to a person's social care needs will deliver the efficiency and other benefits reported in the Netherlands. At the very least, initial investment is required to see payoffs later, and these may be in different parts of the system.

Some other providers of place-based team approaches in the UK described difficulty competing for local authority contracts, leading to reliance on self-funders and spot-purchased or short-notice arrangements.

While price-based commissioning remained dominant, some commissioners did describe their attempts to improve quality in local provision through tendering. For example, some used quality standards as part of their payment structure.

We've also introduced a quality premium payment as well for providers where they hit certain quality measures and we've got that evidence, we will then pay them 50 pence per hour extra on their rate... We engaged with service users and asked them what they wanted... The basic things they wanted were... continuity of staff... timeliness of visits... and they have to prove that staff have undertaken a care qualification... If they hit all three things, then they get 50 pence extra an hour.

Local authority ([Jefferson et al 2017](#))

However, one national stakeholder questioned whether initiatives that rewarded quality resulted in poor providers getting worse.

Some local authorities have paid quality premiums over a long time, but the underlying funding of that is problematic. When quality starts to fail – you need a shift in resources. A key priority is to keep providers from failing. This means putting staff and training in to keep them going (safeguarding concerns), sorting things out, from care workers not being paid to putting fuel in their cars. This is not reflected in rates – but is key to quality.

National stakeholder ([Jefferson et al 2017](#))



Interviewees often stressed the need to achieve value for money through the tendering process. For example, one commissioner described a ‘use of resources’ form that providers had to complete, which enabled the local authority to assess how spending was being used to improve care quality rather than boost providers’ profits.

So the reason for looking at use of resources rather than price is, I could get home care for £11.50 or £11.20, but the profit element could be more in the £11.20 and have less spent on staffing than there is in the £11.50. So what is better value to me? So price isn’t necessarily what you just go off. So to me, we look at use of... resources.

Local authority (Jefferson et al 2017)

Other local authorities recognised that, while they might not be able to raise fees, they would provide other support, sometimes in kind. Many commissioners were offering support to providers other than through fees – for example, by providing free training. However, some commented on differential uptake among providers, as staff shortages were preventing some releasing staff for training. Nevertheless, where these arrangements are in place, fees may not accurately reflect local authority investment in home care.

For home care, we support those seven providers quite heavily in terms of safeguarding advice, training, you know, customer complaints handling areas that... you know, recruitment and retention, with Skills for Care. We work with them quite closely and with our in-borough kind of recruitment job fair... We’re looking at supporting them again with, where we can, with some of the leisure passes and travel concessions that council staff benefit from.

Local authority (Jefferson et al 2017)

Integration with health is patchy

In other work on district nursing and community health, we have identified the potential for greater integration of home care with other health services to improve the quality of services and the experience of service users. There is some evidence that this is happening through the introduction of integrated commissioning teams in the NHS vanguard areas. However, this research with social care providers and



commissioners found very diverse experiences of and opinions about integration, both in terms of commissioning and service delivery.

In commissioning, while some local authorities had worked closely with clinical commissioning groups (CCGs) to share a contracting framework, others had had no contact with the NHS when proposing commissioning arrangements.

It's difficult as well because the NHS providers, the acute [hospital trusts], are increasingly looking to buy community services at rates that are way beyond anything that's in my gift. So they're trying to develop new kind of home-from-hospital, discharge services. So that makes it difficult because there's only one pool of labour out there and they're threatening to soak it.

Local authority (Hall et al 2017)

The other significant factor that increases fees and complicates the market is that the NHS is moving in. I know of NHS trusts picking up the council market supply and paying higher prices or by directly employing home care staff on Agenda for Change rates – this stops the social care market from functioning well. It's not very well co-ordinated – and is evidence of stressed behaviour on the part of acute trusts, coupled with stressed staff in councils.

National stakeholder (Jefferson et al 2017)

There was, however, genuine understanding of the potential for service integration. National stakeholders described the inefficiencies of keeping services separate.

[District nurses and care workers] are going in, in silos, there's very little communication. If there is, it's just written notes and the expectation that the next team of people will read and understand said notes and follow them but without any real [communication]... It's a huge lost opportunity.

National provider (Hall et al 2017)

Other interviewees described the potential impact of integrated services on the individual receiving care.

We're not just saying, 'we've come in, washed and dressed this person and gone out of the house'; we're looking at that person every time as an individual and the



bigger picture, making sure that their care needs are met, but also things that need addressing in their home.

Provider ([Bennett et al 2018](#))

If they're able to deliver outcomes for people in a really flexible service that's person-centred, well, that's what everybody wants.

Provider ([Bennett et al 2018](#))

Because of these potential benefits and current concerns, some local authority commissioners talked about developing a new arrangement with NHS colleagues, either by attempting to establish an integrated community service with input from nurses or seeking a contribution from CCG commissioners for the additional cost of home care agencies carrying out clinical tasks.

We're... trying to promote with the local NHS, a sort of nurse-led model of home care that actually you would have an integrated or pooled joint commissioning of community services that the authority would commission and contract with a number of domiciliary care providers for a particular geography. The model would be a multidisciplinary team with community nurses, having oversight of all the inputs, including the home care and providing that clinical overview. That is a way of trying to create a safer and more integrated provision and I think, in time, should lead to the creation of new, more hybrid roles offering a greater skill set and potential career pathway for some of the individuals who might be interested.

Local authority ([Hall et al 2017](#))

Three local authorities were already working with integrated health and social care teams with a single point of entry into the system for patients and users, and social care and nursing teams working in close collaboration. While the full effect of this integration was yet to be seen, commissioners commented on the greater collaboration and more streamlined approach to delivering care.

I think having an integrated team... is much more cost effective because you'll be providing a more co-ordinated, responsive service to get somebody back on their feet again as quickly as possible.

Local authority ([Jefferson et al 2017](#))



Joint working was, however, far from trouble free. Local authorities cited the lessons learnt from attempts to negotiate with CCGs over the use of the additional funding provided via the Improved Better Care Fund.

The difficulty is, we both hold our own budgets, and anything that looks like part of my budget going to theirs or theirs coming to mine makes it a difficult conversation... I think the only way to do it is to make one body dominant over the other... essentially you force integration... Having two essentially large government directorates, they will co-operate but they will never assimilate because they have different drivers, and the only way to take that driver away is literally to take it away.

Local authority (Jefferson et al 2017)

Another issue was the potential for increased expectations of one service because of reductions in another. In one example, this had resulted in some low-level clinical tasks being built into the work of care workers, which seemed to be viewed differently by providers and commissioners. Several commissioners saw this as a positive step to fund work that home carers were already undertaking through NHS Continuing Healthcare funds, and to ease pressure on nursing staff and meet their local integration agendas. However, providers were concerned about the practicalities of how this level of care could be achieved, particularly given the short times available for each call. This also creates the additional financial burden of having to train staff in wider health roles, which could be particularly onerous for businesses owing to high turnover. One local commissioner also raised the need for greater clinical oversight to ensure patient safety.

When I first was running a home help service, what the home helps were doing then is absolutely nothing compared to what the tasks are now. I don't think that journey's got much further [than] it can safely go without being built into the whole structure of this much greater clinical oversight at least. Now some of our agencies are starting to talk about employing their own nurses.

Local authority (Hall et al 2017)

In addition, providers suggested that home carers were not being sufficiently remunerated for such responsibilities and there was a need to elevate the professional status of domiciliary care to reflect these greater expectations on the role. Some providers described a lack of respect from other health professionals that needed to be addressed.



Working with district nurses, I find often they look down on us... It comes to how people view care staff, and often it's the case – not always – but often it's the case that district nurses, they will just talk down to you... We get it sometimes with paramedics, sometimes with doctors... Some attitudes can vary quite a lot, so patronising and condescending, it's just not good.

Local provider (Hall et al 2017)

There were also 'boundary disputes' about the respective roles of health and social care.

District nurses have got a big argument with us that we should be [applying cream to open wounds]... From our point of view... we can't do it because of insurance. If anything goes wrong, that wound becomes more infected, then we shouldn't have done it. So the nurses are not happy with us, but we're just following procedure... The local authority [say] we shouldn't be doing it because of funding, they class it as a health-related task... This stems from what is happening now where the councils are trying to save money and pass on what is a health-related task. So we're in a transition period really... and we're in the middle.

Local provider (Hall et al 2017)

The way that the two systems operated also meant real communications and logistics issues for some providers. At times, some felt that patients were being discharged from hospital too quickly, resulting in insufficient care provision through domiciliary services and greater pressure being placed on the system.

We'd get a lot of unsafe discharges where somebody would come home, that they would deem was being at their base level, but they'd come home and they wouldn't have any mobility and would be needing equipment. And it would be a case of, they hadn't thought to inform us, or had the assessment in place.

National provider (Hall et al 2017)

We've had a number of instances where the hospitals have discharged service users too soon and within a day or two they've gone back in again.

Local provider (Hall et al 2017)



Another provider described how the local hospital occasionally used ‘reset days’, which created unpredictable levels of demand and potentially unsafe discharges.

They have a periodic time where somebody is deciding, I'm not sure as to the criteria, but where beds are being blocked, so they'll have a reset day to get as many people out as is humanly possible. It creates huge peaks and troughs for us, but the problem is they're not necessarily resolving the issue, they're just moving the problem...

National provider (Hall et al 2017)

Indeed, providers noted unpredictability as a key issue. Contractual arrangements with councils often dictated that they must deliver care within 72 hours of being notified, but the companies they commissioned often lacked the capacity to provide care within this timeframe.

To recruit somebody takes anywhere between 8 and 12 weeks to recruit... So, when the hospitals or the local authority turn up the demand, unless you've got spare capacity sitting there doing nothing, you cannot react.

Local provider (Hall et al 2017)

What we don't get from the NHS is any certainty in terms of when this individual will be coming back home or back into the community. But there is an expectation of when the NHS pushes the button that it will happen tomorrow, which, again, from our perspective, is almost impossible... From our perspective, we recruit [carers] and pay them and say 'just hang about' and we'll just hang about on the belief that, you know, this care package will come along... If the care package doesn't come along, then 'we might have to make you redundant'.

National provider (Hall et al 2017)

While some national providers had taken the strategic decision to create a pool of reserve staff, this was only possible where providers had sufficient resources to do so or could pull staff in from outside a region to cover unpredictably high levels of demand. For others, low margins made it difficult to carry the excess (unpaid) capacity this required.



Let's say, you had a member of staff who was given 40 hours a week and you wanted to keep 8 hours in reserve to be responsive. The risk for places is that they are paying the individual that but they're not getting anything to cover that cost... Margins are already razor-thin, you don't really have an opportunity to build in that redundancy.

National provider ([Hall et al 2017](#))

Some alternative home care models are not new

While some local authorities are exploring new ways of commissioning home care based on outcomes or integration with other services, there are some existing models that replace or supplement home care more fundamentally. We explored these more fully in the New Models of Home Care research, asking whether these alternatives are:

- well evaluated
- high quality
- cost saving
- already widespread or potentially scalable.

The main models we considered were Shared Lives, in which individuals are supported by a paid carer in his or her home, and approaches such as circles of support, asset-based community development and local area co-ordination – all of which aim to harness the resources of a person's family and community to support them more effectively. Both of these approaches are underpinned by the principle of personalisation, which promotes individual choice and control for those receiving social care. This can involve support through direct payments and personal budgets, which in turn allow service users to employ their own personal assistant rather than purchase services from a home care provider. Today, Skills for Care estimates that of the 235,000 adults receiving direct payments, around 70,000 employ a personal assistant ([Skills for Care 2018](#)).

There is no doubt that Shared Lives schemes are popular.



I think the commitment of having somebody live with part of your family and be a part of your family is something that people don't really take on lightly. So, you know, people's values and people's commitment to the people they work with is really extraordinary. It's not just a job. You know, it is a job, people get paid for it, but it is having somebody in your home with you and I think that's just a really... It just shines through with, kind of, the people that we support and the people that offer the support.

Provider (Bennett et al 2018)

Such schemes are also high quality, with 95 per cent of services rated 'good' or 'excellent' by the CQC. There is also evidence that they can reduce costs.

Interviewees described other positive features of circles of support and similar approaches:

... I think for a long time we've so many services and so many different organisations and people with fancy job titles that when we... I think when we think about the need for services it's almost as if the family role has come to an end because it's time for the professionals to get involved... They're the experts in the person's life, not the professionals.

Provider (Bennett et al 2018)

An evaluation (Wistow 2016) exploring the economic case for circles of support and personalisation found that circle members reported 'major social, psychological and practical outcomes for the individual and their family'.

Similarly, a recent national survey of personal budget-holders (Hatton and Waters 2013) found that 70 per cent reported a positive impact in terms of getting the support they needed, being supported with dignity and being as independent as they wanted to be. Over 60 per cent reported a positive impact on physical health, mental wellbeing, and control over their support.

However, these models of care are not new. Local area co-ordination began in Australia in the mid-1980s, while the Shared Lives approach has been used for 25 years. Personalisation as an underpinning concept is considered to have started in



the United States in the 1980s; disabled people in the UK have had the option of receiving support in the form of a direct payment since 1997.

There is, therefore, a reasonable query about the full scalability of these concepts (Shared Lives, circles of support, directly employed personal assistants) and/or the extent to which they can be seen as full replacements for traditionally commissioned home care services. Rather, they may provide alternatives that work well for some people – but not all. In particular, there must be doubts about the extent to which models developed by and for working age people with disabilities are easily transferable to older people (Woolham and Benton 2013; [Glendinning et al 2008](#)).

Recent technological innovations still to prove impact

Other alternatives to existing models of home care look to exploit technological innovation to improve or even replace current services. As with local area co-ordination and circles of support, some of the more interesting technological developments look at how an individual at home can be better connected to a wider support system. Nesta ([Mountain 2014](#)) described a number of ways that technology can support informal care, including: communication tools (such as Breezie or Mindings) to increase connections and reduce isolation; platforms (such as Casserole Club) to engage potential informal carers; care management tools (such as HomeTouch and Jointly), which build networks of support and enable co-ordination and care management; and integration tools (such as Patients Know Best). Community volunteering platforms have been created to match residents with social care needs.

However, these are perhaps best understood as part of broader efforts to improve quality of services and tackle issues such as social isolation – which may improve long-term outcomes for individuals living in the community – as opposed to being replacements for formal care provision.

Other technological approaches build on existing ‘assistive technology’ telecare and telehealth services, with the potential addition of increasingly detailed remote monitoring, analysis and the reactive provision of home care or clinical support. For example, there are many kinds of sensors being used to achieve a roughly similar goal: understanding a person’s level of capability and their safety in their own



home. More established uses of the sensors facilitate the use of rule-based alerting systems. The Belong extra care housing scheme in Cheshire, for instance, uses bed pressure sensors, alerting care teams if the person has been out of bed too long (possibly indicating a fall); in Staffordshire, wireless support systems use room sensors to warn if a child with autism has been in high-risk areas of the home for too long ([Voluntary Organisations Disability Group and The National Care Forum 2013](#)).

The latest schemes feature novel sensing devices and use the data they generate to build a statistical model of a person's routine in order to alert services when important deviations from the routine occur. For example, Correze is a home automation package which includes a light path that comes on when someone steps out of bed, gas and smoke sensors, fall alert devices, alarms and 24/7 remote telecare call centre assistance. An evaluation found it achieved a reduction in falls, hospitalisation, depression, and in carers' time ([Carretero 2015](#)). Similar approaches include the Howz system, which uses devices placed between appliances and plugs (piloted nationally by EDF Energy), and Canary Care door sensors being piloted alongside other innovations as part of the Care City test bed in London. Evaluations of both schemes are forthcoming.

However, there are good reasons to be cautious about the scalability of new technological developments. Previous studies have found issues with older forms of assistive technology, including a lack of ongoing support for its use, inappropriate choice of equipment for personal capabilities and circumstances at the assessment stage, and a failure to keep its use under constant review. There are also issues with the lack of integration and interoperability of different technologies and the data they generate. The consequences of these issues involve a fall-off in use after initial uptake ([Bonner et al 2012](#)).

Another issue is that many of the examples in our evidence review are discrete examples of the deployment of individual products and services. This implies an overall challenge of integrating the technology into home care assessment and working practices, managing and curating information so that it reaches the right people in a support network in actionable form, and ensuring that ongoing support for its effective use is in place. Remote monitoring in particular raises potential privacy concerns and works best when beneficiaries are well informed about monitoring and its purpose, have given their consent, and actively participate in its use ([Age UK 2012](#)).



In a review of evidence for technology-based tools for people with dementia and their carers, a report from the Personal Social Services Research Unit (PSSRU) found that while there were a range of tools available, there was limited evidence of their widespread practical application, and that individuals repurposed everyday technologies to suit their needs (Lorenz *et al* 2017).

Overall, we found that while there are multiple examples of technologies and tools to promote independence and help manage risks, they have had only a limited impact on changing the approach to statutory home care services. There is a real question about the extent of demand for such technologies, both from commissioners of 'time-and-task' services and from service users.

Innovative technologies might best be viewed as an enabling tool for care workers and service users where new ways of working have been developed, as a preventive tool and for supporting informal carers. As highlighted by our interviewees, though, they cannot replace the care workforce:

... it's not the tech that's going to revolutionise the care industry. It's the quality of care and upskilling this workforce that we have and giving them new sets of training standards and new ways of educating them and upskilling them every three months, and I think the tech will be the enabler for that. It will be a process whereby we can provide them with the tools and the skills necessary with the tech that can make them... well, allow them to deliver a job much more effectively.

Provider (Bennett *et al* 2018)

So I think, yeah, tech is going to be the enabler here. But I think... it really frustrates me when people think that tech is, like, the be all and end all solver of things because... especially in the care industry, it is literally the... If we don't have the workforce, we don't need the tech. So we really need to do something more about that.

Provider (Bennett *et al* 2018)

Before rushing to develop new technology, there is also further potential to explore less hi-tech home-based adaptations. These range from minor adaptations that cost less than £1,000 (such as fitting hand rails and lighting improvements) to major adaptations that cost between £1,000 and £10,000, such as stair lifts and bathroom adaptations. A systematic review of the evidence (Powell *et al* 2017) found



that minor adaptations prevent falls and injuries, improve performance of everyday activities, improve mental health and are cost effective. The evidence is less clear for major adaptations but suggests that they can support people to achieve outcomes in some circumstances. It recommends that health, housing and social care commissioners should make specific commitments to improve housing quality, including repairs and adaptations, and put in place preventive strategies to identify and support people at risk.

Several new models of care also recognise the links between housing and home care. As outlined by the Housing Partnership United Kingdom (2012), 'The once distinct boundaries between housing arrangements, domiciliary care and handyperson services are potentially so blurred as to be counterproductive'. Approaches range from adapting a person's home (for example, through adding a stair lift or light sensors) to communal living arrangements with shared home care provision. Team approaches include using handypersons to improve housing, such as the US 'Capable' (Community Aging in Place – Advanced Better Living for Elders) programme to prevent deterioration of people's home environment.



3 Conclusions

There are many home care markets rather than one

At the most basic level, there are two markets for home care in England: the publicly funded market, in which local authorities are the main purchasers (though some CCGs are also active), and the self-funder market. However, this categorisation is far too simplistic because there are significant geographical differences at play. The concept of the ‘the home care market in England’ is therefore misleading, and it is probably more accurate to talk about ‘home care markets’. These heterogeneous markets operate within and across the administrative boundaries of local authorities and CCGs, involve both publicly funded clients and self-funders, and reflect the local balance between demand for, and supply of, the home care workforce. They also reflect differing costs of delivery for home care providers. Consequently, most commissioners regard the UKHCA model as of limited value as a national benchmark for home care commissioning rates.

The challenge of staff recruitment is relentless

Employers face different challenges in different geographical areas but the challenge of staff recruitment is almost constant. In some rural areas or areas of high employment, the challenge is to recruit enough workers in competition with other sectors paying higher wages, offering more stable employment or easier working conditions. The state of these markets reflects a situation where home care providers are competing with other employers for a low-paid, often low status workforce, and the market is further shaped by the minimum wage (or National Living Wage) and interactions with the benefits system. Even where the labour market is stronger, providers find that the low wages typical of the home care sector mean that workers may move to a different employer for small additional incentives. Without fundamental reform of home care commissioning, it is difficult to see how the sector will effectively recruit the new workers predicted to be required by 2030.



Unrealistic tenders add to market instability

Many care markets are showing signs of stress, with increased numbers of providers exiting the market altogether and many arguing that fees are unsustainably low. To a large extent, however, these exits have so far been offset by new entrants, mitigating the impact on local authorities and those receiving care.

In many areas, both home care fees and staff wages are as low as possible, with the minimum wage providing – at least in theory – a pay floor. However, in some cases, commissioners and providers both raised issues of non-compliance with HMRC guidance on reimbursing travel time, suggesting that (at least in some areas), employers could still recruit and retain staff at effective pay rates below the legal minimum wage.

It is important to consider why providers continue to tender at rates that are either unsustainable (leading them to exit the market) or inconsistent with minimum wage legislation. Aside from straightforward mistakes, the low barriers to entry and exit in this market may encourage ‘optimistic’ bids (bids with a risk of failure, but still with a positive expected rate of return). A number of these contracts subsequently fail, potentially where local labour markets tighten or the employer faces unexpectedly high staff turnover. In a market with highly price-sensitive commissioners, this may be the most effective pricing strategy for providers.

The current commissioning approach has serious disadvantages

The use of plans based on time and task alongside tough competitive tendering has enabled local authorities to hold down fees in home care. Given the financial constraints under which local authorities are operating, this may have increased the total amount of home care they are able to purchase for their population.

However, this approach to the market for domiciliary care, despite reducing unit costs, has serious disadvantages.

- It leads to high turnover, of providers and staff, which has negative impacts on continuity of care and potentially wider effects on care quality. CQC quality ratings do not suggest that urban areas have higher quality of care, despite the relative ease with which they can replace providers who exit the market.



- Providers have little protection against fluctuations in demand, against relatively small changes in their own staffing or conditions in the local labour market.
- Any tightening of labour markets for relatively unskilled staff will be likely to create a rapid need to increase fees.

Traditional approaches to commissioning were also commonly cited as a barrier to spreading innovative models of care such as autonomous teams. Providers aiming to change the way care is organised and experienced by service users found inflexible and risk-averse commissioners unwilling to move away from a time-and-task approach to commissioning home care. This restricts providers' ability to enable staff to work in different ways or to provide more flexible and person-centred care to service users.

Fees are a blunt tool in commissioning

Simply raising fees in areas where this is not already dictated by current market forces may be a blunt tool on its own if providers can already attract sufficient staff at low pay rates. Many commissioners are also sceptical that additional fees would result in higher wages for care workers and/or higher-quality service delivery. To work, this may require greater collection and monitoring of quality and outcome indicators in contracts, which is not straightforward and could incur significant administrative costs.

Shaping the market in reality involves little more than stabilising it

There was little in our interviews to suggest that local authorities were taking consistent or wide-ranging steps to 'shape the market', as the Care Act requires them to do. The main intervention that councils made was typically to set the rates at which they bought home care. Though in some areas, the inability of providers to recruit and retain sufficient staff at these pay rates has led local authorities to raise fees, this was typically a reactive approach driven by difficulties in finding enough supply rather than making a proactive choice to do so as part of wider management of the market, and/or concerns over quality. The recent increase in overall care fees paid by local authorities should therefore be seen as a reaction to concerns about suppliers leaving the market or handing back contracts rather than the start of a market-shaping strategy.



Scalability of new models remains a huge issue

There are many examples of alternative approaches to commissioning and family-based support (such as Shared Lives and others mentioned earlier). Despite this, finding examples of these approaches being widely implemented in practice was more difficult than we had anticipated, and the extent to which they could be scaled up was questionable. Though the benefits of well-established models such as family-based support are clear, such models may not be appropriate for all those who need care; there are also likely to be limits to the number of people willing or able to provide this type of care. Even with widely adopted approaches such as personalisation, it is not clear that personal budgets for older people will lead to such a widespread improvement in quality and control as that experienced by many younger people living with disabilities. In terms of technology, though there was a range of interesting and innovative ideas, there was nothing to indicate that these were likely to make a significant difference to the publicly funded home care market. For the time being at least, the robots are still just a speck on the horizon.

The prize is worth having

The estimated 249 million hours of home care delivered each year in England, much of it publicly commissioned, has rich potential for improving population health, far exceeding (for example) the amount of contact time between GPs and patients in primary care. Currently, most of those hours continue to be focused on delivery of task-based care within an allocated time window, by low-paid staff, and with little co-ordination with other health and care services.

New approaches do have potential to improve the quality of home care services if they are not required to compete on a per hour basis with current time-and-task approaches to commissioning. Improving the quality of home care should therefore be seen as part of a wider move towards integrated, preventive approaches to health and care that incentivise better outcomes for individuals and have the potential to lead to efficiency and cost savings in other parts of the system. Focused around the principle of personalised care, they should include a renewed focus on simple home adaptations as well as exploring the potential for newer technologies. They should also aim to build on community development approaches such as support circles, without expecting these to necessarily replace formal provision of personal care. Significant barriers, including distinct funding streams, remain; but a better, more efficient home care service is a prize worth having.



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About the editor and acknowledgements

Simon Bottery is a Senior Fellow in Social Care at The King's Fund. Before joining the Fund in September 2017, Simon spent almost 10 years as Director of Policy at the older people's charity Independent Age.

Simon has wide experience in policy, communications and journalism, including as Director of Communications at Citizens Advice. He has also worked for ActionAid, in the commercial sector for Guinness and in BBC local radio.

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Adult social care: local authority commissioning behaviours

Laura Jefferson
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Karen Bloor
Richard Murray

New models of home care

Laura Bennett
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Care is provided at home each year to more than 350,000 older people and 76,300 young people with disabilities. Commissioning and delivering the highest quality home care should be a significant objective of our health and social care system. But what is the reality?

Home care in England: views from commissioners and providers sets out the key issues facing the home care sector based on discussions with commissioners, providers and national social care organisations. It draws on three linked pieces of research carried out by The King's Fund in association with the University of York:

- *Adult social care: local authority commissioning behaviours*, which examined the factors driving commissioning of adult social care (including care homes) in England
- *Understanding domiciliary care in England*, which considered the mechanisms of purchasing and delivering home care
- *New models of home care*, which explored alternatives to traditional 'time and task' models of delivering care at home, highlighting a wide range of emerging models of care.

The report identifies the fact that home care is a number of very different markets, often but not entirely based on geography. Though the conditions in these geographical areas differ, the challenge of staff recruitment is relentless in almost all of them, and a new approach to commissioning is needed.

Improving the quality of home care should be seen as part of the wider move towards integrated, preventive health and care.

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568

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