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CARING FOR THE WHOLE PERSON

***Home care for older people
which promotes well-being and choice***

Charles Patmore and Alison McNulty

Published by the *Well-being and Choice* website

www.well-beingandchoice.org.uk

Second Impression

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Frontispiece

Panel One

Examples of flexible, person-centred home care for older people, which were mentioned in interviews with either service users or provider staff. The examples come from publicly funded home care at both independent agencies and in-house providers.

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

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

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

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

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

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

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

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

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

FOREWORD

Acknowledgements

The research, on which this publication is based, was undertaken at the Social Policy Research Unit, at the University of York. The Social Policy Research Unit receives support from the Department of Health; the views expressed in this publication are those of the authors and not necessarily those of the Department of Health.

The authors would like to thank all those people whose participation in research interviews – or in organising interviews on our behalf – have made this publication possible. We wish to thank all the proprietors, managers and staff of home care services, all the service users, and Care Managers and other Social Services purchaser staff who contributed to this study. Special thanks also to the Social Services senior purchasers who kindly introduced the provider managers at the start of this project and whose helpfulness has made its successive stages possible.

We would also like to thank Hazel Qureshi for the idea of the three-stage structure of this project, which has had very helpful long-term consequences. Thanks too to Ian Sinclair, who was a formative influence on the second stage of the project through the example of the interview questions employed in his own home care research.

Finally gratitude is due to those on the project's Advisory Group and elsewhere who helpfully read and commented on drafts of this publication. Thanks in particular to Lucianne Sawyer for encouragement to persevere with dissemination of full findings.

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

Charles Patmore and Alison McNulty

First published on the internet in October 2005

Updated with a supplementary final chapter, relating the findings to individual budgets, in March 2007

About this publication

What this publication offers

What enables some home care services to take housebound older customers out shopping with them, or replace a customer's broken refrigerator or change their light-bulbs, or give isolated customers regular quality time for conversation? Some home care services contribute to older people's overall well-being and quality of life by giving such flexible help alongside physical care tasks. But other home care services do not.

This research project explored the factors which make a flexible, person-centred style of service possible. This publication reports the key influences identified, lists the conditions which promote this style of home care, and highlights much information pertinent to developing services in this direction.

This publication offers timely practical guidance relevant to the implementation of *Our Health, Our Care, Our Say* (Department of Health 2006). Key focal points of this research – services which address well-being and which heed customers' priorities - are now at the centre of government policy. The penultimate chapter discusses the social care Green Paper, *Independence, Well-Being and Choice* (Department of Health 2005) in the light of this research. The final chapter was added in 2007. It uses the research findings to identify helpful practical steps whereby Social Services can prepare home care services for transition to individual budgets.

Readership

- Anyone who seeks to encourage the style of home care which is illustrated by Panel One on page 1.
- Anyone involved with the implementation of *Our Health, Our Care, Our Say* or who is engaged with individual budgets.
- Social Services purchasers are identified as a crucial influence. Accordingly, they are a key readership.
- Home care providers in both sectors.
- People who seek to influence Social Services purchasers' policies towards older people:
 - elected politicians
 - organisations for older people and for family carers, which seek input into policy decisions.
 - people involved in formulating strategy, like service review teams.

Terms used in this publication

'Person-centred care'

'Person-centred care' can be used in many different ways. At the beginning of Chapter One, an explanation is given for how the term is used in this publication. Further explanation is given at the beginning of Chapter Four.

Dates of research fieldwork

Chapter Two describes how the project comprised three distinct stages: a literature review, a telephone survey of 23 home care provider managers, and an in-depth study of six of these providers and their Social Services purchasers.

The Stage Two telephone survey of provider managers was conducted between November 2001 and June 2002.

Fieldwork for the Stage Three in-depth case studies took place between October 2002 and March 2004.

Changes to government policy during research fieldwork

The telephone survey took place before the introduction in April 2003 of both Fair Access to Care Services (2002) and the Domiciliary Care Standards (2003). The Stage Three in-depth study was conducted almost entirely after both had been introduced. Only interviews with service users and front-line care staff at one of the six providers were conducted before April 2003. Providers in the in-depth study were questioned about changes resulting from the Domiciliary Care Standards.

Figures on costs

Staff pay and service costs mentioned in this report reflect 2003 figures.

Dates of report writing

Chapters 1-10 of *Caring for the Whole Person* were drafted by March 2005, when the Green Paper *Independence, Well-Being and Choice* published. Chapter 11 was written soon after to relate the findings to the Green Paper. *Caring for the Whole Person* was first published on the internet in October 2005.

A second impression was published in March 2007. This added Chapter 12, which links the findings to individual budgets and other developments since publication of *Our Health, Our Care, Our Say* in January 2006. Aside from this extra chapter and the Foreword, the second impression contains no other changes.

The researchers

Stages One and Two, the literature review and the telephone survey, were conducted by Charles Patmore. Stage Three, the in-depth case studies, was conducted jointly by Charles Patmore and Alison McNulty. During Stage Three, a few interviews were also conducted by non-members of the research team - six interviews by Elinor Nicholas and two interviews by Caroline Glendinning. The project overall was conceived and led by Charles Patmore.

Caring for the Whole Person is jointly authored by Charles Patmore and Alison McNulty, except for the late addition of Chapter 12. The latter is authored by Charles Patmore alone.

This publication is the fullest account from the research project

This publication gives much the fullest account of the third and final stage, the in-depth case-studies. This was the most important part of the project, when key conclusions could be drawn. This publication also presents full conclusions from the project overall.

A medium-length summary was published in 2005 under the title *Making home care for older people more flexible and person-centred*. Chapters 1, 2 and 3 of *Caring for the Whole Person* are present in the latter, as are parts of Chapter 10. But the other eight chapters of *Caring for the Whole Person* do not appear elsewhere.

Social Services purchasers, please note

The subject-matter in this publication may sometimes seem unfamiliar to Social Services purchasers. Budgetary pressures and requirement to follow Fair Access to Care Services may feel very much in the foreground in their work. The flexible, customer-centred initiatives by home care staff, which are described here, may sometimes seem to belong to a different universe – a less bureaucratic, better resourced one. Yet they do not. They are conducted within the very same systems. They illustrate how front-line workers can sometimes find opportunities and resources which are not evident at Care Manager level. This publication explores the processes by which that can happen.

Conversely, if *Independence, Well-Being and Choice* and individual budget systems become implemented effectively, then flexible, person-centred home care will become the norm. Eventually the subject-matter here may come to seem commonplace, obvious and banal. Let us hope that day will come.

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SUMMARIES OF EACH CHAPTER

Chapter One presents the purpose of this research.

- Older home care customers face threats to their morale as a result of the physical disabilities which are the reason they receive home care.
- If given flexibility, home care staff are well-placed to give isolated customers types of person-centred help which can support their morale and quality of life.
- Some home care services appear better than others at supplying such person-centred help. The study aimed to explore what factors explain this.

Chapter Two describes the different stages of the project.

- An initial review of literature.
- Then telephone interviews at a sample of 23 home care providers to probe managers' ideas and capacities to provide flexible, person-centred help.
- Then six interesting providers were selected for in-depth study. Service users, provider staff and their Social Services purchasers were interviewed.

Chapter Three sums up the findings from the first two stages, which have previously been published.

- Relationships between home care customers and familiar, regular care staff are important for flexible person-centred care.
- Social Services purchasers have great influence and must be included in any research.
- Compared to Social Services in-house providers, independent agencies were disadvantaged in terms of flexibility. Pay and conditions for their care staff were poorer.
- Long-term home care for older people is often being transferred to independent agencies. Many Social Services providers were transferring to specialist roles, like short-term rehabilitation. Long-term supportive home care is where a flexible, person-centred approach brings particular benefit. Hence independent agencies merit particular study.

Chapter Four summarises how staff / customer relationships, staff aptitudes and attitudes, and provider and purchaser policies interact to produce different degrees of flexible, person-centred help.

- All six providers in the in-depth study gave types of flexible person-centred care which did not require much extra time.
- A common pre-condition for flexible person-centred help was relationships between home care customers and regular workers who got to know them well.
- Such relationships require that customers are served systematically by a small number of familiar staff. This applied to all six providers.
- The type of flexible extra help, which a customer received as a result of such relationships, was shaped by their own service-givers' particular abilities, motivations, knowledge and interests.
- It also was shaped by the policies of provider managers and purchasers concerning what practices were encouraged or discouraged. Here differences were apparent which explained why some providers gave more time-consuming and complex types of person-centred extra help much more often than others.

Chapter Five examines why some independent agencies were more able than others to provide more time-consuming and complex types of flexible person-centred help. The explanation proved to be the differing standpoints of their Social Services purchasers.

- Agency staff were paid for such help if Social Services purchasers specifically commissioned it.
- They could also get paid for it if they used spare time during care visits. Or utilised care visits flexibly for a different purpose to the Care Plan. Or gave such help as a privately paid extra service.
- Some agencies worked for holistic-minded Social Services purchasers who both specifically commissioned social support services and approved flexible departures from the Care Plan where there was evident customer benefit. These were the agencies which gave more time-consuming flexible person-centred help.
- Other agencies worked for Social Services purchasers who would neither commission social support from home care nor approve any deviation from the Care Plan, and even discouraged privately paid extra help. These agencies' repertoires were, understandably, much more limited.

Chapter Six examines the performance of Social Services in-house home care providers concerning flexible person-centred care. The selected providers illustrated 'traditional' in-house home care in that they supplied long-term home care for older people and their managers had much discretion concerning decisions on care-giving.

- These in-house providers had great potential strengths in terms of flexibility, knowledge and organisational connections to other Social Services resources.
- But how much these were used depended on the manager. If utilised, in-house providers had clear advantages over independent agencies for flexible person-centred care.
- In contrast to independent agencies, the key influence was how holistic was the attitude of the provider manager, not the purchaser.

Chapter Seven describes ways that providers' own management and organisation contributed to flexible person-centred care.

- Successful provider managers explicitly encouraged staff to respond holistically to customers' needs. They actively promoted empathic and holistic attitudes to care.
- They based decisions on prevailing opportunities, rather than following rules and precedents about what their service would or would not do. This allowed them to utilise unpredictable, fluctuating amounts of spare time.
- They made decisions on a situational basis, rather than by rules, concerning potential risks like escorting customers or changing light-bulbs. They safely provided services which were banned at some other providers.
- Managers were ready to immediately help care staff with problem tasks – either by advice or in person.
- A larger management team could increase flexibility – for instance dealing with unexpected or complex care problems. Conversely, however small a service, a lone manager can face difficulties.

Chapter Eight reviews important conditions for the close care worker / customer relationships which underpin any flexible person-centred care.

- Support is needed for care staff concerning the emotional costs from caring relationships which regularly end in a customer's decline or death.
- Customers need continuity of care for relationships with care workers to develop. But systems based on a single main worker per customer can amplify negative effects from a worker's shortcomings. Two or three main workers may be preferable if a customer receives so many hours of care per week that each worker will see them enough to get to know them well.
- To obtain good quality care staff, pay and conditions need attention. Independent agency care staff receive much poorer rewards.
- Reasons for the latter include disputes between purchasers and providers over whether overhead payments to agencies should cover pay to care staff for time in supervision and travel between customers.

Chapter Nine describes some Social Services Care Management issues relevant to flexible person-centred care.

- Whatever model of Care Management was employed, long-term older home care customers were served on very large caselists which cannot promote person-centred care.
- Telephone-based automated systems for monitoring home care activities are sometimes seen as a threat to flexibility. Feedback from a pioneering UK scheme showed that this need not be the case, if a purchaser holds holistic values which support flexible care.
- Transfer of home care to independent agencies means that Care Managers are sometimes given some tasks formerly covered by in-house providers, who had greater autonomy and flexibility. Care Managers are not always equipped for this and it may not be best use of their time.
- Some older home care customers would benefit from time-limited Social Worker help for a combination of emotional and practical problems.

Chapter Ten draws conclusions.

- The key factor promoting flexible person-centred home care is commitment to promoting older people's morale and quality of life – at all levels, among purchasers, provider management and provider staff.
- It is at the level of Social Services purchaser that such commitment probably has greatest consequences. A sympathetic purchaser can probably find or develop like-minded providers fairly easily.
- Social Services purchasers can vary profoundly in their stance on providing holistic support for older people's morale and quality of life. Some strongly support this. Others seek to limit their goals firmly to maintaining older people's physical survival at home.
- A major issue for the future of flexible person-centred home care is how such values among Social Services purchasers are determined. How a purchaser views person-centred home care depends on whether they pursue holistic goals for care.
- The new government policy, presented in *Independence, Well-Being and Choice* (Department of Health 2005), in effect requires all purchasers to adopt values of holistic care and customer choice.

- An important short-coming noted during the study is that flexible person-centred home care often depended on the aptitudes and inclinations among a customer's main workers.
- A set of guidelines is supplied whereby Social Services purchasers can promote flexible person-centred home care among their providers.

Chapter Eleven relates the study's findings to the new government policies presented in *Independence, Well-Being and Choice* (Department of Health 2005).

- The new government policies provide major support for flexible, person-centred home care.
- Large obstacles exist to implementing *Independence, Well-Being and Choice* from current policies and attitudes among some Social Services purchasers and providers which have been influenced by these purchasers.
- No conclusions can be drawn from this research concerning whether existing resources would be adequate for the new style of service. But there were appreciably greater grounds for optimism concerning provider resources than concerning purchaser staff who would manage the new system.
- A major issue will be developing staff understanding and identification with the values behind the new approach and systematically dismantling barriers remaining from the old system.

Chapter Twelve relates the study's findings to the Individual Budgets initiative, introduced by *Our Health, Our Care, Our Say* (Department of Health 2006).

- Some steps are listed, which can be taken straightaway by any Social Services Department, which promote well-being and choice and ease the way for individual budgets.
- If introduced according to In Control's principles, individual budgets promise to be the best route to flexible, person-centred home care.
- Scrutiny is needed that individual budget programmes are not developed on less authentic lines, which do not deliver the envisaged gains.
- Criteria are listed for appraising an individual budget scheme for older people.
- Issues are raised about how government decisions on future funding for older peoples' services will affect flexible, person-centred care.

CHAPTER 1: WHY FLEXIBLE PERSON-CENTRED HOME CARE IS IMPORTANT

Origins of the project

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

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

This project developed from two lines of thought inspired by the above. One was the idea that home care services could focus on fulfilling such requests from individuals as a measure of service quality (Patmore 2001c). The other was the notion that maybe a flexible, person-centred home care service could counteract some common threats to morale among older home care customers (Patmore 2001d, 2002a). Some interviewees in these surveys were encountering disabling health problems of a type known sometimes to precipitate depression in older people (Godfrey & Denby 2004). It was reasoned that, given flexibility, home care staff had opportunity to bolster customers' morale either through supportive relationships or through helping customers circumvent problems resulting from their disabilities. For instance, isolated people with mobility problems could benefit from being taken on walks or occasional outings by car – something which seemed much valued by those fortunate interviewees who already received such help from relatives. For instance, in the first two examples of person-centred help, given above, home care staff were helping a customer obtain a rewarding experience, which their disabilities would otherwise preclude. This viewpoint fits well within the preventative approach to depression among older people proposed by Godfrey & Denby (2004).

Aims of the project

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

It is important to recognise that the project did not attempt to prove that a flexible, person-centred approach to home care produces benefits. It aimed, rather, to discover how to promote such an approach. Of course the former is also a subject worth investigating. But it was not the focus of this study.

A guiding principle has been that flexible, person-centred help from home care workers is especially important for older people without any nearby family or friends who could give them such help instead. Also, the greater a person's disability, the greater are their likely needs, since there will be more miscellaneous tasks which they cannot undertake unaided. For a frail older person, who is also isolated, their home care worker may be their only practicable source of help for many important matters. Flexible help from Care Managers or volunteer befrienders is often hard to obtain when and where it is needed. It is home care staff – and housing wardens – who are widely available and, via existing relationships, well-placed to give prompt, flexible, person-centred help to those older people who most need it.

CHAPTER 2: METHODS USED: THE THREE STAGES OF THE PROJECT

The project comprised three separate stages. This report utilises information from all of them. But it concentrates on the third stage, which crystallises the investigation and is the only stage not already fully reported. The three stages were:

Stage One: the literature review

A review of international literature was conducted concerning:

- (a) different ways in which home care services can be organised and managed.
- (b) ways in which services for older people can be customised to the values of individual service users.

Methods are described in Patmore (2002b).

Stage Two: the telephone survey

A set of hour-long tape-recorded telephone interviews was conducted with managers of 23 home care providers in 12 Local Authority Districts in England.

These Districts were selected to represent contrasting parts of England. For instance they included rural areas, a mining community, an inner London borough, a south coast retirement zone, a high growth area with a labour shortage etc.

In each District interviews were sought with one independent provider and one in-house Social Services provider.

Interviews explored:

- Variations in how home care providers ran their services.
- Variations in whether provider managers gave flexible, person-centred care.
- Factors which these managers named as important for providing flexible, person-centred care.

Methods are detailed in Patmore (2003a).

Stage Three: the in-depth case studies

The in-depth case studies focussed on six providers from the telephone survey. These were selected because they displayed characteristics which the telephone survey had highlighted as relevant to flexible, person-centred care (Patmore 2002c).

Selection of the six providers

Reasons for selection included:

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

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

The providers in the in-depth study

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

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

In terms of size and workload:

- The largest provider was an independent agency which provided 1500 hours of care per week and used around 60 front-line care staff. Mean weekly care hours were circa 5 hours per customer.
- Two other independent agencies each provided 1200 care hours per week. Their care staff ranged from 40 – 60 at different periods. At both, mean weekly care hours were approximately 8 hours per customer.
- A Social Services provider supplied 1000 care hours per week, using 40 care staff. Mean weekly care hours were approximately 3 hours per customer.
- There were also two much smaller provider units. A Social Services provider team with 20 care staff supplied 450 weekly care hours with a mean of 3 hours per customer. A small independent agency also used 20 care staff but its mean care hours for its Social Services customers were over 10 hours per week.

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

The interviews

Successive sets of interviews were conducted. Each set of interviews drew on information gained through earlier sets.

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

- Finally interviews were conducted with senior social care commissioning managers at Social Services. These concerned issues encountered earlier and similarly utilised home care scenarios.

Thus a staff practice mentioned by a service user could be discreetly followed up in all successive interviews to investigate what influences lay behind it.

Across all six sites, total numbers of interviews were as follows.

- Home care customers and their family carers: 42
- Home care provider staff: 23
- Social Services purchaser staff: 18

Alongside interviews, service documents like contracts, job descriptions and staff rotas were studied, and staff meetings were observed. Providers completed a brief diary exercise concerning communications with purchasers.

Dates when research was conducted have been presented earlier.

CHAPTER 3: KEY FINDINGS FROM THE FIRST TWO STAGES

From the literature review

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

The literature review has been published as a resource for service planners and managers (Patmore 2002b), which is available free on the internet.

From the telephone survey

- There were important differences in provider managers' values concerning flexible person-centred care. At one end of a continuum were provider managers who were committed to a holistic approach to their customers and who were keen to address a wide range of their needs. At the other end were managers who sought to limit help as narrowly as possible to whatever was specified in Social Services purchasers' Care Plan. They did not see enhancing customers' services as valuable, but only as something which might introduce avoidable risks.
- Many home care providers in both sectors had developed systems for serving customers through a few regular care staff. Notable gains were reported from this, which are relevant to flexible person-centred care, but also some problems and approaches for managing these problems. There were differing strategies for ensuring a customer was served by regular, familiar care staff and some open questions about which strategies maximised gains and minimised problems.
- There were important differences between independent providers and certain Social Services providers, which retained substantial autonomy. At independent providers, Social Services purchasers were a major influence concerning flexible person-centred care since they controlled many decisions about how provider time was used. In contrast, at traditional, partly

autonomous Social Services providers these decisions were in the hands of the provider manager. Purchaser values and how provider time was controlled were key issues. Also influential was a notable difference between independent providers and traditional Social Services providers in how they determined the length of a home care visit. For the former, a fixed length of time was assigned by Care Management. At the latter, staff left as soon as the required tasks had been completed.

- Other important differences between independent providers and Social Services providers concerned adverse pay and working conditions for independent sector care staff, like non-payment for time spent in meetings or travelling between customers. To attract staff despite such adverse conditions, independent providers sometimes needed to recruit people who were seeking flexible hours to an extent which would bar them from much conventional employment. The fluctuating availability of such workers could pose problems for both customers and managers.
- Some Authorities would commission home care time for older people only for meeting their survival and safety needs. Others would sometimes also provide social or emotional support and address quality of life. In many Authorities, providers said Care Management would commission home care for the latter purposes for people aged under 65 – but not for older people.
- Capacity for flexible person-centred home care was affected by factors like labour shortage in prosperous localities, which made all aspects of service difficult, or whether, as in rural areas, there was much staff travelling time between customers.
- A trend was evident for Social Services in-house providers to secure new specialised roles as short-term rehabilitation services or as home care providers for younger people and people with complex disorders. It seems likely that in many localities routine long-term home care for physically disabled older people will become the remit of the independent sector. It is in routine long-term home care that a flexible, person-centred approach has particular importance.

Findings from the telephone survey have already been reported in detail (Patmore 2003a, 2004). A somewhat longer summary than the above is in Patmore (2003b). These publications are available free on the internet.

Panel Two

Service users' aspirations for extra help or improvements to services

During a long, semi-structured interview, 38 service users from the six providers in the in-depth study were asked to name their most important unmet aspirations for help.

- Much the most common response concerned some sort of help to get out of the house.
 - Often this concerned a helper in a car or taxi.
 - Some people sought self-operated transport like powered wheelchairs or scooters or specialised wheelchairs.
 - Some people sought help to improve their walking – for instance people who were in walking programmes with Health staff but wished more practice than presently available.
 - Sometimes the help sought appeared within the abilities of a competent home care provider, given time and permission. But sometimes mobility aspirations were beyond any home care service on its own and would, at least, require help from Care Management.

Mobility aspirations headed the list at all six providers - both those providers which did not take customers out and those which did. The prominence of mobility aspirations is a striking difference from three comparable previous exercises (Patmore 2001c), though other responses by these interviewees are familiar. Likely explanation is that interviewees here were not Social Services staff and did not bias responses towards a conventional service repertoire. Mobility aspirations were also found in the consultations with older home care customers by Raynes *et al* (2001).

- Other notable types of help sought by interviewees:
 - More housecleaning than currently provided. Some interviewees wanted more cleaning, including tasks like washing upper windows and taking down curtains. Others sought help to find a private cleaning service.
 - More frequent baths or showers than currently provided.
 - Help to organise household modifications like the installation of a key safe, a banister or a bath or to move an inaccessible fuse-box or tune a satellite television.
- Interviewees also desired improvements to specific aspects of their current services.
 - More punctual visiting was sought.
 - Options of later bedtimes were sought, for instance to enable an interviewee to take part in a social occasion or watch a particular TV programme.
 - Criticism was made of weekend care arrangements which introduced unfamiliar or poorly briefed staff.
- Sometimes the aspirations voiced at a provider reflected an area where it was particularly weak – like weekend care arrangements at two providers, or punctuality and failure to phone customers about staff changes at another. The same phenomenon was noted in Patmore (2001c).
- There were some interviewees who seemed quite emotionally distressed and who voiced many unmet aspirations. The latter ranged from practical to emotional needs.

CHAPTER 4: THE FOUNDATIONS FOR FLEXIBLE PERSON-CENTRED CARE

'Flexible person-centred care' was defined simply as anything which involved staff going out of their way or departing from standard home care roles to do something which particularly mattered to a customer. This reflects the aims of the study, described earlier. Panel One (page 1) gives varied examples encountered during the in-depth study. Some examples concern steps to enhance a customer's quality of life or to support morale. Others concern departing from routine to respond to urgent customer needs.

At all six providers in the in-depth study there was repeated information from service users and staff about flexible or person-centred conduct from provider staff which required only minor departure from standard home care roles or which cost little time. For instance staff would include special requests like delicatessen items or birthday cards in their shopping. Some staff let customers choose where in their home the worker's allocated amount of cleaning time were spent. A customer's visit time was changed so as to suit her wedding anniversary celebrations. Some staff offered customers more frequent baths than officially allocated - as Panel Two shows, this particularly matters to some customers.

But important differences between providers became evident in how much their staff undertook roles which required significant extra time or departure from common home care roles. For instance some home care workers would organise the purchase and installation of a new refrigerator when a customer's existing one had broken down. At one provider two home care workers routinely promoted Attendance Allowance to customers, whom they believed would be eligible, and would help them to complete each stage of the application process. The examples in Panel One (page 1) illustrate this category of more ambitious or more time-consuming person-centred care. They merit examination in order to understand this project. At some providers, this category of help was common whereas at others it was rare or absent.

A very clear difference among these six providers was whether they regularly escorted customers on walks or drives outside their homes. At three providers, excursions with customers had become a routine feature, supported by management, on both a planned and an impromptu basis. They were undertaken for leisure purposes, for Health appointments, or to go shopping or to the hairdresser. But at the other three providers excursions were either prohibited or very restricted. Help to get out of the house is important since it was by far the most common unmet aspiration among service user interviewees across all six providers – see Panel Two. If staff could take customers out, this obviously enabled them to give a much wider variety of flexible, person-centred help. Examples can be seen in Panel One.

Chapters Five, Six and Seven explain why some providers showed greater variety, flexibility and imagination in their person-centred care than did others. However a first step is to understand the foundations for any sort of person-centred home care for older people. This lies in benign one-to-one relationships between the customer and a fairly small number of care workers. Such good relationships were evident at all six providers. But at certain providers there were also influences which enabled these relationships to generate notably creative, caring and diverse responses to customers' individual circumstances.

Care worker relationships with regular customers

“I’ve been going to some clients for the eight years that I’ve been doing the job. You get to know them really well and they get to know you and then you get to know their routine and things that they like to eat or what they want from the shops.... Everyone has their own ways and when you’ve been going in for a long time, you get to know all that ...because you build that relationship up with them as well....which is the personal side of the job I think it’s a lot easier when you’re going in to somebody and you know the routine, you know, where all the things are in the house.”

Care worker, Social Services provider

“I think it’s nice when you get to know them and they can talk to you and explain their needs as well, I think that’s nice, you know. That’s why I like having regulars because you learn about them and you know what they want and, and everything, and I think that’s brilliant when you, you know, you get them like.”

Care worker, independent agency

“They might want something, a bit shopping from the shops, I say ‘Well I’ll pick it while I’m there doing my own shopping.’ You know, you get to know what they want and you help out that way, cos sometimes if they’re on their own they can’t get out, it’s very hard to go out and buy like clothes or underwear or something. So I say ‘Oh well I’ll get you some while I’m out,’ you know, cos you get to know them, yeah.... I’m out shopping anyway, you know, it’s nothing just to throw an extra few things in my shopping trolley.”

Care worker, independent agency

“I have a client who just stays in the house and they do nothing, you know, like ‘What do you want to go out to, wouldn’t you want to go to the day centre?’ and I’ve spoken to the family members about it and she goes ‘No, she doesn’t want to, she doesn’t like meeting people’. And the whole day is just sitting down for the whole day... at home. So you decide what else can you do for her. She could buy magazines or you find something a bit interesting for her.”

Care worker, independent agency

“My client, her fridge broke down and we talked to her and she goes ‘Well can you buy me a fridge?’ So one of the other care workers, they sorted out. She got leaflets for her and then chose the fridge. And the carer bought it, organised when it’s going to be arrival and they also went out together and co-ordinated....it was the care worker and the client did it together and they solved it. So it depends, again...if you can deal with it, then you, as a carer you would deal with it.”

Care worker, independent agency

The relationship between customer and regular care staff as a foundation for flexible, person-centred help

Throughout the in-depth study, a common theme was that flexible person-centred care developed within care relationships where home care workers were regularly assigned to the same customers. This appeared a frequent pre-condition for flexible person-centred care.

Interviews with home care workers conveyed how regularly visiting the same customer could produce the following consequences:

- Staff gradually learned what mattered to a customer. This seems similar to the process noted by Woodruff and Applebaum (1996) in a comparison of methods for discovering older home care customers' opinions and concerns. They found that the best results came from simply spending time with an older person as they pursued their everyday routines.
- Through getting to know a customer, home care workers came to care more about that person and to wish to do things which specially mattered to the customer.
- As such a relationship developed, customers sometimes confided more in the worker about their concerns and aspirations.
- If the same home care worker regularly gave a customer many hours care per week, they would find ways of managing the tasks in that household so effectively that periodically spare time could be released. That spare time could be used to give types of extra help which specially mattered to the customer.

When interviewees described instances of flexible, person-centred care, a connection was often evident to the relationship between the customer and a regular home care worker. Often flexible person-centred extra help was both thought up and carried out by the same regular home care worker. While occasionally it was instigated by a provider manager or by a Care Manager following a review, even then a familiar, trusted care worker seemed necessary to carry out the intervention. Interviews with home care workers conveyed how unlikely would be many instances of flexible, person-centred care without such a relationship. Taking the example of replacing a refrigerator, care staff often only would consider this if they knew a customer well enough to handle the customer's money without fear of misunderstandings. For a home care worker to help a customer to apply for Attendance Allowance, it was necessary that the worker had regularly witnessed the customer's difficulties in everyday functioning. For a customer to heed a worker's suggestion to apply for Attendance Allowance or to buy a new refrigerator, the trust developed within a relationship may likewise be necessary.

Two pre-requisites for flexible, person-centred care

A pre-requisite for such relationships is that a home care provider employs a system for serving each customer through the same, regular staff. The case for serving older people by familiar, regular care staff was publicised very effectively among Social Service Departments by Henwood *et al* (1998). Their arguments had evident effects among purchasers and providers at the sites in the telephone survey and indeed were sometimes explicitly cited in contracts and quality assurance documents. While these providers almost always aimed at regular service-givers, they differed in how they provided this. Some used a single main worker as much as possible for each customer, backed by supporting staff in only minor relief roles. Others deliberately

avoided this, preferring say three or four regular major workers. If a customer receives 15 or 20 hours care per week, such a small team of staff can each become familiar trusted workers. These approaches will be compared in Chapter Eight.

Another pre-requisite for a good staff-customer relationship was that a home care worker should have a caring, customer-friendly attitude. Nearly all the front-line home care staff, who were interviewed during the in-depth study, expressed such attitudes. However interviews with customers and managers conveyed that there were also other staff who were not thus motivated. Recruitment problems mean that provider managers cannot always engage staff who have strong caring motivation. Sometimes they must engage staff for whom very flexible hours are the attraction (Patmore 2003a). Some provider managers believed that care staff either were “natural carers” or they were not. But other managers believed that, through getting to know customers, caring motivation could eventually develop among staff who had joined up for other reasons.

A necessary foundation for flexible, person-centred home care was a care relationship with a regular home care worker with a caring attitude. These occurred at all providers in the study. But the type and amount of personalised extra help, which resulted from this relationship, depended on some other factors.

Factors which influenced type of flexible, person-centred help

- The personal skills, interests and resources of a customer’s regular home care workers was one factor which enriched or restricted the help offered. For instance an older home care worker was keen to offer cleaning of curtains – much valued, as she commented, by older women who sometimes specially requested such cleaning for Easter. In contrast, a younger colleague, who disliked housecleaning, limited it to basic cleaning duties but had developed her own expertise in promoting welfare benefits and disability aids. She had also created her own list of tried and tested tradesmen, whom she could recommend to customers who needed household repairs. Some home care staff offered hairdressing. One sometimes offered foot massage. One prepared Afro-Caribbean breakfast fare for a customer to whom this mattered. Another worker sometimes supplied free electrical repairs, taking broken lamps and vacuum cleaners home to her retired electrician husband. If a worker drove a car, this could expand substantially what they might offer.
- Staff differed in how much time they had for flexible extra work. Some staff had a precise upper limit to the hours for which they were available each week, which often reflected their commitments as parents. But there were other staff who could periodically work extra hours quite easily. The latter could, for instance, provide privately paid extra help on either an occasional or a regular basis.
- The management policies at each provider had been a major influence on the type of flexible, person-centred help given. These were a mix of policies promoted by the Social Services purchaser and policies originating from the provider’s own

Service users' comments on issues which mattered to them

“What I like about them is that they let my wife know she's not just a client, she's a human being....She's not just there to be looked after. They speak to her as if she's a human, not just a number on a sheet of paper, and that's what we like.”

“...at one time they used to do the shopping for me. But now they take me out and I go around and look at the shops and it gives me a break you know....We don't only do shopping. We can go out to the park or to the sea or something like that.... We usually have a sort of chat about it beforehand....And now the nice weather's in, it won't always be shopping, it'll be you know, everything...So half an hour on the beach or something you know.”

“ ‘Do you want anything at the shops?’ she will say, because she's near the town, and I write it down for her....I was saying ‘Oh I would love a cream cake’... next time, she'll bring me a cream cake, you know.”

“Well I'm lucky I've got an older person. She's very good and she does matter to me...whereas some of them, the younger ones, they do their job and then that's it....They're there to do a service to you and that's it. They're not there to chatter to you at the same time.”

“One of the things I'd like is for them to be able, say you don't always want some housework doing, especially in the summer....In summer you think ‘Oh golly I could sit, if someone could just take me, sit at the garden centre and see the ducks and things like that’. Really that's half your care really I think.”

“I'm a bit fanatical about, you know, like top cupboards....I used to always be so house proud. But you have to like go by the book, don't you, when you can't do it yourself. And I just said to her near Christmas, ‘Oh, them cupboard tops must be filthy’ and she said ‘Yeah, they are filthy as well’ and she did them for me. But they're not supposed to. But that makes you feel better, you know. If there's something you can't do and they're willing to do it, it makes you feel better. They might do just that one job, you know, but that makes you feel better....Sometimes they'll say ‘Well we're not supposed to do it but, you know, don't let them know’.”

managers. It was these influences which explained the large differences between providers which was mentioned earlier this chapter. Through these influences from purchaser or provider management, care workers were either encouraged to develop varied and imaginative extra help or were discouraged from this. For example there was a provider where a care worker could successfully apply to Social Services purchasers for paid care time to take a housebound customer out shopping. In contrast, there was another provider where care staff were forbidden to meet such a customer request, even if the customer paid privately for the extra time involved.

The next three chapters examine these purchaser and provider management influences on flexible, person-centred help, which are the major finding from the study. Chapter Five concerns the four independent providers in the in-depth study, Chapter Six concerns the two Social Services in-house providers, where somewhat different processes were observed. Chapter Seven examines some factors intrinsic to providers, which affected capacity for flexible, person-centred help.

Sometimes individual care staff pursued their own inclinations

While the next three chapters concern ways in which purchaser and provider managers encourage or discourage flexible, person-centred help, it was also the case that sometimes individual care workers acted contrary to all such influences from management. At one provider, where management was consistently discouraging, one worker nevertheless energetically gave widely varied extra help, including meeting customers' requests for walks, despite strict prohibition. However, from accounts of customers and colleagues, this was understandably rarer at this provider than elsewhere. The research by Sinclair and colleagues (2000) commented how some individual care workers strive to do the best for their customers *in spite of their managers*, if need be. Observations during the in-depth study accord with this. A converse process was also observed: sometimes in spite of much management support for person-centred care, a few staff nevertheless served customers in a careless, inconsiderate way. Overall, however, purchaser and provider policies did greatly influence whether care workers' concern for individuals, which germinated from serving regular customers, evolved into the sort of help in Panel One on page 1.

CHAPTER 5: OBTAINING TIME FOR FLEXIBLE PERSON-CENTRED CARE AT INDEPENDENT PROVIDERS

This chapter concerns how time was obtained at independent agencies for flexible person-centred help, like that illustrated in Panel One (page 1). Independent agencies are complex because of major influence from Social Services purchasers in determining how care time is used, alongside influences from agency managers, care staff and the customer. Independent agencies are particularly important because the telephone survey noted a likelihood that they would become the dominant source of long-term supportive home care for older people. Many Social Services providers were negotiating transfer to short-term rehabilitation roles or to specialist roles, leaving long-term home care for older people to independent providers (Patmore 2003a). It is in long-term home care that flexible, person-centred care is most important.

Purchaser control of care time at independent agencies: background issues

At independent agencies on contract to Social Services, use of time is usually tightly controlled by the Social Services Care Managers who purchase the care. Care Managers themselves are governed by local and national policy. For each client, Care Managers commonly prescribe the number of visits per week, the exact length of each visit and a set of tasks to be undertaken on that visit – and sometimes the exact time when each visit takes place (Patmore 2003a, 2004). Social Services payment to the agency is calculated by the amount of time purchased. Obtaining payment for any extra time requires advance application by provider to purchaser. For instance, during the Stage Two telephone survey a provider manager described how, when a customer wished a short supported walk after lunch, her home care agency needed to apply to Care Management for extension to her 30 minute lunch visit. Since this Authority generally limited help for older people to supporting basic survival, extra time was refused (Patmore 2003a).

The telephone survey noted differences among purchasers in how tightly they controlled modification of their original instructions to the provider in their Care Plan. Generally it was the amount of time which was most tightly controlled, since this affected budgets. At some Authorities there was some room for flexibility about varying the tasks for which that time was used, though most definitely not at others. Flexibility was most likely to be granted concerning the timings when visits were made (Patmore 2003a). For instance, while in some Authorities the change to visit timing in Panel One's Example 'H' would require contact with Care Management, in others the provider would not need permission.

Independent providers face important constraints concerning the purposes for which an Authority will commission care time for older people. The telephone survey found that provider managers in seven of the eleven Authorities believed that Social Services was more likely to address quality of life for home care customers aged under 65 than for older people. For instance an agency manager was commissioned to provide 'baking together' sessions with a physically disabled woman, aged under 65. But, the manager said, the same Authority would not commission this for many older physically disabled women, also served by her agency, who likewise could have benefited from this (Patmore 2003a).

Sources for time for flexible, person-centred care at four independent agencies

Considering such purchaser controls, how did agencies obtain time for flexible person-centred help, like that described in Panel One? Two of the independent agencies in the in-depth study consistently, provided much more diverse and more ambitious forms of flexible person-centred care than the other two.

The following sources were noted whereby time was obtained for flexible person-centred help.

1. Care time specifically commissioned for the purpose by Social Services purchasers.
2. Flexible use of care time which had been commissioned for a different purpose in the Care Plan.
3. Spare time during a visit, after Care Plan duties have been completed
4. Time paid for privately by a customer or their family.
5. Time supplied free by a regular home care worker.
6. Time supplied from a combination of these sources

Care time specifically commissioned for the purpose. Example 'A' in Panel One (page 1) shows how an Authority, which took a holistic attitude to older people's care, regularly commissioned time for morale-boosting excursions for isolated older home care customers. This was part of the purchaser's culture, endorsed by senior management. Social Services Care Managers could commission such outings from home care services, for instance following a review. This practice had inspired provider staff themselves sometimes to suggest such help. The latter was how Example 'A' had occurred. The customer's regular home care worker had first raised the case for these outings and her manager had approached Care Management, which then commissioned care time for this purpose. (Costs were home care time at £8.80 per hour charged by the agency; travel costs paid by the customer.) Excursions for accompanied shopping were a common example of such direct commissioning both at this provider and at the other independent provider where flexible, person-centred care received notable official support. At the latter, Care Managers also sometimes commissioned "companionship visits" by home care staff to lonely, isolated customers for whom day centre or volunteer befrienders were unsuitable or unavailable.

Flexible use of care time commissioned for a different purpose in the Care Plan. Example 'B' in Panel One (page 1) shows how a care visit, commissioned for one purpose, preparing lunch, could sometimes be used for a completely different purpose like taking this customer for a walk. Judging from provider managers' comments during the telephone survey, many purchasers would not take kindly to this. However Social Services purchasers for the agency in Example 'B' had launched a radical policy of enhancing customer choice. At a senior level, they supported this response by provider staff. This was the same purchaser and provider as in Panel One's Example 'A'. A consequence of the purchaser both commissioning

leisure outings and letting customers sometimes choose how care time was used was a provider culture where impromptu outings could take place during visits for other purposes. Owing to the former, there were customers for whom risk assessments had already been undertaken, whether for walks or for car rides. Issues of driver insurance had been well discussed – and largely circumvented through using taxis paid for by customers. Activities like Panel One's Example 'B' could take place openly and safely with the support of the whole system, rather than as a covert forbidden favour. Since time was already commissioned, Example 'B' incurred no extra costs.

Spare time during a visit, after Care Plan duties have been completed

Home care visits by independent providers are calculated in precise units of time – for instance 30 minutes, 45 minutes, 60 minutes – for payment purposes. The length prescribed by Care Management often needs to be longer than the tasks require in order to provide a safety margin. This can periodically generate spare time, which *some* provider staff use to give person-centred extra help in response to customer requests. (Factors which produce spare time are described in Panel Three.)

One of the two markedly flexible and person-centred agencies emphasised that such spare time was “quality time” for talking to customers or fulfilling special wishes. This provider was responsible for Example 'C' in Panel One (page 1), the visits to the cemetery. These were carried out in spare time during a daily visit to prompt a customer to take medication. These medication visits were 30 minutes, much longer than required for this task, but the minimum visit length which could be purchased in a rural community where agency staff drive long distances unpaid. On days when the customer wished to visit his wife's grave, he would be ready in advance and on return he would take his medication in the presence of staff. Sometimes staff added

Panel Three

Factors which produce spare time during fixed length home care visits

- Care Managers recognise that, on days when a customer feels less well, tasks like getting-up and dressed will take longer. Hence they must include a safety margin for such visits. This may be around a third of the total visit length.
- A customer's regular worker often develops ways of completing tasks faster through knowing the customer and the household. But, since other staff must sometimes deputise for her, the visit length cannot be reduced.
- Many providers set a minimum visit length, for instance 30 minutes. Where very short tasks, like check calls and medication prompts are concerned, such minimum visit lengths create substantial spare time.
- Home care is often purchased from a choice of fixed visit lengths. More spare time will result if there are only few different lengths to choose from. Some purchasers bought care only in multiples of 30 minutes. This generates much spare time since, for instance, a task normally needing 40 minutes must have a 60 minute visit purchased.
- Some purchasers assign more time than others for a similar task. In the in-depth study, in different Authorities a lunch visit could be 60 minutes, 30 minutes, or 15 minutes. Obviously if visit lengths are very tight, no spare time arises.

Spare time during a fixed length visit

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

Manager, independent agency

some unpaid time. Thus there were no costs to Social Services additional to the care time purchased anyway.

A major issue is whether provider staff treat such spare time as customers' quality time or, instead, leave as soon as Care Plan tasks are finished. Before the Domiciliary Care Standards (Department of Health 2003), many providers in the telephone survey allowed staff to leave early. The latter was sometimes tolerated or even encouraged by purchasers (Patmore 2003a). But Care Standard 6.2 now requires staff to stay for the full length. However instances of visits being shortened were encountered at all agencies during the in-depth study. Frequency appeared to range from the exception to the routine.

Time paid for privately by a customer or their family. In principle, when Social Services funds home care at an independent agency, a customer could buy privately from the same agency any desired extra help, just like a private customer. This might seem a good means for meeting aspirations which purchasers will not afford – like dusting china cabinets or polishing ornaments. Use of the same agency should smooth matters since staff and customer should already know and understand each other. But, in practice, the telephone survey found reluctance at some agencies concerning privately-paid extra help for customers funded by Social Services (Patmore 2003a). Such help would be supplied if requested – but it would not be advertised. Some agencies even wanted any private extra services to be brokered by Social Services Care Managers, rather than negotiate directly with the customer themselves. Often these providers had few fully private customers and their focus was on their work for Social Services. The in-depth study found an important explanation for this reticence: some purchasers discourage privately-paid extra help from the same agency, as will be explained shortly. Another barrier to privately paid extra help was that some customers could not afford the high charges made by some agencies.

Cost barriers concerning private extra help from the same provider

Independent agency charges to the customer could be prohibitively high, in the view of some Care Managers. They pointed out that the hourly charge for private dusting was the same as the charge to Social Services for skilled personal care. This was approximately double what an agency actually paid the care worker. They argued that lower agency overhead charges for simple private work would be fairer and would benefit customers who could not afford more.

Privately paid extra help was much cheaper from staff at Social Services providers. Staff charged at similar rates to their own pay: they were working freelance and no overhead charges were levied.

Time supplied free by a regular home care worker. At all providers there were staff who gave free time towards additional, person-centred help for regular customers. At one of the most flexible independent providers, free help from staff was particularly common. Staff would add some time of their own to activities like the Christmas outings in example 'I' in Panel One. This reflects both the dedication to a customer which can develop in regular home care relationships and the satisfaction which some staff experienced from leisure activities with customers. But problems can sometimes arise from free help from staff, it was widely recognised among providers and purchasers alike. Sometimes it can eventually burden a worker, who may have started it gladly but then feels obligated to continue. Sometimes it can reflect an over-involved relationship, which can become stressful for either party.

Time supplied from a combination of sources. At one provider, in particular, staff often drew on a mix of sources to enable ventures which addressed customers' quality of life - like Panel One's Example 'I'. There would often be some combination of commissioned care time, spare paid time, privately paid time, staff free time or time funded by the agency itself. Keen to make such services possible, manager and staff found ways to draw time from the full range of sources just listed.

Purchasers' policies affected time available for flexible, person-centred help

How purchasers' policies affected time for person-centred extra help at independent agencies: overview

Two agencies worked for holistic-minded Social Services purchasers who:

- specifically commissioned services for social or emotional support.
- approved flexible departures from the Care Plan where there was evident customer benefit
- wished any spare time during visits to be used for the customer's benefit
- accepted providers giving extra privately paid help.

These were the agencies which gave more time-consuming person-centred help.

Two agencies worked for restrictive Social Services purchasers who:

- would not commission home care time for social support purposes.
- discouraged any deviation from the Care Plan.
- resisted customers choosing how spare time was used.
- discouraged privately paid extra help.

These agencies gave only a limited range of flexible person-centred help.

Providers with 'customer-centred' purchasers

Concerning these various sources for time, consistent advantages were enjoyed by the two independent providers which showed most evidence of more ambitious or time-consuming person-centred care.

- Both enjoyed Social Services purchasers which would commission care time to give isolated, at-risk customers social or emotional support or to promote rewarding, morale-boosting activities in their lives.
- Both these providers had purchasers which approved occasional provider flexibility to depart from Care Plan instructions, if this would bring greater benefit to a customer at the time. As mentioned, one purchaser was promoting a policy of letting customers sometimes choose how care time was used – as in Panel One's Example B. In the other Authority, a remarkable degree of mutual trust had developed between purchaser and provider, based on recognition of shared values and reliable judgement. This enabled Care Management support for occasional marked departures from a Care Plan. For instance a Care Manager approved an incident where provider staff helped a depressed customer to go for a walk during a visit which had been commissioned for a shower. Less of a departure, care staff sometimes used the "companionship visits", which this purchaser commissioned, to take customers to parks or garden centres if a customer wished.
- At both these agencies there was conspicuous agreement among all purchaser and provider interviewees about offering customers full visit time to use as the customer pleased. At one provider, however, actual practice matched rhetoric rather better than at the other.
- At both agencies, extra help on a privately paid basis was acceptable to purchasers. Both providers had already stood out during the telephone survey for being attuned to private service: they had unusually many wholly private customers and they also regularly provided private extra help to their Social

Services customers. During the in-depth study they supplied housecleaning and leisure excursions to Social Services customers on a private basis.

It was no coincidence that it was on all these counts that these two purchasers took a stance which enabled flexible person-centred care. It reflected their holistic values about supporting older people's general well-being and quality of life. Commissioning for social and leisure needs and supporting flexibility, quality time for customers and private extra help all make good sense because each contributes to a core mission of holistic care. 'Customer-centred' seems a useful description of these purchasers' stance, since they supported a diverse range of services on the grounds that these benefited customers.

Providers with 'system-centred' purchasers

At the other two agencies, on all these same counts their purchasers took a contrary stance which obstructed flexible person-centred care. This followed logically from the way these purchasers narrowly limited their core mission to providing physical care which could enable older people to remain living in their own homes. They treated any wider help as irrelevant - even when it did not introduce extra costs.

- In neither of these Authorities would home care time be commissioned to improve customers' quality of life or to provide social support. It was not the case that volunteers or day centre outreach staff were being used for such purposes instead of home care workers. In one Authority, reviews by Care Managers were currently pruning existing care packages of any home care time which appeared social in function.
- Even though it brought no extra care costs, these purchasers discouraged any unscheduled person-centred help – whether through spare time during a care visit, instead of Care Plan tasks, during care staff's free time or as a privately paid extra service.

Concerning any such cost-free extra help, these purchasers argued that it was always possible that one day it might cause a problem which could disrupt the running of the service. Hence no help should be given which was not strictly necessary in terms of fulfilling Social Services' limited core mission. For instance, during private extra cleaning a worker might break a customer's crystal decanter, pointed out one senior purchaser, and bad feeling might then disrupt their standard service. For instance, said another purchaser, if a worker agreed, say, to clean out a customer's fireplace during some spare care time, a staff injury might somehow be possible. Another example from a purchaser was that a customer might ask for silverware to be polished during such spare time. This might provoke criticism concerning such use of home care time, were it to become widely known. Even if a worker's own free time was used to put up Christmas decorations, an interviewee said, the service still risked time-consuming arguments if an accident resulted. Customer requests such as these were irrelevant to these purchasers' core mission. So, very logically, any leeway for customers to get requests met was seen as a source for disruption and nuisance and better avoided.

Private extra services could introduce additional worries, some purchasers commented. For instance Social Services might one day face criticism that a provider enjoyed unfairly privileged access to customers, or that it was exploitatively selling

extra services to these customers. If a customer could privately hire her regular home care worker to take her on outings, reasoned a purchaser, then Social Services might risk some blame if an accident resulted. Another issue, raised by a purchaser, was that private extra help could draw away care staff's spare time, which Social Services might otherwise need some day.

Last but not least, these purchasers saw a problem in the very idea of a responsive, person-centred worker who learned to serve regular customers in ways which they specially appreciated. Were such a worker to leave, they pointed out, a customer can be initially so disappointed by the replacement service that this can prove disruptive. For all such reasons, senior purchasers of these two providers wished service to be restricted to the tasks in the Care Plan. Unscheduled help should not be given in spare care time. Private extra help preferably should come from agencies which had not been introduced by Social Services.

The risks these purchasers noted to smooth running of the service were often fairly remote possibilities, even very remote. Nevertheless these remote potential risks were treated as more important than gains for customers which would be highly likely if care staff met their requests. It appeared that, once customers' needs for physical care were met, their wider well-being did not enter into these purchasers' valuations, even if no financial costs were involved. The welfare of the service-giving system seemed a greater priority for these purchasers. Thus 'system-centred' might be an apposite term. These issues of purchasers' policies are discussed further in Chapter Ten.

How did purchasers' policies affect actual behaviour by provider agencies' staff?

There were clear differences in values between the pair of 'customer-centred' purchasers and the pair of 'system-centred' purchasers. These matched general differences between how their independent providers actually served customers. But were there discernible connections between purchasers' values and provider staff behaviour?

An obvious connection between purchaser values and the actual service given was that the 'customer-centred' purchasers commissioned time for quality of life or emotional support, whereas the 'system-centred' purchasers did not. Purchaser values were intended to guide the Care Managers who initially determined services for each customer and subsequently adjusted these at reviews or when contacted by the provider.

Clear links were also evident between purchasers' values and some policies promoted by agency managers. All four provider managers had understood their senior purchaser's core concerns very well – sometimes rather better than did the senior purchaser's own Care Managers. Provider managers generally sought to steer their care staff to act accordingly. Sometimes this was in a direction which the provider manager already favoured. Sometimes it ran counter to a manager's preferences. It was with some regret, for instance, that one agency manager had been supporting her 'system-centred' purchaser's drive towards limiting service to physical care.

Managers at both providers for 'system-centred' purchasers introduced prohibitions on staff escorting customers, which was a type of help which their purchasers discouraged.

Concerning spare time during care visits, at both these providers it was treated as optional whether staff stayed the full visit length. In fact the 'system-centred' senior purchasers expressed ambivalence on the subject. On the one hand, they discouraged any flexible use of care time for the reasons already given. On the other, they officially expected the full visit length to be offered, since the Care Standards now required this. But they wished such time to be used for conversation only or for preparing for Care Plan tasks on future visits. Their providers however had absorbed the message that spare time during care visits was not valued by purchasers. At providers for 'customer-centred' purchasers the opposite message had clearly penetrated to all levels. It was often acted on, though certainly not always.

The connection between the policies promoted by managers and actual conduct of provider staff was quite complicated. Managers do not always succeed in controlling home care staff where flexible, person-centred care is concerned. For instance Sinclair and colleagues (2000) found some staff who gave person-centred extra care contrary to management directives. The present study found evidence both of provider managers' directives being followed and of them being ignored. All providers had some staff who sometimes behaved contrary to their purchaser's and provider manager's stance on flexible person-centred care. Sometimes these independent decisions by care staff favoured person-centred care. Sometimes they obstructed it.

Some providers appeared more effective than others in getting staff to follow management policy. At one of the two 'system-centred' agencies, staff showed more respect for the provider manager's rules, which enforced purchaser restrictions, than did staff at the other. At the former, staff generally treated customers pleasantly but flexible extra help was consistently confined to activities which required little time. A ban on taking customers out appeared to be fully observed. This compliance may reflect a larger, more effective management team and much more harmonious, pleasant management-staff relationships than at the other 'system-centred' service. At the latter, while some staff were brusque and would not give the smallest extra help, others went far out of their way to help regular customers. Some were ready to break strict management rules - like a ban on outings - in their freelance initiatives for their regular customers.

In general, however, at providers for 'customer-centred' purchasers, types of help were given openly in paid time and with support or direct assistance from managers, which were discouraged or prohibited at providers for system-centred purchasers. Escorting customers on shopping or leisure outings is a prime example. In general there was evidence that the values of Social Services purchasers had major influence on the extent of flexible, person-centred home care given by independent providers. However this is not complete influence, noting the propensity of individual home care staff for giving care in their own way.

The policies of purchasers and their independent providers tend to converge

On the one hand, as just described, purchasers' influence over provider policies was considerable. On the other, providers were most certainly not mere extensions of Social Services purchasers. A provider manager could have enormous influence through cultivating an ethos of flexible, person-centred service among provider staff. Chapter Seven describes influences from values, skills and management resources intrinsic to different providers. However there are forces at work whereby values and policies of independent providers will converge with those of their purchaser if a major partnership, like a large block contract, is to develop and last.

Selection processes promote purchaser and provider values which match

Purchasers and providers naturally prefer a partner whose values match their own – if they get the choice. Usually Social Services purchasers have a much greater choice of partner. Typically they can choose from perhaps 20 agencies and often select around eight “approved providers” for varying degrees of partnership. Through trying agencies on spot contract purchase, Social Services purchasers can decide with whom they wish to work more extensively.

Concerning choice exercised by providers, local geography often means that an agency branch has only one possible Social Services Department. But some agencies are placed to choose between Social Services purchasers. One of the two ‘customer-centred’ agencies in the in-depth study had previously worked for two Social Services Departments, but then dropped one Department partly because its policies contravened this agency's values. It stayed with the other on a basis of compatible values. (Some large agencies have branches in many Authorities. But each branch may relate only to one Local Authority.)

Agencies will seek to harmonise with a major purchaser's values

If an agency aspires to a block contract, it will seek to impress Social Services with their mutual compatibility during work obtained on spot contracts. If it obtains a block contract, provider management will further harmonise its policies with the purchaser. Three of the four agencies in the in-depth study held block contracts – and sought to keep these. Indeed almost all their work came through their block contracts. Their provider managers seemed to understand their senior purchasers' values and aspirations very well. Noting changes between the telephone survey and the in-depth study, it was evident how sometimes provider policies could adapt to purchaser concerns. For instance one provider became more cautious about staff changing customers' light-bulbs after it obtained a block contract with a purchaser which promoted its own Health and Safety restrictions among its independent providers. Two providers, which were on block contracts, had become so precisely shaped around local Social Services' requirements that survival on anything resembling their current scale depended on Social Services. Like it or not, maintaining the block contract had become these agency managers' core mission. As described earlier, one route for transmission of Social Services purchaser values is from senior purchaser to an attentive provider manager or proprietor and hence to provider staff.

The care commissioning process directly shapes some aspects of independent agencies

Policies can also be communicated from senior purchaser to Care Managers, who then affect care through the care plans they commission, their responses to provider requests or their reviews of customers. Thus, as described earlier, Social Services purchasers may variously stimulate or discourage a provider's ability to deliver accompanied shopping trips or social time for customers. A provider's rules and procedures will develop to accommodate the roles commonly requested by a regular, major purchaser.

Shared values produce trust, which makes service run smoothly for both partners

At the two agencies with customer-centred purchasers, there were clear benign consequences from purchaser and provider perceiving that they shared values. There was a climate of trust by Care Management which enhanced these providers' flexibility. One provider manager described how she could get care time commissioned simply by telephoning to recommend it, such was Care Managers' experience that this provider's recommendations would match their own assessment. At the other provider, trust had developed so far that the manager routinely claimed for non-commissioned time retrospectively. She could instruct staff to perform extra tasks, when customers needed these, and simply added the extra time to the bill to Social Services. This eases an important contractual barrier which often denies to independent providers the flexibility of some Social Services in-house providers, which is described in the next chapter. Trust was a two-way affair. Not only did Social Services trust the agency to make some decisions which involved extra care time. The agency also needed to trust Social Services to pay for extra time given in good faith - a source of conflict elsewhere. Interestingly these understandings had evolved entirely informally and they did not have any written contractual basis. It is in this situation, where a provider has much flexibility, that intrinsic provider skills and talents will have most influence on the character of service.

How far did purchasers shape these four independent providers?

Each of the agencies in the in-depth case studies presented a somewhat different tale.

- For one agency with a 'customer-centred' purchaser, it was very clear that its workstyle had not been shaped by Social Services. This agency had its own culture of holistic care, customer choice, and readiness to address diverse tasks (detailed in Chapter Seven), which it had developed through serving a substantial private clientele. Its 'customer-centred' Social Services purchaser had not created this provider culture. Rather, Social Services had been keen to purchase a service with this character for publicly funded customers and had supported it well. This was something which certain other Authorities would not have made possible.
- At the other agency with a 'customer-centred' purchaser, Social Services purchasers played a larger part in how this new, fast-growing service had developed, particularly concerning customer-led use of time. This agency had an intrinsic, proprietor-led culture of encouraging flexibility and initiative by care staff as conducive to job satisfaction. To this culture of flexibility and staff-led initiative, Social Services was adding its own idea that customers could choose how their

care time was used. A proactive purchaser was directing a sympathetic provider towards a more customer-led service.

- One of the agencies with a 'system-centred' purchaser, would probably have developed differently, had purchasers' policies been different. The agency manager held some holistic, person-centred values, which she discretely sought to protect, and regretted Social Services' low valuation of the social element in care. But an employee manager for a large block contract has little choice but to endorse the major purchaser's values. This provider illustrated how far-reaching can be the influence of a proactive Social Services purchaser, given passage of time. Gradually this agency changed to reflect a Social Services master-plan in terms of numbers of customers and staff, its rules and its training programme. Superficially, however, it would not be obvious how much agency policies had been necessitated by purchaser policies.
- It was more difficult to judge concerning the other provider with a 'system-centred' purchaser. Its manager fully agreed with Social Services' view that a home care provider's role should be confined to physical care tasks. This provider manager readily and resolutely applied 'system centred' policies, as expected by Social Services, though some care staff disobeyed these in the interest of customers. It was an open question how any change in purchaser policies might affect this established service.

Conditions which promote flexible, person-centred care at an independent provider: concluding thoughts

Reflection on purchaser / provider dynamics suggests the following.

- Unsurprisingly, the most promising combination is when both provider and purchaser hold holistic, customer-centred values.
- An agency cannot provide holistic, customer-centred service for long if it has a major Social Services purchaser which does not share these values. If a Social Services purchaser supplies a large part of an agency's income, the provider will need to pursue similar values to the Social Services purchaser. Otherwise it is unlikely that partnership will last – either party may terminate it. Indeed, some compatibility is necessary for a major partnership in the first place.
- Where a provider works on spot contracts for a variety of purchasers, the outcome from differences in values cannot be predicted so simply. Generally, the more private customers, probably the more customer-centred will be a provider's style of service (though where there is a seller's market, the telephone survey noted, even private customers can sometimes encounter 'system-centred' restrictions). The telephone survey encountered a largely private-customer agency which also sometimes worked on spot contracts for a very 'system-centred' Social Services purchaser. It covertly treated its publicly-funded customers in a more considerate way than was encouraged by Social Services.

- There are some grounds for optimism that a holistic, customer-centred purchaser could proactively develop a holistic, customer-centred approach in an independent provider which had been neutral on this count. This might be attempted through training, commissioning particular care roles, specifying some provider work practices, and monitoring and feeding back to the provider. At the end of Chapter Ten a formula is presented whereby a Social Services purchaser might try to develop an independent provider in this direction. A natural dynamic among care workers might then accomplish the rest: once staff try person-centred roles, they find them rewarding and want to repeat this. This dynamic was certainly evident at the providers where flexible, person-centred care was most evident.

'Task-centred' visits at a Social Services provider

At this in-house Social Services provider, staff were given an "indicative" length for each visit and an approximate time of day. But these times and timings were provisional since the tasks required on each visit would take varying amounts of time, as a customer's health fluctuated. Staff stayed as long as the necessary tasks required – but usually no longer.

"If the first person takes ten minutes longer it doesn't matter, but at the end of the morning you could be very late. So you have a tendency to try and keep within the time because of the amount of work you've got to do in a morning.

Because we start at eight and we finish at say two o'clock, we have clients running after each other. So therefore we do have to keep reasonably to a time.... generally speaking it does. But you go in some days and they'll have been feeling well and they're up and dressed and you just have to do breakfast. That pushes you forward...the girls don't have to stay there for half an hour.

Generally speaking you go and get on, depending on what time of day it is. Obviously you can't do your lunches too early...You might have a reason not to get on...You might use that time to, say, wipe the fridge over or the odd jobs that might need doing. You think 'Oh well I'll just clean the bathroom while I'm here'something that you don't always have a lot of time for.

.....It may be a person who really, really needs your company, so you wouldn't cut it short if you could avoid it. That might be a time when you think, 'I will have a cup of tea with you this morning Mrs Jones... I won't leave you because I know that you so look forward to me coming and you are allocated this amount of time'. So you would stay in some cases..... Everybody is different, that's the thing."

Supervisor, Social Services in-house provider

CHAPTER 6: OBTAINING TIME FOR FLEXIBLE, PERSON-CENTRED CARE AT SOCIAL SERVICES PROVIDERS

Compared to independent agencies, the situation at the Social Services in-house providers was very simple. Their purchasers had less immediate impact on their everyday work and control of staff time lay substantially in the hands of provider managers. Hence providers' values and priorities shaped usage of time. While purchasers most certainly had influence over these providers, this was manifested over a longer timescale than at independent providers.

The telephone survey had identified important differences among Social Services providers. Some were now treated by Social Services purchasers much like independent agencies. Others maintained a different, more autonomous status. The most autonomous were some in-house providers which still functioned entirely according to the combined assessor / provider model prevalent before most Social Services Departments separated assessment from provision. Considerable autonomy to shape their own work gave such Social Services in-house providers some striking advantages for flexible care, when compared to providers controlled by Care Management. Two suitable Social Services in-house providers were selected for the in-depth study, so such flexibility could be studied. One preserved completely the traditional combined assessor / provider model. The other functioned under Care Management but was delegated appreciable discretion. Both still supplied comprehensive long-term home care, which is where a flexible person-centred approach brings particular benefit.

A distinctive feature of these providers concerned how tasks and time were assigned to visits. Instead of precise specification of length, tasks and timings for each visit being prescribed by Care Managers, these Social Services providers had a list of tasks per visit (and responsibility to vary these flexibly, when appropriate), an approximate visit length, and approximate visit timings. Staff ended a visit when tasks were completed and moved on to the next customer. 'Task-centred' was how these providers described this approach. Visit lengths could be varied according to a customer's needs that day, so there was no need for a safety margin within a fixed visit length as at the independent providers. A worker had flexibility to vary their routine significantly to fit changing circumstances in customers' lives. Also, these services had considerable discretion to give customers substantial one-off extra time when customer needs required this.

Thus time for flexible person-centred care could be accessed as follows, using a similar framework as before.

- Extra care time could be authorised flexibly by the provider manager (though within limits and from a finite overall time budget).
- Considerable flexibility existed for staff to vary tasks which were undertaken during home care visits.
- But there was no spare 'quality time' at the end of a visit. Once the tasks had been completed, a worker usually departed.
- Some staff undertook privately paid extra work for their regular customers – an officially recognised practice. Much lower private charges were made by Social Services home care staff than by independent agencies, since there were no overhead payments to an employer. However, if a customer's own service-givers

did not offer it themselves, private extra help would generally not be available from other members of a Social Services team. (Both the in-house providers in the in-depth study permitted private extra work for Social Services customers, though one much more readily than the other. Typically it was extra house cleaning.)

- Time was sometimes supplied free by a regular home care worker, just as at independent agencies.

An in-house provider strength: flexible access to time for extra needs

A conspicuous strength of the Social Services providers was that they were much better placed than independent agencies to help their older customers flexibly with situations which required substantial one-off extra time.

One example would be taking the customer to the hospital appliance centre in Panel One's Example 'D' (see page 1). This took place at a Social Services provider and required simply a phone-call to a well-informed provider manager. Independent agencies could encounter difficulty in this situation. First they must convince a Duty Care Manager of the need. Even if convinced, some Care Management services would avoid commissioning the customer's regular agency worker for such a purpose because it involves unbudgeted external payments. Instead they might assign a Care Management worker, perhaps an unqualified worker, who had never met the customer, because their pay was already included in Social Services' budget. Since the latter also applied to Social Services in-house providers, this made the latter more acceptable to some purchasers for supplying such help. (Chapter Nine revisits this issue.)

Panel One's Example 'F' shows another situation where flexible, person-centred help is more easily supplied by a Social Services home care provider than by an independent agency (see page 1). The Social Services provider, which gave this brief, informal, post-bereavement support, did not need to first request fixed amounts of extra care time or ask a Care Manager to assess the widow's needs. Nor did it need to first discuss customer liability for care charges for this extra time. Whatever an Authority's charging policy, it is much easier for an in-house provider than an independent service to discreetly relax a small charge like this (total costs around £20), when it could be insensitive and counter-productive to try to levy it. In theory an independent agency might propose the same approach to a person-centred Care Management service. But it can be much harder for an external provider to act in as timely, sensitive and informal a manner as this in-house provider in this particular situation.

The victim support situation in Panel One's Example 'E' received immediate flexible response from a Social Services provider. It is another example of how it is easier to obtain a customer's trusted, familiar worker for a sensitive but time-consuming extra task, where an in-house provider is involved. In that particular Authority, had the provider been an independent agency, local Care Management would not have commissioned extra time from the regular home care worker to help in this fashion. Instead, a Care Manager said, the home care worker would be expected to report the incident to the agency manager, then continue with her other visits. The agency manager should then inform Care Management, who would send their own worker

round - for instance an unfamiliar Duty Care Manager - to attend to the aftermath of the burglary. (See Chapter Nine.)

An important case for provider flexibility is in customer emergencies, like this or like discovering an customer who has become ill. For such emergencies, some purchasers have now delegated to independent providers the same flexibility to spend extra time which Social Services providers have always enjoyed. This applied to both the agencies with customer-centred purchasers and to one with a system-centred purchaser. The latter's policies were usually very logical and careful with detail. Since emergencies were survival and safety situations, this fitted its limited core mission so a flexible procedure was developed and fully supported by purchasers.

If Social Services providers were to pursue their flexible, task-centred work-style, they needed greater flexibility concerning visit timings than allowed to independent providers, where visits are often commissioned for specific times. At these Social Services providers, staff were expected to visit a customer within a 30 minute time window, rather than at a precise time, to allow for variations in a worker's schedule. Staff had discretion to negotiate some changes in timing direct with customers. Example 'H' in Panel One, for instance, which was undertaken by an in-house provider, might have entailed changes to other customers' visit times. Sometimes it is feared that giving home care staff such flexibility will mean that staff convenience over-rides customers' hopes for punctuality. But, concerning visit timing, the two in-house providers received the highest expressions of satisfaction from service user interviewees among all six providers.

Another strength was Social Services procedures and resources

Another strength of Social Services providers was well-established local Social Services arrangements for handling money, which could enable them to buy costly household items for customers. They had procedures for witnessing withdrawals of customers' money from the bank or for giving customers loans from Social Services petty cash. Also, Social Services providers had easier access to other Social Services resources. At one in-house provider, customers described how home care staff directly brought them disability aids, like a long-handled shoe-horn or a urine bottle, when they recognised a need.

A limitation at in-house providers: time for conversation did not readily arise.

The 'task-centred' approach of the Social Services providers meant that, unlike at independent providers, there was no potential 'quality time' for customers at the end of a visit. Once the tasks deemed necessary were finished, the worker left. Social Services provider staff showed much discomfort at initiating any conversation which would involve them in being paid simply for talking to someone. Even if the customer was not being charged, some staff worried about costs to their Authority from their pay. At one Social Services provider, where charges were based on actual time spent, staff worried that chatting would cost customers money and so sought to leave swiftly. They knew which customers were liable to extra charges from a prolonged visit and which were exempted. Sometimes customers in the former category pressed staff to hurry so as to limit charges. More often the matter was never discussed but the worker just worried in silence about minimising time-costs for the customer's sake. Sometimes a customer actually asked a worker to stay and talk,

"I remember years ago going to a call and a lady said to me 'Oh sit down and I'll make us a cup of tea' 'Oh no, I've come to do that' 'No, I want to do it' 'Well OK, you do it' and after a while I thought, she's not going to let me do anything, because I'd made numerous attempts to do. And I actually came out and I rang my line manager and said 'Look, I'm not putting it down on my time sheet, I don't want you to pay me for it' because I felt so guilty and she just said to me 'You must put it down and I will sign it because you've done that person more good than if you'd have gone in and done a spring clean through the flat, they needed to sit and talk to you'.

Team leader, Social Services Provider

accepting the extra costs, but workers could still feel uneasy. No such difficulties arose at independent agencies, because their visit lengths were already fixed by Care Managers, so staying to chat could be seen as giving customers their money's worth. It was feeling responsible for creating conversation-costs which inhibited Social Services staff during flexible length visits. They could find it distinctly easier to undertake extra practical tasks which related to quality of life, than to be paid for talking. One Social Services worker would sometimes meet a request for an unscheduled shower on a morning when she was ahead of schedule. But she did not treat conversation the same way.

Some Social Services home care staff had devices for getting round this problem. One worker scheduled her official tea-breaks during visits to customers whom she judged to specially need company. This way they could talk but the customer would not be charged. Another approach was to organise kitchen tasks so the customer could sit beside you or to talk during the time while a meal was being microwaved. The last visit of a shift offered a chance to spend free time afterwards talking to that customer. "When you get to the last customer in the day", commented a Social Services provider manager, "that last customer's the luckiest customer. Because that customer can actually have the benefit of the Home Carer's sigh of relief, 'I've finished my day in the sense that I don't have to rush on anywhere next'." Panel One's Example 'G' shows how a Social Services provider manager used a fixed time length visit for meeting a customer's social needs, whereas this provider's visits were normally on a task-completion basis. This got round the problem of giving such help within a task-centred framework. Given flexibility, the benefits from both task-centred and time-centred approaches can be combined.

Factors shaping differences between the Social Services in-house providers

Both these providers gave notable person-centred care and utilised the flexibility with which in-house providers are advantaged. But one provider displayed a notably more diverse repertoire of help. Staff were involved in proactively introducing disability aids or enabling Attendance Allowance claims. They regularly took customers shopping. In a remarkable initiative, for years some staff had spent a little time each week running social clubs for their customers. These supplied lunch, social and craft activities plus periodic seaside and countryside trips. Home care workers brokered transactions with private tradesmen for customers who could not arrange these themselves. This provider had a positive attitude to its staff giving their customers privately paid extra help in their own time. In the interest of customer choice, it sometimes advertised private sector alternatives to the Authority's home-delivered

meals. A major influence behind all this was the provider manager's imaginative and holistic view of care for older people. This is described in Chapter Seven.

At the other Social Services provider, staff seemed to have notably good relationships with customers. They received the highest customer satisfaction ratings among the six providers in the in-depth study – the only provider to receive maximum satisfaction ratings on all counts. But their work seemed bounded by quite restrictive rules and regulations. Within customers' homes this provider would address needs for company and occupation with imagination and a very caring attitude – as in Panel One's Examples 'F' and 'G'. But it was rare for home care staff to escort customers outside their homes. This was reserved for things like hospital appointments or taking children to school and senior provider managers generally did not wish to develop this role. Customers were not helped to travel outside their homes for other purposes, although some customers wished this strongly. In fact good opportunities existed for home care staff to broker usage of local transport schemes created for this purpose – but these did not seem used.

Purchasers' values did not contribute directly to the differences between these two in-house providers. In fact the more traditional, restrained provider had the purchaser with more customer-centred, holistic values and vice versa. Both these purchasers were aware that their influence over their in-house provider was in some ways less immediate than over their independent providers. In one of these Authorities changes were planned which would eventually extend Care Manager input to all parts of the in-house home care service. Purchasers' values already affected both these in-house providers, but it was over a longer-term, strategic timescale. In terms of day-to-day decision-making, both these in-house providers were experienced, trusted and very capable services and it was the provider's own policies which set their immediate agenda.

Conclusion: strengths of Social Services providers for flexible, person-centred care

Given a manager with suitable values and vision, Social Services providers are excellently equipped to provide flexible, person-centred care. This reflects their potential freedom of operation and their knowledge, contacts and access to other Social Services resources. Their only intrinsic short-coming is that 'task-centred' visits do not include any spare social time - 'quality time' for customers' own use. But this short-coming can be easily remedied. If certain customers are noted to particularly need such quality time, a manager can instruct staff to include some in visits. It could be short amounts on a daily basis or long amounts less frequently, as in Example 'G' in Panel One. Another common shortcoming is difficulty in providing weekend service, despite good weekend pay incentives. This seems to reflect the presence of staff who were recruited when weekend work was rarely expected, because home care generally served less dependent people than it does today.

But to use these providers' potential flexibility depends on the values and vision of the provider manager – and the home care management hierarchy. Some excellent use of this flexibility was observed during the in-depth case studies. But during the telephone survey other Social Services providers were encountered which could be rigidly rule-bound and unhelpful – even uncaring. Everything depends on how holistic is the manager's philosophy of care. Illustration is given in the next chapter.

Social Services in-house providers were often withdrawing from long-term home care for older people, according to the telephone survey, and transferring to specialist, short-term work. Hence they may not be a widespread resource for flexible, person-centred care in the near future. However they illustrate useful lessons about arrangements which can make flexible, person-centred care easier.

CHAPTER 7: PROVIDER APPROACHES, POLICIES AND RESOURCES

However great the influence of purchasers, providers most definitely contributed influences of their own. The following draws on both independent and Social Services providers to describe provider approaches and resources which influenced whether care was person-centred and flexible.

Ways of thinking about care

Two providers, which stood out for flexible, person-centred care, had managers who had particular ways of thinking about care-giving, which guided their decision-making and seemed to influence their care workers. One was an in-house Social Services provider, the other an independent agency.

For both provider managers, a key construct was 'caring for the whole person'. This was used to encourage staff to broaden their roles to adapt to customers' problems, rather than stick to a tariff of standard services or tasks listed in the Care Plan. It encouraged a problem-solving approach. If a service really cared for the whole person, it had to seek solutions for whatever problems the customer presented and liaise with other agencies as needed. Thus a care worker's role became enlarged. The manager of the Social Services provider commented:

"Because they are the same worker working with that same customer, they get to know them and they want to do the best by them and then they'll see things that that person's struggling with and, and think: 'Well hang on, if I don't help this person, I'm not doing my job properly, you know, I'm not fulfilling my role as not just a home carer but a person who's looking out for the whole person'. So they learn from their colleagues, they learn from the team and eventually... they're looking out for all sorts of things for them."

In this manager's view, every care worker in this team culture eventually adopted a flexible person-centred approach to some degree, such was the influence from colleagues.

"Some come to the service and...they find it very easy....It takes some people longer than others but eventually everybody will get there."

Another maxim at this provider was to make decisions pragmatically – and not get drawn into following precedents or setting up rules. Much potential for person-centred help depends on fluctuating and unpredictable amounts of spare staff time here and there. One week a service can spare some time for some extra help, which might be impossible the next. Some home care providers govern such situations by rules which exclude the extra help altogether. But this provider took care not to set up rules which could stop it using opportunities constructively when they did arise. As the manager put it:

"I wouldn't be tied into that 'Oh well, you did it for him so you've got to do it for her.' I would be saying 'No, that was a management decision weighing up all the consequences – what the person was getting out of it, what member of staff was available, the state of the budget'".

Decisions to give extra help were made on a case by case basis in the light of gains, risks and resources at the time. This way opportunities to help customers could be used, not wasted.

Panel Four

How management policies can make a difference: contrasting responses at two providers

- An independent agency home care worker was repeatedly asked by a customer to take to the bank a large sum of cash, which she could not store safely or get banked in any other way. The worker repeatedly sought advice from managers. She was eventually told simply that this was not a service which the agency provided. In her own time, she then sought out the customer's housing manager and asked her to take over the problem.
- Social Services in-house home care staff were helping a customer to move home and found a large sum of cash under his mattress. After discussion with the customer, the provider manager was phoned. The manager visited, was identified to the customer by his home care worker, and took money and savings book to the bank, then returned with a receipt for the customer.

At both services, care staff acted in a person-centred way. But at the first, provider management set narrow boundaries to the home care role whereas the second took a holistic approach. Both managers were alert to hazards from home care staff handling large sums of customers' money. But one would leave the problem with the customer, whereas the other solved it.

Another principle at this provider was that the manager must be ever-available on the phone to advise or directly assist care:

"I see that as one of the most important roles I have, to be available for staff, to give advice and, if it's more than verbal advice is required, to be able to...bring in the appropriate services...you know, put the referrals in, bring in the right piece of equipment or the right person who can bring a perfect service to that customer."

This was seen as a case for a manager being full-time, to increase availability. Care staff certainly used and appreciated this service. In Panel Four, the second example shows this manager's response to a customer's banking problem.

This manager placed much importance on finding high quality staff to act as leaders of small teams of eight or nine care workers. According to the manager, they needed a combination of organisational abilities, experience as a good care worker, ability to motivate their staff, and readiness to make some difficult decisions on the spot.

A noticeable feature at this provider was how recollections of past problem-solving provided ideas for addressing current challenges concerning customers. This was evident at team meetings.

Panel Five presents some guiding ideas at an independent provider with its own strong culture of flexible person-centred care. It seemed extraordinarily able to elicit and respond to customers' wishes.

Panel Five

Some guiding ideas at a person-centred independent provider

The manager's view

- “Where do you say ‘here is where we stop caring’? Once we’ve got someone washed and dressed, do we stop caring there and say they’re being cared for? Or do you extend that into a social thing and a companionship thing? Because at the end of the day human beings are social animals and being in a social setting is important, you know, because the isolation some of these people feel is more than half their problem. So you can’t just say: ‘Well, I’ve got you up washed and dressed, you’ve had your cup of tea and your toast, I don’t care anymore’ and walk out”.
- “The philosophy is that you treat everybody as you would wish yourself to be treated and you respect their dignity and privacy at all times and, if at all in doubt about how you should behave with someone, imagine you are sat there in front of yourself and consider how would you wish to be treated. And that’s the philosophy basically. It’s as simple as that... We give them examples.” Young care workers were told to reflect on how they would wish their grandparents to be treated.

The supervisor's view

- A supervisor at this provider believed that customers could be encouraged to articulate their wishes if, from the very start of home care, their care worker avoided dominating, sought to elicit and defer to any small customer wishes, and avoided taking over roles which the customer still undertook. Then, after a month, larger wishes would get voiced.

A care worker's view

The key principles according to a care worker:

- Do whatever needs doing – whatever it is.
- But if it’s a task about which you’re in any way unsure, phone the provider manager for advice first.
- “When I do my job, I ask myself ‘If it were my mum or my dad, how would I treat them?’”

Assistant management staff could enhance flexibility

There were some large differences between providers in their numbers of management staff, even where numbers of customers, care hours and care staff were very similar. Sometimes there were as many as four supervisors or management assistants to help a provider manager.

It was difficult to be a small service with only one manager since management roles in home care are so diverse: planning staff rotas, organising cover for absences, meeting new customers, reviewing existing ones, troubleshooting care problems, negotiations with referrers, staff supervision and phone consultations with staff, staff recruitment and training and, not least, paperwork and answering the phone. Where resources permit, independent agencies like to divide management roles between office-based 'Co-ordinators', who man the phones, and 'Supervisors' who visit customers' homes (Patmore 2003a). At some providers, though, all these roles could fall to a lone manager.

Multiple supervisors and management assistants can be important resources for flexible, person-centred care. However, among these providers, they were not always used to this effect. At independent providers, since management staff pay was covered from overhead payments, management assistants could be used to undertake any task swiftly and flexibly, without needing to apply to purchasers for a care worker's time to be commissioned for the purpose. In a sense they represented a fund of ready-paid care time for the agency to use however it chose.

- In emergencies, like when a worker discovered that a customer was ill, one agency would dispatch a supervisor to the customer's home to take over from the care worker, freeing them to continue their rounds. At another provider, the worker would stay with the ill customer but management staff would phone her next customers and find a replacement worker or maybe replace her themselves.
- These extra management staff could also take over from front-line workers tasks which were complex or for which time was short, like payment of a customer's household bills, replacing a refrigerator, finding a plumber or getting keys cut.
- At two independent providers, which had multiple supervisors, each customer was assigned to a supervisor who would undertake all management dealings with that customer. They would meet new customers, assess requirements and customer preferences, select a suitable care worker, and monitor progress informally and via reviews. While it was not possible to assess the effects of these particular ventures, they have obvious interest because they might make care more person-centred. At one provider the arrangement meant that each supervisor needed to get to know around 50 customers. In contrast, at a provider with an identical workload but much less management resource, the provider manager needed herself to undertake the same roles for 150 customers.
- A major gain from multiple supervisors may be better supervision of basic standards of care than can be achieved by a lone manager. However much a manager can inspire well-motivated staff towards creative, holistic work, to be person-centred also requires supervising staff and checking whether customers have complaints. At one provider, which otherwise gave excellent and creative person-centred care, a heavy burden of multiple roles had fallen on a lone

manager. This tied the manager to the office and prevented sufficient systematic contact with customers to supervise staff effectively. A few poorly motivated workers had in fact been providing unsatisfactory service for one of the customers interviewed, but the manager had not discovered this.

- Supervisors could sometimes helpfully deputise for care staff who were sick or on holiday. While this could consume time, it was also an excellent way to get to know a customer and learn how care was normally being provided. One manager believed that providing substitute care, preferably for a whole week, was the only reliable way to appraise a customer's needs and the quality of existing care arrangements. Thus, if supervisors deputised for care staff, this could help them undertake their other supervisor roles more effectively.

There seemed a case for assistant managers or multiple supervisors. How many care hours per week are necessary to make a larger management team financially viable? On this basis, could it be possible to calculate a minimum viable workload for a home care service?

But the presence of auxiliary management staff is simply a tool. It will not promote flexible, person-centred care unless directed by a manager who pursues this goal. Given a provider manager with contrary policies, greater hands-on management could actually restrict person-centred initiatives by care workers.

Other aspects of work and workforce, which can assist flexibility

- One manager pointed out an incidental factor which made it easier to fit in one-off extra visits or changes to timing (like Panel One's examples 'D' and 'H' on page 1). Since this provider still did significant amounts of household cleaning, it could re-arrange these visits because household cleaning does not need to be done immediately. Hence staff could be sometimes drawn from these appointments for another purpose. But the more a home care service concentrates on time-critical work like personal care and meals, the harder it is to reassign staff time like this.
- Similarly, there was greater slack in the system if care staff worked shorter hours, saw fewer customers and worked split shifts. One-off extra tasks either could be done in the time between shifts. Or lateness resulting from emergency tasks would be readily absorbed by the time between shifts. Minimum flexibility would exist where care staff worked long hours in a continuous shift and where visits were short and many. This way disruption from late-running would have greatest impact and the Co-ordinator would be kept busy, phoning customers or fielding their calls. Examples of both work patterns were encountered in staff rotas.
- Provider managers found part-time staff brought much greater flexibility, according to the telephone survey (Patmore 2003a). Part-time staff meant more workers, which made it easier to supply more visits simultaneously at the times of peak demand – getting up, lunchtime, bedtime. Also, because they were part-time, they might have spare time and could be phoned for help concerning extra tasks which arose. But while managers greatly preferred part-time workers, they could not always get them. Local economic and demographic factors shaped the potential local workforce, their earnings requirements and hence the hours which could attract them.

- Flexibility also increased, the more staff who drove cars. The telephone survey noted that car usage was becoming widespread, especially at independent providers (Patmore 2003a). Cars gave the flexibility that any driver could visit any customer. If staff were permitted to drive customers, this brought additional opportunities.

Other practical aspects of service organisation, staffing and management are discussed in the report from the telephone survey, *Understanding Home Care Providers* (Patmore 2003a).

Provider rules which impair flexibility

Providers differed in the extent to which they imposed comprehensive bans on staff undertaking particular activities. Common subjects of such bans were described from the telephone survey (Patmore 2003a):

- climbing to change light-bulbs or clean inside windows
- recommending plumbers, electricians or private cleaners
- escorting customers outside the home.

Any unnecessarily sweeping bans are obstacles to flexible, person-centred home care. For every type of help which was prohibited at any provider, there was at least one other provider which performed it routinely and officially, using commonsense safeguards, and encountering no problems. Escorting customers, changing light-bulbs, or introducing trusted repair workers – these could all be done safely and satisfactorily at services which were sufficiently customer-centred to encourage this and to work out sensible procedures.

Like Sinclair *et al* (2000), the in-depth study found that some front-line home care ignored such prohibitions or had not heard of them. But it also found staff who said that they obeyed them. These prohibitions certainly can have influence.

A noteworthy feature concerning these prohibitions was that misleading information was quite often used to support them.

- Provider managers could lead staff to believe that the terms of insurance policies lay behind prohibition of particular activities. In fact, the provider believed that if it informed staff that an action was prohibited, then it would be immune from any compensation claim for an accident if they disobeyed. It was narrowing its risk area for compensation claims by excluding activities other than those deemed essential. Provider management itself chose which activities could be treated as superfluous - sometimes in response to purchaser concerns, as described in Chapter Five. It was not insurance companies which dictated these exclusions. An example of this practice was a provider whose manager told care staff that they were covered by insurance only for activities listed in a customer's written Care Plan.
- Surprising reasons could be given for prohibitions. At two providers, different staff gave different reasons why changing light-bulbs was banned. Some believed it was risk of staff falling and suffering injury. But colleagues at both services, including the manager in one instance, believed it was to forestall fires or explosions from incorrect insertion of the bulb. The latter risks are not well-recognised by electricians.

- Sometimes it was hard to identify the authority behind a prohibition affirmed by staff. Different staff might state it in different forms – or deny its existence. It could not be found anywhere in documents. At one in-house service, five managers each gave a different rendering of the restrictions on changing light-bulbs.
- Front-line staff might believe an activity was firmly banned. But exploration with the provider manager could reveal that the manager simply had given staff that impression to deter them from something which management usually did not wish to take place. There was no written edict and the activity could sometimes be permitted. At one provider, where staff believed escorting was prohibited, it could in fact occur if some difficult conditions were met.

There seems a case for always checking both the existence and the authority behind prohibitions and for investigating statements that insurance conditions lie behind them. Exploratory discussions with trade insurance companies suggest that the position of the latter is rarely simple or follows precise rules.

Sometimes provider prohibitions on activities like changing lightbulbs reflected influence from Social Services purchasers. In one case the purchaser appeared the instigator, promoting an Authority-wide line on the subject. Two other purchasers were supportive, to say the least, of such prohibitions. Two other purchasers found such restrictions annoying and contrary to common-sense. But they did not challenge providers on this count.

A manager's advice on home care relationships

"All we can do is say to people 'Yes, we know you're going to get attached. Yes, we have no problem with that. But know your own boundaries...Think about your motives for getting that attached. And if you do feel that a client is getting too attached to you and you're finding it difficult, let us know and we'll send someone else in for a little while, because they do become very dependent on certain carers.' Yes, it is part of the job but we just need them to think about themselves as well and know where the cut-off point is, definitely know where the cut-off point is. For example we tell them not to give their mobile phone numbers out because clients will ring them up at all sorts of hours saying 'Oh, you know, my fire's gone out' or whatever and, you know, it's not fair, it's not fair."

Manager, independent agency

The hardest part of the job

"The only thing is you've got to be careful you don't get too attached because you really can. I learnt that lesson. I got attached to one lady and she died and she was really nice but then I thought 'No, I've not to get too attached'. So you do, but I try not to show it, you know. Well that's the only downside really, when you get too attached and they either have to go in a home or they die or something like that. But that's the only downside. You see they're all nice, they are."

Care worker, independent agency

"I am nursing a terminally ill gentleman at the moment and it's hard. We do sit and cry with him. And, you know, he's asked us all to help him to go. And I mean how can you cope with that, you know. We keep the same girls in there, so there's me and his other main carer and, if it's too much for her, she'll ring me or, if it's too much for me, I'll ring her and we'll have a talk, you know. And his wife, we just say 'There's a shoulder there', you know. And she uses it quite a lot as well, you know, so it is hard. That's the downside with older people. You make friends with them and then they're gone."

Supervisor, independent agency

"You make a bond and it's sad when they die or when they go into hospital.... So that's the sad bit, because you know that they will die and...you might be the one that finds them. That's sad, and that's a bit scary. I haven't dealt with that, but I have colleagues that have had to come in and their clients are dead and they've had to deal with that and then continue with work. There's no support."

Care worker, independent agency

When a care worker discovers a customer dead

"Obviously that's very traumatic. We do talk about that in induction to carers that it might happen. You know we say it doesn't happen very often but I think you've got to let them know that that is a possibility....What they do is they ring us straight away and we take over from them. We get somebody out there and we do all the rest, ringing GP, family, Social Services. But obviously we let them stay with us if they want to....Either a supervisor or myself would go out in that instance and help the carer. It is traumatic for them in that position."

Proprietor, independent agency.

CHAPTER 8: FRONT-LINE CARE STAFF AND FLEXIBLE PERSON-CENTRED CARE

“You make friends with them and then they’re gone”: emotional costs for regular home care workers for older people

Caring relationships with regular home care workers were the foundation for person-centred home care. As mentioned earlier, it was through these relationships that staff got to learn about their customers’ major concerns and became motivated to help them. It was difficult to envisage person-centred care without such relationships. But these relationships involved two types of cost for home care staff.

There were some problems which provider managers felt could be avoided, given wisdom, experience or good advice from supervisors. For instance a care worker could give a customer too much free extra help. This might then make the worker feel over-committed to a grateful client and it could be hard to extricate themselves. Either party might find a care relationship had become too close. Some managers felt they could advise new workers on how to avoid such problems. One manager believed staff learned best about these relationships by making their own mistakes.

But another problem was intrinsic to the close relationships on which good care depended. Staff formed heartfelt caring relationships with older people, who sooner or later would always die or be removed to residential or nursing care through dementia or physical decline. “You make friends with them and then they’re gone”, said one agency supervisor. “There are no happy endings”, said another. When asked about negative aspects of their work, loss of cherished customers through death or decline was the most common response by care staff. Nevertheless some interviewees could accept this as an intrinsic part of the job. “You’re in this job”, said a manager, who had been a care worker herself, “and you know that people come, people go...you know that this is part and parcel of life. But you’ve got to take comfort in the fact that you provided these services and, you know, you’ve given some quality because without it people would perhaps have to go into homes and may not get the special care and attention that you’ve given”. But staff still could be greatly saddened by the personal bereavements which their work regularly brought them and certainly could need support. Another manager commented:

“You just have to be there for them and understand what they’re going through. Some of them seem to take it in their stride. We always encourage them, if they’re asked, to go to the funeral because it’s usually a good way of getting over it. I’ll go myself with them, if they’re too upset....It’s the most upsetting part of the job without a doubt, because try as you might, you will not be able to not form an attachment to someone.”

There were different ways in which staff handled their feelings – one worker for instance would never, ever go to customers’ funerals. A particularly distressing situation was where a home care worker visited a regular customer to find them dead. While this did not happen often, it most certainly did occur and every provider

needs a plan for response. In the in-depth study, some providers had much better responses than others.

There were other inevitable strains which followed from the close relationships which developed. Because a customer grew to like a particular worker and to receive person-centred additions to care, that customer might be resistant to other staff during holidays or job changes. While some providers and Care Managers complained about this, there were others who accepted it as a natural downside to a good care relationship – and a price well worth paying.

There were some customers for whom it was stressful to be a regular worker – for instance customers who were depressed or uncommunicative. This was well-recognised by provider managers. It was addressed by changing the customer's main worker, if it became too much, or sharing responsibilities among two or three workers. Managers could be very responsive to staff requests on such counts.

Not too many, but not too few: by how many regular workers should a customer be served?

While all providers in the in-depth study served each customer through a few familiar workers, there were important differences in how few was 'few'. Some providers used a single worker to play a unique, major role in a customer's care, while other staff played only minor relief roles. Other providers spread major roles among two, three, even four main workers. If a customer receives over 10 hours care per week, as is increasingly common, each of these workers may see them enough to get to know them well. The latter arrangement has the strength that when one member of a customer's small care team is ill or changes jobs, there are other familiar workers who can step in (Patmore 2003a).

The in-depth study identified another issue to consider. At one provider, which supplied much care through a single worker, some customers seemed troubled by their particular main worker. One worker for instance would not talk at all to her customer. Another rushed her customer during personal care. Some of this provider's workforce seemed stressed or to lack the friendliness to customers which was so routine elsewhere (though others in its workforce displayed memorable kindness and dedication). Some interaction between funding or management policies and the local labour market was resulting in engagement of some care workers whom customers could find troubling. This was then aggravated by a care policy which could seclude some customers with one of these problematic workers. Had the provider used two or three main workers, each customer would be more likely to have a good relationship with at least one worker and no-one need be secluded with a problematic worker. Naturally it would be better still not to engage staff who present such problems. But the point being made is that a 'single main worker' policy is a risky option if a provider has little choice over its workforce.

Disadvantages from a 'single main worker' policy were also evident if staff included many recent immigrants to the UK. The latter might lack UK background knowledge relevant to some customer requests and their English language abilities were sometimes limited. One interviewee described how her care worker did not understand her request to send a letter by Recorded Delivery. It seemed to take only a little difficulty of this sort for older people to hold back requests from their home care worker, if they thought they would not be met. If a workforce includes many staff

with such limitations of knowledge or language, there is again a case for assigning two or three regular main workers to each customer so that each customer can draw on a range of abilities. Perhaps there is also a case for more management contact with customers.

Another drawback from a single main worker policy concerns its application at independent providers with a very frail clientele, where each customer both has high hours of care and is at higher risk of admission to hospital. In this situation, whenever a customer is admitted to hospital this will cause a large reduction in the income of one worker. If care were shared among three main workers, such losses might be felt more often but they would be smaller. One care worker, at a provider which displayed this problem, spoke of taking on very long, stressful hours – sometimes 70 hours per week - to ensure a certain level of income in the absence of guaranteed hours. This was in a locality with high costs of living.

Some provider managers commented on how customers differed in their attitude to being served by very few workers. While for some this was very important, there were others who did not mind or who valued variety of workers' personalities and styles of conversation – an issue noted previously (Patmore 2001c, Francis & Netten 2004). Interviews with service users found only occasional dissatisfaction concerning the numbers of workers. This mainly concerned too many workers rather than too few.

Retaining care staff: factors related to job satisfaction

All aspects of home care work are likely to benefit from care staff being experienced. A repeated comment in provider staff interviews was that care staff were inspired to help a customer by seeing how another customer had been helped concerning a similar problem. Some managers believed that experience was much more important for care workers than any amount of training. Hence retaining staff was very important.

There was agreement among provider managers that retaining good care staff required attention to individuals' differing aspirations. "If you asked each one of them", said an agency manager, "they'd all come up with something different which motivates them to stay in the job." For some care staff, social activities, like taking customers on leisure outings, were a very rewarding aspect of the job, as has been described. "It doesn't actually feel like you're working because you're enjoying yourself with the client", said one care worker at an agency where this was common. But this was not attractive to everyone. A provider manager commented:

"I've got people that are excellent with the hands-on work. They'll roll their sleeves up and they'll get stuck in to anything, but their communication skills could be slightly lacking. They could sometimes appear to be a little bit brusque. And others that really communicate with people very well. They can sit down and they can talk to people. They can draw things out of them and get them to join in and do things, but don't particularly like the personal care side of things."

There were aspects of work which would discourage care staff from staying in the job. Few staff would be drawn to stay, managers thought, if they were kept doing cover work with different customers all the time rather than regular customers with whom they could form relationships. Two agency managers voiced strong criticism of

pressures on care staff to acquire NVQs, a consequence of the Domiciliary Care Standards. This, they said, discouraged some excellent older care staff who could not do written work. One commented:

“What we find is the older generation don’t like to do training, written work, NVQs. We’ve got some in their fifties who say, ‘We hated school anyway’...and they’re really good and we don’t want to lose them but at the end of the day they’ve got to do it.”

At this agency, some staff had now resigned to avoid training requirements which entailed writing.

Of course another major factor in retaining staff is pay, as follows.

Pay and conditions for front-line care staff

The two Social Services providers in the in-depth study illustrated the sort of pay and conditions which can retain home care staff, since they clearly could do this. Their care staff interviewees ranged from five years in post to 28 years. Basic pay ranged between £5 and £6 per hour. Staff were paid for time spent travelling between customers and time spent discussing work with supervisors or at meetings. They were paid a 50% premium for weekend work. Via a ‘banded hours’ system, they were guaranteed around half their pay if they suddenly lost work through customer admissions to hospital and if other work could not be supplied.

This was not the case at most independent providers. Staff were paid only for time spent actually providing care. They were not paid for time spent travelling between customers, nor for time with managers nor for training. Weekend work usually earned them a mere 50p per hour extra. Large portions of a worker’s income could suddenly disappear if major customers were hospitalised. Yet, for all these disadvantages, independent agency staff generally were paid less than Social Services provider staff.

Independent providers certainly face disadvantages in attracting and keeping staff of sufficient calibre. During the telephone survey, managers repeatedly commented that staff would never stay long unless they found caring work intrinsically fulfilling, so adverse was the balance between stressful tasks and pay in home care (Patmore 2003a). During the in-depth study, many good independent agency care workers were interviewed. Even workers with vocational attitudes could sometimes feel dissuaded because material rewards were so extremely slim. One worker reflected on her true hourly pay rate after she had undertaken, for £5.54p, an hour’s care which had entailed another hour’s unpaid driving plus unpaid petrol costs. Caring people, with conspicuous talents for care work, could feel themselves pushed away by such factors. At a rural independent provider, staff interviewees stressed how much improvement would result simply from being paid for mileage. Their manager believed this would wholly solve recruitment problems. Local factors can shape precisely which aspects of financial reward are particularly influential on recruitment. As just mentioned, in rural areas travel time and costs may be particularly important. In a former mining community a provider manager commented on the need to offer large enough earnings to attract women who were the sole family breadwinner. In areas with high cost of living, staff could work unusually long hours to generate the income they needed - as noted for some London services in the telephone survey (Patmore 2003a).

But some improvements in rewards for agency staff were appearing. One agency in the in-depth study now paid mileage to care staff, additional to their £4.80 hourly pay rate. It also paid the same 50% pay premium for weekend working which is common among Social Services providers. This was made possible by a purchaser's fee of £10.60 per hour to the agency, the highest agency rate in the study outside London. The same Social Services purchaser had created an exemplary system for preserving staff-customer continuity when a customer was admitted to hospital. The customer's regular care worker would continue to be paid during the next seven days so as to remain available to restart care, if the customer were discharged during that period. This could avoid break-up of staff-customer relationships, which could result if a worker needed to fill their hours with new customers.

Important disagreements existed concerning who should pay independent agency staff for non-contact time like supervision and training

For each hour of care, the purchaser pays an independent provider a pre-set fee. From this fee, the provider pays the care worker who gave the care, which often consumes around half the fee. From the remainder, sometimes called the 'overhead', the provider must fund managerial and administrative staff, premises and running costs - and draw its profit from the residue. For instance, a provider, which supplied 1200 hours of care per week, charged Social Services £8.80 per hour. It paid care staff £4.40p per hour, leaving an 'overhead' of £4.40p.

Important disagreements existed about exactly what should be funded from the overhead part of the fee. Purchasers held that it included paying care staff for some non-customer contact roles like attending supervision or training and sometimes even travel costs. Providers disagreed. It seemed surprising that in an environment based around written contracts, such basic matters could be uncovered and open to argument.

A striking exception was one independent provider, where a new contract clearly regulated that overheads should fund care workers' time in supervision, meetings, reviews and training. The provider implemented this. This was the same service with the £10.60p hourly fee, where the large £5.80p overhead also enabled payment of mileage and a 50% weekend premium.

But at the other three independent providers there were disagreements. At one, purchasers did not expect to pay extra for time spent by care staff in supervision or at customers' reviews. Nor did the provider. So supervision was carried out by observing staff doing care work for which they were being paid anyway. Reviews were attended by supervisors, who were being paid out of overheads anyway, and not by the actual care worker involved. At another agency, the purchaser looked to the provider to use overheads to pay care staff for time in office-based supervision. Such payment was not offered and there were suggestions that this reduced co-operation by care staff. Concerning a third provider, the purchaser believed that mileage payments to care staff were covered by the overhead, whereas the provider sought additional payment for this. So no mileage was paid. Premium payments for weekend work could also be the subject of disagreements concerning what was funded through the standard overhead charge.

Why independent sector home care costs less than in-house provision

“ It’s not so much the basic pay because the basic pay has caught up, from what we can gather. But it’s the sick pay, the pay between calls...down time and travel time, meetings time, supervision time that external agencies don’t pay [staff] for...They are expensive.”

Purchasing Manager, Social Services

Many interviewees had heard the criticism that purchasers were not paying providers for non-contact time. Less common was awareness of senior purchasers’ view that they were already doing so but that providers were not passing this payment to care staff. Indeed a purchaser’s own Care Managers could support the former position strongly.

In spot contract arrangements, logically, paying care staff for time in supervision can only be a provider’s responsibility, fundable from overhead payments. By similar logic, time to attend a review must involve extra payment by the purchaser. Yet, come a block contract, and some providers view supervision time costs as a purchaser responsibility, while some purchasers treat review time as the provider’s liability. Mileage and time-costs for travel between customers is a dauntingly large cost. Travel is the area where this dispute about payment most hurts some staff and hence hurts home care service. Simply paying mileage would make a large difference according to some staff interviewed.

At the heart of the disagreement are questions about the size of overhead needed to fund non-contact time and about the scale of agency profit. Has the growth of independent sector home care in fact thrived on confusions about what overhead payments cover? Could independent providers survive, if their overheads paid for everything which purchasers sometimes say they expect? Could they still offer the low prices which brought them their large share of the market? Did purchasers really believe they would get so much from that cheaper hourly fee? Change from the status quo might leave either party questioning the partnership. It must either cut into agency profits or into the imagined financial savings for Local Authorities, which may have prompted the move to independent sector home care in the first place.

CHAPTER 9: CARE MANAGEMENT AND FLEXIBLE, PERSON-CENTRED CARE

The in-depth study cast light on aspects of Social Services' systems for care management, which are relevant to flexible, person-centred home care.

Care Management systems for case allocation and review

Care Managers for older people seemed often so heavily burdened by work that this limited their capacity to influence the character of home care. In different Departments different systems were used to manage and review the long-term caseload and some systems were changed during the in-depth study. But results seemed often the same: over-burdened Care Managers who served long-term service users through very adverse staff ratios, which cannot assist personalised care.

Among the six Authorities in the in-depth study, there were two broad approaches to management of long-term caseloads:

- 'Continuous allocation' : all cases were kept under the long-term management of the same Care Manager who had initially assessed the service user and devised the care package. This Care Manager would conduct regular reviews (for instance annually) and handle any intervening requests for modifications to care. At two services which used this approach, a caseload of 90 clients per Care Manager seemed typical.
- 'Review team service': by a couple of months after assessment and assignation of care services, two-thirds or more of clients would no longer need immediate help from the Care Manager who had set up their care package. The latter would close the case, which would be transferred to a different, less well-staffed tier of care management – sometimes titled a 'Review Team'. The latter would conduct annual reviews of each client and handle any requests for modifications to care. Typical review team staffing ratios were one Care Manager to 250 – 300 clients. Some services sought that within the review team the same worker was always used for dealings with a client. But at other services even on-going work on a client's problem could get handled by different workers on consecutive days, which could obviously confound personalised care. A key aim of the review team model was to free other Care Managers' time to concentrate on assessing new clients, devising Care Plans and working with a few longer-term clients who had complex problems. Under this system, caseloads of these 'assessor' Care Managers could be around 20.

At the start of the in-depth study, two Care Management services employed continuous allocation, while the other four used various forms of review team management for long-term clients. During the study, three Departments changed their practice. Sometimes this reflected central government encouragement that every client should have a named Care Manager and the requirements of Fair Access to Care Services (Department of Health 2002) that Care Management should review every client between April 2003 and April 2004. Sometimes it reflected dissatisfaction with their existing system.

- One Care Management service changed to continuous allocation for all clients in response to FACS. Individual caseloads rose to 100. A Care Manager, who was interviewed, was undertaking 15 – 20 reviews per month.
- One Care Management service changed in the opposite direction - from continuous allocation to a review team system. This was in order to produce smaller, more manageable caseloads for assessor Care Managers.
- One review team service adopted a standard of annual face-to-face reviews for all clients. It also now aimed for each client's affairs to be handled by a consistent worker.

The only service which practised continuous allocation throughout the study worked with caseloads of 60 – 80 people and a target of a review within every six months.

In principle, continuous allocation should lead to care being more personalised since each long-term client's affairs is handled by a Care Manager, who has known them from assessment. In practice, a Care Manager pointed out, any such gains were long lost by the time a Care Manager's caseload had reached 90. In this view, unless caseloads were kept much smaller, continuous allocation was pointless and a review team system would not be significantly more impersonal.

Care Manager liaison with providers

If a service practised continuous allocation, each Care Manager's clients could be distributed round so many different providers that the Care Manager might never get to know any of the providers very well. But if a review team system were used, an opportunity arose - at the point when clients were transferred - to assign them to a review team Care Manager who had a liaison role with their particular provider. Two review teams had tried developing such liaison roles and had noted benefits, since Care Managers got to know a provider's strengths and weaknesses. Care Managers could raise recurrent shortcomings directly with a provider on the basis of feedback from customers.

This could improve on the common practice whereby Social Services purchasers formally monitored providers through a specialised quality monitoring service which was separate from Care Manager teams. Such separate monitoring services lacked Care Managers' acquaintance with what had proved important for individual clients. Quality Monitoring services often evaluated providers according to a set of formal quality standards – for instance punctual visiting, giving customers regular care workers, or maintaining customers' records properly. Relying on these quality standards exclusively could mean missing any unexpected issues of importance which was not covered by the quality standards. Some Care Managers felt frustrated that they could not contribute to the quality monitoring process as directly as they would have liked. In one Authority, some Care Managers had been struggling unsuccessfully to obtain action against a provider whose staff regularly cut home care visits short. Often an Authority's system for monitoring home care providers seemed curiously distant from the Care Managers who directly witnessed a provider's results during reviews of individual customers. A first step towards redressing this is a system which enables certain Care Managers to get to know certain providers. Of course, the fewer providers, the easier this will be.

Reviews of an individual service user's care

By the end of the study, following the stimulus from FACS to review all clients, reviews were often conducted by Care Managers on an annual basis.

In principle these reviews could enable a customer's concerns and aspirations to be explored - an important element if promoting flexible, person-centred care. Only in one Department, though, were steps afoot to purposely introduce this element. This was one of the two purchasers which did most to facilitate flexible, person-centred care. A new review form was directing reviews to scan holistically a wide range of aspects of a service user's life. The same purchasers were also introducing a new approach to assessment which would highlight the customer's own priorities.

At most services, home care providers were invited to the reviews which Care Managers organised. Four providers regularly attended these reviews. At three of these providers, it was a provider manager or supervisor who attended. At the fourth, it could sometimes be the customer's care worker - payment for the care worker's time was provided by the purchaser.

Provider-led reviews, conducted by a provider manager on their own, occurred systematically at one of these same providers and, much less systematically, at one other. This was less than had been expected - and less than the Domiciliary Care Standards (Department of Health 2003) aimed to inspire.

One factor which affects provider-led reviews is who would pay for care workers to attend. Sometimes purchasers would not pay for this even for reviews which had been instigated by purchasers. They deemed payment to be already covered by the 'overhead' paid to the provider, as described at the end of the previous chapter.

Some providers were affected by an increase in reviewing by Care Managers, following the introduction of FACS. At one provider, for instance, regular provider-led reviews had been part of their service to the purchaser and, while Care Managers were invited, they did not always attend. But after FACS these reviews became led systematically by Care Managers instead.

Telephone-based automated systems for monitoring home care staff

Automated, computer-linked systems for monitoring home care activities are an innovation in the management of long-term care. They are sometimes feared to threaten any sort of flexible initiative by staff, through their potential to detect and report deviation from a management master plan. During the in-depth study, opportunity arose to investigate consequences from such systems at two Social Services purchasers which employed them.

In these systems, on reaching a customer's home, a care worker must phone the automated monitoring system, using the customer's telephone. They must tap in their own PIN and an identification number for the customer. On leaving, they again enter their PIN, plus numeric codes for the activities just undertaken. Thus arrival and departure times are recorded, together with services given. The computerised system can be programmed with a work plan for each worker, which plans arrival and departure times for each visit and allows fixed travel time to the next one. When a "deviation", as they are called, arises between the routine being entered by a worker and their routine according to the master plan, an e-mail is automatically sent to a

manager. For instance 10 minutes of unscheduled time spent at a customer may trigger an e-mail. Managers can also use such systems to send recorded phone messages to all staff or to particular staff and these will be heard when a worker next enters their PIN. Staff pay can be calculated automatically through such systems through their recording of time worked.

Two Social Services purchasers were using such systems. One had just introduced it on trial. The other had applied it to a large in-house service for over two years. In the former case a prime motive was to ensure safety of lone staff. In the latter, a key concern was accurate recording of work for the calculation of staff payment.

Both purchasers had a notably person-centred and holistic attitude to community services for older people. Both were fully aware of the dangers that these monitoring systems could pose for flexible, person-centred home care and both were very concerned to avoid this. Because of these purchasers' intentions, these systems were not used to restrict care staff flexibility. In the experienced Authority, the main consequences were a large reduction in paperwork by home care team leaders and an increase in pay for home care staff, who turned out to have been under-recording their work time on paper systems. This made the system popular among care staff, who had originally strongly resisted it.

One manager speculated on whether, in future, the system could be used to facilitate more flexible, autonomous work-patterns among independent sector staff. Some of the common inflexibility in how Social Services commissions work from the independent sector reflects the former's need for clarity about how public money is used. It also reflects problems of trusting a profit-making enterprise to make its own decisions about how much work it can charge for. Perhaps, wondered this manager, a telephone-based monitoring system might make it acceptable to pay agencies for brief check calls, which could be prolonged if a problem were discovered. The monitoring system could supply some evidence about how any extra time had been used.

In this study, while telephone-based monitoring systems did not threaten flexible person-centred care, this reflected the intentions of these particular purchasers. Like many factors examined in this study, the consequences depend on the purposes for which a resource is used. It remains possible that, given purchasers with a contrary purpose, these systems might offer an important tool for restricting service to fulfilment of simplistic, survival-oriented care plans. In the experienced Authority it was still not technically possible to use the system to track and report staff with the speed and precision needed to be truly restrictive. But this Authority had not been trying to develop this capacity. Other Authorities, however, might take a different approach.

How well-suited are Care Managers for former home care tasks which nowadays can land on their desk?

One consequence of transfer of older people's home care to independent agencies is that certain tasks, which were once undertaken by in-house home care workers, are now sometimes passed to Care Managers rather than agency home care workers. There were grounds for wondering both how well such tasks are dealt with and whether this is a sensible use of Care Manager time. An example would be replacing a broken refrigerator. Because it was mentioned by home care customers and care staff during interviews, this example was pursued in interviews with purchasers. It is the sort of task to which a flexible, person-centred service must be able to respond.

Two purchasers made clear that, if an in-house provider were involved, they would wish home care workers to undertake such a task and regarded them as better equipped than Care Managers. But, where an independent provider was concerned, all six purchasers in the in-depth study would place the task with Care Managers. One issue was greater reservation about involving agencies with customers' money. Another issue was that some purchasers preferred always to use an in-house resource, like Care Managers, for miscellaneous extra work, so as to avoid unbudgeted external payments. (Sometimes, however, Care Management would subsequently commission the customer's home care provider to undertake the task and incur an extra external payment after all.)

At three Care Management services neither were there swift, ready systems whereby Care Managers could buy a refrigerator themselves nor could this be delegated to home care. "These are tasks that do not quite neatly fit into the care arrangements...it is a real problem", said one Care Manager. Care Manager time would be spent in particular on the phone. If a customer's relatives could not offer help, Care Managers would try to get Age Concern, volunteer bureaux or refrigerator suppliers to take over the customer's problem. In contrast, there were other Departments where Care Managers would readily organise purchase and installation of a refrigerator themselves. At two independent providers, care staff had done this for customers on their own initiative. Cutting extra keys for a housebound home care customer was another task which could generate problems. One Care Management service seemed unable either to arrange this itself or to delegate it to the home care provider. In such situations, committed home care staff may well just do it in their own time. One Care Manager expressed gratitude for such initiatives by care workers. He acknowledged how much delay could result from Department policy, whereby Care Managers should first try passing such tasks to relatives, voluntary agencies or commercial firms before organising a response themselves.

One Department employed a clearly-established, mutually agreed demarcation between Care Management and home care providers, which increased the role of the former and limited the role of the latter. Care Managers were explicitly intended to undertake many miscellaneous tasks which would fall to home care workers elsewhere. But there was more sign of provider management avoiding these tasks than of Care Managers successfully taking them over. While the provider manager actually liked the idea of Care Managers playing this larger role, she felt it required that they should proactively visit customers, rather than wait for prompts from the provider. But Care Managers seemed to lack time for such visiting. They did much of their work by telephone. Also, despite its intended larger role, this Care Management

Making a meal of it? Ordering an extra lunch

A Care Manager illustrated how simple aspects of service can be fragmented and made less user-friendly through the roles which Care Managers sometimes play when independent agencies are used.

Some customers receive a daily lunch from their home care provider except for days when they attend a day centre. If one day they miss the day centre, they need an unscheduled lunch at home. Under in-house home care provision, often the breakfast care worker, on discovering the situation, would simply re-arrange her lunch time rota to accommodate the extra visit or phone for other staff to do this.

In this Authority a contrasting procedure was applied to independent providers. On discovering the need, the breakfast care worker should phone the agency co-ordinator, who should phone the duty Care Manager. The latter should first phone relevant local relatives to ask them to supply the lunch. Then, if unsuccessful, try the in-house Meals on Wheels service to see if any staff member was unoccupied. While the latter would introduce an unfamiliar worker, the worker's time would be already funded. If no spare MOW worker, the Care Manager could ask a senior manager to authorise an extra lunch from the usual provider.

The minimum estimate of Care Manager time required was equal to this Authority's standard length of lunch visit. A purchaser manager spoke of false economy. The procedure is on balance not user friendly, since it can introduce uncertainty, delay or an unfamiliar lunch-maker. Nor is it friendly to home care providers. The later the provider co-ordinator learns that an extra lunch is needed, the harder to arrange it.

service used a particularly impersonal version of the 'review team' approach, whereby service users would repeatedly encounter different Care Managers. This made it especially hard to thus play an expanded role and to lead care.

Is 'Social Worker casework' available to older home care customers?

In each set of service user interviewees, often there were one or two individuals who seemed distressed. They communicated a mix of emotional and practical troubles and dissatisfactions. It seemed that they might benefit from the combination of short or medium term counselling plus practical help and emotional support, which was once commonly supplied by Social Workers. However much they could benefit from a flexible person-centred home care worker, they seemed to need much more in terms of skills and time than any home worker on their own could give.

A question arises whether such help can be readily accessed when Social Workers are employed in a Care Manager role.

Often these interviewees' problems seemed a mix of depression, limited social networks or alienation from a network, and the need for someone to broker transport, local information and voluntary sector resources. In the section of the interview on aspirations, reported in Panel Two, these interviewees would name multiple unmet aspirations, which could reflect generalised dissatisfaction.

An example would be a woman, who received home care from an independent provider on account of a very long-term physical disability. She had been traumatised by a burglary a year earlier, which had left her uneasy both about staying at home alone and about leaving her home. She was now very fearful of strangers. She wanted help with security arrangements. She also particularly wanted support to get out of her home and to resume her gardening hobby. She had been considering asking her regular home care worker, whom she liked, to use some housework time to help her to the garden centre. Another aspiration was to benefit other people through voluntary work, at which she had previously been successful. Also, she had been unable to use some kitchen electric sockets for a year, since her fuse box was out of reach and she could not obtain help to get this changed.

In a person-centred system, referral needs to be available to a Social Worker, or equivalent, for time-limited work on this mix of problems. In this instance joint work between Social Worker and the regular home care worker has obvious potential – perhaps through escorted outings with the home care worker and emotional support from the latter when the specialist worker withdraws. (However in this particular service the purchaser did not commission home care time for such purposes.)

Can such help be obtained? In two Authorities, there was evidence that emotionally troubled home care customers were being offered day centres. But no instances were encountered of one-to-one interventions, though for some of the relevant interviewees this would plainly be necessary for effective help.

It was unclear what help could be available, if a home care provider were to refer such a customer to Care Management. Care Managers generally seemed pressed for time. At one service, Care Managers had a large backlog of initial assessments.

Another issue concerns home care providers' willingness to refer to Care Management. Two providers generally avoided dealings with Care Management whenever alternatives were available. They would refer to Occupational Therapists, GPs, or Community Psychiatric Nurses themselves, rather than channel this through Care Managers. In one case at least this reflected a cool relationship with Care Management. Home care providers can sometimes refer to these agencies very effectively on their own. However, there is one type of referral which can only be made via Care Management – referral for the types of help for which Social Workers are often trained.

General issues concerning Care Managers

Care Managers do not always follow policy

Some Care Managers would confidently make statements as to what comprised their Authority's policy, but which were in fact contrary to the line taken by the senior purchaser. While in some Authorities all purchaser interviewees presented congruent viewpoints, there were others where Care Managers presented contradictory, personal policies without apparently being aware of this. Sometimes these personal Care Manager policies obstructed flexible, person-centred care. Sometimes they assisted it. Sometimes it appeared as if a Care Manager's personal policy might derive from previous official policy in the Authority. A lesson for senior purchasers is

the need for clear and perhaps frequent communication to Care Managers when introducing new policies. They are a group of workers who can suffer information overload from the many policy and system changes, about which they receive information.

Care Managers' roles

There was much evidence of Care Manager time being spent on tasks which, in the era of the single in-house provider, would either have fallen to the in-house provider or would not have been necessary. These included assessing for care tasks, reviewing and revising care plans, stopping and restarting care, managing requests for occasional extra time, checking service delivery, plus miscellaneous practical tasks now no longer delegated to providers. There was less evidence of Care Managers spending time using some important and distinctive Social Worker skills which can greatly benefit some older home care customers. Such Social Worker skills include counselling, negotiation and conflict resolution with family members, knowledge of welfare benefits, and co-ordination of care from health professionals, housing services and voluntary agencies. The research methods do not permit firm statement that these skills were rarely employed – simply that little sign of them was encountered. This certainly may reflect limitations of the research methods. But it is also possible that much time, which was formerly available for these Social Worker skills, is now consumed in managing the provision of care through independent providers.

Care Managers' influence overall

There were some indications that a Care Manager's role may inherently promote positions of caution and limited flexibility in common situations in home care. This could be evident even concerning Care Managers with strong customer-centred values. It appeared an intrinsic consequence of holding nominal responsibility for actions of many provider staff, who cannot realistically be monitored long distance by the Care Manager. Hence the latter is forced to err on the side of caution and give directives to provider staff which reliably avoid risks, even at a cost to flexibility. A lesson may be that, if you want a truly flexible service, delegate decisions to managers who are sufficiently close to service-giving to assess actual risks, rather than estimate possible risks from a distance. But, overall, Care Managers appeared to face such large demands for their time that their capacity for thus affecting provider staff was muted.

CHAPTER 10: CONCLUSIONS

Key findings

Some key findings, already mentioned, can now be summarised.

- At all six providers there were many examples of flexible person-centred help which did not require much departure from standard home care roles or cost very much time. But differences between providers were evident concerning help which required significant extra time or departure from standard home care roles. Such help is illustrated in detail in Panel One (see page 1).
- A common pre-condition for flexible person-centred help is the relationship which develops when a customer is served by familiar, regular care staff. Staff get to know a regular customer's aspirations and become motivated to fulfil them. Systematic linking of each customer with a few regular workers was employed at all six providers in the in-depth study.
- Providers differed in how they treated the person-centred initiatives which arose from these relationships between customer and a regular worker. At some providers, for instance, a worker was forbidden to agree to a customer's request to take them shopping. At others this was permissible in paid time and supported by both provider manager and purchaser. Some purchasers even specially commissioned time for such a purpose. The interpretation has been made that staff will develop person-centred initiatives further, the more that a provider approves, encourages or actually pays staff for doing so. This climate of encouragement appears the key explanation for why three providers in the in-depth study displayed more time-consuming or original types of flexible, person-centred help. However, even under the most discouraging conditions, certain staff still undertook demanding person-centred initiatives for the benefit of their customers. But these were less common.

Key findings about independent agencies (Chapter 5)

- Where an independent agency is concerned, it requires much more than a provider manager with holistic values, if the provider is to encourage care staff to help in a flexible, person-centred way. Support from the Social Services purchaser is essential. The in-depth study found that there were two broad levels at which a purchaser could promote flexible, person-centred help.
 - The first was the explicit commissioning of services like accompanied shopping trips, 'companionship visits' or excursions like Example 'A' in Panel One (page 1). Here, purchasers in the in-depth study divided sharply. Some routinely commissioned such services. Some would not pay for home care time specifically for social support or for quality of life purposes.

- The second was the climate of encouragement or support which some purchasers gave to flexible, person-centred help which occurred through other channels. Flexible, person-centred help could occur during time paid for by purchasers for other purposes, like Panel One's Example 'B', or during spare time during a visit, like Example 'C'. It could also occur during extra home care time for which a customer was paying privately and in staff free time. This second type of time source represents no extra financial costs to the Social Services purchaser. It was clear that enthusiastic, motivated home care providers could sometimes find time so that person-centred initiatives could occur through such means. The study's methods do not enable comparison of the relative contribution of these different sources for time, simply that each made some contribution.
- Those purchasers, which sometimes explicitly commissioned help to improve a customer's quality of life, also looked favourably on the various other means whereby their provider supplied flexible, person-centred help - like sometimes changing how a care visit was used, or creative use of any spare time during visits. They held a broad, holistic attitude to care for older people and, if something benefited a customer, these purchasers could see it as having value. Hence they were labelled 'customer-centred'.
- In contrast, those purchasers, which did not commission such help, also discouraged all the other means whereby time could be accessed for flexible, person-centred extra help. They dwelt on the risk that any unscheduled extra help – in spare time or in privately paid extra time - might possibly lead to arguments or accidents which could disrupt service. Their services were focussed around limited goals of enabling the survival and safety of frail older people in their own homes. Help which served other purposes, like improving quality of life, was seen as extraneous to this purpose and judged in terms of its potential for creating nuisance. These purchasers were labelled 'system-centred' since they judged person-centred extra help in terms of fairly remote risks to smooth running of their service, rather than fairly certain benefits to the customer.

Ways that purchaser policies influenced provider action were as follows.

- There was direct purchaser influence via the types of services which Care Managers commissioned at assessment or introduced at reviews. For instance, accompanied outings and companionship time were commissioned by Care Managers in some Authorities but not others.
- All four agency managers encouraged their staff to follow their purchaser's stance concerning flexible, person-centred care – whether in favour or against it. Sometimes this policy matched the provider manager's own inclinations, sometimes not. 'Customer-centred' staff norms were promoted by management at some providers and 'system-centred' norms at others.
- At all providers, there were care staff whose stance concerning flexible, person-centred care was influenced by their manager. However, all providers also had

some staff who contravened their purchaser's and provider manager's stance. Sometimes these autonomous care workers promoted flexible, person-centred care. Sometimes they undermined it.

No comment can be made from this study on how typical are these 'customer-centred' and 'system-centred' Departments, which purchased the independent agencies in the in-depth study. The two 'customer-centred' purchasers were selected from the 11 Authorities in the telephone survey partly because they employed interesting policies which supported flexible, person-centred care. The two 'system-centred' purchasers were not selected for their contrasting approach, which was not known at this stage. It should not be expected that all Social Services purchasers will precisely fit one of these two categories. For instance, nuances were evident concerning the purchasers of the two in-house providers in the in-depth study.

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

In-house Social Services providers (Chapter 6)

- At some Social Services providers, the provider manager can flexibly deploy moderate amounts of care staff time without seeking permission from Care Management. This makes it much easier to give some forms of person-centred care, like examples 'D', 'E' and 'F' in Panel One.
- Social Services providers were also better placed for holistic person-centred care by virtue of links to other Social Services resources. For instance they could bring customers disability aids and use Social Services procedures for handling customers' money or obtaining loans for customers.
- How much a Social Services provider used these advantages depended on how holistic was the viewpoint of the provider manager, not the Social Services purchaser – in contrast to independent providers. This reflects that Social Services provider managers can sometimes make decisions which, in the independent sector, would be made by Care Managers instead.
- It was clear from the telephone survey that Social Services providers vary widely in how holistic is their manager's policy and hence in how this autonomy is used. It could be exercised powerfully either in favour of flexible, person-centred care or against it.

Provider organisation and management – findings common to both sectors (Chapters 7 & 8)

- A provider manager can make major contribution to flexible, person-centred care, if they are personally enthusiastic about this. They can encourage staff via training, supervision and prompt support. (However, at independent providers, a provider manager also needs the support of the Social Services purchaser, as described earlier.)
- Flexibility is increased if a provider's staff team includes deputy managers, supervisors or auxiliary senior workers. Such staff can deal with unexpected or complex care problems which need attention at the same time as pressing managerial tasks. Conversely, however small a service, a lone manager can face difficulties from simultaneous competing demands.
- Provider managers need to support care workers concerning the inevitable emotional challenges from caring relationships which repeatedly end in a regular customer's decline or death.
- Pay and conditions for care staff need to be adequate to obtain and retain good quality care staff. Care staff receive much poorer rewards at independent agencies than at Social Services providers. Agencies often do not pay care workers for mileage, travel time and supervision and training time. Reasons include disputes over whether purchasers' overhead payments to agencies cover payment to care staff for such purposes.

Social Services Care Management (Chapter 9)

- Care Managers seemed to face heavy demands for their time. Care Management services tried different ways of distributing their large long-term caseloads among Care Managers. But none of these arrangements appeared superior. All arrangements entailed more long-term clients per Care Manager than interviewees thought was conducive to personalised care.
- Transfer of home care to independent agencies means that Care Managers are now sometimes responsible for practical tasks once undertaken by in-house home care providers - like replacing a broken refrigerator, or getting keys cut. Sometimes Care Managers are less effective for some such tasks than an experienced home care worker, who knows the customer well.
- Some older home care customers displayed a combination of emotional and practical problems. These might have benefited from time-limited Social Worker help, though this was not being received. There seemed a case that it should be available.

ISSUES EMERGING

A notable shortcoming: can it be avoided?

So often, flexible, person-centred care depended on the informal relationship between a customer and a regular care worker. As detailed in Chapter Four, care workers would respond to customer aspirations which fitted a worker's personal repertoire and the time available to them. What seemed lacking was channels whereby important customer aspirations could be met by other care workers, if their own regular workers could not do so. For instance some staff would offer to take customers on walks or drives, whereas others would not. There were customers, even at customer-centred agencies where such excursions were fundable, who wanted such help but were not getting it – possibly because their particular care worker did not offer it.

It is possible that some person-centred extra help cannot easily take place outside an established relationship between customer and a helper who can supply this, as discussed in Chapter Four. It may not be straightforward to refer it to any member of a home care team. If a customer cannot be helped to go a walk with a familiar home care worker, they may not wish to go with a stranger. Even at providers which were well-placed for team work, person-centred extra help could sometimes sound like each worker's private creation for her own customers – for instance resource lists were not shared between workers. However, some person-centred extra help did get provided on a team basis, like Panel One's Example 'C'.

There is a particular reason for seeking channels additional to a customer's relationships with their regular home care workers. Especially important are those many older customers who are at risk of depression owing to illness and disability. Were everything to depend on a customer's ability to develop a good relationship with their regular workers, some needy customers might not attract help. Provider managers clearly recognised that certain troubled customers could be hard for staff to relate to. On the one hand, there were repeated instances of care workers who made a mission of cultivating and getting on with very challenging individuals. On the other hand, it may not always be possible to find such a worker for every such customer. A way forward might be for provider managers or supervisors and Social Services Care Managers to become more closely involved with selected home care customers – perhaps using the review process as a starting point.

Customer-centred values seemed the key factor, not methods or systems

Caring values seemed the motive force behind flexible, person-centred home care – at the level of the home care worker, at the level of the provider manager, and at the level of those purchasers who valued such care being given. "Caring for the whole person" was a phrase used by two provider managers to describe the standpoint from which they promoted flexible, person-centred care. It could equally well describe the outlook of purchasers and care staff who worked in the same direction.

"Caring for the whole person" meant a mix of things. It meant readiness to tackle a diversity of extra roles, whether handling correspondence for a blind customer, ensuring that a partially deaf customer received effective health care, raising the case for Attendance Allowance or for a hearing aid, or helping a customer care for their pet. Panel One (page 1) illustrates further. Partly it was about promoting choice and life-enhancing things like fulfilling customers' wishes to get out and about or, for

instance, enabling a deaf and nearly blind customer to dictate her own shopping list. Partly it was about protecting customers – as in Panel One’s Examples ‘D’, ‘E’ or ‘H’ (see page 1). It could also involve restricting customers, sometimes, in the interests of care. For instance, the same provider managers, while permitting alcohol purchase for most customers, would swiftly restrict it for problem drinkers or raise their case with Care Management. (In contrast, the telephone survey found, some other provider managers either banned alcohol buying for all customers or permitted it indiscriminately.) “Caring for the whole person” was about getting involved with a customer’s problems, whatever they were – mobility, money, changing light-bulbs, problems communicating with doctors, an extremely dirty home – and finding solutions, whether from the home care provider or some other service. It meant embracing a certain amount of trouble and inconvenience and tasks which did not neatly fit any system.

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

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

Interestingly, Kane and her colleagues placed much emphasis on staff values and culture. Testing her new assessment instruments, Kane found it advisable to precede this with a series of seminars and case-conferences to encourage case managers to see their clients’ own priorities as important (Kane *et al* 1999). But the more personalised care, which resulted from the new approach, may either have reflected the new assessment procedure or simply that case managers now had more regard for clients’ priorities, following so much promotion of this idea (Kane *et al* 1999).

‘System-centred’ values –a major barrier to flexible, person-centred care

Chapter Five described the viewpoint of purchasers who, in effect, combated flexible, person-centred care through the policies they sought to promote among their Care Managers and their home care providers. This was labelled ‘system-centred’.

The system-centred position comprised two elements, which were linked together very logically:

- (a) Limiting care to what was strictly necessary to maintain an older person’s continued survival at home. The Care Plan’s focus would be on personal care, food, and cleaning for hygiene and safety purposes only.

- (b) Avoiding anything additional to this specified care – even if it clearly benefits the customer and costs the Authority nothing extra. This is in case one day it *might* cause some possible complication which disrupts the efficient running of the service or causes problems for its managers. Low probability risks to the system were treated as more important than assured gains for the customer, if those gains were irrelevant to the core mission in (a). Thus customers should not receive unscheduled extra help in staff spare time or for private payment, in case this could ever lead to accidents or arguments which interfere with the publicly funded service. Examples were listed in Chapter Five.

Once the service's narrow core mission had been fulfilled, the customer's interests seemed to count for less than almost any other consideration. There seemed a failure to accord any value to things which benefited the customer's wider well-being.

'System-centred' purchasers could follow the logic just described very exactly. Where customers' survival and safety and the general stability of service was concerned, one 'system-centred' purchaser devised bold, creative and well-planned solutions to some common problems noted in the research. Purchasers everywhere could do well to copy. But where broader customer needs were concerned, the same strategic talents were applied to restricting service. The other 'system-centred purchaser' may have set limited standards for quality of service but it showed itself well-prepared to protect these. A senior manager had truly excellent information on how customers experienced their service. Towards the end of the study this purchaser successfully obtained a difficult, large-scale change from the provider, in the interests of service quality. From some points of view, the 'system-centred' purchasers perhaps could be seen as sometimes uncaring. But they could never be called careless.

Among senior purchasers, there were different concerns which lay behind a system-centred outlook. At one system-centred purchaser there were marked concerns both with smooth running of the service and with carefully curbing costs through providing only the essentials for maintaining an older person at home. At another system-centred purchaser, only a concern with smooth running of the service was evident. Here, performance indicators, not cost-control, were said to pervade Social Services thinking. "A very business-like approach", a Care Manager described it.

At the Authorities where 'system-centred' policies were most evident, they preceded Fair Access to Care Services. They were not a consequence. However there are aspects of FACS which can make the opposite approach more difficult for purchasers. A Care Manager in a 'customer-centred' Authority commented how FACS made flexibility considerably more difficult.

'Customer-centred' purchasers and providers recognised the occurrence of the sort of problems which 'system-centred' purchasers sought to avoid. But they regarded them as sufficiently rare and manageable to be a price worth paying for the benefits which a 'customer-centred' approach could bring. Quite often it is time-consuming irritations to managers which the 'system-centred' approach seeks to ward off, rather than risk of expensive compensation claims. An example would be discouraging staff from using spare care time for types of help which might produce demands for justification, if this became known to critics of the service. Chapter Five gave the example of a request to polish silverware during spare care time.

'System-centred' attitudes could be found among provider managers and care staff, as well as among purchasers. For instance, during the telephone survey, an agency proprietor expressed it thus:

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

Parallels can be seen with practices for which in the past institutional care has been criticised – like restricting residents from bringing possessions with them so as to avoid trouble for management if these are stolen or damaged. A common factor may be pursuit of narrow outcomes of survival and safety and low importance attached to service users' wider well-being.

There seemed to be something about formally limiting service goals to customers' survival and safety, which could have far-reaching consequences. It supplied an easy, logical formula for making decisions on a wide range of care situations, which Care Managers sometimes internalised thoroughly. Did it introduce a sort of tunnel vision which could take the human element out of how workers thought about care? In contrast, there were 'customer-centred' purchasers who felt they could not afford many of the services which they would like their older customers to receive. Yet they nevertheless seemed to identify with their customers' unmet needs and expressed gladness if these could be met through other channels, like private resources, instead. They had not distanced themselves from the whole person and their needs. Were extra resources occasionally to become available, their outlook would mean they would be ready to use these.

How are purchasers' values formed? How can 'system centred' values change?

Major barriers to flexible, person-centred care exist in an Authority where senior purchasers hold 'system centred' values. It appeared hard to see how such situations could change. Reasoned argument with purchasers may have no effect because arguments for holistic, person-centred care are based, in the final analysis, on values and thus can appear void, if viewed through system-centred spectacles. As has been described, even small acts of cost-free extra help can be viewed negatively once they are seen from system-centred assumptions – and such perceptions are wholly logical. Once a system-centred outlook is established, everything can be seen in ways which maintain this outlook.

At the close of the research, it appeared that the prospects for flexible, person-centred care depended on whatever values happened to be held by senior purchasers in a Social Services Department. Sometimes these values reflected a long-standing general culture among purchaser staff. Sometimes they were being proactively promoted by an individual senior purchaser – in some cases in harmony with the established culture and in other cases against it. There was no readily-identifiable external political influence which was determining these Departments' values. In theory the 'Challenge' component of a Best Value Review of services for older people offers the opportunity to discuss fundamental values. It could provide an external mandate for Social Services stance on, say, quality of life for older community clients. But, as far as could be ascertained, this had not happened and the influences on values came substantially from within each Department. There was

no evidence that cost pressures were a consistent influence on what policies developed.

There were two Authorities in the in-depth study where senior managers were proactively and energetically directing relevant policy. In one case, leading managers were directing a Department with an established customer-centred culture to develop still further in the same direction. In the other case, they were promoting a system-centred direction. In other Departments, established cultures were apparent among purchaser staff in either a 'customer-centred' or a 'system-centred' direction – but there was no proactive programme to enhance this.

An interview at a customer-centred Authority gave an insight into how general purchaser cultures can be influenced. A decade earlier some service users had been transferred from an experimental social care project, where they had been formally assessed as needing accompanied shopping trips. Following transfer, their new providers were required to provide the same services. Care Managers noted the benefits and began commissioning accompanied shopping for other clients too. A culture developed among Care Managers whereby escorted outings were regularly commissioned. Eventually new home care providers needed to find ways to supply such help, if they were to work for Social Services.

In one of the Shire Authorities in the study, there was a marked divergence in purchaser culture between Social Services HQ and a distant District. The former had begun articulating 'system-centred' policies for older people's services very explicitly. However the latter preserved a very cohesive 'customer-centred' ethos from local senior managers downward. During this study, it was the local District policies which prevailed and which influenced actual service from Care Managers and home care agencies. Some Care Managers had not an inkling of their Authority's restrictive official maxims which were appearing on powerpoint slides at national conferences.

New government policy means a major boost for flexible, person-centred home care

By the end of this research, a set of guidelines could be formulated whereby a Social Services purchaser could promote flexible, person-centred care – these guidelines comprise the final section of this chapter. Yet the research also suggested that these guidelines might not attract much usage. If a senior purchaser were system-centred, they would see no reason to use them. If they were customer-centred, they would be following many of these guidelines already.

The publication of the Green Paper *Independence, Well-being and Choice* in 2005 radically changed this situation. It gives a clear, external mandate to follow customer-centred values and develop flexible, person-centred care. As a result, many Authorities need the guidelines at the end of this chapter.

Chapter Eleven describes the connection between *Independence, Well-being and Choice* and flexible, person-centred care. It also describes obstacles which this research predicts concerning the implementation of *Independence, Well-being and Choice*. Major challenges exist for the new policies in Authorities where system-centred senior purchasers have been carefully schooling Care Managers and provider managers in a completely contrary approach.

What this project has achieved

This study has illustrated ways in which home care workers can contribute to older people's quality of life and well-being, if given greater flexibility than purchasers often accord them. However it has not demonstrated benefits for service users on more than an anecdotal level.

The study's key achievements are to highlight many, varied aspects of service organisation which merit attention from managers who aim to develop this approach. Many relevant details have been usefully highlighted - like spare time in fixed-length visits, options for how customers are assigned regular workers, auxiliary management posts, misleading arguments behind service restrictions etc. The main points for attention are listed in the Guidelines which follow.

As a result of this study, if anyone is minded to develop flexible, person-centred home care, they are now much better equipped to do so.

GUIDELINES FOR PROMOTING FLEXIBLE, PERSON-CENTRED HOME CARE

These Guidelines list the main factors behind flexible, person-centred home care to assist a Social Services purchaser who seeks to promote it. This research suggests that, once such elements are present, the process will gain momentum of its own through virtuous circle interactions between provider staff and customers. Provider staff will be encouraged by customers' satisfaction at flexible, person-centred help and so will take further steps in this direction.

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

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

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

Customers are served by regular provider staff

Familiar, regular care staff

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

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

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

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

Three different means were encountered during this research.

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

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

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

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

Among opportunities for flexible person-centred help, privately paid extra help was the one least likely to be positively promoted by Social Services purchasers.

Yet it is a particularly direct route to fulfilling a customer's own priorities. It would be helpful for purchasers and providers to empathise with some customers' concern to keep their homes attractive through privately paid extra cleaning. Low cost, user-friendly cleaning services could be promoted which reduce the barriers of cost noted during this study concerning private extra help from independent agencies. It is questionable whether the latter should carry overhead charges to the customer which are as high as those charged to Social Services, considering the rationale behind the latter overhead charges.

Purchasers directly commission interventions to address customers' quality of life

- Interviews with service users showed that, at all providers, by far the most common unmet aspiration was help to get out of one's home. Accordingly a customer-centred purchaser would commission some escorted outings for quality of life purposes for selected customers – and monitor results. Reviews by Care Managers and nominations by providers could be used to select customers who would benefit and who lack alternative sources of help.

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

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

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

To utilise opportunities for flexible, person-centred help, a service needs to avoid restricting itself unnecessarily through rules or binding itself to precedents about what it will or will not do. One week it may be impossible to give some help which may be possible the next.

Staff rewards which can attract and retain high quality care workers

Pay and conditions need to be good enough to attract and retain high quality staff. While pay is rarely the prime motivation of high quality home care staff, interviewees made clear that reward at independent agencies is sometimes so poor that it can deter good workers. Problems were noted concerning low pay rates, minimal weekend premium rates, no guaranteed hours, no mileage pay and no pay for non-contact time like travel and training. Exactly which of these elements matters most probably varies locally.

Provider management must be sufficient to ensure basic standards

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

Having enough time is always important

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

- The amount of time commissioned for a care visit. Wide variations were encountered. Sometimes purchasers routinely commissioned visit lengths which were so short that personalised service could be difficult.

- A sense of pressure on time is not conducive to person-centred care. Sometimes providers took on customers for whom they did not really have capacity and quality of service could suffer. Sometimes providers scheduled rotas for care staff such that the visit lengths commissioned by purchasers could not be given in full.

Additional points for attention:

- Although not demonstrated by this study, there is a case for pursuing systems for assessment and review which identify customers' individual priorities (Patmore 2001c). During this study, such processes were largely noted occurring informally in the relationship between customers and regular workers.
- Although no examples were found in the study, Social Services purchasers could use their formidable influence to encourage a more customer-centred approach to tasks like changing light-bulbs. They could work with providers to devise sensible approaches for ensuring that light-bulbs can be promptly changed. Some senior purchasers felt resentful of some providers' unhelpfulness concerning light-bulbs. But none actually challenged it.

CHAPTER 11: 'INDEPENDENCE, WELL-BEING AND CHOICE' AND THE FUTURE FOR FLEXIBLE, PERSON-CENTRED HOME CARE

Flexible, person-centred approaches to home care should be greatly advanced by the radical new policies proposed by the Green Paper *Independence, Well-being and Choice* (Department of Health 2005). The obvious reason is the latter's emphasis on service users' choice and control over their own services and the proposed flexible, individual care budgets to produce outcomes tailored to individuals' aspirations. Another reason is the emphasis on "improved quality of life" as a key outcome from social care, including access to leisure and social activities. This research has identified such a holistic attitude towards service goals as a foundation for flexible, person-centred care. Encouragement for service users to manage risks in their own lives is another supportive element in *the Green Paper. Independence, Well-being and Choice* conveys a clear line on issues like whether a home care customer can sometimes use their allocated house-cleaning or lunch-making time to be helped to go on a walk instead. Where formerly Local Authorities could differ sharply in the response they encouraged, government policy now conveys that the customer generally should have the choice.

New directions from the Social Care Green Paper

- Quality of life, including leisure and social activities, should be addressed for all service users (see Chapter 3, *Independence, Well-being and Choice*).
- Service users should have choice and control over their services and manage risk in personal life (in Chapter 3, *Independence, Well-being and Choice*).
- Services should become based on flexible, individual care budgets to produce outcomes tailored to individuals' aspirations – extending to all service users the advantages now enjoyed by Direct Payments users (Chapter 4 of the Green Paper).

The *Guidelines* for developing more flexible, person-centred home care services, at the end of the previous chapter, can assist implementation of *Independence, Well-being and Choice*. This chapter makes some general comment from the experience of this research concerning implementation.

Success is definitely possible

This research encountered examples of home care for older people which already reflected the values of *Independence, Well-being and Choice*. Panel One, for instance, includes illustrations of how home care workers were able to negotiate constructive responses to widely varied customer requests. Often this occurred within existing resource allocations for routine support with daily living. Even without the help of individual budgets this was occurring - simply through positive attitudes among providers and purchasers, as has been detailed. Given appropriate flexibility, encouragement and support, some home care workers show much enterprise, practical ability, judgement and capacity to communicate and negotiate with their customers. This bodes well for the vision of customer-led service in *Independence, Well-being and Choice*.

Panel Six. Examples of older home care customers' preferences - from the in-depth study

Mrs A was deaf and almost completely blind. Her agency home care staff carefully consulted her about special requests by writing on a white board, which she then placed very close to one eye. Sometimes she asked for a short drive. Sometimes for a walk to the garden gate. Sometimes to be bought snuff. Staff met these requests.

Mrs F had arthritis. Regularly she asked home care staff to help her on a short walk during her lunch visit, if she had been able to make lunch beforehand. Her wishes were met.

Mrs W wanted sometimes to use her home care worker's allotted housework time to take her to the garden centre instead. Following a traumatic burglary, she was struggling to overcome fears of leaving her house. But neither departure from the Care Plan nor taking customers out were permitted at this service.

Miss C was ready to pay her home care worker £20 for one trip to Marks & Spencer to look at clothes fashions. But staff were not allowed to take customers out, lest an accident result.

Mrs Y wanted help from home care to cook a full lunch of her own choice herself, since she could handle certain utensils herself but not others. But this required 25 minutes, whereas Social Services routinely commissioned 15 minutes for a microwave lunch.

Older people will want to use the new flexible, individual care budgets for travel and mobility

Earlier, Panel Two (page 21) presented aggregated information about older home care customers' aspirations, encountered in this research. Panel Six shows some specific examples. Older service users may well seek to fulfill such aspirations through the individual care budgets and the culture of choice pledged by *Independence, Well-being and Choice*. By far the most common aspiration – so often unmet – concerned some aspect of mobility. Interviewees sought accompanied drives, assisted walks or practice to improve walking, or help to obtain powered wheelchairs or scooters, disability friendly taxis or other forms of transport. In some cases the interviewee explicitly envisaged their home care worker as their helper. In some cases the request required a different source of help.

A major challenge will be Authorities which have promoted contrary policies

A major challenge to implementing the Green Paper will be Authorities where purchasers have systematically combated customer choice. This research has described how in some 'system-centred' Authorities, Social Services purchasers promoted an approach to older people's home care which was the opposite to that in *Independence, Well-being and Choice*. They wished home care staff not to heed customers, but to follow to the letter the purchaser's written care plan instead. In such Authorities, it could prove very difficult to bring about such a radical change as *Independence, Well-being and Choice* intends.

The in-depth study conveyed how hard it might be to change such established purchaser cultures. One 'system-centred' purchaser was notable for the thoroughness, careful analysis and ingenuity which had gone into all its systems, including those for narrowing the range of services and curbing customer choice. Any attempt to change direction would clash with well-crafted systems and purchaser staff who had been diligently briefed on how to make care decisions on 'system-centred' grounds. *Independence, Well-being and Choice* enjoins services to heed customer aspirations like those shown in Panel Two and Panel Six. Yet the most common aspirations – accompanied drives and walks and more extensive housecleaning – are the areas where certain purchasers have promoted particularly firm restrictions. Panel Six shows two service users, Mrs W and Miss C, whose aspirations fell foul of purchasers' restrictive policies. *Independence, Well-being and Choice* would expect these customers' wishes to be heeded. A whole new style of thinking about care would be needed in such Departments. How easily could the same senior purchasers create a completely contrary new system? Change may be understandably difficult. Such purchasers may feel they have been conscientiously pursuing government priorities for the use of public money and the spirit of FACS. They may feel they have been prudently downsizing the role of Social Services in anticipation of large increases in numbers of older people.

Some home care providers have developed in ways which make them poorly suited for the customer-led service envisaged by *Independence, Well-being and Choice*. Provider managers sometimes take their cue from purchasers and set their own rules against escorting customers or changing light-bulbs. Sometimes, this research found, provider managers exaggerate possible risks from following customers' requests so as to worry care staff into confining service to the purchaser's care plan.

How easy will change prove in 'system-centred' Authorities? In interviews during this research there were signs that certain of their staff would readily warm to a customer-centred approach. Very occasionally managers were encountered who conveyed an antipathy to holistic care, which might be hard to relinquish. Many staff, though, may fall between these extremes. For them, quite a substantial unlearning and relearning process might be necessary. Major challenges can be foreseen concerning the interlinked purchaser and provider rules and procedures which can work to restrict customers' choice. How can these be changed? Who would be equipped to lead this process?

Flexible, individual care budgets

A solution to the latter might come from the proposed flexible, individual care budgets. If a standard national procedure were developed, this might bypass any purchasers who were so resistant to the idea that any procedures, which they designed themselves, might avoid real change. The individual budget system might elicit new roles and procedures from Care Managers and providers which were compatible with a customer-led service.

Flexible, individual care budgets should remove a key obstacle to customer choice, which this research has identified. In the present system, home care providers can encounter conflicting priorities – those of the nominal customer, the service user, and those of the Social Services Department, which pays the fees and can function as the provider's real customer. Many problems identified during this research result from

Social Services purchasers, rather than service users, functioning as the provider's customer. The report from the telephone survey discussed how often independent agencies treated Social Services purchasers as the real customer (Patmore 2003a). Hence they sometimes showed less customer-sensitivity with respect to service users than might be expected from an independent sector service. But flexible, individual care budgets should radically change this situation. The service user would become the only customer. Independent agencies might treat their Social Services customers like private customers.

To make major improvement on the present situation, the proposed flexible, individual care budgets need to be usable by any service user – including very disabled people, like Mrs A in Panel Six. They must not be limited to people with abilities to manage their own care, as is the case with the present Direct Payments system. As Panel Six shows, Mrs A could not even instruct her staff without help. Yet she clearly benefited from being given choice and she actively used opportunity for this. But making individual care budgets accessible to very disabled people would surely require much more intensive long-term involvement by Care Managers or Social Workers than is common at present.

Resources for the new style of service

Immediately following publication of *Independence, Well-being and Choice* there was repeated public comment that the envisaged resources would be insufficient for the new style of service. This research did not examine resources or costs systematically. But it could not help but notice some resource issues. The following limited comment is worth making.

Resources and the new Care Manager / Care navigator services

During the in-depth study, the area where shortage of resources was most conspicuous was purchasers' Care Management systems. Chapter Nine described universal problems concerning very large caseloads of long-term service users. The new system would introduce some new roles with respect to long-term service users. While some existing Care Manager roles would probably be discarded, it is unclear exactly how much time this could release for the new roles. Given the pressure on Care Managers, which was noted during this research, the notion that the new system would be cost neutral is questionable.

Generally, the proposed changes to Care Manager roles might resolve problems noted during this research. There was an overall impression that Care Managers' skills could be used better than at present. There were service users who could have benefited from direct access to Social Worker skills like care co-ordination, inter-agency liaison, counselling or family work. If *Independence, Well-being and Choice* transfers Care Managers' energies towards these roles, this will advance flexible, person-centred care. But a large question remains concerning whether changes to the time budget will add up, noting the widespread sense of burden among Care Managers.

Resources for the new provider service

In contrast, the idea that the new system could be cost neutral on the provider side appears plausible, though not proven, in the light of this research. The research noted a tendency for the costs of a flexible, person-centred approach to get exaggerated by people whose seniority made them distant from its realities. In one Authority, senior purchasers deemed prohibitively costly a type of help which, unknown to them, front-line

provider staff were regularly squeezing in for no extra cost. Many things seemed simpler, less risky and less costly, the closer one was to front-line care work. Once flexibility was permitted and a worker-customer relationship existed, care workers were motivated to seek out opportunities for extra care. This reflected care workers' pleasure at customer satisfaction from such help, which made them wish to give more. A regular home care worker could judge when she was ahead with a customer's housework and a visit could be used instead for an outing together. Keen care staff would glean time from the cumbersome, inefficient process whereby care is purchased from independent agencies. As described in Chapter Five, there was sometimes substantial regular spare time from visit lengths which included a safety margin or which reflected minimum visit lengths, set to compensate for unpaid travelling time. It was much easier for providers, than for Care Managers, to see where time permitted person-centred enhancement to a customer's service.

But some person-centred, holistic help could cost purchasers more. For a customer to go shopping with a home care worker definitely takes longer than for the worker to go shopping on her own. However these extra costs were moderate, identifiable, and controllable. The substantial excursions in Panel One's Example 'A' cost £13.20p per week, including overheads (see Page 1). If this is deemed excessive, the option of fortnightly excursions exists.

Considering all the examples in Panel One (page 1), only 'A' and 'G' involve recurrent extra costs to Social Services. Examples 'D', 'E', and 'F' involve one-off extra costs of around £20 each. Examples 'B', 'C' and 'H' involve no extra costs. Turning to the customer aspirations in Panel Six (page 85), none involve extra costs to Social Services, except for Mrs Y's request. Concerning the latter, since this is a daily service, to allocate this extra time every single day could add costs of several hundred pounds a year. However a compromise could be offered. For instance, if Mrs Y could make herself cold lunches every other day, she could be helped to do her own cooking on the others for no extra cost overall.

This research can point to grounds for optimism that customers and regular care workers could negotiate to meet the customer's choices from within a fixed budget of care time. Resources are often short for home care and this situation needs remedying. But within the limited scope of this study, no evidence was encountered that the style of service proposed by the Green Paper would make great inroads into existing resources on the provider side. (However, as mentioned, there were grounds for envisaging resource problems for the co-ordination of the new service on the purchaser side.)

Possible resource advantages for the new service

This study conveys that some virtuous circles might result from the holistic, customer-led service enjoined by *Independence, Well-being and Choice*. As well as benefiting customers, these might to some degree reduce pressure on resources.

Definitely, high quality care workers will be more easily attracted and retained by a service which allows them to care in an autonomous, creative and personalised way. Service quality will improve through retention of such staff - managers and care staff in this study emphasised how staff skills grew from experience. Considering widespread problems in recruiting care staff, this is very important (Patmore 2003a). Care workers' roles may become more satisfying, if their customers become more satisfied through a

customer-centred approach and hence more rewarding to work with. An earlier study discussed how disabled older people, whose morale was good and who were glad to be alive, could encourage home care staff, whereas staff found contact with depressed customers discouraging (Patmore 2002a).

More speculatively, it is possible that through a customer-led approach some older people may become more motivated to maintain their own functioning and this may to some extent reduce their needs for help. Older people's independence and functioning is supported in a natural way by the flexible, person-centred approaches encountered during this research. For instance, as result of managing to make her own lunch, Mrs F in Panel Six benefited through being helped to go for a walk, which was her choice. Her morale, her catering ability and her walking ability were all supported – independence, well-being and choice in unison. Her remaining areas of independent functioning may well last longer than if the same staff time was always spent on making lunch for her.

Where resources are inadequate for the present service, they will be inadequate for the new one

It will plainly not be possible to implement *Independence, Well-being and Choice* from existing resources in any Authority where resources are already inadequate. An abiding image is the November 2003 Panorama exposé of home care services, where cover staff struggled with visit lengths which were too short for unfamiliar workers to gather basic information about customers' needs (BBC-TV 2003). The SPRU home care research suggests that a pre-condition for person-centred care is that each customer has at least one regular worker who gets to know and care about them. If staff rewards are insufficient to retain a regular workforce, the style of care sought by the Green Paper cannot begin. Staff retention is affected both by pay and conditions and by job satisfaction, as was repeatedly affirmed during this research. Job satisfaction can depend on whether the roles and visit lengths, which purchasers assign, allow workers to give what they feel is good quality care. Obviously there must be a level of resourcing below which customers' needs cannot be properly met and where good staff will leave the service.

Communicating the new vision of social care to purchaser and provider staff

As mentioned, the Green Paper's new vision of social care may conflict with some fairly common attitudes and practices in Social Services Departments. New ways of thinking need to be promoted. Regulations and procedures which will obstruct the new approach need to be identified and changed. A case may exist for training activities which encourage purchaser staff to view care situations in fresh ways and which highlight where radical change to services is needed. For instance such measures were found advisable in an American programme for encouraging care managers to regard older people's values, which was described in an earlier report from this project (Kane et al 1999, also in Patmore 2002b). To support a new assessment procedure, seminars and case conferences were organised to show care managers possible gains from the new procedures. With respect to the Green Paper, one purpose for which such activities could be relevant is to clearly illustrate the new vision of care. Identifying local barriers to this approach, which need to be tackled, is another. Promoting enthusiasm for the new approach could also be an aim. There remains nevertheless the problem touched on earlier. The Departments which most need such consciousness-raising activities are those which are furthest from the ideals in *Independence, Well-being and Choice*. In such Departments who can enthusiastically lead a programme for change?

Staying true to the new vision

We should expect that in many localities the new customer-led, holistic approach to older people will repeatedly clash with established service structures, procedures and rules, which prioritise the interests of the service instead. Respect for customer choice requires that a frail 90 year old home care customer can get a light bulb changed or be put in touch with a reputable private cleaner. Yet we know from the telephone survey that both these simple requests can be refused in many Authorities (Patmore 2003a). Customer choice is on a collision course with many common restrictions promoted by Social Services purchasers or their providers. How these collisions are resolved will greatly influence whether *Independence, Well-being and Choice* succeeds. They can be resolved in ways which put the system's interests first, in which case *Independence, Well-being and Choice* will bring only superficial change. Or they can be resolved in ways which genuinely place service users' interests at the centre of the service.

Sometimes solutions will be challenging because some common restrictions do concern genuine potential risk - like taking frail people on outings or including alcohol in the shopping list. New procedures and practices are needed which put the customer first, though in a wise, caring way which does address genuine risks. The experience of this research has been that this is perfectly possible. Some experienced home care provider managers were encountered who seemed routinely to make such judgements successfully – and without much difficulty. As mentioned before, their guiding principle seemed an attitude of holistic caring. Respect for customer choice grew out of this, but it appeared to be secondary.

People, who wish *Independence, Well-being and Choice* to succeed, may need to campaign for effective implementation in Authorities where its spirit clashes with current practice. They can expect gaps in 'joined-up thinking' concerning implementation among both local and central government agencies - and they may need to draw attention to these. They should anticipate that sometimes implementation will be led by people with little sympathy for the new policy. Sometimes implementation may be led in false directions, which suit the system rather than the service user. This research offers advocates for the Green Paper a simple test to apply to local decisions on how it is implemented: which option most benefits service users?

Older people's services at a cross-roads?

If faithfully implemented, *Independence, Well-being and Choice* could probably solve many of the problems which this research has found to obstruct flexible, person-centred care. Indeed, the proposed government policy has come to the rescue of this style of service. Immediately before the Green Paper was published, flexible, person-centred home care for older people appeared something of a lost cause. Anecdotal evidence made the forces of change appear stacked against it. The changes one heard about seemed so often to be reductions - to home care visit lengths, to the range of needs addressed, to staff rewards, or to staff roles which satisfy and retain good staff - changes which can interact unexpectedly. It was hard to envisage flexible, person-centred care becoming more common. If anything, it seemed more plausible to foresee home care becoming a minimal cost, impersonal service which 'warehoused' older people in their own homes.

Older people's services may now be at a cross-roads. *Independence, Well-being and Choice* offers a credible route to revitalization of care through a mechanism which could genuinely transfer influence to the service user - the individual care budget. But, if these proposals are not implemented with integrity, prevailing currents may take services in the opposite direction.

CHAPTER 12: A BRIDGE TO INDIVIDUAL CARE BUDGETS – THIS REPORT’S CONCLUSIONS AND ‘OUR HEALTH, OUR CARE, OUR SAY’

“This White Paper confirms the vision in the Green Paper of high-quality support meeting people’s aspirations for independence and greater control over their lives, making services flexible and responsive to individual need.”

Executive Summary, *Our Health, Our Care, Our Say*, Department of Health, 2006

In January 2006, after completion of the rest of this report, the White Paper, *Our Health, Our Care, Our Say*, was published. Very encouraging for flexible, person-centred home care is its piloting of individual care budgets. The latter is being conducted in 13 Authorities to help decide whether individual budgets should be introduced nationwide.

Less encouraging is that, in practical terms, the White Paper’s promotion of well-being and person-centred home care is confined to this trial of individual budgets. No other development in these directions is promoted before the trials of individual budgets are complete in 2008. The “vision in the Green Paper” would seem to be on ice till then at least.

Yet, in the interim, valuable opportunities exist whereby Authorities could both bring services closer to the vision in the Green Paper and pave the way for individual budgets, if these become national policy. The ‘Guidelines’ at the end of Chapter Ten offer a formula whereby an Authority can straightaway begin development in this direction. The present chapter describes why such bridge-building towards individual budgets needs to be undertaken and summarises ways in which this study can help this purpose.

Individual care budgets: the radical route to flexible, person-centred service

Individual budgets have drawn inspiration from the In Control pilot studies. Clear descriptions of In Control’s approach are given by Duffy (2005) and Poll *et al* (2006). If individual budgets are implemented in this particular spirit, they promise to be the best route possible to flexible, customer-led home care. They could combine the best of all worlds - giving publicly-funded service users the same autonomy as a private customer, plus a ‘care navigator’ adviser. Individual budgets could produce much greater change than Chapter Ten’s ‘Guidelines’, which work within conventional current care purchasing arrangements.

- Individual budgets should maximise the service user’s control of resources since they would depend less on the goodwill or judgement of a Local Authority purchaser. Thus individual budgets should insulate service users from any Local Authority purchasers who fail to relinquish habits of restricting service user choice, even when national policy changes.
- The individual budgets, which are now being piloted, cover not just Local Authority funding for an individual’s social care but also money from Supporting People, the Independent Living Fund and other funding sources. The larger the amount which can be deployed flexibly, the wider the choices for the service user.

A challenge for individual budgets is to develop a system which genuinely transfers power but does not require too much skill, ability, time or energy from the service user for many disabled older people to adopt it. It is widely recognised that many older people regard Direct Payments as too demanding on the service user, if the latter must act as an employer. In contrast, Chapter Ten's 'Guidelines', while promising much less transformation, can be applied immediately and to all service users within the conventional care purchasing arrangements round which they have been devised.

Progress towards “the vision in the Green Paper” needs to begin immediately

Whatever the outcome of the individual budget pilots, important steps towards well-being and customer-led service should be taken straightaway by all Local Authorities. Where home care for older people is concerned, Chapter Ten's 'Guidelines' lead towards the White Paper's affirmed goals. The case for beginning such development work straightaway is as follows.

- 1) Some of these steps prepare the ground for individual care budgets. They would draw service users, provider staff and Care Managers into roles and arrangements necessary for individual care budgets. They promote staff outlooks which would assist individual budgets.
- 2) Chapter Ten's 'Guidelines' offer an alternative, less ambitious route to choice and self-directed care, which would benefit any service users who might end up, in effect, outside an individual budget system. A major question for the individual budget pilots is whether this system suits many more older people than Direct Payments. The individual budget pilots include an option for the Local Authority to manage a budget on behalf of individuals who are unsuited to the new system (Routledge and Porter 2006). The latter would benefit from measures which made management by Local Authorities more flexible and sensitive to service users' well-being and choice. Also, what if the government decides against individual budgets, after the pilots have reported? Alternative means for promoting choice and self-directed care would be necessary, if these are now national policies.
- 3) Older people urgently need services to fulfil the vision in the Green Paper. They should not have to wait for years before any change. Pioneering developments, like individual budgets, most certainly needs piloting and planning at length. But, now that the government has affirmed the new values, there is no justification for delaying more modest, commonsense steps towards promoting well-being and choice. As many older people as possible should benefit as soon as possible.
- 4) There is urgent need for change, too, in terms of encouraging those purchaser and provider staff, who support the Green Paper's values, to stay in their jobs. Activity is needed which demonstrates real change after what some staff see as years of demoralising work, acting as cash manager rather than care manager, providing increasingly meagre, unsatisfactory services. Policies which drive customer-centred staff to quit working in care services need to be reversed immediately and visibly. In older people's services, action is swiftly needed which shows that the Green Paper's values really will be implemented.

The following policies both pave the way for individual care budgets and also promote a flexible, customer-led culture of care immediately, within conventional care purchasing arrangements.

Develop some customer-directed care time for every service user

Provider staff could be directed to steadily expand opportunities for home care customers to direct how their own care time is used. This applies to spare time arising towards the end of a visit, as discussed in Chapter Five. It also concerns a customer wishing a visit to be used for a purpose completely different to that in the Care Plan. In Chapter 11, Panel Six supplies two simple examples of the latter. One is a customer who wanted sometimes to use her lunchtime home care visit to be helped instead to go on a walk. Another is a customer who wanted occasionally to use her care worker's housework time to be accompanied to a garden centre. If the rhetoric of *Our Health, Our Care, Our Say* is taken seriously, then from now on service users should generally have the say over their care time in such situations.

Sometimes, as this research has described, home care staff and customers already thus negotiate freely about how care time is used – sometimes with approval of managers, sometimes not. In some Authorities though, purchasers do not wish even a spare fifteen minutes near the end of a visit to be used as the customer chooses, as Chapter Five described. The recent CSCI report on home care conveys that rigid prescriptiveness by purchasers, concerning tasks during visits, is common nationally (Commission for Social Care Inspection 2006).

Provider staff should now be encouraged, where possible, to negotiate with customers concerning how care time is used, rather than rigidly following a written care plan. The more this is practised, the more that both customer and care worker assume the roles which will be entailed by individual care budgets.

For some older customers it will be practicable straightaway to treat all their allocated care time as a time budget which they can direct flexibly. At some providers in our in-depth study, such practice was already quite common. Under the right circumstances, the spirit of individual budgets can flourish despite there being no formal individual budget system.

For other customers, self-directed care may be less straightforward, like people with dementia. But even for the latter it should be possible to find at least a little time, like end-of-visit time, which could be placed entirely in the customer's hands.

If customer-directed care time represents a marked change of policy, an Authority needs to spell out the new rights for service users to both staff and service users. Change may be difficult for both parties. Where customers are accustomed to restrictive policies, effort may sometimes be needed to revive customer requests. Customers interviewed during this research showed how some older people are reluctant to repeat requests which have not received a positive response. There may be scope for checking progress in developing customer direction of care time via reviews by Care Managers and supervision and training for provider staff.

Commission new types of help, which individual budget-holders are likely to seek, to ensure that providers can supply them

In some Authorities, established home care providers will be ill-prepared to meet certain common customer requests which the freedom of an individual budget should empower. Accompanying customers on walks or drives is a prime example, as described early in the previous chapter. Dusting tops of cupboards, taking down curtains for washing, or changing light bulbs would be others. Our research found that some Authorities systematically discouraged such help as superfluous to their own goals and would magnify any possible risks. Both provider and purchaser managers sometimes imposed prohibitions, deliberately exaggerated risks or circulated fictions about restrictive insurance conditions, as a means for deterring such activities (see end of Chapter Seven). Some provider staff were influenced by this, though others were not.

To prepare the ground for customer-directed service, some purchasers may need to systematically commission types of help, which they formerly discouraged, in order to accustom providers to give it willingly and safely. Local Authority purchasers may be more effective at changing providers' ways like this, than were it left to older people to argue with their providers after individual budgets have been introduced. Chapter Ten described how, if Social Services commissioned accompanied outings for a customer, a provider needed to address risk assessment procedures, transport costs and staff motor insurance premiums. Once solutions had been devised, they became used for other customers on an ad hoc basis.

Modifying attitudes to risk is named as an aim in paragraphs 4.40 – 4.42 of *Our Health, Our Care, Our Say* (Department of Health 2006). The SPRU research noted that the types of help where providers exaggerated risk were often those which Social Services either discouraged or regarded as unimportant. Things which mattered to Social Services did, generally, get done. To prepare for individual budgets, Local Authorities need to show that a new set of tasks now matter to them – and check that they now get done.

Support service users in purchasing private help.

Under individual budgets, older people will need to purchase help themselves – sometimes from quite a variety of sources. The new 'care navigators' will need to assist them to do this. However, this research noted reluctance in some Social Services Departments to help older home care customers concerning privately paid services. This included older people whose frailty and isolation meant they required some service navigator help for this purpose. Resistance was evident concerning help to find a private cleaner, plumber or gardener or buy extra time from the same home care agency engaged by Social Services. Factors included worries about possible complaints from the customer about quality or from rival tradesmen about fair access to trade. There were objections to recommending tradesmen who had not been checked for criminal records - though, choosing on their own, older people faced at least as much risk. For individual budgets, Local Authorities now need to find ways round these objections if 'care navigators' are to help older people spend their budget on whatever combination of care worker, cleaner or household handyman they choose.

Local Authorities can now prepare for the 'care navigator' role by encouraging positive responses to customer requests for help to engage various privately-paid services. This research can affirm that this aspect of the 'care navigator' role is readily achievable.

Certain home care providers, both in-house and independent sector, routinely helped customers find and negotiate with plumbers, electricians or gardeners – and felt very confident in such roles.

As detailed in Chapter Five, some Authorities disliked customers purchasing privately paid extra time from the same agency which supplied their Social Services care. As a result, some independent providers downplayed the availability of private extra help. But privately paid extra time involves the very customer-directed relationship which is needed for individual budgets. Also, the option of privately paid extra help is surely part of the individual budget concept. Purchasers should now promote privately paid extra help as legitimate, indeed desirable.

In our in-depth study, one independent agency had many wholly self-funding customers and a very customer-responsive style of service. For its Local Authority customers, just like its self-funding customers, it supplied a printed tariff of services and prices, which included items like pet care and transport on shopping trips or to social events. In some Authorities this might be perceived as too close to advertising. But, if individual budgets lie ahead, is not this a desirable provider style, which helps service users to exercise choice?

Promote a counsellor / caseworker role among Care Managers ahead of the transition to ‘Care Navigator’

Near its end, Chapter Nine considered indications from service user interviews that a significant minority of older home care customers were emotionally distressed. They might have benefited from the combination of counselling, family work, and service brokerage which was often given by Social Workers before the era of Care Management. Plainly such needs will still arise in a service which has adopted individual budgets. Some distressed service users will need time and support to discuss feelings, aspirations and priorities if they are to use their individual budget to greatest advantage.

As an important part of emphasis on well-being, the new ‘care navigator’ role should include such help. The more that this marks a change from current practice among Care Managers, the more important that a Local Authority promotes this role straightaway. If delayed till the introduction of individual budgets, when there are other role changes to implement, this element risks getting overlooked.

Enable a freer care market

In the ‘In Control’ pilots, an important aspect of individual budgets was that service users could choose their own providers. This meant that often they chose to hire people whom they knew, like relatives or neighbours, rather than anyone from the established social care workforce.

However, freedom to thus choose providers clashes with common systems in publicly funded home care. Very often each Authority lists a limited number of ‘Approved Providers’ of home care. Our research noticed trends towards further restrictions on choice of provider:

- A trend to ever fewer and larger ‘Approved Providers’, as block contracts were developed. For instance, in one Authority in the in-depth study, service came predominantly from only two providers, which had large block contracts to fill.

- Rules whereby each customer's home care must come from one provider only – no 'split care packages' where two or more providers serve an individual.
- Emergence of 'zone provider' systems, where an Authority is divided into geographic home care zones and each zone has a single provider. For each customer, a single eligible provider is indicated by the customer's post-code. Such systems aim to reduce the time it takes staff to travel between customers. Sometimes they even centrally assign home care job applicants to the agency whose 'care zone' is nearest the worker's home.

Another step in preparing for individual budgets would be to rethink policies which thus restrict number and choice of providers. Customers should be enabled to find or choose their own providers – and to use combinations of providers, if that suits them.

This would run counter to a tendency among many Local Authority purchasers to draw chosen independent agencies into well-intentioned, comprehensive master-plans for a locality. Selected agencies are often expected to conform to standardised Local Authority policies on fine details of service-giving, as described in Chapter Five. Via 'zone provider' systems, Local Authorities sometimes steer where independent agencies work. In one Authority in the in-depth study, Social Services had instigated a major change in size for one independent agency in order to complete the Authority's 'zone provider' plan. In one Authority in the telephone survey, Social Services seconded staff members to some independent agencies to encourage particular approaches to management.

Not only is customer choice of provider reduced by such central planning but so is the variety of service, as agencies on block contracts adjust to standardised Local Authority policies. It is a far cry from the early days of Local Authority purchase from independent providers, when hopes were voiced that market forces would generate innovation and variety of service. "Stimulating the market to respond to new demands from more powerful users of social care" should be a gain from individual budgets, according to paragraph 4.30 of *Our Health, Our Care, Our Say* (Department of Health 2006). This would seem difficult indeed for the select "independent" agencies, with standard policies promoted by Social Services, which were being marshalled by certain Authorities in SPRU's study.

There seems a case for Authorities to pause on rational master plans which involve a single major Local Authority purchaser in orchestrating the local care market. Something closer to an ordinary free market might maximise gains from individual budgets. Maybe, a creative free market dynamic requires a multiplicity of individual purchasers, not a single, dominating public purchaser. Individual budgets might enable the care market to work in a way which has not been seen so far. Local Authorities would need to rethink and perhaps modify certain of their established, well-intentioned policies.

But these are complex issues and there are no easy answers. Key aims behind Local Authority orchestration have been to develop providers which were sufficiently stable to rely on and to enable all localities to be served. 'Zone provider' systems address important travel costs and can make home care jobs viable for workers without cars. These purchaser policies seek to retain in a pseudo care market important strengths of

the former in-house Social Services providers. The same issues remain. Can a true free care market, comprised of individual budget holders, generate better solutions?

Raising front-line staff attentiveness to customer aspirations and well-being

Are there ways of encouraging outlooks among front-line staff, which would promote customer well-being and choice in everyday work? The SPRU home care research has generally seen this as a short-term challenge, easier than among managers, since changes by front-line staff are soon reinforced by customers' satisfaction. Chapter Eleven considered the role of training for promoting fresh thinking among front-line staff.

A valuable update is recently published information about a controlled experiment in training social care staff in person-centred care for depressed older people (Lyne *et al* 2006; for a summary see North Yorkshire & York Psychology Services 2007). This pioneering project provides:

- A straightforward, low-cost model for training front-line care staff to work with an older person concerning well-being goals and the customer's own priorities for help. While the study was conducted in residential care homes, a home care provider could use the same method to promote personalised care, attention to well-being, and customer-led service.
- Clear evidence of important benefits for mental health from giving older people the same types of help with well-being and quality of life, which have been the focus of SPRU's research on flexible, person-centred home care.

Lyne and colleagues evaluated a person-centred care planning approach for depressed older residents in care homes. This was supplied by a resident's regular care worker. Care staff received 12 hours of training about depression among older people and about a one-to-one care planning procedure, adapted from Barrowclough & Fleming (1986). Next, for two to three months they worked individually with depressed residents, under supervision from a mentor, to achieve particular life-improvements sought by the resident. Examples included:

- regular accompanied transport for a disabled resident to visit friends;
- access to large print books;
- quality time talking to one's main care worker;
- individualised excursions to places of interest;
- liaison with opticians, dentists and audio-clinics.

People who received the intervention showed pronounced improvements according to depression ratings. But there was no change among a control group of depressed fellow residents, who did not receive this extra help. The difference was highly significant statistically.

The approach proved easily grasped and well-liked by care staff. Some said that, via staff meetings and informal discussion, this person-centred approach had influenced workers who had not participated and affected the general culture of their care home. Some staff thought it worth applying to all residents, depressed or not.

As a means for ensuring that individual budgets produce most benefit, this person-centred planning method deserves attention. It seems a promising route whereby an

older person can communicate the types of help which particularly matter to them - and thus maximise benefits from an individual budget. The training materials are being made available nationally – see North Yorkshire & York Psychology Services (2007). Trainer and mentor roles can be provided by professionals widely available in Community Mental Health Teams.

As well as showing a model for staff training, this intervention approach offers an answer to a problem identified in Chapter Ten. Under ordinary circumstances, person-centred initiatives by home care staff often grow out of good relationships between customer and regular worker. This can exclude some depressed people, who particularly need such help, but whose problems mean they cannot develop sufficient relationship to inspire a care worker. The intervention approach in this North Yorkshire care homes study provides a means whereby relationships can develop between care staff and depressed or uncommunicative people. This is through the structured care planning procedure and through guidance from a mentor.

The North Yorkshire care homes study (Lyne et al 2006) demonstrates how measurable, important outcomes can result from addressing older people's well-being and quality of life. It shows the sort of benefits which are often envisaged – as in SPRU's home care research - though so hard to demonstrate conclusively. Here now is evidence.

Individual budgets under 'system-centred' management: what might result?

“The purpose of an individual budget would be to promote independent living. This is not just about being able to stay in your own home but is also about providing people with choice, empowerment and freedom.... People could have individual support to identify the services they wish to use, which might be outside the range of services traditionally offered by social care.”

Independence, Well-being and Choice (Department of Health 2005)

The SPRU home care research concluded that some Social Services Departments had developed cultures of 'system-centred' thinking, which might stymie implementation of new policies promoting well-being or choice. 'System-centred' managers pursued narrow outcomes around safety and personal care and thereafter prioritised cost-reduction, performance indicators or smooth-running of the system (Chapters Five, Ten and Eleven). Crucially, service users' well-being did not matter. They maintained a mindset which treated service users' wider well-being as less important at any level than the system's costs or efficiency. They would discourage small items of cost-free help, which would have brought definite gain for service users' well-being, because this mattered less than very occasional, hypothetical risks to smooth-running (Chapter Five). If one accepted their underlying premise that older service users' well-being was none of the Local Authority's business, 'system-centred' cultures had considerable logical coherence. Indeed, so strong was their logic that it was hard to see how they could change (Chapter Ten).

How might such 'system-centred' cultures affect individual budgets? Two contrasting possibilities can be envisaged.

- 1) Individual budgets may be the best way to halt the influence of a 'system-centred' culture on service-giving. Individual budgets could insulate service users and front-line staff from 'system-centred' purchasers even if the latter do not change their outlook.
- 2) 'System-centred' purchasers might implement individual budget systems in ways which benefit the system rather than the service user. They might produce inauthentic versions of the individual budget concept, which fail to deliver full benefits for service users.

It is certainly possible for 'system-centred' Local Authorities to be attracted to individual budgets, despite incompatibility of underlying values. During SPRU's home care research, one such Department energetically and very successfully promoted Direct Payments among older people, although simultaneously restricting autonomy among its home care customers – indeed, a local Care Manager commented on the contradiction involved. Its promotion of Direct Payments was found to reflect this Department's high priority for national performance indicators, though older people still benefited as a result. Recently a comparable Local Authority publicly identified itself very strongly with individual budgets.

For whatever reasons, there will be some 'system-centred' Authorities who energetically embark on an individual budgets programme. An open question is whether this will genuinely transform the service – or whether individual budgets themselves will be transformed into a tool for making services cheaper or easier for Local Authorities.

Concerning the latter prospect, it is important to recognise directions in which 'system-centred' cultures might steer individual budgets. On the one hand it is excellent if the system, as well as the service user, benefits through individual budgets. But, on the other, it is a serious problem, if advantages for the system, like the following, actually replace the service user as the priority focus.

Gains for the system could include:

- Simpler, more predictable spending patterns through using a small set of standardised individual budget sizes.
- Shorter, simpler procedures for initial assessment could reduce the number of qualified Care Managers needed for assessments.
- If service users hire relatives or neighbours as carers, this reduces demand on the stretched social care workforce and on the Local Authority as an organiser of care. Indeed, individual budgets might transfer degrees of perceived responsibility from Local Authorities to the service user or their family in respect of finding care providers.
- Opportunity to shift costs to other budgets through the merging of different funding streams.

- Reduced funding for care packages may not reduce customer satisfaction so much, if this is balanced by freedom to choose how staff time is used. Customers could decide how low funding would affect their own services.

The original customer-centred purposes of individual budgets could be undermined if they are introduced with an eye to benefiting the system instead. For instance if cost-reduction is the aim, individual budgets may go to people who would require little 'care navigator' time and be with-held from those who would need much. People, who could particularly benefit from the flexibility of an individual budget, include older people without nearby family or friends, who thus lack sources for miscellaneous help aside from paid helpers (Wenger 1992, Woodruff & Applebaum 1996). They also include people with pronounced disabilities, who hence need help with a particularly wide variety of tasks (Patmore *et al* 1998). But from a system-centred motivation, both groups might be the last people to be encouraged to manage their budget themselves, on account of the 'care navigator' help which they would need. Instead, prime candidates might be people with local social networks from which they can enlist helpers, hence relieving both 'care navigators' and the established social care workforce. They could be people who, themselves or via local relatives, can direct and manage their helpers without a Social Services intermediary. On page 85, Panel Six described Mrs A, who had major communication difficulties, yet who made meaningful and achievable requests to care staff when trouble was taken to listen. Would a cost-motivated Authority allow the 'care navigator' time for someone like her to utilise an individual budget?

Another false direction would be systematic reduction of funding for an individual budget below the level of a conventional care package. For each individual, there must be a threshold for number of hours of care below which flexible use of time – and hence gain from an individual budget – becomes very difficult. Also, if reduced funding affects pay and conditions for care workers, it will become harder to retain good, regular workers. During the SPRU home care research, personalised care appeared to depend on relationships developing between older people and regular helpers. If pay and conditions become insufficient to retain regular helpers, than the necessary relationship will not develop.

Systematic reduction of a care package's funding was in fact suggested recently by the Audit Commission as a means for recovering extra care navigator costs for Direct Payments (Audit Commission 2006). Extra costs were defined by comparison with ordinary care management. Yet commonly the latter is severely, dysfunctionally under-resourced as described in Chapter Nine – ratios of 90 older service users per care manager, for instance. That its costs can be viewed as a standard, which can guide reduction of funding, indicates the sort of arguments which may await individual budgets.

‘How truly customer-centred is this individual budget scheme?’

Concerning any local individual budgets system for older people, it is worth asking the following basic questions, in view of findings from SPRU’s home care research. Negative answers to any question should trigger search for explanation and scrutiny whether the scheme matches the In Control ideal. If older people somehow still cannot get much-sought items like walks, drives and curtain-cleaning, then the aims are not being achieved.

Are older people obtaining the types of help which they want, from whatever sources?

- Can they get their curtains taken down for washing?
- Can they get a light-bulb changed?
- Most important, are they getting accompanied on trips out by car or taxi? Are they getting help to go walks?

Does the new system retain the strengths of good home care providers under the old system?

- Do older people have a suitable number of familiar helpers – few enough that they know them well, but many enough to obtain familiar faces during emergencies, staff holidays or when workers change jobs?
- Do older people enjoy their relationships with their workers?
- Are workers’ hours, pay and conditions conducive to long-term service?

Is the individual budget system accessible to those older people who would most benefit from care workers who flexibly follow their wishes?

- Older people without nearby family or friends, who hence lack sources for miscellaneous help aside from paid helpers?
- Older people with pronounced disabilities, who hence need help with a particularly wide variety of tasks?
- Is ‘care navigator’ time sufficient to help older people with such characteristics to obtain and direct suitable helpers?

Much local variation may be possible among individual budgets schemes. Among the 13 Authorities in the Individual Budget Pilot Programme, some schemes may prove more ‘customer-centred’ than others.

How can ‘system-centred’ traditions in local social care management be reversed?

Earlier this report envisaged major difficulties in a ‘system-centred’ Authority changing its policies, were new leadership to take over. Purchaser managers, whose help would be needed, might be steeped in a contrary philosophy to the point that they might not understand the new ethos, let alone support it. Provider staff might be mired in prohibitions and insurance worries promoted by the old regime. Very many aspects of the system might need redesign. Even a contrary new policy, like individual budgets, might, it has just been suggested, get implemented in ways which reflect the old regime’s values.

Where could one start? Elsewhere suggestions have been made concerning training approaches which might assist purchaser managers to revise their outlook (Patmore 2006). Increasingly pertinent may be to draw on the expertise evolving among the growing number of Authorities which have allied themselves with In Control's approach to individual budgets. They constitute a national movement, which is distinct from the government's individual budgets programme. Authorities, which have acquired experience with individual budgets, are sources for advice on the obstacles facing a 'system-centred' service when it first seeks change. Some should become able to provide a practical example for how a complete alternative system functions. During the SPRU home care research, it was notable how one 'customer-centred' in-house provider had, over the years, developed comprehensive expertise in solving common home care problems in a person-centred way. It could supply tried and tested answers to many practical objections to a flexible, person-centred approach which got raised elsewhere. Hopefully in the same way some Authorities in the In Control individual budgets network can provide practical examples of the path to change. Contact details for the latter can be found in the Links and Contacts section on In Control's website:

www.in-control.org.uk/home.php

Government policy and the future for flexible, person-centred home care

On the positive side, individual budgets as a possible standard mechanism for providing social care are receiving earnest consideration by the government.

Widespread support for individual budgets already exists among Local Authorities (Brindle 2006a). As discussed, individual budgets are much the swiftest, most complete route for ensuring that home care becomes flexible and person-centred. During our research, it would have been hard to envisage such a potential total solution to the problems which this research has examined.

But this potential may not necessarily be realised. A crucial factor may be whether the government changes its funding policies so as to ensure adequate and predictable funding for older people's care. Publicly funded home care has become overshadowed by a growing shortfall between rising numbers of needy older people and funding from central government, which has not kept pace with this (Local Government Association 2006). Rationing of service has meant that sometimes older people with substantial needs are no longer eligible for care and that care packages are sparser for those who do qualify.

Alongside enforced service cutbacks, there may be profound effects on Local Authority attitudes, which can likewise stymie any initiatives to improve service quality. The arbitrary nature of the growing shortfall between funding and rising need can feed fear that no limits exist to how far central government funding for older people's care, on a per capita basis, eventually might be reduced. How might individual budgets be construed by a Local Authority purchaser who believes that eventually state provision will become minimal, because of huge future numbers of older people? From this viewpoint, Local Authorities' role, for coming decades, would be to manage an increasingly severe reduction in availability and quality of service. It could appear prudent, forward-looking stewardship to trim quality from local service sooner rather than later, if one believes that a much worse funding shortfall is to come. Charging for home care and cutting back house-cleaning services might be seen as the start of a long-term

service reduction process. Transferring home care to independent providers could seem a move to downgrade care staff pay and conditions, as described in Chapter Eight. Next, in this view, an explicit service rationing procedure emerged via *Fair Access to Care Services* (Department of Health 2002). From such a viewpoint individual budgets might be treated as another centrally-inspired policy which can enable the state to step back from older people's care in terms of funding and responsibility. Such a viewpoint might make it hard to engage with anything labelled as improvement, especially if it concerned well-being and choice. Restrictive policies, which ignore well-being and were earlier labelled 'system-centred', might seem obvious good sense on the long march to a bleak new care world, envisaged for coming decades.

The growing shortfall between government funding and older people's needs can make such perceptions seem founded in reality. This may make it hard for Local Authorities to treat individual budgets with any enthusiasm as a means for service improvement. If the government allows the funding shortfall to increase, it will become impossible for individual budgets to function as such.

A Wanless-style long-term funding plan?

To make individual budgets credible as a means for improving older people's services, the government needs to present a clear vision of how the growth in need can be addressed. A rational formula for future funding is necessary, which can enable planning for achievable service, rather than panic measures for a catastrophe of unknown dimensions. A striking positive example is the Wanless review of future costs for social care for older people (Wanless 2006). This grasps the nettle of the imagined demographic time-bomb and systematically calculates the changing costs of social care for an ageing population over the next 20 years. Its upper figures for future costs are not infinite and impossible but finite and affordable, even if large. Additionally, Wanless calculates costs for three different levels of service quality – two of which address only older people's personal care and safety, while the third explicitly includes "well-being outcomes". Notably, two of Wanless' levels of service quality involve higher quality and costs than current service, because Wanless judged that this is warranted and practicable.

Future services for older people need to be funded through a formula drawn from Wanless-style calculation of long-term costs. This would enable planning according to predictable funding levels. Individual budgets need this, if they are to succeed. Very damaging to older people's services is a situation where government funding for social care seems arbitrary and disconnected from rising need. This not only forces service cuts but it encourages pre-emptive austerities in anticipation of worse to come. It can drive down spending to levels well below what can be afforded. It may cause hard-to-reverse damage to the home care workforce, if experienced and dedicated care staff quit because austerities have eroded job satisfaction and other rewards. Will the government now balance its rhetoric about demographic crisis with a long-term funding plan for how this will be addressed?

From Green Paper to White Paper – a veiled change of tune?

Have there been changes in the government's reasons for interest in individual budgets? The social care Green Paper *Independence, Well-being and Choice* conveyed a lively interest in gains for service users, identification with their well-being and desire for a more holistic, user-led service. But, following its pre-election publication in March 2005

and the transfer of the minister responsible, there has been much less evidence of champions for 'well-being' at the Department of Health. The latter's usage of 'well-being' seems changed. Is 'well-being' still a leading concept? Government interest in individual budgets certainly still seem vigorous (Brindle 2006b). But it is less clear what is now firing this interest.

The 2006 White Paper, *Our Health, Our Care, Our Say*, formally declares support for the Green Paper. But it employs curiously prosaic, detached language which "fails to do justice to one of the most exciting developments for many years in adult social care" (Glasby 2006). It submerges the Green Paper in a much larger, later Health Service agenda which dominates implementation. Indeed, everything in the Green Paper, which would directly change front-line service, is in effect suspended for years through being incorporated in the Individual Budgets piloting exercise. Of course, it is essential that a complex, pioneering venture like individual budgets should be piloted at length. But why did the White Paper not also include some injunctions whereby Green Paper values would immediately affect front-line practice in social care? Ways of doing this were mentioned early in this chapter. A sceptic might wonder what the government will be judging, when the Individual Budget Pilots are completed. Is it judgement on individual budgets, which are only one method for implementing "the vision in the Green Paper"? Or is it judgement on the Green Paper itself? If in 2008 individual budgets are not implemented nationally, what exactly would be left from the acclaimed Green Paper in the implementation of *Our Health, Our Care, Our Say*? The present account of implementation does not promise much (Department of Health 2006b). From this viewpoint, the future for flexible, person-centred home care for older people looks far from secure.

The situation seems undetermined, very much in flux. There is an unbridgeable disjunction between government rhetoric about personalised services and the practice of not increasing resources in line with rising need among older people. Which will prove the more accurate harbinger of the future? Very important may be the outcome from the 2007 Comprehensive Spending Review. It may indicate the government's core intentions and hence the role which individual budgets can play.

On the one hand, given adequate resources, a universal system of individual budgets could make care for older people more flexible and person-centred than ever before. On the other, individual budgets might become merely optional – which might in effect make the Green Paper's values merely optional. Or they might be implemented in ways which do not give the service user's interests the pride of place which In Control's model intended. Indeed individual budgets could become tools of a long-term agenda of service dismantlement in the name of demographic crisis. They could be used for cutting care costs or saving the service-giving system from the difficulties of recruiting care staff when demand is rising but pay and conditions have been downgraded.

There are four national resources which, combined, now could create an era of well-being and choice in community support for older people.

- The social care Green Paper, *Independence, Well-being and Choice* (Department of Health 2005) supplies an overall philosophy of service.
- The work of In Control (Duffy 2005), which supplies a promising practical method, the individual budgets model, and has had an inspirational effect among many Local Authority staff.

- The Wanless report (Wanless 2006) supplies a model for planning for funding older people's care for decades ahead. It shows that even a higher quality service could be affordable. It confronts the notion that the only direction for older people's services must be downwards.
- The fourth resource is not new – people who work in older people's services, in many roles, in all sectors. Many embarked on their jobs because they wanted to give good quality care. The dedication and talent of the existing workforce lies behind all the examples of person-centred care in this report.

Through its decisions on funding, the government will show whether the potential of these resources for improving older people's services will be allowed to succeed.

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