The personalisation agenda: Threats and opportunities for domiciliary care providers

Abstract
The personalisation agenda offers an opportunity to make home care (and other services) more responsive and flexible so that it is actually doing what people who use services want and need, rather than being constrained in rigid task and time specifications. There are, however, some unintended consequences for service providers, especially home care providers, which could spell large-scale destruction of the sector. This paper attempts to set out in more detail what personalisation will mean, how it may work, and discusses to what extent it is likely to happen. It then turns to what these changes may mean for services and how services may respond. It sets out in some detail the likely threats to homecare, particularly risks to its financial viability and to future capacity. It then considers the opportunities these changes present, especially the potential for improved relationships between providers and people using services. It also suggests ways in which providers can make the most of existing services and the potential for developing new or more specialised ways of supporting people at home. It ends by pointing out that huge culture change is required of providers, as well as by health and social care authorities, and the failure, so far, to provide any financial support for their transformation.

Keywords:
personalisation, culture change, capacity, direct payments, commissioning, contracts, financial viability, better relationships, outcomes
THE BACKGROUND

The Government’s vision for adult social care

*Putting People First*, the cross-Government and multi-agency concordat published in December 2007,¹ set out a new vision for the radical reform of adult social care in which personalisation, together with a greater emphasis on prevention and early intervention, is the hallmark. Personalisation is the process by which state-provided (or purchased) services are adapted to suit each individual. Service development is moving away from a system where people have been told what services they can receive, from a very limited menu, to one where the person themselves, rather than a social care professional, is at the centre of the process of identifying needs and putting in place services (or other resources) that provide the outcomes that each person wants for themselves. This is referred to as ‘self-directed support’.

Personal or individual budgets (IBs) are only one step in the trend towards self-directed support. *In Control* — developed for and with people with learning difficulties — provided the model for the IB pilots.² Direct payments have been pushed and extended over the last few years, although they have not been taken up with as much enthusiasm as the Department of Health intended. Development of the ‘Expert Patient’ programme and self-management of longer-term chronic conditions are all examples of the drive towards self-directed support.

The process

A person-centred approach suggests a number of strands which, each or all, aim to assist in ensuring that those who need help or support are offered a positive and empowering route which makes the most of their abilities, preferences and circumstances, taking into account their family and social environment, rather than emphasising the difficulties and disabilities they face (as is the case with a needs-based approach). The process may include:

1. Self-assessment, in which the individual identifies from their own perspective, with or without help from a carer, advocate or professional, the areas of daily life in which they may require some assistance. Many people will not be able to self-assess or will need significant help to do so.
2. The intention is that the assessment process should result in the identification of the costs of care, support or activities, using the Resource Allocation System (RAS) developed by In Control and which is intended to offer transparency, and that these costs should then be allocated through a personalised budget to the individual. There has been some uncertainty over the terminology here as ‘personal budgets’ (PBs) consist solely of social care funding, while IBs may be made up of a variety of resources and benefits. For the time being it is PBs which are
envisaged as there were some problems in bringing the range of funding streams together during the IB pilots. For the majority of older people, social care funding is likely to be the only applicable source in any case.

People who need care or support may have recourse to a mixture of personalised budgets and their own or family resources (there will also be people who are assessed as ineligible for public services or funding, or who themselves or their families have the necessary resources, and choose to fund their own services).

3. Once the individual is informed of their indicative budget, they are able, with or without help, to make their own support plan. They need to be offered as much choice and control as possible over the types of support, care and other facilities, which will enable them to live safely, maintain their chosen mode and quality of life, and achieve their goals. They may also need assistance to exercise that choice and control.

4. Before the individual plan is put into action, it will be submitted back to the council for authorisation and validation. At this stage there should be a full discussion with the person concerned and the carer or advocate. Part of the aim at this stage is to consider carefully whether there are risks and how these can best be managed or minimised. The intention is not to eliminate all risk and there should be recognition of the individual’s right to take risks, in the same way as everyone assesses and takes risk in their own lives. The support plan has to state how it will meet Government-specified outcomes in keeping the individual healthy and safe and contributing to their wellbeing. It has to be signed off by the local authority.

5. Once the plan is agreed it can be actioned along the lines of the following options:
   — the entire budget may be taken as a direct payment;
   — where people require a balance of arranged service provision and self-selected facilities, part of the budget will be taken in a direct payment and part managed by the local authority or someone else on behalf of the individual (where PBs are managed by the local authority they are likely to be referred to as ‘virtual’ PBs);
   — there may be a system of individual support funds (ISFs) where the individual determines the care plan but then commissions the services and gives the provider the responsibility for holding and managing the money.

Increasingly, a range of brokers from a variety of sources, often voluntary or user-led organisations, will help guide people and their families through available options. Advocates, friends or family members are likely to be involved in helping to get the necessary arrangements in place. Care managers (both working for the council and working independently) may adopt much more of a traditional social work role in assisting and supporting people to make their own decisions and carry them through.
6. Individuals are expected to change and adapt their own support plans as their needs change and/or as they learn what works best for them.

The Government has clearly stated that it is not the intention to impose one approach to implementing a personalised system. The process above has been worked out based on In Control and the IB pilots, but no doubt other ways forward will emerge as more authorities start planning their own approach.

**Will this happen everywhere, and how quickly?**

Some authorities are already embracing these proposals and are likely to move quickly towards getting the necessary changes in place. Others are not easily persuaded and more wary about moving in this direction. Some of these have indicated their concern about too rapid adoption of change before even the formal evaluation of IB pilots has emerged. Nevertheless, the programme set out in *Putting People First* requires councils to have made significant progress towards transforming their adult social care systems by March 2011 and the Government is supporting this with a grant of £152m to local councils: the social care reform grant.

A very interesting and helpful paper published by Demos, a think-tank which focuses on issues of democracy, discusses some of the potential barriers to personalisation becoming the normal and conventional way in which individuals access the support and services they need. The paper suggests that:

- Scaling up innovative ways of doing things from the pilot stage to universal adoption can be very difficult, either because the Government turns a promising approach into a policy requirement too rapidly, or because there is not a strong enough incentive or capacity for those not involved in the first innovative development to take them up. Leadbeater *et al.* point to problems in scaling up direct payments (less than 5 per cent of those eligible for such payments actually receive them) and other innovative programmes.

- The supply of more flexible, personalised services may not materialise and little is yet known about the extent to which providers will cope with the necessary transition, but Leadbeater *et al.* also comment that this was not the experience in areas where IBs have been piloted and that people did not have difficulty in finding services which met their needs.

- There may be large workforce turbulence for local authorities as the shift from social work to care management grinds to a halt and goes into reverse. In acknowledging that some professionals may welcome a return to the traditional social work role, Leadbeater *et al.* also recognise that a reduced workforce at this level will be needed and care managers particularly are likely to feel threatened.
On the other hand, Melanie Henwood talks about the ‘express train of personalisation, which is rapidly building a head of steam and powerful momentum’ and says that ‘personalisation is developing its own unstoppable force’. She points out that *Putting People First* and the follow-up local authority circular both make it clear that personalisation is not an option, it is the way forward and will become the ‘standard operating system’ for social care.

Whatever the reality of these concerns and hopes, what is absolutely clear is the extent of change which will be required. There is always a danger that politicians and senior managers at the local level, who perhaps are not fully persuaded of the benefits of moving to the new ways of working, will go through the gestures and make some of the changes without understanding the need for extensive preparation, communication, training and involving partners and stakeholders across all sectors. The challenge to professionals too of losing their power to control services should not be underrated. This need for a fundamental culture change is perhaps the greatest challenge to achieving personalisation over the next five to ten years.

**What will this mean for services?**

Essentially, the consequences of this massive change — nothing short of a revolution — in the way in which people are helped and supported, mean that, to a much greater extent, individuals will be designing and commissioning their own services, rather than being supplied with something commissioned by the local or health authority. In particular, the extent to which large-scale block contracts are used as the basis of service commissioning is likely to reduce markedly over the next few years. It has been recognised for some time that the provision of services through block contracts erodes choice for service users although large-scale contracts, of course, have been championed by Gershon in the drive for cost-efficiency. Where contracts are commissioned they will be outcomes-based.

Having said that, it is likely that conventional services commissioned by adult social care (and by children’s services or primary care trusts) will continue to be needed, but these will be provided less frequently or purchased on behalf of service users by local authorities and more often be purchased directly by service users themselves. Commissioners will be more focused on the needs of the whole population, including those who will be purchasing on their own behalf, rather than just the needs of service users for whom the council is providing or purchasing services. An authority with large rural areas, for example, might well have concerns that particular skills, such as dementia care, might not be available to its more far-flung population if this was left entirely to the market. Commissioning a homecare service with specifically trained workers might be one way of making sure that the authority fulfils its obligation to ensure availability of resources, while calling off some...
of those resources for people with dementia who have not opted, or who are not suitable, to deal with their own budget (even with help).

In addition, service users are likely to use their budgets to purchase assistance or support from a much wider range of sources and much of this will not be in the current form of homecare. Experience from both In Control and some of the IB pilots shows that service users can be quite innovative, choosing to solve their problems in perfectly sensible ways, but not ways which fit into existing service models. As an example, one older woman, a wheelchair user, now chooses to spend her respite funding at a hotel with facilities for those with disabilities in Tenerife, taking her personal assistant (PA) with her. She returns enthusiastic and confident, her elderly husband (her carer) has had a good rest, and the cost has been less than for the nursing home which she dreaded.

Unlike the FACS eligibility system, although eligibility will still be a requirement for PB provision, personalisation will not restrict service providers to a specific set of tasks. The general idea is that the only restriction on the way in which a PB is spent is that it must be used for services (or other resources) which are legal, which contribute to meeting the outcomes or goals of the person’s support plan, and which help to keep them safe. As people get used to this freedom, the demands and expectations of homecare services may well change. For example, there may be more emphasis on the need for help with domestic tasks, gardening and other assistance such as taking people out, the lack of these things at present being a main source of complaint. These types of task are also those which meet the prevention and social inclusion agendas which may be said to have been compromised by the emphasis on those currently most in need.

HOW WILL THE HOMECARE SECTOR RESPOND?

Providers of homecare generally welcome the change. They can see the benefits of these proposals to service users. Being able to choose how and when they are supported and by whom, and having the power (money) to control the way in which this happens, is a situation which most people would almost certainly want for themselves.

Service users who have experienced PBs are extremely positive about the change. Evidence from IB pilots and other self-directed care schemes shows greater satisfaction and improved outcomes, giving many examples of the way in which having control of the budget has revolutionised the life of the individual, and also their carers.10

Among the Government’s objectives in devolving budgets to individuals is to promote innovation and ensure service providers offer services which are more attractive to users. Another is to create more competition between providers in the expectation that the highest-quality services will thrive while those of dubious quality will go to the wall. There is no doubt that the shift from

People may choose unconventional resources and help with more varied tasks

A general welcome for homecare
trying to please relatively small numbers of local authorities to
trying to attract and please large numbers of ordinary people will
open up opportunities to homecare providers, but there is also no
doubt (and little or no recognition as policy colleagues rush to roll
out the change) that there are also major threats to the homecare
industry — good and poor providers alike. The remainder of this
paper will set out the threats and the opportunities for homecare,
as the author sees them, and consider how providers may respond.

THREATS FOR HOMECARE SERVICES

An increase in the private market but decrease in local
authority purchasing?

In theory at least, growth in the private market for homecare should
benefit providers — it has even been referred to as a potential
‘bonanza’ for the industry. There are some important caveats
however, the chief one being that there is widescale evidence that the
direct payments which, as we have seen from above on the actioning
of individual plans, will constitute the basis of new purchasing
power are likely to be paid at a level which is insufficient to enable
individuals in receipt of PBs to purchase from organised homecare
providers. Agencies may also lose existing private clients who
choose to organise their own care service.

The system within which homecare providers have been working,
to an increasingly greater extent over the last few years, has forced
most of the industry into a somewhat rigid and unresponsive
straitjacket in which local authority purchasers determine precisely
the tasks which must be done and set (often unrealistic) time
allowances for completing them. While satisfaction surveys are
generally positive, not surprisingly there are complaints about
unresponsiveness and the impression of being rushed. Service users do
not necessarily ascribe these problems to commissioning and tend to
view agencies as prescriptive and inflexible. The experience of both IB
pilots and direct payments is that people relying on these funding
sources tend to want the greater freedom associated with recruiting
their own care staff/PAs. Nevertheless, there is also evidence that
many of the older people who are already receiving homecare are
taking up direct payments specifically so that they can retain a
relationship with a provider who no longer holds a contract or who is
no longer a ‘preferred provider’. Also, recent research suggests that
gradually a larger proportion of people using direct payments may
opt to use agencies rather than trying to recruit their own PAs.

Alongside these factors, which suggest that there may be little
benefit to formal homecare organisations from the change to self-
directed care, there are likely to be fewer block contracts and an
overall reduction in local authority purchasing. The speed of these
changes and the resources devoted to enabling providers to respond
to them will be vital determinants of the success or otherwise of the
policy.
Financial viability at risk?
On the face of it, the future for properly organised and regulated homecare providers does not look good, particularly for those agencies which have focused their business largely on public sector contract work. The danger, perhaps one of the unintended consequences of the Government’s proposals, is that large sections of organised, properly regulated homecare will disappear. The industry, as is well known, is highly fragmented with many very small providers. While small providers tend to be less dependent on local authority contracts and more in tune with the private market, they may well lose spot purchase work (ie contracts from local authorities to supply a service to an individual, with no built-in timescale or guaranteed volume).

Homecare is bought and sold on the basis of ‘contact time’, ie the time the care worker is actually with the service user. The income from this has to cover all other overheads involved in running the business, including the costs of management and administration and, increasingly, the costs of the various checks required for workers, CRB and, in the near future, ISA checks and GSCC registration. The main expense, rightly, is staff wages which, with add-ons, will absorb more than 60 per cent of the hourly rate and providers also increasingly find that they need to pay for non-contact time when the worker is in training, requires supervision etc. Prices have been kept low, considerably less than the cost of in-house homecare, and margins are very tight, dictating the need for high volume. Even small organisations need ‘critical mass’ if they are to remain financially viable. Medium-sized and large organisations will be even more at risk. It is generally agreed that there will continue to be a need for properly organised services with trained and vetted workers. Some 78 per cent of all homecare is currently provided by such organisations. The real question is whether or not this resource will still be there when it is needed.

Fewer block contracts — Does it matter?
The commercial opportunity arising from councils’ new responsibilities in the early 1990s to both provide and purchase social care services has always been something of a double-edged sword. With a carrot-shaped contract dangling in front of them, providers from both private and voluntary sectors have willingly accepted contracts which unfairly apportioned risk, often demanded the unreasonable and increasingly forced them into agreeing specifications which have eroded the standard of care they could offer. The attraction of a contract, or perhaps the fear of no contract (and no work) has enabled councils to hold down prices to a level which now seriously risks compromising the quality and viability of services.

Nevertheless, the prospect of a big reduction in the availability of large-scale contracts, because they do not fit with the intention to pass choice and control to the service user, is a major concern to
Consequences of fewer contracts

many providers. Clearly, the loss of a large contract can mean a big reduction in volume (and income), all in one go. For example, a big organisation that has been largely dependent on local authority purchasing may be losing contracts across the board within a relatively short period, meaning a rapid reduction in guaranteed volume.

Losing contracts is not just about losing volume, it is also about losing value, which is important when planning an eventual sale of the business, or it can mean the loss of confidence in the business and thus share value if shares are publicly quoted. This is the reality, and yet ascribing value on the basis of homecare contracts flies in the face of experience and knowledge given the way that contracts can so easily be lost on a whim rather than through any fault of the provider — for example, the authority concerned decides to reduce the number of providers it does business with, decides not to continue with a particular service, or perhaps the provider has indicated charges that are slightly higher than the competition, and so on.

Contracts, of course, are not going to disappear just like that. The length (term) of contracts may well determine the speed at which a local authority can move towards self-directed social care, perhaps putting those organisations which hold longer-term contracts in a good negotiating position. Contracts currently coming up for tender are already increasingly focusing on achieving outcomes for service users and often require some flexibility around volume.

In a situation where providers are dealing with a large number of self-funders, rather than with a smaller number of public sector purchasers, some providers have expressed concerns about increased costs of administration, particularly additional invoicing and credit control. Drawing from analysis prepared for an earlier paper, this paper suggests that there may be some play-offs to compensate for any additional costs, as shown in Table 1.

Another way of looking at the fact that fewer contracts may be available is to recall the many service providers who have experienced the problem of being tied into a contract at a price which, as time goes by, does not enable them to attract staff. Consequently, they are unable to accept referrals and have to watch competitors, who are able to reflect increasing labour costs as they are charging ‘spot’ rates, accepting the work at a far higher price than the contracted supplier is able to charge. So contracts are not always all that they are cracked up to be.

Concerns about credit control, of course, are not just about increased administration — a much greater worry is that of potential non-payment. Agencies interviewed by the York SPRU research team had sometimes experienced great difficulty in getting payment from people funded through direct payments or Independent Living Funds (ILF).
problem where the money was managed by someone other than the service user. There could also be delays and problems in getting payment after the death of a service user.\textsuperscript{16} Providers will need to establish systems to protect their organisations from non-payment.

**Capacity — The critical question**

Social care capacity should be a major concern,\textsuperscript{17} yet there have been a number of important reports over recent years which, although they have correctly identified the demographic trends and shifts leading to significant increases in demand, have made little or no comment about the ability to meet the need in terms of people resources.\textsuperscript{18,19}

The point about continuing financial viability has already been made. When agencies close there is no guarantee that staff will move to other providers. They may well move out of social care altogether, reducing capacity overall. Even when provider organisations survive, some of the planned changes are likely to make staff retention more difficult.

One of the benefits of public sector contracts is that they can make it possible for providers to guarantee at least some of their front-line staff’s work. With the potential for these guarantees gone or reduced there is the likelihood of more instability in the labour market and an increase in the churn of workers between employers as they seek to make a portfolio of work to meet their needs.

Not only will there be less financial security in terms of guaranteed income — one of the main requirements of most people from their work — but there is also likely to be less work on offer overall, and possibly more fluctuation. Providers have reported elsewhere the tendency for staff to leave if their work schedule is

---

**Table 1**: Some of the increased costs which may be incurred when providing homecare through a public sector purchaser

<table>
<thead>
<tr>
<th>Local authority purchaser</th>
<th>Self-funded purchaser</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often has to account for large numbers of very short visits</td>
<td>Rarely required to make very short visits, often provides longer blocks of time</td>
</tr>
<tr>
<td>Invoice format and back-up data may be quite complex — IT systems may have to be re-programmed and each authority may require different data and different formats</td>
<td>Receives a standard company invoice</td>
</tr>
<tr>
<td>May be required to collect charges, involving complex stamp systems or other means of recording and accounting for contributions</td>
<td>Never a requirement with individual customers</td>
</tr>
<tr>
<td>Can be left funding huge wage costs for long periods due to delays in paying, perhaps as a result of one or two small queries or errors on an invoice</td>
<td>A delay or query on an invoice only involves funding the cost of care for that person until it is sorted out, not the whole caseload (but see below)</td>
</tr>
<tr>
<td>Cost of tendering is not insignificant and can absorb large amounts of management time</td>
<td>No tendering costs for self-funders, although there may be marketing costs</td>
</tr>
<tr>
<td>The nature of contracts varies, but it is not unusual for a provider to be required to accept referrals, even when this involves short visits to users long distances from each other at times laid down by the purchaser</td>
<td>Providers are able to negotiate with customers to provide the service at times which enable staff to be used in the most cost-effective way</td>
</tr>
</tbody>
</table>

---
Workforce availability will be affected

unavoidably and unexpectedly reduced due to death or hospital admission and the agency is not rapidly able to provide alternative clients. Those leaving may well be lost to the industry.

Another concern is the importance to careworkers from all sectors to see opportunities for development and learning, and a career path. Commissioners will have to consider the availability of specialised care for groups such as people with dementia, sick or disabled children, people with mental ill health etc and, in order to ensure that these resources are available, authorities may well commission such services. The supply of specialised services has frequently been retained for in-house provision, however, and this is usually justified on the grounds of the additional cost of in-house homecare and its (supposedly) superior quality. The Commission for Social Care Inspection (CSCI) ratings throw some doubt on the latter argument; however, the cost argument certainly stands. Although people will be able to use PBs to purchase in-house services, the cost, if not heavily subsidised, is likely to rule out that choice. It is very likely therefore that, if in-house teams are to be retained at all, they will primarily have responsibility for specialised services, leaving independent providers even less able to provide any kind of career path for their staff.

One of the consequences of moving to self-directed care, and especially the possibility of a rapid increase in the number of people receiving direct payments, since these will be the format in which people will have purchasing power under a personalisation system, is the risk to formal domiciliary care suppliers of losing their staff to self-funders. There is already much anecdotal evidence that this is happening. What providers say is that the rates received in the form of direct payments by service users who have previously been their clients are usually not enough to enable them to continue to purchase the agency’s service or, alternatively, that if they can obtain the services of the care worker they already know at a lower-than-agency rate, they will be able to buy more for their money. The service user employing the care worker directly, rather than through an agency, can then offer the care worker a little more than the agency is able to pay as there are none of the agency’s overheads. But do the facts bear out this assertion?

Decisions about the rates set for direct payments are made by each local authority. The rate should equal the authority’s estimate of a reasonable cost of lawfully securing the provision required, to fulfil the needs for which the direct payment service relates. Complexity revolves around:

- different user groups;
- regional and country variations;
- times/days service needed — day, evening, weekend, bank holiday etc;
- night care usually provided per night, rather than hourly;
- whether or not tax and national insurance are included;
may include flexibility related to need or to location, eg in rural areas;
additional ad hoc payments may be made which would cover;
start-up costs, contingencies or such things as employer’s liability insurance.

Bearing all this potential variation in mind, the research results are shown in Table 2. The majority of local authorities in England and Northern Ireland, and all authorities in Scotland and Wales, stated that their direct payment rates were lower than the average costs of preferred independent sector providers of homecare, confirming the point made above. The research suggests that the level of pay service users on direct payments can offer to independently employed PAs is inversely related to the intensity of their care package (ie lower for more hours per week) and they come up with an average weighted package size per service user for different service user groups. In England they suggest that this means possible pay levels as shown in Table 3. These figures need to be taken with a pinch of salt as the average package size was based on data from one authority, and because there may well be marked variations in the rates of direct payments for all the reasons given above, but especially between regions and between north and south. Nevertheless, this certainly suggests that service users funded by direct payments may well be able to offer staff better rates than most agencies are currently able to offer. In addition these calculations are based on the service user employing a single PA (care worker), whereas most service users will prefer to employ a minimum of two staff on some sort of rota system in order to reduce the risks of unexpected non-availability and to ensure adequate cover during holiday periods etc. This may well mean that one or both employees do not work sufficient hours

| Table 2: Core payment rates for direct payments across each of the UK countries23 |
|---------------------------------|----------------|----------------|----------------|
| Country                        | Day    | Evening | Weekend | Bank holiday |
| England                        | 8.87   | 9.06    | 9.43    | 10.46        |
| Northern Ireland*             | 7.82   | 7.82    | 7.82    | 9.10         |
| Scotland**                     | 9.70   | 9.70    | 9.99    | 13.49        |
| Wales***                       | 6.74   | 6.69    | 7.89    | 7.81         |

* Northern Ireland Health & Social Services Trusts  
** Scottish council areas  
*** Welsh unitary authorities

<table>
<thead>
<tr>
<th>Table 3: Potential rates of pay based on average weighted package size per service group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user group</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Older people</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Learning disability</td>
</tr>
<tr>
<td>Physical disability</td>
</tr>
<tr>
<td>Disabled children</td>
</tr>
</tbody>
</table>
to trigger the requirement for tax and NI contributions, thus releasing a larger proportion of the funding which can potentially be used to bolster pay.

Although direct payment rates appear to reduce the choice for service users if they cannot choose to use a formal regulated agency, some local authorities were said to provide direct payments at special ‘agency’ rates. It may well be worth pursuing this as an example of good practice. In the meantime it is extremely disheartening for providers, who are trying to reach targets of 50 per cent of their work done by people with at least NVQ2 by this year, to find that they are losing staff, and often their best staff, to independent purchasers in the same way as they now see them moving into the statutory or voluntary sectors where pay and corresponding unit costs are often higher. This is not only very worrying for providers, but it also raises serious concerns about capacity as the objective for the industry, working with local authority partners, has been to build up a reliable and competent workforce to meet current and future needs. To this end, providers have invested heavily in training, have worked hard to meet the standards for registration and regulation, have complied with EU and UK legislation which have added to the costs of their services, and have had to fund CRB checks, POVA checks which will soon be taken over by ISA checks (at even greater cost) and, in the near future, will also find themselves funding GSCC registration for care staff. All of this has been in a worsening climate for recruitment and with turnover rates at an all-time high of around 27 per cent. To many people, not only homecare providers, it would seem as if the Government is sanctioning a parallel workforce — one highly regulated, trained and risk-proofed, the other none of those things.

Of course, staff who move over from an agency or other care service to work with an individual service user will have received induction and probably at least started on NVQ2. They may well have attended other training courses, but there is nothing which requires self-directed employers to provide training for their staff, nor to carry out any security checks. Indeed, there is some evidence that individual employers tend to be unenthusiastic about training, while some spokespersons for the disability lobby have argued strenuously for their right to employ anyone they choose, even those with criminal records. Skills for Care reports that although 28 per cent of a sample of individuals employing PAs via direct payments were concerned about the quality of people applying for PA positions, in a third of cases where the applicant was not known previously to the employer no checks were made. In only about half the cases was the employer aware of whether any previous employment references had been sought. Notwithstanding this worrying evidence, the experience of people when using direct payments was rather better than that of people when receiving services via local authorities, with ten per cent of the former,
compared with 18 per cent of the latter, having experienced any kind of abuse, although it has to be said that the period on direct payments was relatively short in comparison with the time being helped by local authorities. While the evidence at present indicates the majority of PAs have had previous social care experience, increasingly PBs are going to be on offer for new referrals who will not have existing contacts with formal homecare providers, and will be more likely to seek to recruit from among neighbours or friends. A current consultation from the GSCC is debating whether to introduce a requirement for GSCC registration for all independent PAs. This might give a degree of protection to the more vulnerable service users, but one of the Government’s objectives may well be to attract people into social care who would never have thought about it were it not for a request from a neighbour, friend or relative, and a requirement to go through GSCC registration might well put off this important resource, which would also be very counterproductive from the service user’s point of view.

OPPORTUNITIES FOR HOMECARE PROVIDERS

Despite the gloom of the previous section, there are exciting opportunities from the personalisation agenda for homecare providers, although they do not necessarily come without the requirement for major change. This paper will now consider how providers can make the most of their existing service, and what the potential benefits are, and then make some suggestions about the potential for new aligned services.

Making the most of the existing service

The point has already been made that there will continue to be a need for conventional services, and some of these will be in the form of block (as opposed to spot) purchases, even though the emphasis is more likely to be on making a whole range of options available for individual purchasers. It would also appear that older people tend to behave somewhat differently from other user groups in that those who have opted for PBs or direct payments are often said to have done so in order to retain a relationship with an existing provider who no longer holds the contract, or is no longer a preferred provider. In addition, reports indicate that older people with PBs are more likely to choose conventional services and they very often have a particular person in mind or purchase from independent providers. (That they are able to do this must mean that the average figures given for core payment rates for direct payments (shown in Table 2) hide a great deal of fluctuation, that people are topping up their funding from their own resources, or that they are buying less time, spreading their funding over fewer hours than intended.)

Recruiting a PA may not be a realistic option for older people because they have tended to have relatively small packages based almost entirely on the need to carry out critical personal care tasks.
Providers must change

at intervals during the day and evening, rather than any ‘quality of life’ input — unless the RAS is applied fairly, which may happen as a result of the new equality legislation. A number of short visits each day is unlikely to be sufficiently attractive to a would-be PA unless this can be combined with other work. Older people form the majority of service users for most providers.

In addition to the likely ongoing services for older people, private purchasing can be expected to grow. The combination of tightening eligibility criteria and higher charges imposed by authorities for social care services is leading to increasing numbers of private purchasers. This trend is likely to be even stronger as the demographics increase demand and changing family patterns lead to larger numbers of people living alone, with fewer family supports nearby.

For providers whose work is already wholly or partly among private clients and older people, especially small organisations where there has been no reliance on multiple purchases via contracts, the personalisation agenda is unlikely to feel threatening. Indeed, in many ways, it is a return to the pre-1993 position. Providers, often the larger organisations, which have depended mainly on local authority contracts, however, will be at risk. All shapes and sizes of organisation will need to change the way in which they do things and, perhaps, change what they do, if they are to survive and thrive. But as well as that impetus for change, there are some real potential benefits to providers if they are willing to work with the system.

Improved quality and better relationships with service users

The council, because of its power to give, refuse, or even take away work and reputations, has become the legendary ‘third person in the marriage’ between service users and providers. For many providers, there is likely to be some ambivalence about who or what is their customer. Is it social services — which makes the decision to purchase the service, determines the price to be paid, specifies the nature of the service including the tasks to be done and the time available to do them and other details about its delivery, monitors (to the extent that it is often involved in day-to-day issues) and pays for the service — or is it the service user? Of course providers understand the council’s responsibility in relation to all these activities but there will be important beneficial effects to both users and providers from having a more direct relationship.

This is about people deciding what their own priorities are and organising their support accordingly. Where people have PBs, times will not be rigidly imposed, enabling providers to negotiate directly with the user what will be the best use of service time and to offer in accordance with the organisation’s current availability. This should improve continuity and reduce some of the volatility and stress which currently characterises homecare provision. In addition, where the user requests a change of time or visit for some temporary reason, provider and user can make the arrangements

Improved relationships between service providers and those who use services
between them without having to go back to a care manager for permission.

Tasks also will be subject to the choice of the user, rather than being imposed. Homecare organisations were always intended to deliver what it says on the tin — care at home — but the full range of assistance needed to ensure wellbeing and quality of life (as well as having a preventative function) has gradually been whittled away. The current concentration almost entirely on personal care results from requiring councils to increase intensity of provision to those in greatest need and, at the same time, failing to ensure adequate resources, so that cutting back on the length of visits and dealing with just critical care needs, was an easy solution. When eligibility criteria no longer dictate the tasks that can be done, service users are highly likely to ask for a wider range of help, including housework and being taken out — the two things which users (particularly older people) complain about. Of course, whether it is possible to fit these other activities into a tight timescale is questionable, but at least if the individual can gradually regain confidence to take over some of the personal tasks, homecare may be able to respond to these requests.

Even where services are still commissioned and purchased by the council, the fact that they will need to be outcomes, rather than output, based will mean a much closer relationship between service users and providers. Increasing satisfaction levels when services become outcomes-oriented is already known. Along with provider autonomy which allows them to work out with the service user how best to achieve their priorities (desired outcomes) and to be more responsive and flexible, service users gain in confidence and self-worth as a result of feeling in control, rather than just being on the receiving end. Key to all this is the need for services to be person-centred. This means that care staff particularly will need to think about the whole person rather than just a series of tasks to be done. Getting to know the individual and something of their history, family and friends, work and leisure interests will all help in building a relationship of confidence and trust in which constructive support will flourish.

The gain from all this is certainly not just for the service user, although it is the gain for the service user which makes it exciting and stimulating for providers. Care workers particularly adapt easily to this way of working and the evidence is of improved retention, which is a real plus given the concerns about capacity highlighted in the previous section.

**Presentation is everything**

There are two questions here:

- ‘What are local authorities going to be looking for in providers in the new social care world as it is in the process of transforming itself?’
An Attracting public sector work

Attracting individual customers

- ‘How can homecare organisations best present themselves to individual purchasers, however they are funded?’

The problem in identifying what is going to make a homecare organisation attractive to local authorities or health authorities in the new era, as has already been said above, is that they are all proceeding at different paces, some reluctantly, others enthusiastically, and they will not all interpret or implement the changes in the same way. Nevertheless, they are likely to be looking for organisations which may help them in achieving their own goals and in meeting their responsibilities. Councils are going to have to go through an enormous culture change themselves. They are more likely to welcome providers who are well versed in the proposals and intended processes and who are willing and able to adapt and change their services. Providers who understand the basic concepts of outcomes working and have some experience of working in this way will be in a better position than those who do not. Being able to provide evidence of the results (outcomes) of their service will also be a strong suit.

It is also possible that, along with authorities’ hopes that independent homecare providers will adapt and provide a wider range of services, they will have some unrealistic expectations. For example, it has been suggested that they may envisage providers being able to undertake rapid response — without a contract to do so — or being able to provide immediate cover. Of course, some organisations may launch such services but capacity and take-up will be big determinants of success, and costs inevitably would be high.

Effecting the change from being an organisation which has primarily sought local or health authority contracted work, to attracting individual customers, regardless of how their funding is obtained, will be challenging. Everyone in the organisation currently will be geared up to meeting the requirements of the authority, rather than the very different approach required for individuals. This is going to need a complete culture change throughout the organisation. Table 4 represents an attempt to help organisations to start thinking through what might be the unique selling points (USPs) they may need to aim at, compared with those for public sector purchasers.

Instead of starting by telling potential service users what they can offer, providers will need to start by finding out, through a real discussion with that person (and where appropriate with a family member or friend, or perhaps an advocate) what they want and what they hope and expect to achieve as a result of the service. The emphasis needs to be on getting a clear idea of how the individual wants to live their own life, and what are their priorities. The manager (or whoever has made the initial visit) then needs either to give the assurance that the organisation can provide what the potential service user wants or that they will do their best to sort
out a way of meeting the person’s requirements. Presenting the organisation as one which is responsive and supportive to individuals who are making choices and decisions for themselves will need to be imaginative, possibly offering a range of add-ons, or additional services (see below) as well as broadening the range of tasks.

The potential for new services

The potential to develop new services is perhaps one of the most exciting aspects of the planned changes, and certainly it promises to be the most innovative. There is a huge range of possibilities, depending on where providers see the need and what might suit their particular organisation. The local authority may be starting to find out from users what they want, or providers may know from their existing service users the sort of additional services which would make their lives easier and which they would currently have difficulty in finding. Because there is not a lot of published information yet available on this topic, the suggestions here must be regarded as tentative, but it is hoped they will at least provide some ideas and provoke some thought.

There are various ways in which homecare organisations could assist people with PBs and people more generally with support needs who wish to purchase on their own account. In most areas there are already organisations, mostly voluntary sector and often user-led, which assist and advise people with direct payments. There is nothing to stop agencies from setting up something similar although they will need to be aware of potential conflicts of interests; however, there are particular aspects of this sort of service which could usefully be duplicated if for no other reason than because homecare providers have appropriate expertise.

Support for people who are choosing to go it alone

Table 4: USPs for public sector and individual purchasers (in order of importance)

<table>
<thead>
<tr>
<th>USPs for public sector purchasers</th>
<th>USPs for individual purchasers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size: well-run organisation, well-resourced and adequate management structure</td>
<td>Rapid response to first contact, usually a home visit</td>
</tr>
<tr>
<td>Professional tender documentation</td>
<td>Sympathetic and understanding discussion of wants and needs</td>
</tr>
<tr>
<td>Knowledgeable about personalisation process etc</td>
<td>Understanding needs and wishes of carer, as well as service user</td>
</tr>
<tr>
<td>Understands outcomes concepts. Has experience of outcomes working. Able to provide evidence of outcomes achieved by their service</td>
<td>Assurance that they can help (if they can) and ability to ‘think out of the box’ about how they might help</td>
</tr>
<tr>
<td>Specialty service</td>
<td>Information about their service and price</td>
</tr>
<tr>
<td>Willingness to offer wider range of services</td>
<td>Careful selection of competent and sensitive care worker and continuity of care</td>
</tr>
<tr>
<td>Evidence of financial stability</td>
<td>Reliability</td>
</tr>
<tr>
<td>Ability to provide monitoring data to demand</td>
<td>Continued accessibility of manager</td>
</tr>
<tr>
<td>Ability to accept referrals (often rapidly)</td>
<td>Willingness to undertake a variety of tasks, as requested</td>
</tr>
<tr>
<td>Reliability and continuity</td>
<td>Able to advise who else might be able to help, ie good local knowledge</td>
</tr>
</tbody>
</table>
example, offering training for PAs, offering to take over some of the employer responsibilities such as paying and dealing with tax and National Insurance, or providing a back-up service to people who normally employ their own PA. Homecare providers could also set up specific services:

- Authorities will probably be worried that specific services, such as for people with dementia, children, palliative care and so on, may not be available for people who are trying to purchase their own support. Providers who are already offering a specialised service, or who take the decision to develop one, may do well.

- Organisations which are already providing some aspects of healthcare — for example, home nursing or nursing homes — may well make decisions to focus their efforts more on developing the health component. Generic teams, offering a combination of both health-related and social care may well have a bigger role in future, and tying this in with telecare support and/or with call centre and rapid response facilities could be an option for large organisations, perhaps operating over regions or even nationally.

- Homecare organisations of any size already have a register of care workers, all of whom have been security checked and have completed induction training. It may be possible to offer them as much work as they want, but that is often not the case and there is likely to be a risk of losing them anyway if they are offered better pay by people with PBs. This suggestion offers a way of providing a service, keeping some control/contact with the organisation’s staff, and an opportunity to forge good relationships with independent purchasers, who may well ask for other types of support further down the line. It involves providing a register of care staff who would be willing to work independently for people who are trying to recruit PAs. The register would need to contain data such as qualifications, length of experience, any specialist training etc. Initial contact would be arranged by the organisation, for a fee, but thereafter all arrangements would be between the care worker and the customer, including decisions about rates of pay and other terms and conditions, although the organisation could include advice for both sides on contracts and provide examples. Care staff might see this as an opportunity for developing their own career and obtain additional training at their own cost. They would have an incentive to stay with the organisation as it could provide both direct work and further introductions. This is clearly not a money spinner, but registers of this sort are very likely to spring up anyway and, if homecare organisations are not doing it for them, their staff may well drift away to find other sources of work.

- Another variant on the above suggestion is to develop a domestic service as an adjunct to the existing homecare operation. Help with domestic tasks is probably the most frequently requested service, and the failure of homecare now to provide domestic
assistance is one of the main complaints of service users. It is also known that, among the IB pilots, people often choose to spend their budget partly on domestic help.

- One of the difficulties for homecare organisations is the fact that demand is very variable throughout the day, with big peaks in the mornings and evenings, and a lesser peak over lunchtime. This does not necessarily suit care staff and it is often very difficult to provide people with enough work if they cannot work at those times. By setting up a domestic service, run on the same lines as the PA register mentioned above, but with a set pay rate for staff, and charging an introductory fee only for service users, it would be possible to provide staff with sufficient work, at times which suited them and which fitted in with their scheduled homecare visits, while providing a much-needed source of domestic help at a reasonable cost and with staff who have been security checked.

- Small repairs and handyman jobs are another area which service users, particularly older people, find very difficult. A van kitted out with the necessary tools could provide part-time work for someone who had the right skills and was semi-retired. Equally, a gardening service might be very welcome. People who have previously been proud of their garden can become depressed when they can no longer look after it themselves, feeling that it is a sign to others that they are not coping. Homecare organisations would do well to think about how they could organise a gardening team, or alternatively could negotiate an agreement with an existing service so that individual purchasers had access to a reliable and security vetted service.

- As well as setting up or organising specific services, providers will need to consider how they can make their existing homecare service more flexible. This is likely to be more difficult for those organisations which have relied on public sector contracts for the bulk of their work because staff will be used to fulfilling pre-specified tasks, rather than using their own initiative. It will be important to gather information from both staff and service users about the sort of things which people may want as part of their homecare service and then to plan in training time so that the change in approach can be fully explained to care staff.

Preparation will need to include risk appraisal of proposed new activities. For example, taking people out in staff vehicles will require appropriate insurance. Spending time on social activities, say a pub lunch for a small group of lonely PB holders, must be seen as a means of achieving the outcomes of inclusion, participation in the local community and quality of life, rather than an activity which is ineligible under the FACS regime. Helping someone sort out their bills and correspondence must be recognised as being as important as providing some aspect of personal care. Achieving this sort of culture change within an organisation is not easy and it would be good practice to plan for a series of staff meetings over the initial six months of working in
this way in order to provide a forum where ideas can be shared, concerns raised and problems solved.

CONCLUSION
There are significant risks and threats for homecare providers from the Government’s plans for social care which have hitherto been little acknowledged; however, there are also considerable potential benefits for people who need support. The move is from a profession-dominated system in which people’s needs are assessed and they then have to choose from a very limited menu to a system where decisions about what?; who?; when? and how? literally will be handed over to individuals, who will have their own PB with which to buy the services they consider will best help them to achieve their own priorities and outcomes. There are also opportunities and benefits for homecare providers. Changing the emphasis away from strict adherence to predefined service specifications to judging success by the results achieved for the people who use it is one such opportunity, not least because it will ensure better relationships with service users and better staff retention. There are also exciting opportunities to develop new services and new ways of doing things. Providers will, however, have spent years trying to ensure that services are delivered to a rigid specification and thinking innovatively is not going to come easily. Homecare providers certainly need to help themselves. Understanding the agenda, taking it seriously and planning their own responses are going to be critical, both to survival and, potentially, to playing a key part in this new social care world.

But this cannot be one-way traffic. If the grand design system is to work, having the independent homecare providers on board is critical. They are currently responsible for supplying around 78 per cent of all publicly funded homecare and they employ some 274,000 care staff. Independent organisations are not going to be able to contribute in the ways described above without support themselves, yet none of the government’s transformation money is going to the independent sector. The evidence too is that, so far, learning events being offered centrally (and perhaps regionally) are primarily involving only or mainly voluntary (currently referred to as third sector) organisations, although the vast majority of provision comes from private sector providers. Neither do other relevant government departments, for example, the department of Business Enterprise and Regulatory Reform (BERR), appear to be stepping into a support role.

Anxiety, both from the centre and locally, that the necessary flexible services will not materialise, leaving people unable to purchase the type of help they are seeking has resulted in some emphasis on supporting very small organisations. The Department of Health, for example, is currently funding the Small Community Services Project which is working with a number of very small organisations (with five or fewer employees) in Kent and Oldham...
As well as helping itself, homecare needs support if it is to transform to test out different ways of offering them support, advice, information and training. A large number of domiciliary care organisations, however, while being small, are not as small as the micro providers which might get support from this organisation. Their management resources tend to be sparse and are necessarily focused on day-to-day priorities. Providing funding to support their change process is going to be critical if they are to continue to contribute to social care resources. None of the Government’s transformation money has gone to the independent sector, but as councils make their own plans for implementing the changes, they will need to include local providers. The difficulty of achieving the necessary culture change within organisations is already recognised as one of the key barriers to achieving these ambitious plans. Changing cultures needs to happen not only within organisations, but across departments, across sectors and across stakeholder groups and it is very much hoped that authorities will involve homecare organisations in the whole programme of change as they prepare to put people first.

© UK Home Care Association, 2008

References and notes


2. In Control, set up as a social enterprise, was developed in order to help people to take control of their own lives. Initially focusing on people with learning disabilities, it brought together individuals, their families, local authorities and a large range of other organisations, including the Department of Health, in a unique partnership. Now including everybody who wants to control their own support, it aims to play a key role in the new personalised system of social care. www.in-control.org.uk

3. Department of Health, ref. 1 above.


5. Ibid.


8. Ibid.


10. Leadbeater, C., et al (2008) ref. 4 above. Demos quote from an analysis of data from *In Control* projects which shows 77 per cent of people directing their own support saying that their quality of life had improved.

11. Davey, V., Fernández, J-L., Knapp, M., Vick, N., Jolly, D., Swift, P., Tobin, R., Kendall, J., Ferrie, J., Pearson, C., Mercer, G. and Priestley, M. (2007) *Direct Payments: A national Survey of Direct Payments Policy and Practice* Personal Social Services Research Unit (PSSRU), London School of Economics, found that direct payment rates tend to be pitched at below the ‘going rate’ (i.e. lower than the average costs of preferred independent sector providers of domiciliary care) in the majority of local authorities in England and Northern Ireland, and in all authorities in Scotland and Wales, it should be noted however that this research was not based on direct payments made in relation to individual or personal budgets and it is not yet known whether they will be regarded in any way differently when part of the personalisation system.


20. CSIP, ref. 17 above.

21. How does your local council measure up? (2008) UKHCA, reports that the average cost of in-house homecare provision in 2006 was £21.53 per hour, whilst the average per hour councils pay independent providers for homecare is £12.19 per hour.


23. Knapp, M. et al, ref. 11 above


25. The National Care Forum’s annual survey of 35 non-profit adult home care providers (37,249 care staff) showed turnover rising from 24.5 per cent to 29.5 percent with over half (54.2 per cent) of leavers quitting within one year. Community Care, 20th August, 2008, Corin Williams


27. Mickelborough, P. Domiciliary Care UK Market Report (for appropriate years) Laing & Buisson. These reports provide estimates of hours purchased privately each year and show, for example 32 million hours in 2003, 44 million hours in 2007 and 68 million hours in 2007. Hours purchased may not correlate with numbers of purchasers, particularly if there has been an increase in purchasing live-in care, nevertheless these figures probably do indicate the trend.


29. Commission for Social Care Inspection The State of Social Care in England 2006-07 (2008) shows the dominance of the private sector over both council and voluntary providers in terms of numbers of agencies. Although this is not necessarily correlated with the volume of state purchased homecare, it can be regarded as indicative of the position. See: http://www.csci.org.uk/about_us/publications/state_of_social_care_07.aspx

30. SCS News Issue 1 (Oct. 2007) contact sian@naaps.org.uk

31. As an indication, the update workforce survey of UKHCA members in 2004, with a response rate of just over 20 per cent showed that just under 50 per cent of responses were received from agencies which provided fewer than 500 hours of care per week. McClimont, B., Grove, K. Who Cares Now? (2004) UKHCA, Sutton, available at: http://www.ukhca.co.uk/pdfs/whocaresnow.pdf