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Where the heart is ... a review of the older people's home care market in England

October 2012



IPC Market Analysis Centre

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Introduction

With an expanding older population, changing health and social care needs and expectations, and a wide recognition that acute care services are not the best place to support older people, the question about what kind of home based care services are needed in future might be expected to be at the heart of public care debate. We hope that this report will encourage wider discussion about this question and ultimately a clearer view about what home care is for, and how it can be best delivered.

Currently, home care services are struggling. A wide range of different services are delivered or commissioned through health, housing or social care, and the catch-all title of home care includes many different activities, with different purposes and very different results. The evidence-base to show how effective home care can be is limited and inconclusive. A major employer across the country, home care is generally a low wage sector with low status and profile, and has been susceptible to further cost-cutting in recent years as a result of reduced local authority budgets due to the economic downturn.

It is a sector still characterised mainly by small private employers running small or medium sized businesses, but larger providers also see opportunities for responding to potentially increased demand as the population ages. Self-funders and personal budget holders are becoming increasingly important purchasers of care and some providers are developing new and very different ways of approaching this market.

This report offers a picture of the current home care market, some of the challenges it faces, and a model for its future development. It aims to provide a basis for dialogue between commissioners, consumers and providers about what home care services might look like in the future. It is written during the period of consultation on the proposals put forward by the Government in the 2012 Care and Support White Paper¹.

¹ Caring for our future: reforming care and support, HM Government Cmnd 8378, 2012

The report has been produced by the IPC Market Analysis Centre, part of the Institute of Public Care at Oxford Brookes University. IPC has been working for well run evidence-based public care for over 25 years. The report has been compiled using data from published sources, interviews with a number of leading home care organisations, recent IPC studies and projects on the home care market, published research reports and company annual reports.

Section 1: Where are we all now?

1 What is home care?

Figure 1 The spectrum of home care services



Home care is the generic term generally used to cover a range of care and support interventions delivered to a person in their own home. It can include support with domestic tasks, shopping, home maintenance, personal care, social activities, rehabilitation and recovery and support for people who are dying.

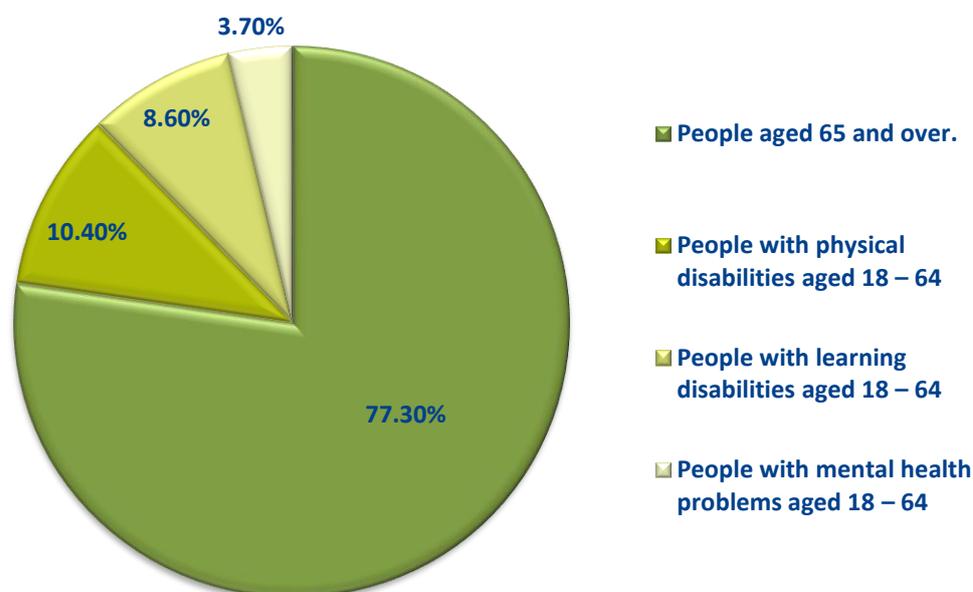
Its purpose and function varies greatly from place to place, service to service:

- It can be preventative, providing early intervention to avoid a deterioration in health and wellbeing.
- It can help maintain people who need some support within their homes to delay or prevent the need for residential care.
- It can be designed as a reablement service, helping people regain ability and capacity following illness or injury.
- It can be part of an intermediate care offer, targeted at facilitating hospital discharge or preventing hospital admission.
- It can offer palliative care at home to people during the last stage of their life.

Both providers and commissioners recognise that in recent years as policy has moved more towards supporting older people in the community, home care has come to cover an increasingly wide range of functions. This diversity, while generally welcomed, has sometimes made it difficult to differentiate between services, and means that the intended outcomes of particular interventions are not always clearly identified.

This report focuses on provision for older people, who form the majority of home care users, as Figure 2 shows. However, it is worth noting that home care is not just an old age service. Many of the providers considered in this report also provide care to other groups of people.

Figure 2 Population by age: % distribution of those receiving state funded home care 2010/11²



Despite the size of the market and the amounts of money that are invested by local authorities and their partners, this is a field somewhat poorly served by evidence-based evaluations of impact. This may reflect the wide scope of activities and interventions it covers, and the many purposes for which these services are secured and provided. For example, some commentators argue that traditional 'generic' home care lifestyle and maintenance support through shopping, washing, cleaning and dressing inevitably helps people to remain at home. Others suggest that this kind of support might actually encourage some people to become more dependent on external help, and lead to them needing intensive packages of support or care earlier than would otherwise have been the case. There is little evidence to prove either position, or to help identify the characteristics of particular individuals or services which will lead to these very different results.

² Referrals, Assessments and Packages of Care data England 2010-11, The Information Centre, 2011

There is more research available on the impact of some of the intensive home care services intended to reduce a person's long-term care needs, such as reablement and intermediate care. This is probably because these services have been developed in recent years, usually with a clear stated purpose such as to avoid or delay use of more acute services.

However, even for interventions which have been developed with such a clear purpose, there is not necessarily a consistent comparable model of intervention based on evidence of best practice across the country. For example, a recent study found variations in reablement service delivery, design, staff skills and mix, the needs profile of consumers and differing routes of referral³. Reablement, although growing as a home care subsector in fact covers a range of purposes from helping prevent hospital readmission within 6 – 8 weeks to a broader approach which has a simpler aim of maximising users' potential for achieving and maintaining independence.

Nevertheless, studies of preventative services concerned with intensive support for people with complex home care support needs, have been able to demonstrate their value. For example crisis response home care services have been assessed for effectiveness⁴ and found to have had impact in several areas:

- Reduction in ambulance call-outs.
- Reduction in A&E attendances.
- Reduction in unplanned hospital admissions.
- Reduction in the use of residential and nursing places, both short and long-term.
- Reduction in ongoing care packages in those services which have a reablement focus⁵.

Similarly, some well targeted home care interventions have been identified as having an effect on overall demand for other services and thereby a positive impact on cost and efficiency. For example the Audit Commission identified such practice⁶ in its review of the integration of health and social care work in Essex in 2011. In this case study, a whole systems approach to health and social care was used and local organisations focused on the consistent implementation of integrated intermediate care, reablement and crisis response services. These, with other changes, were assessed to

³ Glendinning, C., Jones, K., Et al., Home Care Reablement Services: Investigating the longer-term impacts (prospective longitudinal study), Social Policy Research Unit, York University, 2010

⁴ Care Services Efficiency, Delivery Guide to crisis response services Department of Health, 2011

⁵ Care Services Efficiency Delivery, Guide to crisis response services Department of Health, 2011

⁶ Joining up health and social care, improving value for money across the interface, Audit Commission, 2011

have contributed to approximately £30 million efficiency savings across health and social care in the county.

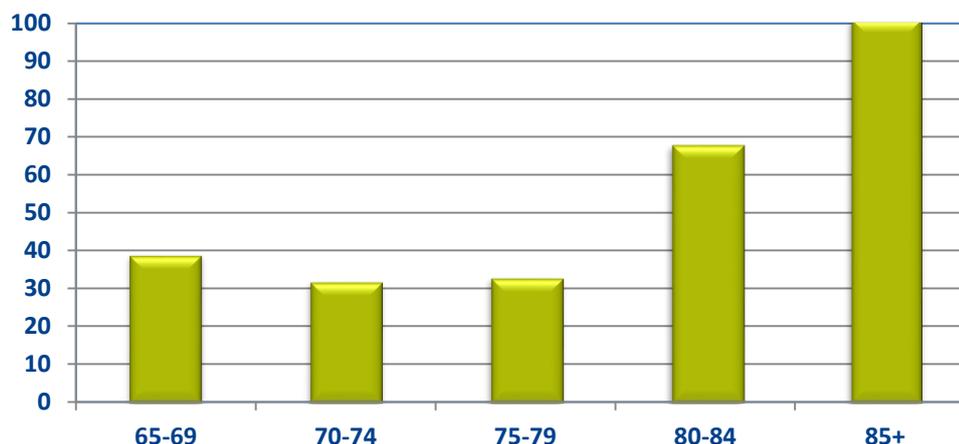
2 Who buys home care?

Over 6 million hours of regulated home care are delivered a week in England. Publicly funded home care, excluding direct payments, was estimated at 3.9 million hours a week in 2010/11.⁷ Laing and Buisson, using their own survey data and government statistics, estimate that in addition there were 2.5 million hours per week purchased privately and through direct payments in 2009⁸.

Consequently it is an activity that has a considerable economic value. A recent valuation of the total home care market was put at £5.5 billion. Gross annual public expenditure in England on home care in 2010/11 was estimated to be £2.2 billion⁹ which suggests that privately purchased care is equivalent to approximately £3.3 billion¹⁰.

Simply on the basis of population projections it is reasonable to assume that this market will continue to grow. For example in its final report in July 2011, The Commission on Funding of Care and Support, chaired by Andrew Dilnot, summarised the projected increase in older people in England between 2010 and 2030 as follows¹¹:

Figure 3 Projected increase in the number of older people in England 2010 – 2030, percentage change



⁷ Community Care Statistics 2010/11, Social Services Activity report England table 4.2, The Information Centre, 2012

⁸ Domiciliary Care in the UK Market Report 2011, Laing and Buisson, 2011

⁹ Personal Social Services: Expenditure and Unit Costs -England 2010-11, The Information Centre, 2011

¹⁰ Community Care Market News, Laing and Buisson, May 2012

¹¹ Commission on Funding of Care and Support, Fairer Care Funding, p17, 2011, Source: 2008-based population projections, Office for National Statistics

As well as living longer older people are also more affluent due to both housing equity and to the growth in occupational pensions. This in turn has an impact on potential future demand for home care in two ways. Affluence influences life expectancy and hence, all other things being equal, a greater pool of people with care needs and greater affluence means that more older people are likely to become funders of their own care.

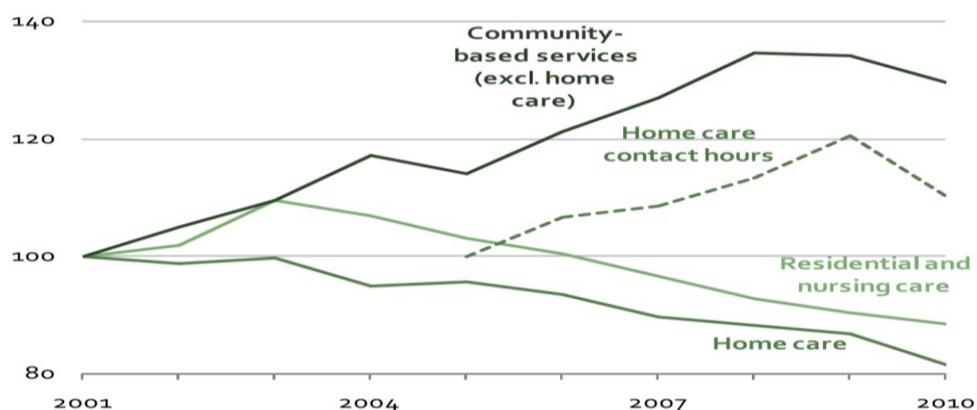
Table 1 Wealth of different age groups in England, 2007¹²

Age	Mean Income (taxpayers)	Total Capital	Average Capital
20 - 44	£26,700	£90.04bn	£30,136
45- 65	£38,900	£127.7bn	£96,086
Over 65	£22,600	£105.1bn	£120,209

2.1 State funded home care

During 2010/11 over 400,000 older people received a state funded home care service with an estimated quarter of a million receiving home care at any one time.¹³ Over recent years there has been a change in the intensity of home care provided to state funded consumers. This has seen a reduction in the total numbers of clients, and more recently a peak and decline in the total number of hours of care provided after a steady rise for the four previous years.

Figure 4 Number of service users, by general type of service received (index - 2001=100)¹⁴



¹² Extrapolated from <http://www.hmrc.gov.uk/stats>, Distribution of Income and Tax by Age and Gender 2008-09, and Identified Personal Wealth 2005-07, downloaded 2 March 2012

¹³ According to the NASCIS PSSEX Activity Data 2010/11, 437,150 older people received home care during the year 2010/11, with 244,080 being in receipt on 31 March 2011.

¹⁴ Reprinted from Fairer Care Funding: Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support, July 2011, Department of Health. Data relates to all home care not just older people

Whilst the numbers receiving home care and the total number of hours delivered may have fallen, there has been an increase in the average number of contact hours per service user between 2005/06 and 2010/11¹⁵.

Table 2 The increasing intensity of home care 2008/09 – 2010/11¹⁶

	Number of home care clients aged 65+ - whole year	Average number of contact hours per client per year	Intensity of care (% clients receiving 10 hours + care per week including live in/overnight care)
2008/09	472,870	344	33.8%
2009/10	452,610	n/a	36.0%
2010/11	437,150	369	37.6%

This increase in the levels of intensity is probably attributable to three main factors:

- A perception by local authorities that low levels of care tend primarily to provide support for domestic tasks are not critical to maintaining independence.
- Changes in FACS eligibility criteria. Local authorities increasingly only fund provision to those with high levels of need, eg, it was estimated in 2010 that around 72% of councils only offered homecare services to those with “substantial” or “critical” needs.¹⁷
- An increased use of intensive home care, alongside other services, to enable people to live independently at home for longer,¹⁸ and reduce the use of residential care.

So state funded home care, although reducing in volume is still clearly a significant market and one where it is likely to experience increased demand in the future. Indeed the level of reduction in state funding may also be somewhat illusory given other factors. For example:

- Some people are in receipt of home care services through reablement programmes or through intermediate care services which are short-term and not always counted as home care when LAs are completing national returns.

¹⁵ Community Care Statistics 2010/11 Social Services Activity report England, The Information Centre, 2012

¹⁶ Personal Social Services: Expenditure and Unit Costs -England 2010-11, The Information Centre

¹⁷ The State of Health Care and Adult Social Care in England. Key themes and quality of services 2009, The Information Centre, 2010

¹⁸ A Vision for Adult Social Care, Department of Health, 2010

- Some people living in extra care housing may not always have their home care accurately recorded, in particular the number of hours or the type of care received.
- There are an increasing number of people in receipt of direct payments which may be spent on home care services or personal assistants, but this information is not recorded or reported in any central return. For example, whilst it is known that 44,000 people aged 65 or over were in receipt of a direct payment in 2010/11, the proportion of that spent on home care remains unknown¹⁹. It is, however, likely that a substantial proportion may have been spent on home care given that it is reported that older people are more likely than other groups to spend a direct payment on traditional services²⁰.

2.2 The balance of public and private purchase of care

The English Longitudinal Study of Ageing (ELSA) provides one of the better estimates of who buys home care. It explores the numbers of people in receipt of both privately funded and state funded care (excluding those in care homes). As Table 3 below shows, in general the numbers of older people in receipt of state funded care (although this includes more than just home care) are similar to those funding care for themselves (it is also noticeable that a higher proportion of older women than men use home care, particularly in the over 75 age group).

Table 3 Private and state paid help for older people by gender and age 2008/09^{*21}

Gender and age group	Private paid help		State paid help	
	%	No.	%	No.
Men 65-74	1.18	25,765	1.45	31,660
Women 65-74	3.33	79,527	1.29	30,807
Men 75 and over	4.23	39,749	4.38	41,158
Women 75 and over	9.69	240,622	9.09	225,722

*Paid help defined as privately paid help but not from a state source.

State help defined as reported help from social services, nurse or care assistant, eg, more than just home care.

However, Parker's earlier study²² using the Family Expenditure Survey suggests an even larger number of self-funders with nearly twice as many

¹⁹ The Size and Structure of the Adult Social Care Workforce Skills for Care, 2011

²⁰ IBSEN summary report, Social Policy Research Unit, University of York, 2008.

²¹ This table represents a re-working of Table 9.1 in Breeze E & Stafford M, 'Receipt and giving of help and care', (2008), The English Longitudinal Study of Ageing, to adjust for total population as compared to population with one or more limitations of daily activities

retired households purchased domestic help as compared to those funded through state provision.

Therefore, people funding their own care clearly comprise a significant proportion of home care users. This is in terms of the purchase of both regulated and unregulated care services. Although there is some dispute as to whether this market is growing²³ it is generally suggested as being on the increase by providers. Given the gradual increase in the numbers of the oldest old people within the community and the increased wealth of older people such an estimate would seem reasonable, and that this growth will be sustained.

However, there is no national estimate of the numbers of people who purchase unregulated care. It is generally considered to be very extensive across the country, particularly when it includes people who are paying a neighbour or friend for 'giving a bit of help' or helping with 'gardening' household maintenance, or cleaning. In a small study of self funders for example, nearly all those interviewed paid something for informal help with cleaning, and half paid similarly for gardening²⁴. Estimating accurate numbers is inherently difficult given that many of those working privately as domestic helpers may be outside the employment mechanisms of national insurance and taxation.

In addition, self-funding also occurs through the substantial group of people receiving publicly funded home care but who top this up with privately purchased care. In 2010/11, 31% of people receiving publicly funded care or support also made additional private purchases of care, with a further 7% having additional care purchased by their families²⁵. An IPC study in 2011 found that a number of people who had previously been eligible for state funding were now paying for their home care²⁶.

Providers report that self-funders often initially want low levels of home care or intermittent support (for instance when relatives are away, following an illness or as a regular source of support with a specific maintenance activity). However, as their needs increase they may then begin to purchase more intensive and extensive care from a provider with whom they have established a rapport.

²² Parker, R (1990a) 'Care and the Private Sector' in Sinclair, I, Parker, R, Leat, D and Williams, The Kaleidoscope of Care. HMSO.

²³ McClimont, B., Grove, K. Who Cares Now? An updated profile of the independent sector home care workforce in England, UK Home Care Association, 2004

²⁴ Follow on study: people who pay for care, (2012), Think Local Act Personal Partnership

²⁵ Domiciliary care market in the UK 2011, Laing and Buisson, 2011

²⁶ Follow on study: people who pay for care, Think Local Act Personal Partnership 2012

2.3 Health service funded users

It is worth noting that home care is also used by people assessed to be in need of NHS continuing care for which they need to demonstrate severe and enduring health problems to be eligible for funding. This is a relatively small group of people (55,500 in 2010/2011) but a group which has a high level of need and large care packages. They include older people, for instance with complex co-morbidities, and also younger people who have a chronic or degenerative condition.

Home care is only likely to be one element of the total care required in such packages, and tends to focus on services which help to maintain an individual in the community rather than which are concerned primarily with rehabilitation.

3 Who provides home care?

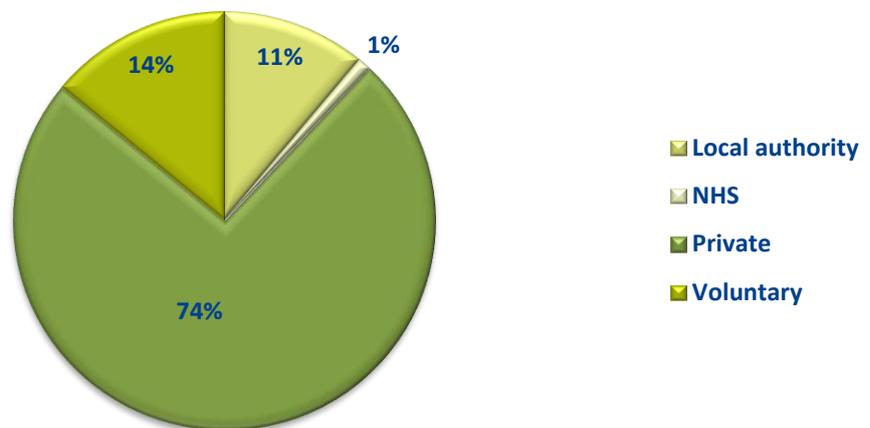
3.1 The suppliers²⁷

The Care Quality Commission (CQC)²⁸ reported that there were 4,515 registered home care providers in England in March 2012²⁹. In 2010 nearly 12% of home care providers were still public bodies. More up to date figures by sector are not available as under the Health and Social Care Act 2010 the CQC is no longer required to differentiate between private and voluntary sector providers, nor identify local authority direct provision as a category in its records.

²⁷ The material in this section concerning providers, relates unless specified, to services across all sectors not just older people.

²⁸ These are the publicly reported numbers of providers by CQC. However, some caution is needed, due to the way businesses are registered, some single office providers are in fact part of larger companies. It is possible that the total number of providers is lower than generally reported.

²⁹ CQC database of registered providers March 2012

Figure 5 Home care providers by sector 2010 ³⁰

Overall, the market is characterised by a wide range of providers and business models. This varies from very small local companies based out of a single office to large corporate organisations in the public, private and voluntary sectors some, of whom provide a range of services in addition to home care. The bulk of agencies are still small: of the 4,515 registered home care providers with CQC in 2012, over 3,900 were providers operating with a single office³¹. There is no clear correspondence between business type and service type. Many larger providers plan to or already do deliver the full range of home care services described in section 1. Smaller providers and local authorities also vary in their offer from lifestyle and maintenance support to highly specialist rehabilitation care.

As Figure 6 shows 87% ³² of local authority commissioned care was provided by the independent sector in 2010, an increase from 72% in 2005. This increase is further illustrated by the fact that contact hours from local authorities have fallen by 47% since 2005/06 while contact hours from the independent sector have increased by 36% over the same time period³³.

³⁰ Special analysis provided by the Care Quality Commission,

³¹ CQC database of registered providers March 2012

³² Community Care Statistics 2011, Home Care Services for Adults NHS Health and Social Care The Information Centre

³³ Community Care Statistics 2011, Home Care Services for Adults NHS Health and Social Care The Information Centre

Figure 6 Percentage of contact hours of local authority funded home care provided by sector as compared to all other providers³⁴

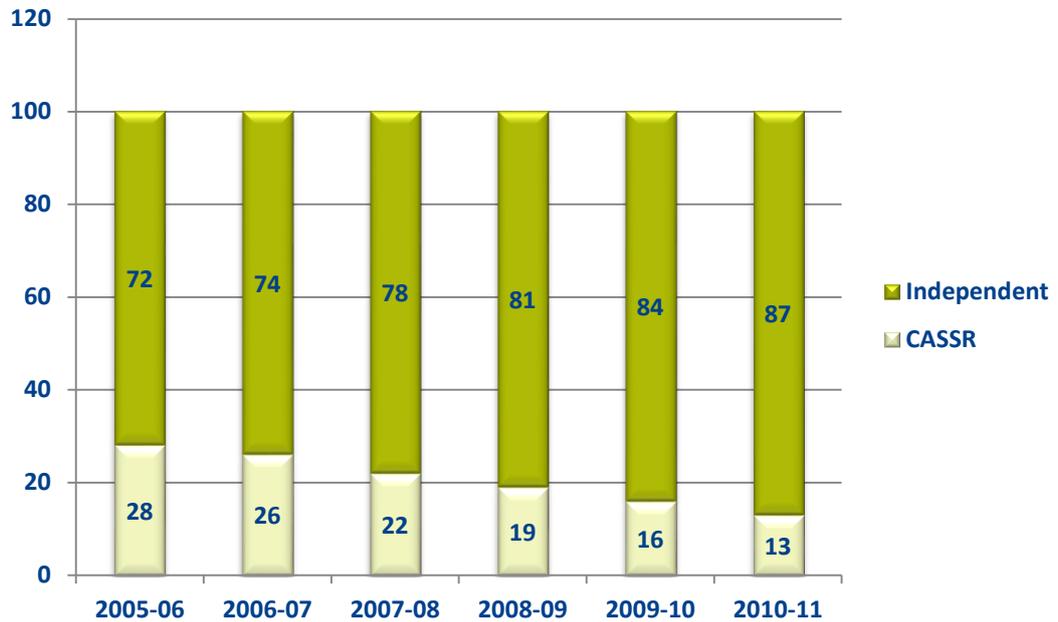
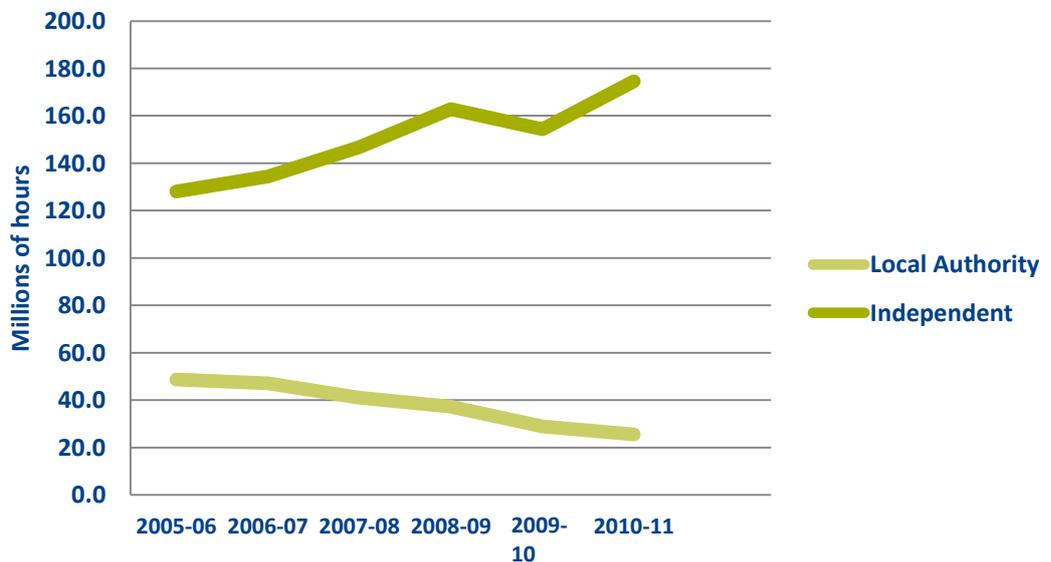


Figure 7 Actual number of contact hours of local authority funded home care by year and sector³⁵



³⁴ Community Care Statistics 2011, Home Care Services for Adults NHS Health and Social Care The Information Centre

³⁵ Taken from PSSEX Activity Data 2011, NHS Information Centre. The data relates to all home care not just older people

Traditionally, most private and not for profit providers have been reliant on public sector contracts for their business. From a survey carried out in 2009, it was estimated that for 55% of independent sector companies 80% or more of the value of their business was through contracting with local authorities³⁶.

However, about a quarter of providers had no contracts with local authorities and focused their services entirely on self-funders³⁷, and this is an area where anecdotally providers are becoming increasingly interested and active.

3.2 Market share

3.2.1 Large providers

The home care market is not by any means the same in structure as the residential and nursing care market. Large providers currently have a comparatively small share with the ten largest home care providers having in May 2012 only just over 16% of the market³⁸. Larger companies are capable of achieving greater economies of scale and management efficiencies, which help them deliver returns on investment.

In recent years, private equity houses have invested significantly in some of the larger home care providers, now holding some 13% overall as at May 2012. Their investments are typically based on a strategy of acquiring and growing medium sized businesses although private equity companies usually want to invest money for a relatively short time, for example three to five years, build up businesses and then sell. For example in 2011/12 Acromas Holdings Ltd reported that

*'We have a strategic intent to grow our healthcare business and invested almost £250 million in the acquisitions of Nestor Healthcare and Allied Healthcare. The combination of these with our existing care business has created Saga Homecare, a nationwide domiciliary care business. Our 16,000 carers make some 40 million visits a year delivering over 20 million hours of care.'*³⁹

Companies owned by private equity can sometimes have relatively complex governance arrangements such as using holding companies to manage a number of different home care businesses and in some cases other businesses as well.

³⁶ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

³⁷ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

³⁸ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

³⁹ Annual Report 2011-12 Acromas Holdings Ltd, 2012

Figure 8 Company ownership of ten largest home care providers by percentage of market share, May 2012⁴⁰

Saga	•4.7% market share. Owned by Acromas
Carewatch	•2.4% market share. Owned by Lyceum Capital
Care UK	•1.9% market share. Owned by Bridgepoint
Mears Group	• 1.9% market share. Publicly quoted company
Housing 21	•1.5% market share. Industrial and Provident Society with exempt charitable status. Also owns subsidiary private companies
Lifeways Community Care	•1.2% market share. Owned by Omers PE. Was owned by August Equity until June 2012
Enara Group	•1.1% market share. Owned by August Equity
City and County Healthcare	•1.1% market share. Owned by Sovereign Capital
Sevacare	•0.7% market share. Privately owned company
Marie Curie	•0.6% market share . Registered Charity

Note: in this table owned may mean a controlling interest as compared to 100% ownership.

⁴⁰ Community Care Market News, May 2012, Laing and Buisson

Franchised businesses are reported by UKHCA⁴¹ to form an increasing proportion of new entrants to the market.⁴² Several of the larger franchise businesses, such as Home Instead, Bluebird Care, Caremark, report on their websites that they now have over 50 branches nationally.

Not-for-profit providers are also significant within the group of larger companies. For example, Housing 21 is one of the ten largest providers in England, with over 90 branches, and 1.5% market share as at May 2012. In 2009 it became the first not-for-profit company to buy a publicly listed company, Claimar Care. Anchor Trust, Leonard Cheshire and United Response are other examples of not-for-profit providers who have developed home care as an integral part of their offer. Other not-for-profit providers have developed from externalised local authority care providers and expanded either through developing other services such as residential care or through spreading beyond their former geographical catchment area.

Not-for-profit providers include co-operatives, mutual societies and companies limited by guarantee. There has been a small but noticeable development of new worker co-operatives and social enterprises. The pioneering model comes from Sunderland Home Care Associates (SHCA). Established in 1994 with an advance payment for work from Sunderland Council and a £10,000 grant, SHCA now delivers some 9,000 hours of care per week to approximately 600 clients with an annual turnover of £2.8 million. Examples of home care social enterprises include Home Care Rutland, Social Care in Action in Southampton and Care and Share Associates (CASA) in Knowsley.

3.2.2 Small and medium sized home care providers

Medium sized businesses working at regional or local level generally have a different profile to the largest companies. Providers with three to fifteen branches include a large number of social housing providers and charities as well as private providers. Former local authority providers are also represented at this level.

Of the small providers, independent businesses make up the large majority (88%) of home care agencies registered with the Care Quality Commission (CQC). They are typically set up by an individual and remain in single or family ownership. Setting up a home care business can be attractive because of the low barriers to entry as home care has little requirement for capital, and staffing is relatively easy to obtain. Voluntary sector organisations also make up a large part of providers with only a single office. Although some of these are national organisations with a local presence such as Crossroads Care, others are often local charities.

⁴¹ Private communication to IPC by UKHCA, 2012

⁴² Domiciliary Care In the UK Market Report 2011, Laing and Buisson

Smaller businesses in some cases provide specialised care, eg, to particular communities or faith groups.

3.2.3 Local authorities

Local authorities only deliver 11% of the home care market although their involvement varies considerably across the country. Some have no in-house provision whilst others still have a substantial market share. For example, in 2010 Bradford Metropolitan Council⁴³ purchased 20,752 hours per week, equating to 69% of Council purchased care. The number of hours supplied by the 'in house' service was 8,555 hours per week, equating to 28% of the market.

Many local authority home care services have now been turned into reablement or intermediate care provision (for example Bradford also provides around 800 hours of reablement provision). Some local authorities have, or are looking to set up trading companies (LATCs) which allow them to outsource their provision, while retaining a share in the company. They are not numerous but are seen by some councils as a way of reducing costs and commitments whilst still retaining a stake in the services. Essex Cares was set up as a LATC in 2009. The London Borough of Barnet has also investigated this option, and other councils have indicated an interest in setting up LATCs⁴⁴.

3.2.4 Informal and unregulated home care

The recent growth of personal assistants introduces a new sub-market within home care. Personal assistants are individually employed by consumers using direct payments, and are not subject to regulation and safeguarding checks as registered home care providers are. Estimates of the numbers of personal assistants vary considerably. Recent research into the social care workforce suggests that there may be as many as 355,000 jobs employing personal assistants⁴⁵.

In addition, as noted earlier in the report there is also a substantial, but unquantified, volume of unregulated and informal care provided through casual arrangements.

⁴³ See Bradford MDC's Market Position Statement at http://www.bradford.gov.uk/bmdc/health_well-being_and_care/adult_care/related_information/market_position_statement_autumn_2010

⁴⁴ Community Care, February 2011

⁴⁵ Fenton, W., The Size and Structure of the Adult Social Care Sector and Workforce in 2011, Skills for Care, 2011

3.3 The workforce

A national survey of the social care workforce, published in 2011, found that home care accounted for approximately 771,000 jobs across all sectors⁴⁶. It is a workforce characterised by a high proportion of part time workers, although accurate estimates are hard to find given that some home care workers create an effective full time job by working for more than one agency. A survey of home care agencies in 2009⁴⁷ found that 22% of home care workers worked less than 20 hours a week, and fewer than half worked more than 30 hours a week. Over 80% of home care workers are female⁴⁸.

In such a labour intensive industry it is of little surprise that the major cost to providers is workforce pay. This is typically low, and often close to the 2011 national minimum wage of £6.08 per hour for a person aged 21 or over. Skills for Care reports a median wage of £6.65 per hour for care staff in 2012.⁴⁹ Staff may have enhancements added to this for travel, or out of hours working. Pay rates will vary slightly between local labour markets, although the average variation between regions in hourly care and wages costs for home care is within a 4% range⁵⁰.

Even given the current economic environment and the level of unemployment nationally, obtaining staff is problematic in some areas of the country, particularly the South East, where providers are competing with other low paid forms of employment. These may be less personally demanding, may offer more sociable and regular working hours and greater certainty of earnings. Home care workers are often employed on a zero hours contract, which offers little financial security.

Interestingly, whilst many of the discussions between the local authority and providers centre on price, some providers suggest that the key to success is in control of the labour force. Some providers suggest that they do not bid for contracts on the basis that if they control the labour force local authorities will be obliged to come to them regardless of to whom contracts are awarded. Others have given examples of being less likely to bid for contracts with local authorities where there is no available supply of staff, for instance preferring to take contracts in conurbations.

“We work mainly in conurbations where there is business, staff supply, and little travel time between jobs, which makes contracts affordable for us”.
(A large provider)

⁴⁶ The Size and Structure of the Adult Social Care Workforce, Skills for Care, 2011

⁴⁷ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

⁴⁸ Analysis of National Minimum Data Set 2011, Skills for Care

⁴⁹ Analysis of National Minimum Data Set 2011, Skills for Care

⁵⁰ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

Access to workforce is a key constraint that local authority commissioners need to recognise in working with local care markets.

4 Price

4.1 Costs of delivering home care

Employers see the rising costs of home care as a continuing business challenge within a context of local authorities' downward pressure on prices. Providers report that some local authorities have in 2011/12 introduced small uplifts of 1 – 2%; however this is often in the context of having pushed prices down or frozen them in previous years. Most recent data suggests that local authorities pay an average of £15.00 per hour for independent sector home care, with a range between £8 and £31.00⁵¹.

Home care providers also face the same challenges as any employer in managing and containing price increases following legislative change in areas such as taxation, national minimum wage, pension and national insurance contributions as well as employer obligations such as holiday or maternity leave.

In most industries such price increases would tend to be passed on, at least in part, if not in total, to the consumer. However, for providers that are dependent on local authority contracts and framework agreements, this is not achievable unless clauses are included which allow for uplifts within such agreements. The only options for these providers are to try and further reduce costs (particularly labour costs), to gain economies of scale through a greater market share, to cost shunt higher prices onto self-funders or to stop providing to the public sector market.

Regulation brings its own burden of cost. Providers must pay for registration, and invest in training, policies and systems to ensure compliance with national standards. Those interviewed by IPC in the development of this report commented on the multiple inspection and regulation regimes to which they are subject, including PCT standards, Health and Safety inspections, as well as CQC and local authority requirements. Some authorities add additional standards into contracts and may also require providers to use specific electronic recording and monitoring systems, again introducing additional costs. Therefore, ensuring compliance and reporting for these different regimes is a cost in itself, and can have the consequence of excluding smaller companies from such arrangements.

The CQC regulation charge is also not based on the number of hours delivered or the number of workers employed but on the number of office

⁵¹ Personal Social Services Expenditure data 2010/11, The Information Centre, 2012

locations providers operate from⁵². Some organisations with multiple offices report having reduced the number of locations they work from to reduce regulation costs, although this can have its own challenges in terms of changes in service delivery and supervision models, eg using remote working, equipping staff with suitable technology to do so.

Providers report that profit margins for public sector contracts have reduced significantly in recent years. They report currently working to a gross profit margin of 4 - 7%, whereas previously margins have been in excess of 10%. A surplus is critical to allowing businesses to continue to invest sufficiently in training management systems and quality improvements. Some providers have reported that each home care visit provided for a local authority contract will typically bring in a surplus of no more than a few pence. Consequently, lower profit margins work more in favour of larger companies where higher volumes of care delivery produce higher profits even if the margins per visit are low. One regional provider estimated a volume of 25,000 care hours per week as a minimum level for business viability; a national provider estimated 65,000 care hours per week.

Published annual accounts show that some medium sized and larger home care companies are now operating home care services at a loss. Some smaller providers have reported that they only continue their businesses because they cannot sell without incurring unsupportable losses; or because they personally do not want to let down clients and staff. On the other hand some local authorities reported that even at lower prices there were still plenty of new (small) entrants to the market. Therefore, the overall consequence of lower prices may not necessarily be fewer providers, but fewer viable businesses and hence higher turnover of providers.

4.2 Contracting for home care

4.2.1 Impact of public sector contracting models on providers

With a majority of home care commissioned by local authorities and the NHS, contracting models have a considerable impact on the structure, delivery model and capacity of provision.

The move by many local authorities from block contracts to framework agreements potentially introduces greater flexibility and choice into the market. However, for providers, a framework agreement may also introduce greater uncertainty about cash flow and volumes of activity. It also requires a considerable investment of time and energy into a bidding process, but with no guaranteed work at the end of it. Framework agreements as compared to contracts may also limit providers' potential to raise funds against contracts from sources such as banks.

⁵² CQC registration fees range from £720 annual fee for a single office to £32,000 for 25 offices plus.

However, there are alternatives emerging. For example, Wiltshire Council⁵³ has developed an approach to home care funding that:

- Is built around the expressed wishes of consumers, but defined as a set of outcomes.
- Combines home care, housing support and reablement (although not health provision).
- Is based on outcomes assessed by the LA, but with providers and customers together determining how they would be met.
- Sees providers paid on the basis of the outcomes achieved rather than the volume of what is provided.

Although early days, these kind of approaches point to a more mature approach to the market involving shared risk, a focus on impact rather than just activity, and a constructive dialogue between local authorities and providers.

4.2.2 Choice

It is clear that the public sector purchase process is undergoing radical change with the implementation of personalisation. In future, home care consumers are likely to divide into three broad groups:

- People who purchase their own care either from their own resources, via a direct payment or using a personal budget.
- People who make the choice about their care but then the local authority purchases on their behalf or recommends a preferred supplier from within a framework agreement.
- People on whose behalf the local authority purchases care.

Whatever category into which people fall there are still many unresolved questions introduced by the concept of choice, some of which are discussed in greater detail in the concluding section:

- What kind of choice do consumers want? Is a choice of provider their paramount concern?
- What happens when all the providers offer the same type of care?
- What happens where the local authority is still a provider?
- What are the implications for older people in of extra care housing, where the move into this form of support is sometimes taken to mean acceptance of the care offer on-site?

⁵³ John Bolton: Wiltshire Help to Live at Home Service Report, IPC Publication, April 2012

4.2.3 Time based units of provision

Of equal concern to providers and the government is the process of purchasing care based either in short time blocks or minute-by-minute billing often required by local authority commissioners⁵⁴. Time based contracts are broadly based on an assumption that the same level of care is needed by an individual daily or weekly on a regular basis. Alongside this many local authorities ask for electronic call monitoring, which requires care staff to register electronically or call in to record the start and end of their visit to a home.

Home care staff report experiencing time based models and electronic monitoring as stressful⁵⁵, because of the pressure on them to deliver within a short time period. Examples have been cited of a carer's first action on entering a house being to ignore the client while they make their phone call and of job satisfaction being lost. A survey in 2011⁵⁶ found that over half of local authority funded visits lasted just 30 minutes. 16% were just fifteen minutes long. This has an impact on the proportion of time spent by home care staff between jobs. A further 19% of carers' time was spent travelling.

The impact is not just on staff but also on consumers. The Information Centres survey of home care users in 2009⁵⁷ found that one of the features people most disliked about the care arrangements provided were where the carer was in a hurry.

This finding has been echoed by 'Which?' who in 2012, noted from their research that "a key theme ... was that of rushing, with only 59% agreeing that there was enough time to get everything done without rushing, and this is arguably how mistakes happen"⁵⁸. Time based work also prevents carers being flexible and able to respond to the client's need on a given day. These findings were also reported in the CSCI report "Time to Care" in 2006⁵⁹.

There is little analysis available about the purchase of regulated home care or the length of visits by self-funders and even less where the purchase concerns informal and unregulated care. However, self-funders do not contract by the minute; and are likely to have fewer very short visits as required by public sector commissioners. Several home care providers are reported to have a policy for self-funders that a 30 minute – or in one case a 60 minute - visit is a minimum length of visit⁶⁰.

⁵⁴ No more pips to squeak, UKHCA, 2009

⁵⁵ No more pips to squeak, UKHCA, 2009

⁵⁶ Domiciliary Care In the UK Market Report 2011, Laing and Buisson

⁵⁷ Home Care Users in England aged 65 and over 2008-09 Survey, The NHS Information Centre, 2009

⁵⁸ Home care policy report, Which?, The Consumer Council, 2012

⁵⁹ Time to care?, CSCI, 2006

⁶⁰ Interviews with UKHCA and home care providers

5 Consumer satisfaction

The evidence on user satisfaction with home care is predominantly supplied from those in receipt of state funded home care. Little is published about the views of those who purchase their own care from either regulated providers or those who buy unregulated provision although a survey by the NHS Information Centre⁶¹ in 2009 suggests there is little distinction in satisfaction between those with direct payments as compared to those where the local authority pays.

The key findings from the NHS Information Centre survey is that between 2003 and 2009 there was little change in satisfaction levels (between 50-60%), and that, in addition to concerns about time based monitoring and staff 'rushing' there was a strong correlation between satisfaction and:

- The care workers being prompt and reliable on time.
- Continuity of staff.

Finally the recent 'Close to Home' inquiry by the Equality and Human Rights Commission⁶² further endorsed these findings. This inquiry stated that the characteristics of home care that older people most valued were, "Consistency of staff, reliability, staff interacting positively with them or having time to talk to them, control over tasks to be carried out". It should be noted that a quarter of the respondents to this survey (although small in number with only 40 respondents) were those who privately funded their home care provision.

6 Summary

In summary, this is a picture of a home care market characterised by a wide range of interventions, varying provider models and services, with relatively low barriers to business entry and employment. It is a market in transition, characterised by:

Demand

- The number of older people, their continued preference not to enter residential care and the emphasis on prevention and community based alternatives all suggest that the number of potential consumers of home care will increase.
- However, the numbers of older people supported directly by state funding to receive home care are reducing, although the intensity (or quantity) of care they are receiving is increasing.

⁶¹ Home Care Users in England aged 65 and over 2008-09 Survey, The NHS Information Centre, 2009

⁶² Close to Home: An inquiry into older people and human rights in home care, Equality and Human Rights Commission, 2011

- Self-funders (including direct payment recipients) account for between a third and a half of home care purchased, and are likely to increase.
- Consumers identify good quality home care as the care worker being on time and at times that suit that individual. There is a strong correlation between dissatisfaction and care workers being in a hurry.

Supply

- Home care encompasses a broad range of services trying to meet many different needs for many different purchasers and users.
- Although the market is dominated by the private sector, there is a significant not-for-profit sector and local authorities still provide around a tenth of services.
- The market remains very fragmented, dominated by small, local companies offering care across a limited geographical area.
- With an estimated 80% of all home care business still being contracted for by or via local authorities their market influence remains considerable.
- The market is increasingly characterised by acquisition and mergers, particularly of medium sized companies by larger companies.
- The ten largest providers represent only 16% of the market; the majority of these companies are owned by private equity but they also include not for profit companies.
- Home care is a major employer of predominantly female, unqualified, low paid staff and access to workforce is a key constraint for providers in some areas.

Market challenges

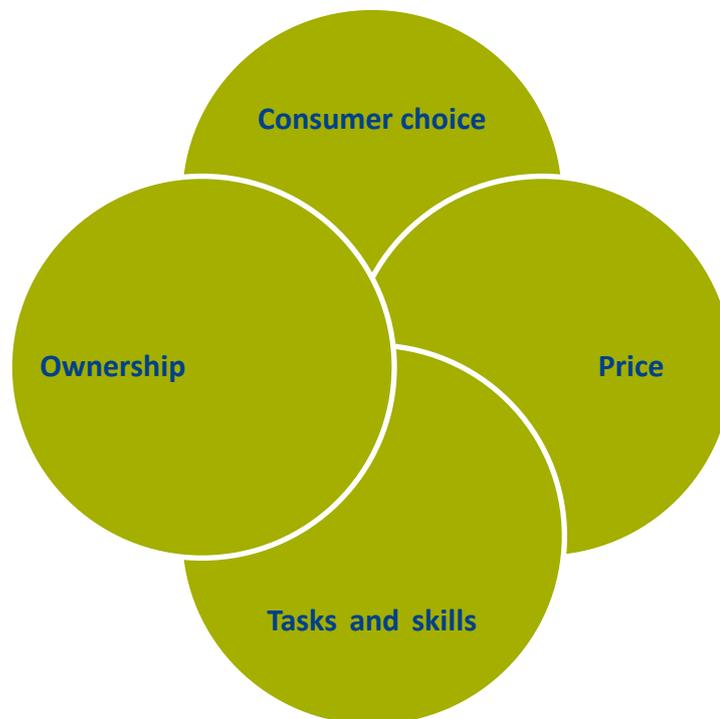
- The current contracting practices used by many local authorities focus on controlling the time of workers and can work against delivering the quality and type of home care valued by consumers.
- A number of home care providers see themselves to be on the edge of financial viability, with wage and management costs increasing, while the price paid by local authorities has either remained static or fallen.
- There is little evidence about the impact of home care and what particular interventions work, and why. Home care combines a wide range of different types of support and the value and impact of each service is not always clear to purchasers and to providers.
- Commissioners and providers alike are going to need to get better at differentiating the range of activities involved and make better judgements about the impact these are likely to have if home care is to be delivered wisely in future.

Section 2: Where do we go from here?

7 Factors influencing the future direction of home care

This section draws on the analysis in Section 1 to look at the potential future shape of home care and the context in which it will need to play its part. There are 4 particular factors which are currently most likely to influence the future style and range of home care services and businesses in England:

Figure 9 Factors influencing the future direction of home care



7.1 Consumer choice

Both the Government and the Association of Adult Directors of Social Services (ADASS) have emphasised that state funded social care is 'not fit for purpose', and that a major factor in this is the lack of user choice and control⁶³. The policy intention is that this should be resolved through an emphasis on social care consumerism through increased information and help to those who fund their own care and developing direct payments and personal budgets for those who are state funded. In this mode the individual becomes the purchaser or consumer, and the state simply facilitates making a choice of provision available.

⁶³ See p 13, Caring for our future: reforming care and support, HM Government Cmnd 8378, 2012

However, there is some evidence that many older people do not necessarily want to have this choice and control, and that when they do, they might not exercise it in the way policy makers prefer. For example, initial research on direct payments and personal budgets⁶⁴ found older people as a group more reluctant than others to take on arranging their own care and when they did, that they tended to purchase traditional services. It is also clear from consumer research that whilst older people do want to avoid admission to residential care,⁶⁵ the type of home care they appear to value the most, is what might be seen as low intensity, lifestyle support and maintenance provision, ie, the type of home care which is rarely now supported by state funds.

Finally, choice and control are not fixed qualities. For many older people choice of provider organisation is likely to be far less important than 'choice' about which care worker provides them with individual support and 'control' about when they visit. In some more rural parts of the country there may even be little choice available of either provider or worker, given the difficulties of recruiting and delivering provision at an affordable price.

Therefore, for the foreseeable future there may only be quasi-consumerism in home care for older people, with the capacity of the individual to drive real choice limited by what is on offer and, for many, by the funds the state is prepared to release to allow people to pay for their care. Conversely, local authorities, through framework or preferred provider agreements, through being asked to act as a care broker or simply through providing recommendations and assuring quality, may still exercise a considerable degree of control over the home care market.

However, the Government not only wishes to create greater consumerism it also needs home care to deliver a preventative agenda and reduce demand for more acute and residential care. There may be something of a tension between:

- Promoting consumer choice.
- Allowing providers to sell their services directly to people.
- Needing to reduce demand arising from health and care pressures.
- Needing to shape the types of care which people use to ensure it promotes independence and does not draw people into greater dependency on care services.

⁶⁴ Individual Budget Evaluation Network (IBSEN) (2007) *Individual Budgets: An Evaluation: A Summary of Early Findings*. SPRU, University of York; Davey, Fernández, Knapp, Vick, Jolly, Swift, Tobin, Kendall, Ferrie, Pearson, Mercer and Priestley (2007), *Direct Payments: A National Survey of Direct Payments Policy and Practice, Personal Social Services Research Unit and Hutton and Walters, The National Personal Budget Survey*, In Control and Lancaster University, 2011

⁶⁵ Wanless D, *Securing Good Care for Older People: Taking a long-term view*. King's Fund, 2006

Only by differentiating different home care services, and for each, being clear about their purpose and intended impact can consumers, commissioners and providers ensure that different types of intervention are appropriately delivered at the right time to the right people.

7.2 Ownership

Both the previous and the current Government have stated that they wish to have a market in social care that encourages the growth of mutuals, voluntary sector providers and social enterprises.⁶⁶ This is presented as a way of encouraging diversity and local responsiveness in the wider social care market. Given the types of business models being encouraged there is an implicit suggestion that Government would prefer to see this type of approach grow as compared to private or state ownership.

Yet, the home care market is not necessarily following this pattern. As was shown in Section 1, the market is still very diverse in terms of the number of providers and the ownership models used. As compared to residential care, market entry is easy and low intensity home care support for individual's lifestyle and maintenance is still predominantly the province of small and medium sized local providers. However, changing market conditions are making these businesses increasingly vulnerable. Some smaller providers feel themselves under threat from the development of personal assistants, while other more specialist services are concerned that increases in regulation or training requirements can disproportionately impact on smaller providers' resources. Small providers are also concerned about the contracting arrangements with the local authority, including the limited surety of framework contracts and the complexities of individual service purchasing. Finally, the squeeze on price has resulted in many of these small businesses becoming financially marginal. As one provider told us:

“The price of care cannot be reduced further, as we are at the limit now. “

On the other hand, in recent years there has been a growth of some of the larger providers through acquisitions. Acquisitions are a key strategy, not only as represented by the recent Saga/Nestor/Allied Healthcare merger but also by others, such as Sevacare and Enara. Amongst the ten largest providers of home care, all bar two are private companies and a substantial proportion of them are funded or owned by private equity companies. Even Housing 21, as a registered provider of housing, has private companies within its portfolio.

⁶⁶ P.45 Caring for our future: reforming care and support, HM Government Cmnd 8378, 2012

Some people question the motives of private equity in this market, given that it is sometimes associated with asset stripping⁶⁷. However, as home care has precious few assets to strip it is more likely that private equity investors see it as a good investment for other reasons, eg, the potential to capture more of an expanding market through purchasing existing businesses with good names or by making in-roads into unregulated care. Certainly there may be efficiency gains to be made through better management systems, consistent service standards and contracting arrangements, and customer gains through greater expenditure on advertising and promotions.

Some larger organisations clearly see an opportunity to build an integrated service offer, covering informal lifestyle and maintenance support at one end, and going through to high intensity rehabilitation and recovery support at the other.

While it is unlikely that the existing distribution of business models will change substantially over the next few years, it is likely that larger businesses with a capacity to invest, and develop more integrated service provision will continue to expand.

7.3 Tasks and skills

Home care is relatively under-professionalised, with, generally, no formal qualifications required, and little career structure. This is illustrated by the implicit assumption behind the development of personal assistants as a replacement for home carers given that this new role is neither regulated nor requires trained personnel. Many consumers and some commissioners still see home care as a form of domestic service, delivering tasks such as cleaning and shopping.

On the other hand the more complex rehabilitation and reablement services which combine health and social care tasks, are likely to require more highly trained (and paid) practitioners. There is a danger that in an economic downturn individual purchasers and commissioners will try to obtain the latter type worker at the price of the former. For example, one small business owner commented:

"I used to be a district nurse before I started my home care business. My home care staff now perform many if not all of the tasks that district nurses used to do. We do dressings, we administer eye and ear drops, we supervise people taking medication. We receive no money for that from the health service. One day we visited a client and the health visitor or GP had just left a note of tasks to do without even asking us. It was just assumed

⁶⁷ See David Miliband on Southern Cross, Daily Telegraph 2/7/12. See also Zoe Wood and Ian Griffiths, The Observer, Sunday 29 May 2011 on the collapse of the FOCUS DIY chain

that we would do them. If we had refused or said we wanted more money the job would simply have been given to somebody else.”

Without further differentiation between the skills and tasks required in very different parts of the home care market it is difficult to see how the quality of care required by intensive rehabilitation services can be delivered safely, or how more straightforward maintenance tasks can be delivered cost effectively, whichever organisations or businesses are responsible for the service.

In addition, the labour market for care services does not operate in a vacuum. At the moment most care providers report that despite turnover it is possible to recruit care staff. The fear is that if there is an economic upturn combined with continued public sector spending restrictions then retaining staff on the current levels of financing could be impossible. This in turn may increasingly create a two tier service, between those who self-fund and pay a higher price for a more skilled service as compared to those who purchase through their receipt of state funds.

7.4 Price

The price paid for home care by local authorities has, in general, either remained static or fallen although there are exceptions. Providers often compete for lowest tenders on price in a “Dutch” auction. At the same time there has been an increased emphasis on short time period visits or minute by minute billing as mechanisms for reducing costs. Local authorities argue that quality has been protected, which by implication suggests that too high a price was paid in the past. However, the government in the White Paper has stated that it will rule out what it describes as ‘crude contracting by the minute’⁶⁸.

As discussed in Section 1 there is a strong view from providers that the price for state funded home care has dropped to a level where it is barely sustainable and, in terms of pay rates, only marginally above minimum wage. Given the local nature of the vast majority of care providers they often feel constrained to accept the price the local authority offers, whether through direct payment, personal budget or contract, because they do not have the capacity to expand or take their business elsewhere. Some of the bigger home care providers may be able to deliver services for a low price for a short period of time on the basis that if it squeezes supply out of the market then they will be able to charge a higher price in the future through having gained a greater local market share, but this would be a high risk strategy and not sustainable for very long.

In the longer term some providers clearly see their future in terms of providing services for predominantly or exclusively for those who self-fund

⁶⁸ Caring for our future: reforming care and support, HM Government Cmnd 8378, 2012

their care, with the assumption that realistic prices will be chargeable without the intervention of the local authority. Certainly businesses which are not reliant on the local authority for business are in a much stronger position when it comes to negotiating price with it. Framework contracts which set an agreed maximum price to people using local authority personal budgets and direct payments will only remain powerful as long as there is significant business which is transacted through them. Some business no doubt will find themselves competing with the personal assistant market and reducing skills and charges accordingly. It is likely that the market will need to continue to be more clearly stratified and differentiated so that consumers really understand exactly what they will be getting, whatever price they choose to pay.

Although price tends largely to be defined in terms of the time provided by a service (£ per hour), providers and commissioners in many parts of the country have been exploring alternative ways of paying for service, particularly in terms of payment for outcomes achieved. This is particularly the case for more complex home care services such as rehabilitation and reablement, or for home care services as part of a wider package of care and support. This is a mechanism which might offer not only an effective way to share risk between purchaser and provider, but, depending on how contracts are agreed, might offer a way to clearly specify those services which are designed specifically to divert people from hospital or residential care.

7.5 Summary

This section has so far outlined the tension between who is the purchaser, of what kind of home care, at what price. All markets have such tensions between demand and supply. For example, if in home care, a higher price is paid, more providers may be attracted into the market. However, a saturation point would then be reached where supply exceeded demand, prices would fall and businesses would fail, thereby restoring the market to equilibrium between supply and demand. The converse is equally true. If the price paid for home care falls, more providers go out of business until there is an excess of demand over supply, at which point prices then begin to rise, and more providers find it attractive to enter the market. Of course the home care market has not always followed these rules of supply and demand due to the intervention of the local authority as a dominant purchaser.

Now, with the growth of care consumerism, there is a greater potential that a more traditional market will be created. What is not known is how these consumers will behave. For example if the state reduces funding will more people find the money to 'top up' their care provision? Will those consumers want to buy lifestyle as compared to preventative services? Will a growth in self-funders create a demand for a more highly skilled workforce? Even, who makes the decision about care is open to question,

if elderly parents live at a considerable distance from their concerned, care purchasing, offspring.

The danger is that in the desire to increase choice and control through making all who are in need purchasers of care, is that sight is then lost of the other goals that public policy needs to achieve. Given the substantial growth in the older peoples population as outlined earlier, the policy task might be not to find better ways in which older people can purchase care and support but to reduce the demand for it.

We already know that people often have a considerable period of ill health prior to death and that this drives demand for a high volume of health and social care. The assumption is that as the population grows so will demand. However, if people's health and well-being improved then this may not be inevitable. It is this task that should be central to public policy. Achieving such a goal, should lie at the heart of a reconfigured 'care at home' range of services capable of delivering prevention and promoting greater health, well-being and independence.

8 Positioning home care

From the preceding debate a number of conclusions can be drawn.

- That home care is not a single entity but a range of provision, whose general complexity looks to be increasing.
- That the future market for home care will increasingly be dominated by self-funders and those who individually purchase using state funds, although a pure consumer market may be some way off and may not even be desirable.
- That what people identify as wanting home care to deliver is not necessarily what the state needs them to buy.
- Some of the recipients of care may not even be the people who make that purchase given the involvement of other family members.
- That currently the task of maintaining more older people within the community, and out of hospital, is fragmented between a whole series of different commissioners and providers. This is both costly and in some instances seemingly ineffective.
- That providers recognise the need for change but do not have the influence to drive the change in policy that is needed.

This section attempts to reconfigure the future home care offer, in the light of these confusing and sometimes conflicting trends and provide a framework within which different parts of the market can develop. To deliver such a model would require Government (both local and national) to work together with providers whilst at the same time persuading older people (and the general public) that older old age does not always have to

be a period of incapacity and ill health or one where care (whether state funded or privately purchased) is inevitable and beneficial.

8.1 Meeting aspirations

Potentially care at home needs to be able to meet three very different user needs or aspirations.

1. Supporting people to live well in the community

When people purchase home care themselves there is a tendency to focus more towards the lifestyle-end of the market. These are services such as being taken shopping or being able to visit friends or go out, or about house and garden maintenance. These may all be seen as low level services requiring only a small level of skill, yet as IPC research in Oxfordshire in 2009 indicated⁶⁹, social isolation and loneliness may play a significant part in older people's decisions to leave their community and go into residential care when a crisis occurs.

2. Prevent people with significant health or care needs from having to use residential or nursing care and hospital

With the increasing pressure on the NHS, the need is for community orientated services to divert older people from, and reduce demand for, acute hospital, nursing home and residential care admissions, both in terms of preventing such admissions occurring and facilitating early discharge. Home care through reablement, crisis response services and intermediate care already plays a part in achieving these. However, this is a model that needs to focus more strongly on achieving the right outcomes for consumers based on the achievement of rehabilitative goals. It is an area that lends itself to payment by results and outcome based contracts.

3. Helping people with care needs maintain themselves in the community

A third approach is home care as maintenance. This will offer services that help somebody to remain within the community, even though there may be little improvement or even a decline in their health and well-being over time due to frailty or a long-term condition. However, such services still need clear outcomes. They may also need to run in tandem with lifestyle provision and offer a greater degree of consumer choice about who delivers them.

Therefore, the provision of home care for older people can be seen as falling into three categories; lifestyle, preventative and maintenance services, as the tables below illustrate. They are not mutually exclusive and a person may need all or a combination of these over time.

⁶⁹ Taylor, Cairncross & Livadeas, Oxfordshire County Council's research into preventing care home admissions and subsequent service redesign, Research, Policy and Planning, 28(2), 2010, pp.91-102, 2010

Table 4 Examples of differential focus to home care style interventions

Lifestyle (tasks which help a person to live well in the community)	Prevention (tasks designed to reduce the dependence of a person with significant care needs on acute or residential care)	Maintenance (tasks which help to maintain a person with care needs in their community)
Visits to shops	Exercise programmes	Home repair
Social visits to friends and relatives	Continence training	Medication reminders
Outings	Training programmes for carers of people with dementia	Domestic cleaning
Home visiting service	Home-based reablement programme	Washing and bathing services

8.2 An approach to the reconfiguration of home care

Although there are services across the country in each of the above areas the distribution of services in much of the current system is left to chance. For example, voluntary organisations may or may not be present in a given locality and may or may not be able to provide a range of services. Home care often remains un-integrated with other forms of provision dedicated to keeping people within the community. Reablement is often limited to a six-week time period based solely on funding rather than a person's potential to recover their capacity to live independently. Even getting access to provision is often left to the older person or their carer knowing what is available and how to obtain it.

In effect, home care that straddles the range of provision described above is a low paid, low expectation, service often held together by the good-will of front line care staff. It is not the professional, integrated service capable of substantially improving health and well-being that will be needed in the future.

We suggest that commissioners and providers need to work together to reconfigure these different elements within the overall market, so that service design and delivery for each is clearly focused and targeted on those who are most likely to need and benefit.

Below is set out an approach to reconfiguring home care, in the context of the range of community based provision. This approach includes some proposals for different care funding and organisational models.

8.3 Supporting people to live well in the community – the lifestyle offer

Commissioners and providers need to consider how these services are best configured locally to ensure that as many older people as possible remain active and engaged citizens even though they may need some help with specific tasks to do so. Table 5 covers some of the ways in which community based services may be given greater focus and reconfigured.

Table 5 An approach to reconfiguring home care – the lifestyle offer

The lifestyle offer	
Aim	To deliver a range of health and well-being services designed to promote independence and continue older people's active involvement in their community regardless of age or condition. In particular, these services would be incentivised to target those older people who have pre-disposing factors likely to indicate high health needs or likelihood of later care home admission.
Provided by	Voluntary organisations, community interest groups or companies that already provide maintenance or rehabilitative services. These might have to have a given proportion of users as directors / management committee and have the capacity to span the range of tasks likely around the outcomes to be achieved. Each local authority might guarantee the range of services in a given area proportionate to the size of its older people's population and be clear about the characteristics of the services which will ensure they do not inadvertently draw people into the care system.
Services provided	<ul style="list-style-type: none"> ■ Basic care and support; eg, community alarm services, toenail cutting, access to dentistry, meal services and meal sharing schemes, chiropody services. ■ Exercise; eg, access to leisure facilities either in own home or community facilities, personal trainers. ■ Community access and involvement; eg, accompanied transport to social activities and health services, visiting and companionship services.

The lifestyle offer	
Funding	<ul style="list-style-type: none"> ■ Fees from individuals ■ Contracts with LAs on the basis of the achievement of a set of targets / outcomes for given populations. ■ Replaces Supporting People funding of older people's provision. ■ Top slices a proportion of leisure and sports funding for LA's.
Clientele	Open to all, but LA funding targets populations most at risk.
Staffing	Staff may be unqualified, and could be volunteers or waged.
Regulation	Unregulated but has to deliver a performance report to the local authority and individuals have to be registered with a recognised organisation.
Problems addressed	<ul style="list-style-type: none"> ■ Integrating a wide range of community provision into a single umbrella, including Supporting People. ■ Moves away from a series of single issue charities some of which increase rather than diminish the need for care. ■ Funding based on capacity to attract funding and the achievement of outcomes. Also brings together into a single funding stream, grants and commissioned services currently provided by local government and health care. ■ Providing incentives for a range of people to receive tax and national insurance-free honorariums in recognition for volunteering.

8.4 **Preventing people with significant health or care needs from having to use residential, nursing care or hospital – the prevention and reablement offer**

Commissioners and providers need to consider how services are best configured locally to meet the needs of people who might traditionally have had to go into hospital, residential or nursing care, but who could, with the right interventions, remain in the community.

Table 6 An approach to reconfiguring home care – the prevention and reablement offer

The prevention offer	
Aim	It aims to take older people with identified risk factors who have suffered a critical incident, (such as an illness or injury), and restore them to their state of wellbeing prior to the incident.
Provided by	Teams drawing on health and social care expertise.
Services provided	Brings together reablement intermediate care and community health provision post hospital. Focuses on key conditions that lead to repeat admissions and lengthy hospital stays, eg, falls strokes, dementia.
Funding	Funded by health and social care but for consumers free to all who satisfy the admission criteria.
Clientele	Only serves a tightly targeted population. This is people who have had a critical incident that could either lead to a care home admission, a hospital admission or a restoration into the community, post hospital, of older people.
Staffing	Brings together home care, physiotherapy, occupational therapy, personal trainers, community nursing (including mental health) other GP led services.
Regulation	CQC using joint health and social care outcome measures to judge performance.
Problems addressed	<ul style="list-style-type: none"> ■ The performance of the NHS in terms of old age conditions such as strokes, falls, continence and dementia is currently poor. The suggestion is that people then end up needing care through system failure rather than due to their long term condition. This service aims to reverse that process through targeted, evidence based restorative and rehabilitative interventions. ■ Provides a non-time limited outcome led recovery service. ■ Could attract social investment bond funding.

8.5 Helping people with care needs maintain themselves in the community – the maintenance offer

Finally, commissioners and providers also need to consider how services are best configured locally to meet the needs of people who need help to maintain their life in the community, even where they have significant care and support needs.

Table 7 An approach to reconfiguring home care – the maintenance offer

The maintenance offer	
Aim	<p>To sustain within the community older people who require help and support to meet their health and care needs.</p> <p>In providing support to always identify how greater independence can be encouraged and supported.</p>
Provided by	Home care providers with additional skills and able to deliver the range of provision specified below.
Services provided	<p>Home care services plus care and repair, community alarm, aids and adaptations and district nursing.</p> <p>How, when and which services are provided to be agreed between the service user and the provider.</p>
Funding	<ul style="list-style-type: none"> ■ Self-funders. ■ Direct payments and personal budgets. ■ Where health care needs have been assessed, these will be met through the provision of services with costs reimbursed through the NHS. <p>Where the service user seeks state assistance for funding then this is only provided on the basis of achieving the goals defined by an outcomes-based assessment.</p>
Clientele	Open to all who wish to pay or for whom the service has been arranged.
Staffing	Staff have to be trained and qualified commensurate with the tasks to be delivered. Lead care workers co-ordinate and underwrite the arrangements so that consumers receive a seamless service.
Regulation	CQC (but with a much greater consumer input than in the past)

The maintenance offer	
Problems addressed	<ul style="list-style-type: none"> ■ Encourages a move away from a range of services aiming to maintain somebody in the community into a single integrated health and social care community service for older people. ■ Takes a 'what needs to be done' approach by lead care workers rather than constant referral on or signposting elsewhere. ■ Saves funding through integration at the point of delivery. ■ Potentially brings new providers into the sector.

9 Implications for commissioners and providers

9.1 A change in relationships and roles

The material above suggests a radical shift but achievable through organic change from the current approach to home care. It should be aimed at delivering:

- A seamless service offer between self-funders and those in receipt of state funding.
- Making savings in state provision through encouraging and / or contracting for integrated services.
- Encouraging the development of single agencies that are multi-disciplinary rather than focussing on one particular discipline or aspect of care.
- Adopting an outcome led approach to contracting for preventative services and having the confidence to pay by outcomes.
- Making consumer choice real by offering a choice of services and greater user control rather than simply a choice of providers offering the same type of provision.
- Giving a better shape to the informal life style type of tasks which might be low level but nonetheless may be critical in encouraging someone to remain within the community.

As stated previously, even in a world of self-funders, direct payments and personal budgets these are not changes that can be consumer driven. Consumers can decide on price and make purchases based on what is available. They can make their views of existing provision known through feedback mechanisms and can state to government what they would like to see happen. However, re-shaping the market needs both central and local

government working with the sector to provide the stimulus and the framework within which a re-defined home care offer might work.

It may be argued that the approach advocated is a much wider agenda than just home care as currently perceived, which of course it is. However, in a world which focuses on financial restraint and outcomes; organisational boundaries, definitions, job roles and functions become less important and achieving the desired goal more important. A shift in thinking is also necessary if in the eyes of the public and of professionals we are to move to a culture where a service is there to achieve a particular goal. The service ceases once that goal is achieved rather than as at present where the acquisition of care is seen as a good thing and something that only gets more, rather than less, intensive. Home care provides the most obvious vehicle around which a reconfigured and targeted, 'care at home' offer can be made.

Therefore, the combined commissioning task is twofold:

- To identify on the demand side how do we best target the populations that are most likely to command high cost care and health services.
- On the supply side how do we encourage the reconfiguration of community health and care provision so that it can offer an evidence based, integrated, set of services designed to reduce demand and sustain a healthier population at a lower cost.

9.2 The commissioning task

To achieve something even approaching the model suggested will require a considerable number of different organisations working in close cooperation. This includes the government and the regulator as well as commissioners and providers. To do this successfully will require much greater direct engagement with providers and consumers, and work with them to identify how they can move forward in developing the kind of home care market needed in by a local community.

Almost certainly it will require the new health and wellbeing boards to have a good grasp of the issues their area faces in terms of demographics and current performance. They will also need to set some very clear guidelines for what they expect their Joint Strategic Needs Assessment (JSNA) to show and how Market Position Statements (MPS)⁷⁰ should be used to plan with the provider sector the future shape of services needed.

The table below outlines some of the key interventions that commissioners may need to make in order to facilitate and purchase future care at home.

⁷⁰ For guidelines on an MPS see IPC 'What is a MPS' produced for the DH Developing Care Markets for Quality and Choice' Project 2012 at www.ipc.brookes.ac.uk

Table 8 The commissioning agenda - the lifestyle offer

Some current characteristics of provision	Commissioners need to...
Commissioners across the local authority and health services having diverse aims and ambitions.	Work to achieve unified clarity on the goals and outcomes expected of lifestyle delivering services. The local MPS should clearly outline what this is based on, using an effective JSNA. Goals should be shared discussed and agreed with consumers but also be based on the weight of evidence rather than simply opinion or vested interest.
Fragmented funding mechanisms which are rarely tied to outcomes and with few measures of success.	Bring all funding into a single financial stream tied to outcomes. Funding may also look to voluntary sector contributions to match any public sector input and contracts may include a requirement for a level of volunteer support in cash or kind to be achieved.
A suggestion that low level provision is of less importance and can be easily discarded.	Recognise that for more older people to remain in the community people have to have a reason for wishing to stay. Judging efficacy by intensity of delivery may be a false economy. If some community provision is essential for long term health and care then there should be a minimum guarantee of what will be available rather than it being left to chance.
A lack of targeting of provision.	Provision might be available as a universal offer but there is a need to ensure that it is targeted on the basis of risk eg, if we fund services to reduce social isolation we need to make sure that it is those who are socially isolated and have other risk factors who receive them.
A poor evidence base of what works.	Only fund provision where there is a clear evidence base that it will deliver desired outcomes or where such evidence does not exist, it is recognised that funding is a short term time limited experiment.
Few incentives for volunteers.	In the absence of any central government stimulus or tax breaks etc, the local authority should explore what it is it can offer that might encourage greater local volunteerism.

Some current characteristics of provision	Commissioners need to...
A suggestion that some services increase dependency.	In contracts insist that providers show how they will increase independence and use outcome measures to determine success rather than measuring the number of people provided with a service or activities performed.
Greater recognition by planners of likely future demand	A key element of lifestyle is ensuring there is a sufficiency of supply of suitable housing for purchase, lease or rent for older people. Part of this requires planning policy to recognise the impact of demographic change on current tenure patterns amongst older people. Planning policy also needs to support neighbourhood configuration eg shops, transport and services that might be required by an ageing population.

Table 9 The commissioning agenda – the prevention and reablement offer

Some current characteristics of provision	Commissioners need to...
Recent Royal College of Physicians reports, amongst others, have outlined poor performance in some of the key drivers towards repeat hospital admissions and care home admissions.	Work across disciplines and sectors to identify which are the areas of poor performance in their area that stoke up demand. Develop a clear integrated plan for how they might commission services differently to improve outcomes. Particular areas to focus on would be strokes, falls, continence, dementia and community dental services.
Just as commissioning is not necessarily driven by identified areas of poor performance so services are not driven by the evidence about what works and what does not.	Commissioners need to agree evidence based intervention programmes that clearly identify good practice and where appropriate how this will resolve poor performance. In addition, commissioners need to review models of who delivers what kind of provision, eg, home care services supervised by physiotherapists may well be able to deliver evidence based exercise programmes at a considerably lower cost.

Some current characteristics of provision	Commissioners need to...
Arbitrary time limits for intermediate care and reablement.	Commissioners need to identify how they can safely move away from using fixed time limits for these two services to an outcomes based commissioning model.
No linking of outcomes to performance to incentives	In terms of prevention the current incentives in home care are perverse. In effect businesses are incentivised to encourage demand rather than to reduce it. Commissioners need to develop mechanisms (whether through direct contract, framework agreements or through direct payments) whereby payment is based on outcomes achieved rather than on the volume or length of service provided.
Health commissioners tend to ignore the benefit of housing gain.	Health and Wellbeing Boards in driving forward integrated commissioning need to have a greater recognition of what good housing can achieve. The Boards need to involve both planning and public health to drive this forward.
Older people are often assessed in hospital when still ill and move to a care home prematurely.	Boards may wish to look at how they can create a policy of whereby no-one moves from hospital to care home and how assessments can be community based. Particular regard should be given to avoiding assessing people when still suffering from infections such as MRSA, urinary tract infections.

Table 10 The commissioning agenda – the maintenance offer

Some current characteristics of provision	Commissioners need to...
People tend to get badged with long term conditions as a label which then implies the condition is either unchanging or only deteriorating and that service provision is inevitable.	Some people face degenerative conditions where the objective for health and care provision is maintaining, as far as possible, a reasonable quality of life through to death. However, there are also many older people where 'a good enough recovery' is seen as the outcome of a health care intervention and where social care is then funded for a long period of time. Of particular concern is stroke but also incapacity through falls etc.

Some current characteristics of provision	Commissioners need to...
	<p>Some of the change in approach will be dependent on commissioners purchasing better and more evidence based assessments, some on having improved rehabilitative services available for purchase and some on simply resisting ageism and labels.</p> <p>There is also a need to identify the cost-effectiveness of different forms of intervention over a longer time period and across funding streams. Intensive post- stroke recovery services that reduce dependency may initially appear expensive but be a cheaper option than long term care and support. Health and Well Being Boards should address as a priority how to set up funding mechanisms that straddle current organisational configurations.</p>
<p>Maintaining an older person within the community can involve a plethora of different services all of whom deliver one aspect of care. This is both costly and ineffective.</p>	<p>Commissioners need to start by working with providers to identify how they can begin to integrate provision at the point of delivery. In some instances this may be able to take place fairly swiftly, in others, where it may require integrating roles such as home care with health care functions, this may take longer.</p> <p>There will need to be guarantees to providers that if they are radically reconfiguring the shape of their organisations then contracts will be sustainable and not reversed at short notice.</p>
<p>Dementia is not managed well in the acute sector and creates poor outcomes.</p>	<p>A number of recent reports have identified how poor care in the acute sector of older people with dementia results in a care home admission.</p> <p>Commissioners need to explore how when older people with dementia require acute sector interventions, then their home care service can transfer with them to the hospital. This could increase hospital resources in an area where staff readily admit they are poorly trained and resourced and also provide a familiar face for the person with dementia in what is a very alien environment.</p> <p>Further work also need to be undertaken to look at how hospital admissions for people,</p>

Some current characteristics of provision	Commissioners need to...
	with dementia can be avoided through community based interventions.
Support for carers is neither well targeted nor integrated with funded provision.	For many older people a family member acting as a carer is their main form of support. Such carers may be providing very high quality, integrated and intensive care with a minimum of support. There is a need to commission flexible home care that can 'wrap around' an existing carer and be available as and when required rather than waiting until intensive home care becomes an alternative to an exhausted family carer.
Direct payments being offered without clarity of what they are to achieve and monitoring of how they are spent.	For many older people the offer of a direct payment to purchase care and support, particularly for those with a need for some form of long term care is both appropriate and beneficial. However, this does not mean an open ended commitment to funding. It should be outcome based and monitored. Commissioners also need to make sure that there is a sufficiency of supply for older people to purchase. Having funding whether from your own, or the state's resources, is pointless if nobody wishes to offer the service you need or want at a price you can afford.

9.3 The provider agenda

Clearly the implication of much of the above is that to kick start a reconfiguration of provision requires strategic commissioners across health and social care to have identified, preferably through Market Position Statements, the shape they would like the market to achieve. However, providers also have a key role to play in making sure that they are in a position to respond to both strategic commissioners and consumers.

There are a diverse range of views in the provider market. Some see home care as remaining within its traditional confines and a purchase process based on cost and volume. Others recognise the wider agenda and would welcome a much greater dialogue about the ways in which change can be brought about. There are also concerns about the tension between price and innovation and how if the former falls the latter becomes impossible. Markets also thrive on competition yet this may not be the best way to deliver change. Some would argue that if commissioners change their

approach there may be a competitive advantage to be had by being first in the queue with a reconfigured service.

There are a number of future challenges that providers might want to consider:

- Are there potential alliances that we could form to develop more of an integrated approach, possibly straddling the private and voluntary sectors or home care providers working with alarm / care and repair/ supporting people providers?
- How could we reconfigure some of the range of health and care tasks into a single approach? If there is a wider role to develop across health and social care what would we need to do at what cost to reconfigure our provision to achieve this?
- How can we introduce flexibility into the care offer, eg, do we need to develop micro teams of carers that could serve a small group of consumers which could give better flexibility when a crisis comes along or when no service is needed?
- How can we configure our offer to increase independence and reduce dependency and how might this fit a revised business model?
- What might an outcome based funding model for home care look like from a provider perspective?
- Do we have a knowledge based prevention offer?

The response from providers may be none of the above unless they are backed by funding. However, in the current resource climate the amount the state pays for care is unlikely to increase substantially based on the traditional home care product. Private sector (and to some extent voluntary sector) organisations are therefore presented with a choice if they wish to expand:

- Look to build greater business by gaining more work from self-funders who have previously used informal care.
- Increase turnover by merger and acquisition and hence total profit although margins remain the same.
- Look to increase share of the whole market through taking on a wider range of tasks.

Obviously, it is the third of these that best fits the model as outlined in this report. However, making sure this happens will take a different kind of dialogue between providers and commissioners, a preparedness from providers to embrace change and an evidence base that includes current and future consumers.

9.4 Conclusion

The above approach begins to set out a shift in thinking about our expectations of what home care could and should be able to achieve. The end point will be a radically different set of services. Such a shift may initially be driven by the public sector but its impact needs to stretch across all future home care users regardless of their funding route, particularly if the necessary health gains are to be achieved. The reconfigured services will not be publicly provided but need to start by being publicly commissioned. They will offer consumers a choice of outcomes and how they might be delivered. The new model will need to recognise that where providers are being asked to take on new roles and tasks that they may initially require some public funding to lessen their business risk and to encourage innovation.

If we continue to have a fragmented set of services, provided by a wide range of organisations, who sometimes not only fail to work together but can work in opposition to each other, where there is constant referral on from one body or individual to another, to the bewilderment of the end user and at considerable cost, then, in the face of demographic growth of the older people's population, at some point the system is likely to collapse.

The vision presented here may be ambitious but it does try and distinguish between sustaining communities and lifestyles as compared to acute and targeted interventions designed to halt a decline in health and well-being, whilst recognising that both interventions are necessary. It is a vision that allows large and small organisations to play a part and for all to be funded on the basis of achievement rather than cost and volume.

The need to maintain and support more older people in the community at a lower cost is essential. Achieving this not only means having an approach designed to reduce the period of ill-health prior to death but also that it lessens the impact of ill health and acute conditions when they do occur in old age and reduces rather than increases the need for care. Home care has an important part to play in the future in achieving both of these goals.

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