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**QUALITY IN HOME CARE FOR OLDER PEOPLE:
FACTORS TO PAY HEED TO**

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ABSTRACT

23 home care providers were interviewed concerning what promotes or impedes quality aspects of service-giving, as defined by older customers – like service from familiar staff or flexible help. The influence of Social Services purchasers and of structures for purchasing care proved notably important. Purchasers affected service quality through the amounts of time which they commissioned and through whether they would purchase help for customers' quality of life as well as for their physical survival. Quality was affected through whether care was purchased through fixed quantities of time or through the fulfilment of specified tasks. Some purchasers controlled details of everyday care-giving which other purchasers left to providers' discretion. Also influential was the attitude of providers themselves to giving miscellaneous occasional help like changing light-bulbs, finding reliable private tradesmen or taking customers with them on shopping trips. Some providers readily gave such help and found it unproblematic to do so. Others prohibited it, though this seemed not always implemented earnestly. The most marked differences in willingness to give flexible help occurred between different independent sector providers, rather than between independent and Social Services in-house providers. A third type of influence on quality of home care was 'economic' factors like the purchasing power of local home care pay rates within the local labour market, local geography and demography. Some questions are itemised which merit inclusion in any evaluation of the quality of a home care provider.

[234 words]

KEY WORDS

Quality older people home care
person-centred purchaser care management

QUALITY IN HOME CARE FOR OLDER PEOPLE: FACTORS TO PAY HEED TO

[3,986 words]

INTRODUCTION

Research on older home care customers' views on service quality has highlighted customer priorities like receiving service from familiar staff, reliable and punctual visiting, customers being kept informed about changes, and help with miscellaneous household problems like house-cleaning, changing light-bulbs or obtaining a trustworthy plumber (Henwood *et al.* 1998, Clark *et al.* 1998, Raynes *et al.* 2001, Patmore 2001). This paper reports some preliminary findings from an on-going research project which explores what helps home care providers to deliver service with these characteristics (Patmore 2002, pages 1-4). What enables some providers to serve customers through regular, familiar staff while other providers do not? Why do some providers treat the changing of light-bulbs as a standard home care responsibility, whereas others prohibit it? How can some home care providers regularly take customers out shopping or find them private cleaning or repair services, when others deem this impracticable or hazardous? Another research aim is to discover how providers can best tailor service to the differing values and preferences of each customer. For instance one older person may prioritise familiar staff whereas another may prize help with household maintenance (Patmore 2001).

While only the first phase of this research is complete, early findings may benefit researchers and managers who evaluate home care services. Initially the project had envisaged explanations for providers' differing performance – on counts like those just mentioned – to lie in characteristics of providers like manager attitudes, how staff are supervised or systems for staff rotas. While early findings confirm that provider attitudes are important, they also highlight powerful influences from the policies of Social Services purchasers and from their procedures for purchasing care. They illustrate some important areas for attention in any investigation of home care quality.

METHOD

For scoping purposes, the first phase of the research included an in-depth telephone survey with managers at 23 home care providers. Twelve localities (in 11 Authorities) were selected to provide a range of contrasting communities, using the Office for National Statistics classification of Local Authorities (Office for National Statistics 1999). They included a mining community, a south coast retirement zone, a booming Home Counties area, inner and outer London boroughs, northern industrial towns, a rural locality and a new town development. Communities can differ in ease of recruiting home care staff, for instance, or their proportions of very old people, or travel distance between home care customers.

In each locality Social Services Purchasers were asked to arrange for SPRU to conduct two telephone interviews with provider managers. One was with the Social Services in-house home care provider and another with an independent agency contracted by Social Services. Twenty-three providers were interviewed in total. Independent providers were mainly single unit agencies, though there were also regional and national organizations and a franchise. Bias may be towards selection of independent agencies which were well-regarded by Social Services purchasers – most had been awarded block contracts. More detail is available in Patmore (2003a).

Interviews included a focus on control exercised by Social Services purchasers, inspired by Sinclair *et al.* (2000). Some sections examined how a provider treated customer preferences, requests and common concerns. For instance questions were asked about policies on how many staff were assigned per customer and on punctuality and variation of visit times. Willingness to help flexibly with miscellaneous occasional tasks was investigated concerning: taking customers shopping, changing light-bulbs, arranging extra house-cleaning, organising repairs, writing letters for blind customers and helping customers to look after their pets.

This paper is based predominantly on these phone interviews, though occasionally drawing on the second phase of research, still in progress. The latter comprises interviews with older home care customers, care staff, provider managers, and Social Services Care Managers and other purchaser representatives.

FINDINGS

Purchaser influences: variations in how home care was purchased - and how this could affect service quality

Degree of control by Care Management

The 23 home care providers covered a spectrum of purchasing arrangements.

At one end of the spectrum were two Social Services providers which still managed their work entirely themselves, as did all in-house providers before the Purchaser / Provider division became common elsewhere. At these two providers, provider managers received referrals directly from GPs or families, assessed them and decided themselves on what tasks and number of visits a customer needed each week. Provider managers assigned staff set tasks for each visit. Staff were expected to spend as long on each visit as proved necessary for those tasks – with recognition that this might vary day-to-day if a customer's health fluctuated. This is sometimes called 'task-centred working'. Under these arrangements service quality reflects considerably on provider management.

At the other end of the spectrum were six providers, both independent sector and Social Services in-house providers, whose services were prescribed in detail by Social Services purchasers. The latter would initially assess each customer and prescribe: how many visits per week, the exact time of day for each visit, exactly what tasks should be done on each visit, and the precise length of each visit. The prescription of fixed visit lengths (by which payment to a provider is calculated) sometimes leads to the label 'time-centred working'. None of these prescriptions could be changed without permission from Care Management. This could substantially restrict providers' flexibility. Any one-off extra time required Care Management's approval as the purchaser. These providers' customers could not alter their visit times without the provider contacting Care Management. A manager of a Social Services provider commented: 'If a service user says "Can you do my shop on Tuesday this week instead of Thursday?" that means a phone-call to the office, then a phone-call to a Social Worker to ask permission to do this.' Obtaining permission was not always swift since some Care Management services often closed cases soon after assessment and a new Care Manager might need to be allocated to assess the request. Thus much control on providers' everyday work was retained by purchasers. A purpose behind this is to ensure that an individual's requirements are not over-ridden to suit provider convenience. One provider, though, felt the system could tie customers rigidly to outdated requests about visit timings, which they themselves had made years earlier to Care Management at assessment. Any change would also require permission from Care Management concerning other customers whose visit-times might be affected.

Other providers lay between these two extremes. Seven independent providers were allowed minor flexibility to negotiate with customers concerning the timing of visits, though visit lengths and the tasks for which visits were used remained under Care Management control. The remaining providers were given still greater flexibility by Care Management. Some of these – all Social Services providers - were allowed to vary the amount of time which they gave a customer. Some could add around 15 minutes per visit without Care Management permission. Others had negotiated virtual return to traditional Social Services 'task-centred working'. For the latter, Care Management still produced a list of tasks or goals and sometimes indicated approximate visit lengths. But actual visit lengths and timings were substantially at the provider's discretion. They used a 'task-centred' approach, whereby each visit takes as long as needed that day to complete necessary tasks.

'Task-centred working' and 'Time-centred working': advantages and disadvantages for customers

'Task-centred' services are well-placed to deal with unforeseen problems, emergencies, increased needs for help or anything else which requires substantial extra time. If a home care customer's refrigerator breaks down, some

'task-centred' services can swiftly deploy staff time to organise replacement without seeking Care Management permission. In contrast a 'time-centred' service would first need permission to spend the extra time. This would not necessarily be granted. In some Authorities Care Management would seek a different service for such a purpose anyway, a source of delay.

But a disadvantage of 'task-centred' services is that they are less able to provide punctual visits because their visit lengths fluctuate. Also, staff leave a customer immediately that their tasks are finished, since they do not know what time-consuming emergencies might lie ahead that day. Thus characteristically they are reluctant to spend time chatting with customers, unless towards the end of their round when they know whether they have spare time.

In contrast, an important *potential* strength of 'time-centred' services is spare 'quality time' left at the end of a fixed time slot after the tasks prescribed by Care Management are completed. An independent agency manager described this:

'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.'

Two factors are crucial to whether 'time-centred' home care gives customers this benefit. One is whether Care Management commissions visit lengths which are long enough for spare time to arise. The Care Management service, which commissioned the provider just quoted, deliberately commissioned slightly longer visits than usually needed so as to allow for customers' fluctuating health. When spare time arose, Care Management expected it to be used exactly as the provider described. But there were other Authorities where providers said that Care Management commissioned visit lengths so short that spare time could never arise. The second crucial factor is whether home care staff actually stay the full time prescribed and offer extra help, if they finish Care Plan tasks early. Some provider managers firmly insisted on this, as a key element in service quality. But half the providers allowed their staff to leave, if they finished early. Some independent agencies saw early departure as compensating for non-payment of travel time between customers. Some Care Management services expected providers to offer customers the full time they were paid for. But there were others which preferred, even pressed, for staff to leave early as long as they informed Care Management, since this showed where visit lengths might be reduced. Standard 6.2 of the new Domiciliary Care Standards now requires staff to 'work for the full amount of time allocated' (Department of Health 2003). But, where early departures have long been officially sanctioned, arguments about

interpreting this can be anticipated.

While 'time-centred' visits can routinely give customers small extra services and company, a disadvantage concerns any occasional help which needs longer than the spare time at the end. During this research, various incidents have been encountered which recall the desire for flexible help often voiced by older home care customers in research on quality. A home care customer lost her keys – could her home care worker be authorized to spend time getting a duplicate cut from the keys held by the agency? A care worker arrived at a customer's home to find she had been burgled overnight - could the worker spend time comforting the customer, contacting the police and organising repairs? Likewise, who could help a customer whose refrigerator had broken down? These situations are especially difficult for those older people who have no nearby relatives nor helpful neighbours to turn to. Some 'task-centred' home care services in the study could respond immediately and effectively. But, as mentioned earlier, a 'time-centred' service would normally first need Care Management's agreement to purchase the time required.

Purchasers differed in types of help commissioned for older people

A particular issue was requests for extra time which concerned an older person's quality of life rather than simply maintaining their survival. Here there were important differences between Authorities in their readiness to commission help. This affected both the services initially purchased from a provider and Care Management's responses to subsequent requests. Some Authorities would commission only help which was necessary for maintaining physical survival - like personal care, meals and cleaning of kitchen and bathroom. In contrast, other Authorities would sometimes add, say, help with an older customer's pet, extra house-cleaning or periodic accompanied shopping outings. Two Care Management services sometimes included instructions that home care should make sure they chatted with certain isolated customers during visits.

Providers often recognised when Care Management was restricting help for older people, through contrasts with the more varied, holistic help which was commissioned for their customers aged under 65 years. For instance one independent agency manager was commissioned to provide regular 'baking together' sessions with a physically disabled woman aged under 65. She commented how similar help would not be commissioned for many older physically disabled customers of hers, though their morale might likewise benefit. Another manager described how her disabled customers' services would be trimmed of such quality elements when they reached 65. In seven of the 11 Authorities studied, providers said that Care Management restricted help for older people's quality of life, compared to their younger customers from Social Services branches for Physical Disability, Learning Disability, Mental Health or Children and Families. An obvious difference concerned the commissioning of home care workers to provide leisure outings, which was common only for younger customers. Yet this is something which older home care customers seek too (Raynes *et al.* 2001). Age discrimination runs counter to the National Service

Framework for Older People (Department of Health 2001) and Fair Access to Care Services (Department of Health 2002).

Provider influences on the quality of care

Alongside these influences from purchasers, there was evidence of important differences between provider managers' viewpoints, which affected the quality of service which customers received. For instance, some providers would take customers out shopping or to a park or look after their pets if, and only if, Care Management commissioned such help. But some providers would not give such help even if Care Management tried to commission it - including Social Services providers which refused such requests from within their own organization. And some providers routinely gave such help even when Care Management did not commission it – either through the flexibility of 'task-centred working' or, at 'time-centred' independent agencies, somehow squeezing it in. One agency manager deliberately circumvented a highly cost-conscious Authority through discreetly adding tea and conversation to home care tasks.

Certain providers, notably independent agencies, strove to organize each customer's service so that much of it was provided by a single, main worker, who sometimes had a formal keyworker role. Other providers, in contrast, strove to prevent such relationships lest the main worker leave or complications arise in the staff-customer relationship.

Providers' policies varied concerning different types of flexible help - like accompanied outings, help to find plumbers or gardeners, changing light-bulbs, extra cleaning or pet care (Patmore 2003a). Some activities were routinely permitted, some routinely forbidden and some required management permission. Quite often the managers interviewed seemed more permissive than their organisation's official position. Their staff may bend the rules still further, as described by Sinclair *et al.* (2000) .

Notably, even where managers defended restrictions, they often could not supply examples of actual problems which had generated the restriction. An exception was restrictions on close staff-customer relationships, where cautionary tales were readily forthcoming as explanations. But, for every activity which some provider prohibited because of envisaged problems, there was another provider which was performing it without difficulties. There were providers who routinely and confidently were taking customers shopping, changing light-bulbs, supplying a key-worker or engaging private tradesmen for customers' home repairs.

Two contrasting independent agency managers convey how provider attitudes to flexible help can differ. On every topic investigated, Manager A actually required her staff to provide types of help which were often, at best, given only semi-covertly at other services. Recommending private tradesmen, like plumbers, gardeners or electricians, was widely forbidden among survey respondents and this prohibition was taken unusually seriously. Manager A, however, not only

recommended such services but, if needed, would also have her staff phone them on behalf of their customers and be present to promote a fair transaction when the tradesman called. She explained:

'They're asking the home carer to do it for them because there isn't anyone else to do it for them – they've got no family, friends or neighbours to rely on ... We've always done it. It's part and parcel of caring for someone really.'

Manager B, in contrast, prohibited staff from changing light bulbs, let alone recommending repair services. His focus was on minimising risk to his agency.

'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'.

Independent providers often divided quite sharply between those which broadly shared Manager A's outlook and those which resembled Manager B. Social Services providers came somewhere between the two positions. It seemed possible that certain independent agencies had learned to address common customer priorities through serving many private customers alongside their publicly-funded customers. Private customers were a quarter or more of customers at these customer-responsive agencies, which were also keen to offer publicly-funded customers private extra services, if desired. But at many other independent agencies private customers were less than 10% of the list - and two would not accept them at all. Nor were they keen to sell private extra services to their publicly-funded customers. For instance they might not advertise private extra services and, if asked for them, some wanted them administered by Social Services Care Management, rather than dealing direct with the customer. Behind this seemed a view that the Social Services Department was the customer of importance, not the individuals it funded. Fulfilling the block contract with Social Services was what mattered to these agencies. This meant fulfilling those tasks prescribed in customers' Care Plans, not giving them supplementary help. Offering private extras might even, one provider suggested, look like unprofessional 'touting for trade'.

Access to privately-paid extra help is, anyway, important for any study of home care quality to investigate. Its presence or absence can explain customer satisfaction or frustration, since it can ameliorate shortcomings of publicly funded home care – in either sector. Some customers of Social Services providers were receiving privately-paid extra help via freelance work by their home care workers. Where cuts have been made in cleaning by publicly-funded staff, the same workers may continue cleaning for their customers on a private basis. At some Social Services providers this is widely supported by managers.

'Economic' influences on quality of home care

Quality of home care was also affected by what could be called 'economic' influences – how local home care pay and conditions interacted with the local labour market, local geography and demography.

An independent agency manager, in a partly rural catchment, described how she felt forced to give some customers 6 pm bedtimes, a commonly criticised practice in home care. Customers' bedtime preferences, she said, covered an 8 pm – 10 pm timespan. But staff could not be induced to travel out in the evening for the earnings possible during just a two hour period – for which neither higher rates for evening work nor travel time were paid. So a small number of staff provided all evening visits from 6 pm to 10 pm, thus earning more through a four hour 'run' of visits each.

To retain staff in London could require that an agency offered them very long hours – far above 40 per week – if low hourly pay rates were to cover London living costs. If those long staff hours are largely spent providing morning rises, lunches and bedtimes, some of these may occur at times of day which do not suit customers. The latter can occur too if a Social Services provider has staff on full-time contracts, dating from the era when home care undertook much house-cleaning, and these long hours must now be used for personal care and meals. (Wherever possible, in fact, providers sought part-time staff, whose worktime could be all deployed simultaneously at the peak times when customers needed service.)

Some economic factors seem beyond the influence of purchaser or provider. In remote rural areas, customers who live near each other may have to be visited at similar times, preferences regardless. One independent provider worked in a high growth area which has featured in national news stories about shortfalls in many basic services through labour shortage. It faced serious staff shortages and trimmed home care to basics. It would not advertise private extra help to publicly funded customers, reserving staff time for its block contract with Social Services.

But some economic factors can be addressed. One independent provider had faced repeated difficulties in supplying reliable, consistent weekend service – a common source of customers' complaints (Sinclair *et al.* 2000). The problem had been solved when increased funding from purchasers was used for a 50% premium for weekend working. This secured staff agreement to rotate weekend work on a regular basis. Normally independent agencies paid only 10% or 15% extra for weekends. Yet the Social Services providers, whom they are replacing, paid 50% extra, sometimes double for Sundays. In a very rural area, a purchaser and independent provider were likewise jointly tackling problems of obtaining staff when pay was low and travel time both lengthy and unpaid. Purchasers agreed to pay a new very high pay-rate plus mileage costs for visits to particular villages. The provider was also planning an innovative staff recruitment approach.

CONCLUSION

The initial scoping interviews with provider managers showed plainly how provider attitudes and strategies were only one of the elements which shape the quality of a home care service. There were separate purchaser, provider and 'economic' influences.

However, while separate in one sense, these influences can interact. Examples have just been given for how purchasers and providers could counter certain 'economic' influences. Also, 'economic' influences may affect the policies of both purchasers and providers. For instance, two of the most cost-conscious purchasers served localities with high proportions of older residents.

Purchasers can select or terminate providers on the basis of whether provider attitudes and practices appeal to them - though sometimes they use providers, who are not ideal, through lack of alternatives or knowledge of provider quality. Providers can adapt themselves so as to attract a particular purchaser.

Sometimes providers can choose purchasers with whom they feel compatible. For instance a small independent provider had worked extensively with two Social Services Departments plus private customers. It then chose to drop one Department and increase its private clientele. But there were other independent providers which depended on a single Social Services Department, since geography permitted none other and they lacked private customers. Social Services in-house providers faced strictly limited options. But some had negotiated successfully to change to short-term or specialized work with older people, which permitted a preferred, more autonomous relationship with purchasers, or to increase work for other branches of Care Management (Patmore 2003a, 2003b).

Sometimes Social Services and an independent provider become mutually dependent through a large block contract. What interaction between purchaser and provider approaches to quality occurs under these conditions? Subsequent stages of this research examines this.

An important general finding is how much home care quality can be affected by a public purchaser's policies and the procedures whereby care is purchased (for instance whether providers can vary visit lengths or timings). Figure 1 lists some enquiries useful within any evaluation. Subsequent stages of this research examine in detail the practical approaches taken by those providers which successfully provided flexible, customer-responsive care. It also explores how Social Services purchasers might use their formidable influence to encourage providers in this direction.

[ENDS]

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Figure 1.

Evaluating quality of home care – questions worth including

- What parts do purchaser, provider and customer play in determining the following:
 - Amount of time per customer?
 - Timing of visits?
 - Tasks undertaken?

- Are fixed lengths prescribed for visits?
 - Is enough time commissioned for staff to complete prescribed tasks comfortably?
 - Do purchaser and provider *positively want* staff to stay full length?
 - How do staff use any spare time during visits?

- For what range of tasks / needs / purposes does Social Services commission home care? What will it *not* commission?

- Does a home care provider maintain a list of prohibited tasks?

- Do customers privately purchase extra services - from their main home care provider or elsewhere?