HOME CARE
IN LONDON

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IDEAS to
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EXECUTIVE SUMMARY

Over the next two decades, the number of people aged over 80 is set to double in Britain. Public services must adapt to the challenge that this poses, central to which is the need to deliver social care to older people.

Systematic failures in the care system mean that many older people end up in hospital because of a lack of care before they reach 'crisis point'. Age UK has estimated that 165,000 older people in London alone are unable to access the care support they need (Age UK 2009a) and this is set to worsen with increasingly restrictive care criteria used by local authorities. This has fuelled fear of a costly 'bed blocking' crisis in the NHS.

Home-based care has the potential to reduce the pressure on more costly public services such as hospital beds and care home places. It can also enable older people to enjoy the benefits gained from remaining in their homes and communities for longer, significantly improving their quality of life.

Despite the importance of home-based care, a number of problems continue to plague its provision. Most significant is a lack of investment in the system. The rising number of older people drawing on care has not been matched with adequate funding, either through public or private contributions. This is something which will be exacerbated in the short-term by budget cuts to local authorities: if this translates into a 7 per cent real-terms reduction in funding over the spending review period then by 2013/14 a gap starts to open up, reaching a total shortfall of £1.2 billion by 2014/15 (Humphries 2011). The forthcoming report of the Dilnot Commission on Funding of Care and Support will set out how more money might be injected into the system. The most likely solution is for the state to increase its funding of social care while incentivising older people themselves to contribute more, either through insurance payments or the release of equity in their houses.

Other problems also prevent home-based care from delivering on its potential, including low productivity, poor integration with health services, and a very fragmented market.

All this comes at a time of great upheaval in the structure of the NHS and social care. GPs will be given more power to commission health services at the same time as local authorities continue to commission social care. Meanwhile, the health regulator Monitor, coupled with Health and Wellbeing Boards in each local authority, will be charged with ensuring better integration between health and care services.

These challenges are being felt particularly acutely in London. Like the rest of the UK, London's over-80 population is increasing – the Greater London Authority estimates it will rise by 40 per cent over the next 30 years (GLA 2009). Older people living in London are more likely to require home-based care services compared to other areas of England. This is because they are more likely to live alone, lack support from their families and suffer from poverty, resulting in a greater need for public services (GLA 2010a). The city also presents a set of unique circumstances – including a particularly high proportion of migrants working in social care, an over-reliance on acute hospital beds, and a large number of neighbouring authorities in a small geographic area – which makes commissioning services very difficult.

This paper explores the issue of home-based social care in London. It provides policymakers and commissioners with a clearer idea of what makes for good quality home-based care, the challenges that exist for delivering it, and how the increasing

demand can be met. Our research identified three key tests to ensure home-care is of good quality.

Test 1: **Care is provided by well-trained care workers who have enough time to care and can provide a consistent service**

Home-care is currently failing this test. Low wages, poor progression opportunities and a stressful working environment have led to persistent job vacancies, a high turnover of staff, a low skills base and a reliance on migrant labour. It has been estimated that social care will require between 0.5 and 1.5 million additional recruits in England by 2025 (Skills for Care 2010). Staff turnover is higher in London than in other areas, and the city also relies more heavily on non-UK-born recruits to fill social care roles, with 75 per cent of its in-home care staff originating from another country.

This is a long-term problem and it cannot be properly addressed without more money in the system. A key priority for any new funds should be to develop care professionals. Given that social care is a labour-intensive service, productivity cannot be increased without improving the skills of staff. This in turn will require better pay, training, regulation and progression.

In the short term, policymakers can take other steps to address these problems:

> **Recommendations for policymakers**
> - A single professional body should be created to support training, provide advice and information on career options, and represent the workforce's interests. There are a number of bodies which do individual elements of this but the industry lacks a central resource that provides easy access to information, such as that provided for health workers by NHS Careers.
> - Local authorities and health services should pilot the employment of professionals who can deliver both health and social care in the home, in order to raise the status of the profession by requiring more skilled staff. It would involve health and local authorities pooling their budgets and commissioning some home-based care services together, a process which could be overseen by the proposed new Health and Wellbeing Boards and Monitor.

In order for home-based care to be of a good quality, it needs to be provided by a familiar care worker who is able to meet the individual needs of the person using care. High staff turnover rates and employees on temporary contracts mean that older people rarely benefit from consistency in their care workers. This is a particular problem in London, with 10.3 per cent of care workers in the city being on temporary contracts compared with a 4.3 per cent average across England. Interviewees taking part in our research spoke of the disruptive nature of changing care workers and the importance of building trust with someone who enters their homes. This is confirmed in a recent report by the Equality and Human Rights Commission (EHRC) into home care, which highlights a case in which one woman received care by 32 different carers during a single week (EHRC 2011).

That care workers have enough time to listen to and care for an older person in a way that accommodates their preferences is important. Many of the people we interviewed spoke of the limited time allocated to care workers for each older person and the lack of flexibility

in their job descriptions. The skills of the care worker are central to delivering high-quality home-based care and the way in which a carer interacts with an older person affects their experience of care significantly. Providers need to equip care workers with knowledge of what constitutes good care and the skills to delivery it.

> **Recommendations for home-based care providers**
> - Ensure older people are matched to carers with similar 'personality profiles', so that good relationships can develop while care is carried out.
> - Ensure older people are allocated the same carer where possible, in order to allow time for trust and relationships to develop.
> - Give carers more flexibility in how they go about frontline tasks and move away from a task and time-based approach to delivering care.
> - Put in place training on how to build positive interactions with older people.

Test 2: Care is personalised to individual needs rather than prescriptive services

The most effective home-based care is personalised around an individual's needs. Giving older people personal budgets – which means they can choose what they spend their care budget on – can help to achieve extensive personalisation of services.

However, there are a number of concerns with how personal budgets have been implemented in London. Many of the people we interviewed expressed concern about the lack of support for managing a budget, a lack of information about what services are available for purchase, the time it takes to be assessed for a budget, and the risks associated with older people hiring their own carers without screening them first. This supports other research that found that older people are more likely to find managing a budget burdensome than other groups who are eligible for them (Glendinning et al 2008). For personal budgets to deliver on their promise, two things need to happen. First, much better information must be shared on how personal budgets work and the services that people can spend them on. Second, a better range of services must be provided for older people to choose from, so that the market is not restricted to services that were already being commissioned by the local authority.

> **Recommendations**
> - Support the creation of peer networks, which have been found to be the best tool for spreading information on personal budgets. This would require a small amount of investment, for example by assisting with the set-up of websites or training coordinators.
> - Develop a streamlined system of funding and provision of personal budgets so that the Attendance Allowance, health services and social care services are integrated, to provide greater flexibility and choice.
> - The Greater London Authority (GLA) should oversee the care market in London, ensuring that local authorities are creating an effective market in care providers and monitoring the cost of services.

Test 3: Care allows the older person to be independent and reduces reliance on acute health services

Local authority support for home-based care is often provided at very late stages, when people have a critical level of need. There is a lack of coordination between health and social care of the kind that might achieve a more preventative approach. Although there are a number of approaches to home care which could reduce the pressure on more costly services down the line, these are often not utilised. Assistive technology and telecare can help support the work of a carer and enable problems to be identified earlier, but currently there is a lack of awareness of what technology is available and how it can be used. Assessments of and adaptations to the home environment can also be used to prevent falls, which cost the NHS £5 million per day (Age UK 2010a).

Intermediate care and reablement can be used to sustain independence in old age and to reduce the costs of care that result from readmission to hospital. The extent to which health and social care professionals work in partnership is variable, and older people are often caught in a revolving door between home and hospital. Reablement services have been shown to reduce the cost of later care by as much as 60 per cent, but London is not taking full advantage of these potential savings (Glendinning et al 2010).

> **Recommendations**
> - A greater proportion of the NHS budget should be dedicated to preventative social care, reablement and innovative assistive technology solutions. In London, giving the GLA a greater role for overseeing the integration of health and social care could ensure there is consistent partnership working across the city.
>
> - Local authorities and health providers should use the same set of metrics to monitor outcomes and assess performance. This would help to align objectives and ensure a 'whole systems' approach is taken to care. Monitor, which now has responsibility for overseeing integration between health and social care, could be made responsible for developing the metrics to be used and helping to embed them into health and social care providers' systems.

INTRODUCTION

At a time of both rapid ageing and a changing health and social care landscape, policymakers and service providers are faced with the huge challenge of providing a social care system that is capable of meeting need. Demand for social care is growing fast, with the number of older people over 85 set increase two and a half times between 2010 and 2035 (ONS 2011). London is no exception to this trend: over the next two decades, the over-65 population is expected to grow at twice the speed of its total population (GLA 2010a). As life expectancy increases at a greater speed than disability-free life expectancy, the role of social care is also magnified (ONS 2010).

In an environment of severe cuts to public budgets, the extent to which services and communities can meet the coming challenges is under threat. The Kings Fund has recently estimated that cuts to local authority budgets will translate into a £1.2 billion shortfall in social care funding over the next four years. In London, some of the most deprived local authorities have seen the largest cuts to their budgets: Tower Hamlets, Newham and Hackney are three of the most deprived areas in England but all received an 8.9 per cent reduction in their overall budgets, which means the pressure on social care may be greater just where the need for it is greater. How we pay for the increasing demand for social care is currently being considered by the Dilnot Commission on Funding of Care and Support, but it is clear that whatever recommendations stem from that inquiry, a complete re-appraisal of the systems now in place is going to be required.

Over the past 20 years, we have witnessed a change in the way policy and research have approached the issue of social care. The political rhetoric has shifted towards supporting the increased independence of older people. The previous government put in place a number of strategies to drive change towards a system that allowed for personalised approaches to care. Central to this shift was an increased emphasis on 'ageing in place', where older people are able to remain in their own homes and communities rather than moving into residential or hospital-based care. With the NHS and social care currently in a state of reform, it is a critical time to ask how we can overcome the present and future challenges faced by both systems.

The aim of our project[1] is to provide evidence on how we can better adapt to changes in demand and on how services can be delivered in a way that both achieves efficiency and meets the needs of older people. The focus of the project has been on older people over the age of 75, to reflect the diversity of needs among older people of various ages, which is largely ignored by research. It is also the time when older people are likely to experience the greatest level of need for supportive services. Older people over the age of 87, in particular, undergo a rapid decline in activity rates, and so care services become crucially important in the later part of an individual's life (Sauvaget et al 2001).

This paper focuses on home-based care services but it is important to acknowledge other areas of relevance. Many of the older people we interviewed combined home-based care with community-based services, and the social interaction and sense of independence taken from this was seen as extremely valuable. The issue of residential care was also raised by interviewees; in all cases, older people spoke about their fear of being placed in a care home. Lastly, we are excluding the role of informal carers, who often play a central role in supporting older people living at home.

The first section of this paper outlines the current context for home-based care in the UK, looking at why it is important and where it fits within the overall approach to social care

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1   Older Londoners. See http://www.ippr.org/research-projects/44/7117/older-londoners

and the current financial environment. The second section covers home-based care in London by giving an analysis of the home care market and some characteristics unique to London. The third section outlines three key tests that need to be met for home care to be delivered effectively and to a high quality. Sections four, five and six investigate whether home care in London is successfully meeting each of these tests. The final section brings together our conclusions and puts forward recommendations to address the issues that emerge.

Methodology

The research undertaken for this paper involved analysis of secondary information, including surveys and reports, academic literature and case studies of good practice. It also draws on primary qualitative research carried out by IPPR staff using semi-structured interviews[2] with older people using home-based care or community-based services, as well as with a range of providers of home care services, including representatives from local authorities and private and voluntary organisations.

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2   A total of 50 semi-structured interviews were conducted with a range of service providers, carers and service users and across a range of London boroughs. All interviewees gave their consent to take part in the research. Where appropriate, service users were accompanied by a carer or interviews were undertaken within service provider premises.

1. PUTTING HOME-BASED CARE IN CONTEXT

Defining home-based care

Home-based care can be defined in a number of ways, ranging from specific services received within the home to services that enable independence and allow an individual to remain at home. Examples of home-based care services include:

- help with everyday household tasks such as cleaning, shopping and household maintenance
- personal assistance with getting up, washing and dressing
- assistance with managing medical conditions, such as medication management
- monitoring of health and wellbeing through technology
- more complex medical care for long-term conditions
- intermediate, rehabilitation and reablement services following a period in hospital.

These can be provided by a range of organisations from the public, private and voluntary sectors, and are commissioned primarily by local authorities. Although some local authorities provide their own in-house services, increasingly these are being outsourced to independent providers. Home-based care can also be provided informally by family, friends and neighbours.

The importance of home-based care

Home-based care should be seen as providing a number of benefits to older people and to the health and social care system as a whole. When delivered well, it has the potential to increase the dignity and independence of older people, and it can be used as a way to deliver more sustainable care, by enabling people to live more independently and thereby reducing their need for support. This was emphasised in the Wanless review of social care for older people (2006).

Despite this, local authorities tend to provide access to assisted home-based care only at the critical stages of need, leaving older people often to struggle to access the home care services that might prevent them from needing more complex care in the future. Evidence shows that older people also lack support following a stay in hospital, which is leading to 'bed blocking', whereby older people remain in hospital longer than necessary because they lack the services to support their transition back into the home.[3] In 2003, the House of Commons Public Accounts Committee estimated this to cost the NHS £170 million annually.

In short, home-based care delivered effectively and in unison with other services offers potential for greater efficiency and better outcomes for older people.

Policy

Health and social care policy underwent significant changes under the previous Labour government. These resulted in greater support for increasing the level of independence and personalisation delivered through services for older people. For example, Making a Strategic Shift Towards Prevention and Early Intervention (DoH 2008) set out a move towards a more preventative approach to health and social care, while Putting People First (Ministerial Concordat 2007) placed individuals at the centre of their own care and proposed that they should be able to control what is delivered and how. This led to the introduction of personal budgets, which placed the budget for services in the hands of individuals.

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3   In a recent survey of 502 doctors working in UK hospitals conducted by Doctors.net.uk, 450 of the respondents said that bed blocking had either not improved or had become worse.

On the surface, the messages of the Coalition government have not changed significantly from those of the previous government. It has outlined plans to extend personalisation, increase the use of personal budgets and intensify efforts towards preventative care (DoH 2010). Although the details are not yet fully clear, the proposed Health and Social Care Bill is likely to radically reform the structure of the NHS and care services by placing health service commissioning in the hands of GPs. Strategic Health Authorities are also unlikely to survive the current plans for reform and although a National Commissioning body has been put forward this is unlikely to be able to play a significant role in overseeing local commissioning in the same way. Local authorities are to retain responsibilities for commissioning public health and social care services but will also be required to set up Health and Wellbeing Boards to help coordinate local health and social care services. Integration of health and social care is also put forward as a greater priority as a result of the recent discussion on reforms. As a result, Monitor, the independent regulator of NHS trusts, has been handed responsibility for ensuring integration and 'clinical senates' made up of a range of health professionals have also been proposed as a way to facilitate partnership working across care.

The government has also taken some positive steps in protecting the position of older people. In October 2010, the Chancellor announced £2 billion of additional funding for social care: £1 billion through the NHS and £1 billion through a grant to local authorities. Despite this additional funding, the ability of reform measures to improve the way social care is delivered is threatened by a period of extreme austerity. As noted above, the Kings Fund has estimated that these cuts will mean a 7 per cent real-terms reduction in funding for social care and that this will leave a £1.2 billion gap in funding over the next four years. The real impact of these cuts is as-yet unknown and will depend on the priorities and efficiency of each local authority. Funding considerations underpin the future of social care.

The future of social care funding

The way social care is funded in the UK is currently under consideration by the Dilnot Commission, whose recommendations are expected to be released in July 2011. Given the UK's ageing population and budget deficit, it is essential that the underlying structures and financing of social care are able to meet growing demands and achieve greater efficiency.

The scale of the challenge identified in this paper cannot be matched through efficiency savings alone. While there is some potential to increase efficiency and productivity and to redirect spending from other areas, the system will require additional investment in the long run. Further investment in social care should be a major priority for any government.

The convening of the Dilnot Commission provides a unique opportunity to set out how this investment can be generated. One option is to shift the burden onto the working age population by raising taxes and encouraging them to care for their older relatives. However, this is not a sustainable solution. It would make it harder for working people to save for their own retirement, remove people from the labour market as they care for older family members, and increase inequality, as those who could not afford to pay for private care would suffer.

A more effective solution would be to encourage people to contribute towards the cost of their care, topped-up with contributions from the state. People could be encouraged to insure themselves against a certain level of care throughout their working lives – this is currently the case in Germany.

While a form of social insurance could solve care funding in the long run, it will not resolve the issue for those baby-boomers already approaching retirement. If this group is to contribute to the cost of their care, one option will be to tap into the wealth that is locked up in their homes. This can be done through a form of early equity release or property tax. In New Zealand, for example, local government is able to reclaim money on a person's estate when they die, in order to cover the cost of their care. This prevents older people having to downsize their homes upfront.

These will be politically contentious issues over the coming years, but they must be tackled to ensure money is injected into the care system. Once the funding questions have been addressed, it will then be possible to turn to the substantive questions posed in this paper about the quality and provision of social care.

2. HOME CARE IN LONDON

London faces a number of key challenges – some are distinct features of the capital itself and others are issues facing England as a whole. This section outlines the challenges facing London and details the services in place to meet its demands, including the home-based care market and the way services are commissioned.

Demand for home care

As a global and highly populated city, London presents some unique challenges. With the over-65 population set to increase by 240,000 by 2030 and a quarter of a million residents already aged over 80 (GLA 2010a), the need to adapt services and meet increasing demand has never been more urgent.

Map 1 (over) highlights the changing profile of older people in London, looking at the percentage of people aged over 80 in each borough in 2011 and projections looking 30 years ahead. It shows that the outer London boroughs are projected to have the highest proportions of older people when compared to the rest of London and that in all cases the percentage of older people over the age of 80 will increase significantly. There is a big variation in the extent to which older people are supported to live independently in their own homes. In Waltham Forest, for example, 6.2 per cent of older people are supported to live independently, whereas in Westminster 17.1 per cent of older people are supported to live independently (National Social Care Indicator Set 09/10).[4]

Other factors mean that demand for home-based care in London is likely to expand to a greater extent over the coming years. Older people living in London are more likely to require home-based care services when compared to other areas of England. This is because they are more likely to live alone, to lack support from their families and to suffer from poverty, resulting in a greater need for supportive public services (ibid). There is also an overall shift in preferences towards care within the home as opposed to residential care, which means that a disproportionate share of the increasing demand for social care from an older population will fall on home care support services in particular.

There are a number of other factors which mean older people in London are at risk of missing out on the services they need. The majority of councils only fund care when the person has 'critical' or 'substantial' need, according to the Fair Access to Care Services criteria. This means that many older people are reliant on their own ability to pay for services and, in reality, the extent to which older Londoners can afford to do this is limited, with London having the largest proportion of pensioners living in low income households, compared with other English regions (London's Poverty Profile 2010). It is already estimated that 165,000 older people with care needs may not be able to access the services they need unless they take on the costs themselves (Age UK 2009a). A recent report by the Law Commission highlighted the complex and inconsistent nature of the legal framework for adult social care, which results in an inconsistent system that limits the ability of individuals to protect their rights to care. The commission calls for a simplified single system that includes codes of practice for local authorities to adhere to, under which they are obliged to provide a universal set of preventative services as well as targeted services for specific need groups (Law Commission 2011).

There are worrying trends in the way social care resources have been allocated which suggest that older people may lose out the most from reductions to social care budgets. Since 2006, social care expenditure on older people has increased only very slightly by comparison with other social care user groups, recording a 3 per cent increase compared

Map 1
80+ population as a
proportion of total
population, 2011 vs 2031

2011

Less than 2.5%
2.5–3.49%
3.5–4.49%
4.5% or more

2031

Less than 2.5%
2.5–3.49%
3.5–4.49%
4.5% or more
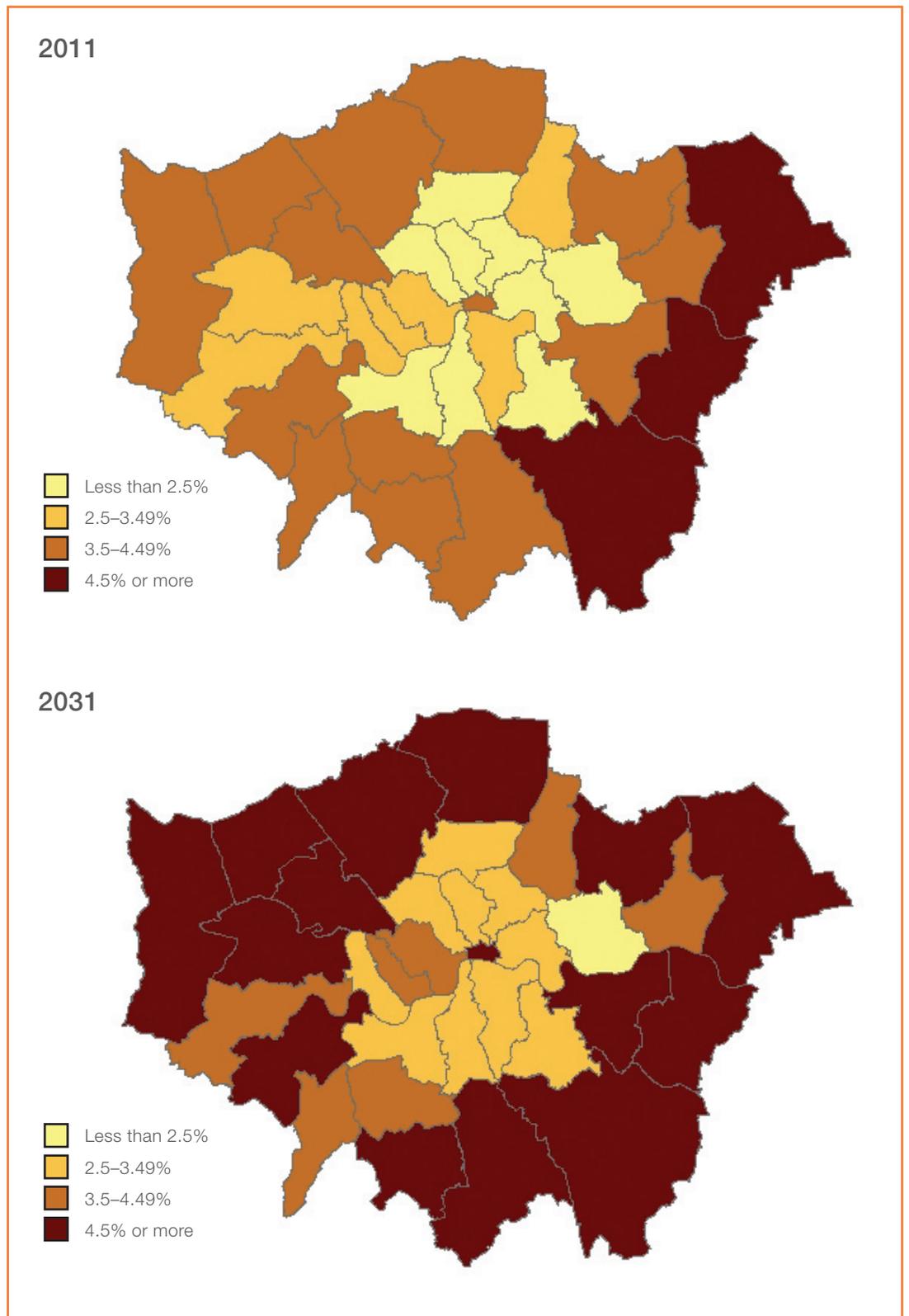
to an increase of 20 per cent for people with physical disability and 14 per cent for those with learning disability (Humphries 2011). The combination of recent cuts to local authority budgets, a lack of ring-fenced budgets in social care, and the slower increases of expenditure on older people compared with other social care users indicates that potential shortfalls could fall disproportionately on older people. There is a significant risk that without sufficient action these factors will result in a future home care crisis in London: it is critical that steps are taken now to put in place a structure that will respond to changing demands and adapt to increasing pressures for efficiency.

While older people should be able to expect at least a minimum level of service regardless of the borough in which they live, it is important to acknowledge the role of local authorities in making decisions about service provision in their areas. One natural consequence of this is variation in the type of services on offer in different authorities. However, there are a number of issues that affect the ability of local authorities to meet need through the services they commission.

Commissioning home care at the local level
Home-based social care is currently commissioned by local authorities. They either deliver the services directly or commission other providers to deliver them. When outsourcing, tenders for specific services are released and a number of accredited providers are given the contract to deliver these services under certain conditions, such as the requirement to achieve certain results. Care is means-tested according to a person's level of need and ability to pay.

Health care is currently commissioned in a very different way. It is centrally administered through the Department of Health, regional Strategic Health Authorities and smaller-scale Primary Care Trusts (PCTs). It is a universal service funded by the taxpayer. The division between social care and health care is a long-standing problem in England. It prevents joined-up working, such as might be achieved by, for example, investing in preventative measures in a person's home in order to stop them needing a hospital bed. A number of organisations have called for funding for health and social care to be better integrated (Humphries 2011).

There have been efforts in the past to achieve better integration between health and care. For example, under section 75 of the Health Act, Primary Care Trusts and local authorities are able to sign a partnership contract by which they can pool budgets to commission work together, and this has been taken up by some London boroughs, such as Westminster.

Despite the potential of this approach, pooled budgets in 2009 made up only 3.4 per cent of the total health and social care budget, and this was concentrated in specific service areas – according to the Audit Commission, 'pooled funds are mainly used for learning disability, community equipment and mental health services but rarely for older people's services' (2009:1). There is, therefore, considerable scope to expand the integration of these services.

The current government is proposing a radical shake-up of the health system, which may bring health and social care services closer together. It is proposing to abolish Strategic Health Authorities and devolve a lot of health commissioning to GP

consortia, which will be required to align with local authority boundaries. Aligning the boundaries in this way has the potential to improve integration, provided that the proposed local authority Health and Wellbeing Boards have sufficient powers to oversee health commissioning as well as the provision of social care. The government has also signalled that the health regulator, Monitor, will be responsible for promoting the integration of health and care.

While the government is making much of its plans for integration, the best way to align health and social care is ultimately to integrate their funding assessments at the central level (Humphries 2011). There have been successful pilots of schemes through which health and social care budgets have been pooled to commission services jointly – in one example, the POPP pilots saw money from the Department for Health being spent on preventative home care.[5]

Commissioning home care in London

In London, commissioning in social care currently faces a number of problems:

- The abolition of the Strategic Health Authority will mean there is very little oversight of the health or care systems across London as a whole.

- The high concentration of neighbouring boroughs means older people are likely to use cross-borough organisations to deliver their care, which blurs the boundaries in terms of commissioning.

- Procurement professionals are often used to commission social care services, with the aim of achieving the best 'value for money'. Cost efficiency is therefore prioritised at the expense of other important goals, such as personalisation or ensuring there is a choice of providers available.

- The tender process itself can work against personalisation – it is not shaped by the people for whom these services are intended, while bureaucracy and price competition in the market can limit the ability of smaller voluntary organisations to deliver services.

In order to resolve these problems, a number of steps need to be taken:

- The GLA should take on some of the oversight function provided by the Strategic Health Authority, to ensure that services being commissioned at the local level are joined up.

- Local authority Health and Wellbeing Boards need to be given sufficient powers to coordinate both health and social care.

- Local authorities could employ professionals that can deliver both health and care in the home.

- Commissioning in local authorities could be undertaken by a mix of health professionals, social care professionals and procurement experts, so that financial efficiency does not come at the expense of other important goals.

- A more ambitious 'minimum entitlement' to care could be put in law. This would ensure people do not lose out because of where they live.

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5   **Partnerships for Older People Projects** – see www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/ Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

- Councils could introduce a revised system of tendering that makes it easier for voluntary sector organisations to bid for work and that involves older people in the process.
- Local authorities and health agencies could use a single set of metrics to monitor and assess their services. This would enable greater coordination between the two services.

London's home care market

The market for home care in London has a number of distinct features. A report commissioned by London Councils (2008) found that, in London:

- In 2008, the home care market was worth over £401 million and made up 29 per cent of the total care market, with the remainder being commited to residential care and nursing services
- Demand is high and growing, with home care replacing residential care, meaning there are opportunities for changes in the market
- Providers operate at high levels of efficiency, with profit margins of 5–10 per cent
- The market is fragmented: 51 per cent of the spend goes to private providers, 23 per cent to voluntary providers and 26 per cent to local authorities; but the role of local authorities has been reducing over time and will continue to do so (National Market Development Forum 2010)
- The market is highly competitive, with sub-regional providers being stronger than national providers
- Costs of providing care differ significantly between independent and public providers, with the average cost being £12.20 per hour when contracted out to a voluntary or private provider and £20.60 per hour when delivered directly by a local authority
- Local authorities wield the greatest buying power in the market, accounting for 74 per cent of the total spend
- Suppliers hold little power, with local authorities being able to re-tender contracts at will
- Barriers to new suppliers entering the market exist because of procurement and accreditation processes, the difficulty of recruiting staff to vacant positions, and low profit margins.

This summary shows that the market is large and growing but that there are issues that may limit the number of providers entering the market and thereby offering choice to older people. High efficiency levels mean that there is limited scope for further price reductions, which may mean that those organisations which are able to benefit from the greatest economies of scale will be the most successful.

3. THREE TESTS FOR HOME-BASED CARE

It is important to start our analysis by asking 'what makes a good quality home care service?' 'By asking this question in our research, we were able to identify both those features that matter to older people and the aspects that service providers believe supports their ability to meet people's needs. Our findings identify three key tests that home-based care has to pass in order to be considered 'good quality'.

Test 1: Care is provided by well-trained care workers who have enough time to care and can provide a consistent service

The way in which staff carry out home care is central to meeting the needs of older people. Older people we spoke to felt uneasy at the idea of having someone come into their home and so would prefer their carer to be someone they have a good relationship with. As one carer said about an older lady she works with 'it's got to be the right staff who she feels comfortable with'. Professional care workers are often required to carry out very personal tasks, such as getting someone washed and dressed, and so trust between the carer and the older person is extremely important. In order for an older person to feel comfortable and secure, it is important that they are familiar with their carer, and previous research has shown that quality relationships are crucial for achieving positive outcomes for older people (Patmore and McNulty 2005).

Workers also need to be given enough time to carry out more than just manual tasks – time should be allocated for more personalised aspects of care, such as going outside on a sunny day or spending time talking, which have been found to positively impact the wellbeing of older people (Patmore 2001).

The skills and approach of the care worker are also central to delivering good quality care, as one social care provider said:

> 'You cannot underestimate the skill and quality of your frontline staff who are working for any provider, whether they are an independent sector provider or a local authority provider.'

The way workers approach their work and interact with an older person is crucial to ensuring their wellbeing is supported – for example, responsiveness, warmth and cheerfulness all contribute to a better care experience (Francis and Netten 2002).

Test 2: Care is personalised to individual needs rather than prescriptive services

Care provision often centres on particular tasks and may exclude things that would be more useful or beneficial to the care user. Facilitating individual choice in care can provide people with greater independence and put them at the centre of their care. A number of the older people we interviewed spoke of the importance of personal approaches to care, which meant being able to structure their day according to their own preferences. One service provider spoke of the new ethos this requires, saying personalisation involves:

> '[G]iving power back to the person who is receiving the service, and you're looking at working with them in ways [so] that every interaction is of value.'

Other research has also found that having a say over when and how care is delivered is valued by older people and is used to judge the quality of their services (Francis and Netten 2002). Older people value having an active role in their own care which allows their aspirations to be integrated into the design and delivery of services (Glendinning et al 2006).

This requires shifting services to focus on 'outcomes' that are prioritised by older people, so that their care is working towards achieving their own personal goals.

Personal budgets, which give individuals access to a budget which they can use to purchase the services that matter to them, are seen as a way of facilitating a person-centred approach,. While there are a number of pre-conditions to this being successful, it is arguably the only way to deliver total personalisation.

Test 3: **Care allows the older person to be independent and reduces reliance on acute health services**

Preventative care services can ensure older people live more independent, active and socially integrated lives within their community, which can in turn improve their quality of life (DoH 2008b). Interviewees spoke of the importance of remaining in their own home at all costs. Failing to take a preventative approach coupled with insufficient co-ordination between health care and social care services can create a revolving door between hospital and home (Curry 2006). This is both highly damaging to the wellbeing of older people as well as costly, with an estimated 41 per cent of the NHS budgets being spent on over-65s (DoH 2001: 1). One London borough council service provider noted the benefits of introducing a more preventative approach:

> **'The emphasis on what we deliver has changed to one of prevention …
> and people who've been through that service generally have given us
> very positive feedback about the intervention and subsequent levels of
> independence that they've regained.'**

Having adequate recovery, rehabilitation and reablement services to ensure older people are able to recover and manage with any longer-term health issues has been found to be successful in preventing admissions to hospital and increasing independence in the long–term. To achieve this, health and social care services need to ensure integrated and holistic services are delivered (Age UK 2009b).

The remainder of this paper explores where home-based care in London is failing to meet each of these tests, and sets out ways it could improve. Examples of good practice – from within London and from further afield – are included to show that things can be done differently and more effectively, given the right conditions and support.

4. DELIVERING QUALITY HOME CARE THROUGH THE CARE WORKFORCE

Ensuring that the home care workforce in London is able to meet the growing demand of an increasing older population is likely to become one of the most important issues in social care.

In 2005, a strategy was developed for the adult social care workforce. It outlined the main challenges to ensuring 'the right people with the right skills' are delivering care (DoH 2006: 3) and found that there were a number of key workforce issues to address, including recruitment and retention, workforce development, workforce remodelling and commissioning. With local authorities increasingly outsourcing their social care services, the level of direct influence they have over care workers is increasingly limited and the complexity of the workforce is increasing (IDeA 2008). Pressure to provide care at the lowest cost may have a knock-on effect on the pay and conditions of the workforce, which may subsequently lead to poorer quality care (IDeA 2009). As long as local authorities prioritise financial efficiency over quality, the ability of the workforce to meet the needs of older people is arguably restricted.

The social care sector is one of the largest in the country, employing over 1.6 million people in 2009 (Skills for Care 2010). The majority of these are employed in the independent sector, and primarily in private organisations. Outsourcing of services leads to a greater use of agency staff; currently, 3.7 per cent of all workers in social care are on temporary contracts and this reaches 4.3 per cent for direct care workers. The sector is predominantly staffed by women: 80 per cent of all adult social care workers are female, and women working in social care are also more concentrated within direct care roles. Females are paid less – on average, 53 pence per hour less than their male counterparts (ASHE 2009). The workforce also has very low unionisation levels, with only 24 per cent of domiciliary care workers being members, compared with 58 per cent of managers within social care (McGregor 2011).

Meeting London's need

London's care workforce is unique in a number of ways. With 75 per cent of care assistants and home carers born outside the UK – compared with 20 per cent across England as a whole (Skills for Care 2010) – London's care market is vulnerable to any changes in economic migration rules. Between 2005 and 2008, over 50 per cent of non-UK-born recruits to social care in England originated from the Philippines, India and Poland. With such a heavy reliance on two non-EU countries to fill roles that are perceived to be low-skilled, there is a risk that restrictions on non-EU migration will squeeze workforce supply.

Recent projections suggest that for the social care workforce to meet increasing demand in England it will have to grow by 24–82 per cent by 2025, meaning that between 500,000 and 1.5 million extra recruits would be needed (Skills for Care 2010). In reality, the recent trend has been for vacancy rates to grow: for example, the average three-month vacancy rate for care assistant and home care worker positions doubled between December 2006 and December 2008 (Skills for Care 2009). Vacancy rates in social care are also higher in London than elsewhere in the UK, although this varies from borough to borough.

Many service providers spoke of the lack of incentives for joining the care workforce. Wages are traditionally low, with the average worker in London receiving between £6.30 and £7.38 per hour, well below the London Living Wage of £8.30 an hour. The demands of the job are high but there is little opportunity for progression – as one service provider put it, 'there's no real career structure' – and many of those that are in the role for longer periods do it as a way to work around family life, rather than looking at it as an opportunity for a career. There

is a significant barrier to recruiting the right numbers of staff to ensure the growing demand in home care is met, with Poor development opportunities and low levels of pay present a significant barrier to recruiting sufficient care staff, and this may be compounded in the future, particularly in London, by any tightening of economic migration rules.

Good practice example: London Borough of Richmond-upon-Thames adult services workforce strategy
In response to the growing demand for social care and the challenges of meeting that demand, the London Borough of Richmond-upon-Thames has devised a strategy[6] that sets out the key principles and practical steps required to prepare the workforce and ensure it can deliver quality care.

It also outlines a number of key actions the council needs to take to ensure the strategy is delivered. For example, it sets out plans for promoting investment in e-learning and other training initiatives and for developing a culture of continuous improvement, so that care workers are equipped with the right skills and knowledge. It also sets out plans for more integrated work between health and social care professionals and for encouraging private and voluntary organisations to put in place a shared programme of work, so that they can support each other to deliver good quality care.

Alternative sources of care have been emerging which rely on informal and community-based solutions, such as the growing phenomenon of 'home sharing'. By this scheme, an older person provides accommodation to someone in need of low-cost living, such as students or migrants, in return for assistance with domestic tasks as well as companionship. There are over 100 households in London using this scheme.[7] 'Time banking' is another community-based approach to providing access to services. Time banking is a transactional system but, rather than relying solely on money, these schemes are based on time credits: if one member spends an hour doing something for another member they gain an hour's credit, which can be 'spent' on receiving assistance in the future. This allows for low-level care activities such as cleaning or gardening to be undertaken by someone outside of the care workforce. It also allows older people to build better community networks, thereby reducing their reliance on professional provision and providing an affordable way to receive assistance.

Good practice example: Rushey Green time bank, Catford
The Rushey Green time bank allows its members to put 'time in' by taking part in voluntary work in the area or getting involved in group activities. For example, an older person might receive some help with the garden or cleaning the house in exchange for their time spent knitting for a babies charity. The Rushey Green scheme has received awards for best practice and is recognised as having positively impacted the wellbeing of people in the area.

For more information see http://www.rgtb.org.uk/index.html

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6   See http://www.puttingpeoplefirst.org.uk/_library/Resources/Personalisation/Localmilestones/Richmond_
     strategy_211010_finalpdf.pdf
7   See http://homeshare.org/uk.aspx

It is imperative that we plan for the future and ensure there is an adequate supply of home care services to meet growing demand. London is at significant risk of failing to do this if it is unable to build a forward-looking strategy for care worker recruitment. Although it may be difficult to achieve in the short term, **it is crucial that we aim towards making social care a career that offers good pay and good progression opportunities** so that it attracts workers and provides a good standard of living. The scale of the challenge also means that alternative approaches to care need to be in place. **Schemes which encourage community-based and informal care should be promoted** to ensure low-level needs are met.

Delivering a quality service

In our interviews, older people continually stressed the importance of the relationship with their care worker and voiced their preference for having 'familiar faces' come into their homes. Having someone who appreciates their interests and personal aspirations was also seen as being important, and research has shown that where carers are matched with older people according to their interests the service can be more beneficial to the user (Cattan et al 2005).

When talking to service providers, it seems clear that there are a number of factors that cause care workers to leave their jobs – this turnover results in an ever-changing staff and a lack of familiar faces at the door. Low pay and the lack of career structure were both mentioned as reasons for people treating care work as a short-term option. London has particularly high staff turnover rates and a high proportion of staff on temporary contracts: 10.3 per cent, compared with an average of 4.3 per cent average across England (NMDS-SC 2011). With many of the temporary workers being employed by agencies, there is a particular problem with ensuring care worker consistency – as a result, many older Londoners miss out on the benefits of building a relationship with a care worker who understands their needs and with whom they have established trust. Findings from a recent commission into home care have highlighted the inconsistency of carers to be a particular problem for older people, with one woman receiving care by 32 carers in one week (EHRC 2011).

> **Good practice example: Macintyre 'Great Interactions' Initiative**
> Macintyre, a national charity working with children and adults who have learning disabilities, went through a programme that aimed to ensure staff were able to deliver personalised care.
>
> After outlining the personality profile that would be best suited to delivering high-quality care, this was used to identify the competencies required in care roles and to shape the recruitment process. An assessment of what made for 'great interactions' was undertaken through the analysis of video footage: key features included responsiveness, eye contact, touch, good listening and personal warmth. A policy and implementation plan was then introduced to ensure all staff knew about their responsibility to deliver good care, and 'great interaction champions' delivered four-day workshops on lessons learnt to senior colleagues.
>
> See http://www.macintyrecharity.org/Resources/?/Great+Interactions/45/

Achieving a personalised service also means hiring staff that are well suited to the role and who can develop their understanding about what good care is and how they can deliver it. A number of service providers stressed the point that social care is not a job

for everyone and that even those who are well suited to it still need support and training to make the most of their skills. Without an attractive career structure, pay or working conditions, the sector is unlikely to appeal to many of those with the right characteristics and skills. Whether in the private, public or voluntary sector, care employers need to adopt recruitment strategies that reach the right people and to ensure that conditions are sufficiently attractive to encourage long-term employment and progression within the sector. Where temporary contracts are in place there is an even greater imperative to ensure that carers are managed in a way that limits the disruption to older people receiving care.

In order to deliver truly personalised care there needs to be **a recruitment strategy that can attract the best people** as well as ensure that **recruits are provided with the right training and information** to recognise and respond to the needs of older people.

Time for caring

For older people, direct interaction with their care worker is one of the most important aspects of home-based care. Care workers are significantly restricted in the amount of time they can spend with the older person, and job descriptions are said to be narrowly prescriptive in terms of the type of tasks they can undertake, in order to ensure that they can deliver the *volume* of care required. As one provider put it:

> **'Homecare workers aren't allowed to just decide to do things for somebody. They have a very strict list of tasks, and that's what they have to do. Now imagine, you have a disability and you require somebody to help you, how much longer is that going to take? And actually, most of our homecare workers get 30 minutes to get somebody up, dressed, washed and breakfasted.'**

Care workers are, therefore, under pressure to provide high *quantities* of care, meaning care for any individual older person may be or feel rushed.

One service provider highlighted that 'there's no recognition for transport problems in London for home care workers', for which they often don't get reimbursed. This has been found to be a particular problem for staff working for independent providers (Patmore and McNulty 2005). Having to travel from home to home restricts the length of time a carer can spend with any individual and consequently risks damaging the *quality* of time spent with them.

The way a carer's job is structured may limit the extent to which carers can provide quality care. Restrictive job descriptions require carers to perform specified tasks in limited time frames. This was also highlighted by emerging findings from the commission into home care (EHRC 2011), which found evidence of older people waiting in bed for 17 hours because of their carer's restrictive schedule. Tight schedules and transport issues also make for a highly stressful working environment, can be seen as a barrier both to achieving a personalised service for older people and to encouraging carers to stay in their roles. Developing good relationships with older people takes time and being 'person centred' means having the time to listen to an older person and find out what matters to them.

There also needs to be **a supportive structure in place that allows care staff adequate time to understand and meet the needs of older people**. The way care is commissioned is particularly important to ensuring the workforce is able to meet the needs of older Londoners.

Recommendations

- A single professional body should be created to support training, provide advice and information on career options and represent the workforce's interests. There are a number of bodies which do some of this but the industry lacks a central resource that provides easy access to information, such as that provided for health workers by NHS Careers.

- Local authorities and health services should pilot the employment of professionals who can deliver both health and social care in the home, in order to raise the status of the profession by requiring more skilled staff. It would involve health and local authorities pooling their budgets and commissioning some home-based care services together, a process which could be overseen by the proposed new Health and Wellbeing Boards and Monitor.

- Home-based care providers can improve their care provision in four ways: by matching older people to carers who have similar interests and 'personality profiles' so that good relationships can develop while care is carried out; by allocating the same carer to an older person where possible, in order to allow time for trust and relationships to develop; by giving carers more flexibility in how they go about frontline tasks and moving away from a task and time based approach to delivering care; and by putting in place training on how to build positive interactions with older people.

5. ENABLING PERSONALISATION THROUGH PERSONAL BUDGETS

Personal care is important to older people and plays a central role in quality care provision. The previous Labour government made steps to shift policy from a top-down social care system, where local authorities and Primary Care Trusts determined the care services, to one that puts the individual at the centre of their own care. This resulted in the introduction of personal budgets for disabled people, people with learning difficulties and older people. Personal budgets give care users control over their own care budgets, either through direct payments into their bank account or by externally managed budgets controlled by the individual. First piloted by 13 local authorities between 2005 and 2007, they were intended to promote independence, choice and flexibility within the social care market.

The current Coalition government has also pledged its commitment to personal budgets, aiming to extend the scheme to over 1 million people by 2013 (DoH 2010). Take-up rates have so far been low among older people compared with younger disabled people. Previous estimates suggest that in London there are between 5,000 and 6,000 older people using personal budgets, representing around 4–5 per cent of older people receiving community services, and only 1,000 are using direct payments (Age UK London 2010b). These figures have risen following the Coalition government's move to increase the number of recipients.

Despite this low take-up, there are a number of benefits to personal budgets. They can enable a person to choose the care that is most appropriate to them, rather than having to rely on a specific service provided by the local authority regardless of whether it suits their needs or not (Wood 2010). Personal budgets have also been found to increase some older people's level of satisfaction with their care, giving them access to better suited services (Age UK 2010b).

But there are a number of specific challenges to making personal budgets work for older people. The first evaluation of personal budget pilots highlighted that they were less well perceived by older people than by younger care users. Older people were more likely to see personal budgets as a burden, and the scheme did not promote greater levels of aspiration around the care older people wanted to purchase (Glendinning et al 2008). Our research has identified a number of key areas that limit the success of personal budgets, including information, support and advice, safety, and choice.

Providing information, support and advice

There is a lot of confusion among older people around how personal budgets work and how they would go about accessing the services they need. One older lady we spoke to, who was preparing for the use of home care services, said:

> **'At the moment, I've got no idea how much you would get and how you would go about accessing your own carers – I just don't know.'**

A recent poll confirms this, finding that 65 per cent of care users did not know what a personal budget was (Wood 2010). The same study also found that most people using council-funded services would need greater information on what their budgets could be spent on. Information and advice is a vital aspect of personal budgets: it needs to be tailored to an individual's needs and to be available continually for when needs change (Age Concern London 2010).

The administrative requirements can also be very confusing to older people, and problems have been identified in our research around the language and clarity of guidance on how

to manage personal budgets. Personal budgets can place an older person in the position of being an employer, which brings with it a number of bureaucratic demands. 'Support brokerage', whereby a third party assists an older person to develop a care plan and provide them with advice on how to manage their care, has been central to successful implementation of personal budgets (DoH 2008c). Support can be provided by peers with experience of personal budgets, by family and friends, voluntary sector organisations, independent brokerage organisations or local authority social services. Research has shown that the current support system in the UK lacks capacity (SCIE 2010). The most beneficial scenario is seen to be where support services are user-led (Duffy 2009) but local authorities vary in the degree to which they fund such initiatives (Pearson 2006). A handful of charities, such as Age UK, also act as brokers.

Some older people may find personal budgets more appropriate than others, and it is important for the support needs of the most vulnerable to be taken into account. One service provider highlighted this:

> **'It's about people being educated and understanding that we're here, and what their rights are. And for lots and lots of older people, some who may, you know, lack capacity, this is not going to be a very good option.'**

This is also confirmed in research carried out by Age Concern London which found that for people with more critical needs personal budgets were less suitable and that there is a greater need for well-developed support and advice services to ensure the scheme does not result in less favourable outcomes for older people (Age Concern London 2010).

Good practice example: Leeds 'Free to Live' personal budget support network
In 2009, a number of people who were using personal budgets decided to set up a network for supporting others who were either already using a personal budget or considering taking it up. Originally, the group started by having community meetings but, through a process of partnership with the Leeds Centre for Integrated Living and Leeds Adult Services, it has expanded to incorporate a website with an online forum and resources as well as a telephone support network. These services connect people who are using personal budgets so they can learn from each other's experiences.

The project is user-led and involves continuous partnership working, with members determining the key aims of the service and getting involved in council activities to shape personalisation agenda, for example with members attending council meetings. With an average of 400 visits per month, the website has had a good reach and is used as a source of both peer support and practical advice.

For more information see www.freetoliveleeds.org

Providing older people with **relevant, timely and individualised information and support** so they can make informed decisions about the care they need is therefore vital. Without good advice, support and guidance, personal budgets have the potential to be particularly stressful for older people. Information and support is also vital for ensuring that those who have the most critical needs are empowered to exercise the same level of control as others. User-led networks offer an opportunity to deliver this support in an effective way.

Ensuring safety

Personal budgets also raise issues of safety, because there is no guarantee that recipients choose to spend their budget on services that have been 'quality assured'. For those who are arranging their services directly it is crucial that they are aware of the risks and carry out the relevant checks on providers and individuals. As one service provider put it 'there is a window here for people to be very vulnerable'. For those using services accredited by the local authority this is less of an issue, with such organisations going through an accreditation process before becoming a provider.

Many personal budget holders have preferred to hire their own personal assistant, which is often more affordable and allows them the option of being able to pay a neighbour or family member to undertake the care they want. This scenario does however, have potential to increase the vulnerability of older people, who would be responsible for undertaking security checks. One service co-ordinator expressed their concern:

> 'For some people they won't have the prior experience or knowledge on how to become an employer and how to select somebody and check them out, or people that say, "I can't afford to do this and buy the care that I need" I'll bet your bottom dollar that the care element is going to come before the checking.'

This was confirmed in a survey which found that 48 per cent of direct payment users employed personal assistants without running a CRB check on them (Skills for Care 2008). Older people need to be equipped to recognise and react to risks appropriately, and practitioners need support from local authorities to ensure safeguarding is integrated into the working processes of social care (SCIE 2010).

> **Good practice example: Personal Assistant Service through Outlook Care and the London Boroughs of Havering, Barking and Dagenham, Redbridge and Waltham Forest**
> This cross-borough partnership for social care has employed the services of Outlook Care, who provide access to police-checked and well-trained personal assistants. This enables older people to employ a personal assistant who has already been vetted and quality-assured. It also provides them with easy access to a service which can be completely tailored to their needs, promoting their independence and ability to choose services that will be most helpful.

Without adequate information, guidance and support on safeguarding personal budgets may put older people into a vulnerable position. There is a responsibility on councils allocating personal budgets to ensure that they provide the necessary guidance on how to undertake these checks or to provide an intermediary service to do this. Local authorities, voluntary and user-led organisations need to provide a strong safety net to ensure that those who are at risk have the full protection required to identify and manage risk. But this needs to be done in an efficient way that does not bring unnecessary bureaucracy into the system.

Enabling choice

The ability of personal budgets to enable choice for older Londoners is vital if they are to command real control over their care. There is a risk that people using personal budgets are limited to purchasing the same services they were already receiving through the local

authority – they may lack the access to services which can provide more individualised or innovative solutions to meet their needs. The National Market Development Forum (NMDF), which was created in 2010 as part of the 'Putting People First' consortium, includes representatives from social care, housing, councils, government and the Care Quality Commission (CQC). The NMDF's role is to look into ways of ensuring the market is ready to respond to the increasing demand for personalised services and ensure there is real choice for people with personal budgets. The first barrier to delivering choice identified was the risk that reduced funding for local authorities would result in personal budget reductions, restricting the affordability of many services (NMDF 2010). Secondly, differences in local markets combined with varying eligibility criteria for free services may mean that some older people benefit from better access and choice than others.

Our interviews with service providers have revealed the barriers that exist to entering and remaining competitive in the market. One strategic-level interviewee highlighted:

> 'With constrained public spending … the council calls the shots. So providers are in a real tough position at the moment.'

In particular, smaller providers are suffering from price competition. One voluntary sector provider in Southwark stated 'we're no longer in the market, because of our prices basically'. All of this works to restrict the number and variety of services available for older people to purchase and use. Ensuring there is **a varied market of affordable services** is crucial if personalisation is to deliver genuine choice for older people.

Good practice example: Harrow Shop4Support
Shop4Support is an online resource where people can shop for the services and goods which support their independence. It was developed by In Control, a national charity promoting choice and control, and Valueworks, an e-procurement company, and was awarded a grant from the Department of Health. It is also linked into the Harrow Council website, which allows members to search for services, get information and advice, and find out about other activities and groups in the area.

The Shop4Support website has been used to stimulate the care market in the area. By allowing members to access the details of all registered providers it broadens awareness of what is available.

More information can be found at www.shop4support.com/harrow

Personalisation without personal budgets

It is important that older people who are not using personal budgets also have access to the same level of personalisation and choice in the services they use. With a large proportion of older Londoners using services but not using a personal budget, there is a need for individual choice and control to be realised in other ways.

Central to this will be local authorities integrating personalisation into their service commissioning objectives. To ensure services deliver personalisation, there needs to be both the right number and the right variety of services which are affordable to people outside of the personal budget system. To integrate personalisation into commissioning objectives, there is a role for a more 'user-led' approach to outsourcing. This means ensuring older people are able to shape the way tenders for work are put together,

requiring local authorities to consult with older people – both those using services and those who do not – to ensure future provision meets individual needs.

While personalisation offers great potential for a better system of care delivery, it is clear that it has so far failed to deliver on its promise, particularly for older people. There are some problems with personal budgets – nevertheless, it seems they do offer the best route to achieving personalised care. There are ways for local authorities to increase the level of personalisation delivered through the services they commission, for example by using 'outcomes-based' commissioning that requires providers to deliver outcomes for older people rather than specific volumes of work, or by involving older people in the development of tenders. Despite this, the diversity of needs and preferences among older people means it is unlikely that the local authority's efforts would give *all* older people access to suitable services. For this reason, it is important that policymakers prioritise the expansion of personal budgets but also that they ensure the right foundations are in place so that older people can get the most out of them. It is important that they are easy to use and that they represent a meaningful choice for services.

Recommendations

Personal budgets can bring many benefits to older people but they are currently not delivering on their promise. If they are to be extended, the following recommendations should be taken into account:

- In order to ensure personal budgets are set at the right level and offer older people choice, the GLA should be given responsibility for overseeing the overall care market and the effectiveness of personal budgets.

- Older people using personal budgets lack the information and advice to manage and spend them properly. There is evidence that peer networks are the best way to spread information. Charities or local authorities should coordinate peer support networks for people who use personal budgets, for example by assisting in the setting up of websites or training coordinators to manage community groups.

- A streamlined system of funding and provision of personal budgets should be developed so that the Attendance Allowance, health services and social care services are integrated. This would provide a higher level of flexibility and choice around where an older person spends their money. Integrating the system would result in an expansion of the range of services that a personal budget can cover and incorporating health services. The use of personal budgets in health was explored by the previous government and is being piloted in some areas; research by the NHS Confederation (2009) has shown that there is support for expanding personal budgets into health. This process may help to bridge divisions between health and social care, so that budgets can be spent freely across different service types, and would form part of a greater aim to integrate health and social care more comprehensively across both systems and at every level.

6. ENABLING INDEPENDENCE THROUGH PREVENTATIVE AND INTERMEDIATE SERVICES

Preventative services and services that support older people to remain independent in their homes have been put forward by policymakers and professionals as a way to secure a better quality of life for older people and to reduce public expenditure on care. There is a wealth of services and initiatives that offer the potential to deliver a more preventative approach to care and older people. These span both the health and social care realms, intersecting with issues such as the home environment and assistive technology, range from falls prevention in the home to intermediate care and reablement following a period in hospital. Being preventative means addressing needs at the earliest stage possible and requires service providers to work together and coordinate approaches so that the 'whole system' is complementary. It also entails more proactive approaches to identifying needs and ensuring older people are equipped at an earlier stage in their lives to maintain their own independence.

The success of preventative services was highlighted in the recent evaluation of the Partnerships for Older People Projects (POPP) which aimed to deliver a range of preventative services locally to support greater independence (PSSRU 2010). In total, 29 pilot projects involving £60 million of funding by the Department for Health were carried out by local authorities, each developing partnerships with health and voluntary organisations to deliver services ranging from lunch clubs to home-based hospital recovery services. The evaluation of POPP showed that every £1 spent produced a cost saving of £1.20 in the use of hospital emergency beds. There was also a 47 per cent reduction in overnight hospital stays and 29 per cent reduction in visits to accident and emergency wards. In projects where there was 'proactive case coordination' there was also significantly less pressure placed on health services. Although much of the savings were felt by NHS-based services, this came at no extra cost to social care services. In many cases, cost reductions were felt across secondary, primary and social care but it was more difficult to turn this into a cost saving because of the inability to move money around between the different areas.

Accessing preventative services in London

Despite the range of benefits from a preventative approach, there are a number of barriers to promoting independence and reducing the use of residential and hospital care. Interviews with local authority service providers in London indicated a shift of policy towards prevention, but many service providers highlighted that, in practice, care was provided at the last minute. As one manager of a care agency put it:

> **'What we've seen is this gradual trend to have none of that, and only deal with the eleventh hour of everything, so actually, we're putting in care because if we don't that person is going to be in hospital in two weeks.'**

This perspective is confirmed by a recent report produced by the Greater London Authority. It shows that the vast majority of London boroughs only provide care when older people have 'critical and substantial need', with only a handful of boroughs offering services when needs are 'critical, substantial and moderate' (GLA 2010b). The report also outlines problems across London in relation to the time older people have to wait to be assessed for home care service entitlement, which means they are accessing care at later stages, when their needs are more critical. Between 2007 and 2008, the number of older people having to wait more than three months to be assessed stood at 1,700, with 1,500 of those people going on to wait six weeks to receive the services that they were found to need (GLA 2010b). This means that people whose conditions have reached a

critical stage can be waiting up to four-and-a-half months before they receive the care they need. It seems inevitable that this could result in many older people being admitted to hospital before care reaches them, which may have longer term impacts on health and independence.

The cost of care is also going up and individuals are increasingly expected to meet these costs, unless they are eligible under the strict criteria faced by most older people. Those who cannot afford care but still have moderate-level needs may miss out on the opportunity to improve their independence and quality of life until their problems have escalated to an unmanageable degree. The degree to which this will impact each London borough is likely to vary according to the costs and their approach to care. For example, in Tower Hamlets there is no means testing for home care and it is provided free to all users with higher levels of need.

Service providers talked to us about the role new technologies play in providing more preventative and efficient care. Using technology such as telecare[8] and assistive technology early on in the development of a condition can help people to live in their own homes, maintain their health and increase safety, control and choice within the home (Dougherty 2004). One example of how technology can be preventative is in the use of monitors that can be externally monitored and which indicate when an older person's health begins to deteriorate. This can allow conditions to be flagged up earlier on and the necessary services provided to prevent escalation.

> **Good practice example: Preventative technology in North Yorkshire**
> In 2007, North Yorkshire Council received funding through the Preventative Technology Grant, supplied by the Department of Health under the previous government to local authorities to develop the infrastructure for telecare and assistive technology. The council used their budget to train coordinators who then trained 3,800 people in the community to make them aware of how telecare works and its benefits, including partner organisations such as the fire service and housing providers.
>
> Surveys were also undertaken to assess the impact on those using telecare, which found that over 95 per cent of users felt safer and more confident. The use of telecare also showed cost savings, with a 38 per cent reduction in costs compared with other care approaches, representing a total saving of £1 million.

Supporting technology may also be a way of improving the quality of service provided. One service provider said:

> **'I think what [technology] will do is mean that home care workers continue to do the bit of their service that requires the real skill and actually allows us to do more with the workforce that we have.'**

For example, much of the available technology designed to work within the home can assist an older person to carry out everyday tasks – such technologies range from the complex, such as a medication alert system that tells a person what medication to take and

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8   Telecare involves using remote technology to monitor a person's health and care, for example through sensors which trigger an alarm if a decline in health indicators occurs.

when, to more simple equipment, such as that which makes a bathroom more accessible. Technology reduces the number of tasks a carer is required to do and frees up their time for providing more personalised care. It would also support greater flexibility in when a carer's visits are carried out. The evidence to date also supports the finding that assistive technology can generate savings in health and social care (Beech and Roberts 2008).

One of the issues identified within our research is the lack of awareness around what assistive technology is available and how it can be accessed. One strategic level interviewee spoke of the mystification that surrounds technology in home care:

> **'There is a huge problem of awareness not only in terms of the general public, not only in terms of family and carers but in terms of health care professionals as well.'**

This restricts the demand for technology, particularly when professionals are unable to recommend particular technologies to the older people they work with. There are also market barriers to introducing technology on a wider scale. Our interviewee also told us that 'the market is very fragmented' and that products are often developed out of a negative perception of ageing, which makes them less attractive to older people. The view was expressed that technology should be supported as part of a *positive* ageing agenda and that technological research and development involving older people was central to this.

Interviewees also raised the importance of the home environment in enabling older people to live independently at home. Considering that older people are likely to spend greater amounts of time in the home, the environment itself is especially influential (Gitlin 2003). Good housing conditions have been strongly linked to positive outcomes in health and wellbeing (Moore 2000), whereas poor housing is linked to negative health and wellbeing outcomes. Poor housing conditions are strongly linked to the incidence of falls within the home, a problem that costs the NHS nearly £5 million a day (Age UK 2010a).

Service providers also highlighted the need to coordinate housing services with health and social care to ensure a preventative approach is taken – one interviewee felt that:

> **'Home improvement agencies need to be better joined up with home care providers and all the other services that are out there that help keep people living independently at home'.**

International good practice example: Preventative visits in Denmark
In 1996, Denmark introduced the Preventative Home Visits to the Ageing law, which requires that every older person receives a home visit twice a year once they have reached 75 years of age. The visits are used to ensure older people are aware of what services and support is available and to help provide them with the skills and knowledge to manage their care more independently. Denmark has around 700,000 people over the age of 67. Approximately 172,000 of these older people receive long-term home help and the vast majority do so within their own homes; a high percentage of the over-80s group also receive home care. This approach supports an active ageing agenda that promotes the health and independence of older people. Studies to measure the impact of the initiative showed that older people over the age of 80 were more independent and were admitted to nursing homes less often (Rubenstein 2007).


It is important that **health and social care services integrate prevention into their services and working practices** so that care is more effective at maintaining independence. This involves **utilising new innovations in technology** which can be used to alert of conditions earlier on and can help an older person manage their everyday life. It also means **working with a range of other agencies** to ensure preventative checks are undertaken at every opportunity.

Recovery and reablement

Services that help older people to return to their own home following a period in hospital are vital for ensuring independence is regained and reducing the incidence of future health problems. These services straddle the boundary between health and social care, and require an integrated approach to ensure a smooth transition between hospital and home and to promote longer term independence. Intermediary care refers to the functions that aim to facilitate a transition from 'medical dependence to functional independence' (Steiner 1997: 24). The NHS has a package of guidance for intermediary services which is tailored to older people and requires all agencies involved in an individual's care to ensure that a personalised package of care is developed using cross-professional approaches, single assessments and relevant information sharing (Age UK 2009b).

Politically, there is a commitment to delivering effective intermediate services. It was one of the eight core goals of the previous government's National Framework for Older People in England and has been acknowledged by the Coalition government as essential to enabling people to live independently. Despite this, Map 2 (over) shows that across London there is high variation in the success of the transition from hospital to home. These maps show the number of older people who are discharged from hospital, using rehabilitation, intermediate and reablement services, and are still in their own home three months later. For example, in Croydon and in Barking and Dagenham less than 65 per cent of older people across all age ranges are still in their homes three months after being discharged; by contrast, Lambeth and Southwark manage to assist over 95 per cent of over-84s, the frailest group, to remain in their home for at least three months after leaving hospital.

Interviewees also commented on the 'revolving door' between home and hospital that is highly disruptive for older people and often results in greater overall care costs. One reason put forward for this was the insufficient level of coordination between a person's medical needs and their home care needs, with people having insufficient skills and support to manage conditions they have or to achieve a full recovery from illness. This is confirmed by other studies which have found that preventative and rehabilitative services are not embedded in either health or social care, compounded by a lack of communication between professionals (Allen and Glasby 2010). Service providers of home care also mentioned a high level of confusion around the management of medical conditions. In some cases, home care workers were unaware of the medication a person required or discovered that the older person was not using their medication correctly.

Map 2
Rehabilitation and
intermediate care for
older people in London,
2008–09

65–74 years old

Less than 65%
65–74.9%
75–84.9%
85–94.9%
95% or more

These maps show the proportion of
older people discharged from hospital to
rehabilitation, reablement and intermediate
care who were still living at home three
months after being discharged, 2008–09.
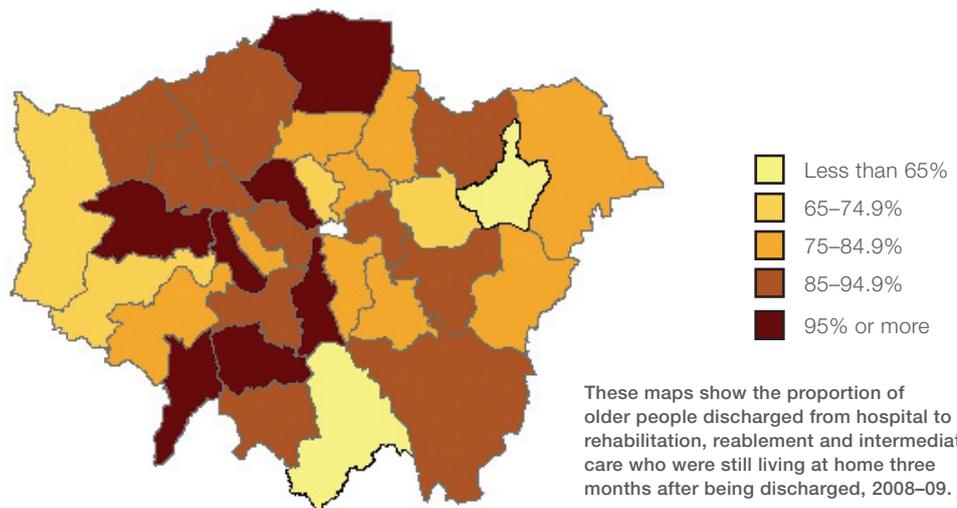
75–84 years old
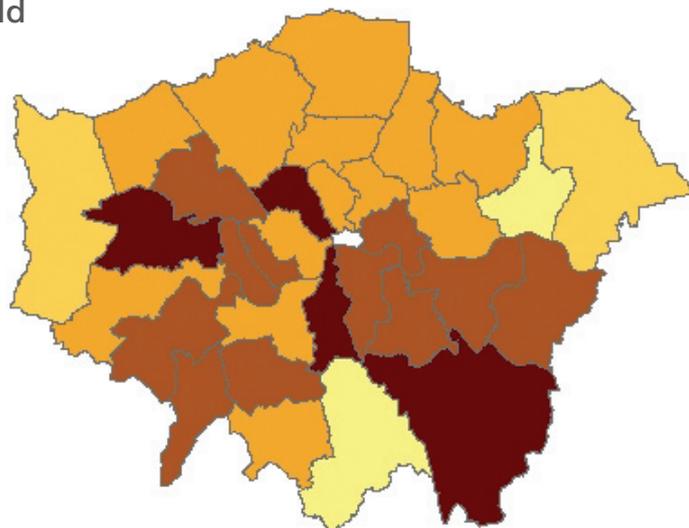
85 and older
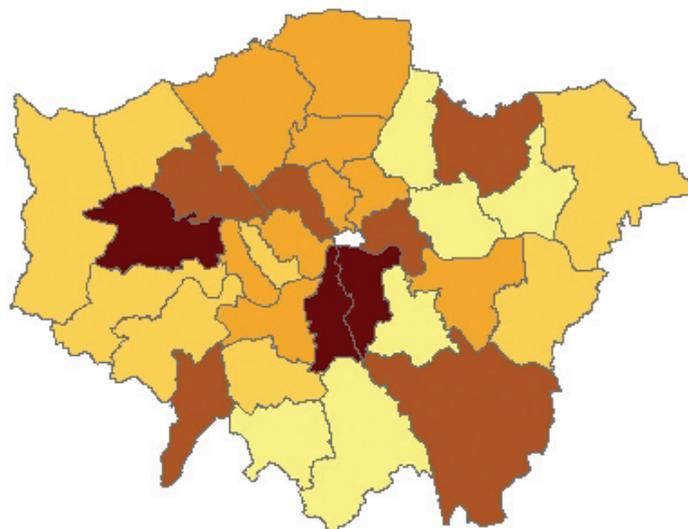
Source: Final disaggregated
social care indicators 2008–09,
available at:
http://www.ic.nhs.
uk/statistics-and-data-
collections/social-care/adult-
social-care-information/
social-care-and-mental-
health-indicators-from-the-
national-indicator-set--further-
analysis-final-england-2008-09

> **Good practice example: Northumberland FISHNETS Scheme and integrated case management**
>
> The FISHNETS Scheme (fit, involved, safe, healthy, through investments in sustainable community networks) was funded through POPP and has been used to develop an inter-agency approach across health services, care management and community matrons, housing, home care and day services. Projects within FISHNETS have been developed to encourage both greater independence and community involvement, driven by a user-led management board.
>
> The scheme also involves Community Rehabilitation Teams which work alongside accredited providers to ensure a preventative and joined-up approach is taken to rehabilitation. Integrated case management ensures that single assessments are made and they also allow for intensive and holistic rehabilitation to take place. It also works to be preventative by identifying older people at risk of falls or chronic disease and providing them with the relevant information and training to manage risks.

> **Good practice example: Integrating health and social care, Torbay**
>
> Torbay Care Trust has been successful at reducing admissions to care homes and hospitals by introducing a system of close coordination between health and social care. The trust has built specific knowledge on the needs of those using health and care services and targeted spending in the most appropriate areas. This has involved using integrated health and social care teams and pooled budgets to deliver intermediary services in a joined-up way. By undertaking a mapping exercise of need and assessing outcomes and costs in an integrated way, Torbay was able to achieve reductions in hospital use and increase the use of direct payments (Thistlethwaite 2011).

Reablement services can be used to provide older people with the skills to live and manage everyday tasks when they are living with mental or physical health conditions, allowing them to remain in the home and achieve lower levels of dependence on care workers. Such services involve providing people with the resources to independently manage their lives, reducing future reliance on home-based care services. One study has recently shown that care costs can be reduced as much as 60 per cent in the first 10 months after using a reablement programme, which highlights the potential for cost savings overall (PSSRU 2009). The North East Improvement and Efficiency Agency has recently identified potential savings of between £14.8 million and £35.4 million through using reablement services.

In 2009, the London Joint Improvement Partnership (LJIP) assessed the use of reablement services across the city and found significant differences in their use and level of implementation. Based on research that shows that 2.1 per cent of older people could benefit from reablement, The study estimated that expansion of reablement services could generate £650,000 savings in the first year and £1.1 million in the second.[9] The review recommended London boroughs should develop a clear business case for introducing reablement, backed by strong leadership so that services can be scaled up. It also

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9   See http://www.dhcarenetworks.org.uk/News/NewsItem/?cid=6630

recommends that a plan for delivering reablement is developed as soon as someone is admitted to hospital, and emphasises the need to ensure evidence is collected to demonstrate the benefits (DoH 2009).

Using effective preventative, intermediate, rehabilitation and reablement services has benefits for older people, by assisting them to live in greater health and with greater independence, and for the public purse, by providing a more sustainable way of delivering care. **Preventative services offer longer term savings in health care**: by being proactive about care, the likelihood of more costly care in the future is reduced. There also needs to be a system for recognising the savings that local authorities create through using preventative services.

To provide a system where each element is used to best effect it is critically important that there is a **joined-up approach between health and social care**. This will require health professions to give **social care staff the necessary information to support an older person's medical needs in the home** and to ensure rehabilitation is considered as soon as a health issue is identified. Monitor, the independent health organisation, has recently been put forward as being responsible for driving through integration, along with 'clinical senates' made up of a range of health and social care professionals. This can be seen as an important step, but without a comprehensive systemic shift in the way health and social care services are commissioned it is unlikely that it will be enough. Integration has to be at the heart of the whole system rather than being 'tacked on' to proposals for reform.

Recommendations
- A greater proportion of the NHS budget should be dedicated to preventative social care, reablement and innovative assistive technology solutions. In London, the GLA should also be responsible for overseeing the integration of health and social care, ensuring there is coordination and partnership working across the city.
- Local authorities and health providers should use the same set of metrics to monitor outcomes and assess performance. This would help to align objectives and ensure a 'whole systems' approach is taken to care. Monitor, which now has responsibility for overseeing integration between health and social care, should be made responsible for developing the metrics to be used and helping to embed them into health and social care providers' systems.

CONCLUSIONS AND RECOMMENDATIONS

Under the right conditions, home care services offer a real opportunity to improve the quality of life for older people and can provide a more sustainable way to adapt to an ageing population.

Despite this, London is failing in three key areas. The home care workforce is currently failing to meet demands for a consistent and high-quality service and is at risk of failing to meet demand unless there are significant increases in recruits. Personalisation has been a positive step for social care but is not delivering on its promise. Finally, the independence of older people is being threatened by a lack of preventative and intermediate services that can keep older people out of hospital or residential care.

In order for the rapidly increasing demand to be met, there will need to be a complete rethink on the way we design and deliver care. This will require wholesale reform of the workforce, integration with health, and support for prevention and personalisation. Our research has outlined some areas in which change is needed but at the heart is the way care is funded. The UK is now in a unique position to introduce a more sustainable system equipped to meet the growing demands for care – our findings and recommendations below provide a way forward to help achieve these goals.

Home-based care workers play a central role in providing good-quality care and their skills and working approach greatly impact the experiences of older people. The care workforce needs to expand significantly if it is to meet the increasing demand for home-based care. However, at present the sector is unattractive to prospective recruits and is heavily dependent on migrants. In the long term, this shortage can only be solved by investing more money in the care workforce. In the short term, the following recommendations could help address these issues:

- Care providers can change the way they operate in four ways. First, they can ensure older people are matched to carers with similar 'personality profiles'. Second, they can try to ensure older people are allocated the same carer in order to allow time for trust and relationships to develop. Third, they can give their carers more flexibility in how they go about their frontline tasks, leaving it to the care worker to decide which tasks need to be completed and how to go about them and moving away from a task and time based approach. Fourth, they can put in place training on how to build positive interactions with older people.

- Local authorities and health services should pilot the employment of professionals who can deliver both health and social care in the home. This would enable a truly joined-up approach to delivering both services, and would also serve to raise the status of the profession, requiring more skilled staff. It would involve health and local authorities pooling their budgets and commissioning services together – something that could be overseen by the proposed new Health and Wellbeing Boards and Monitor.

- Further steps to galvanise and strengthen the voice of the social care workforce can be taken by introducing a single professional body to support training, deliver advice and information on career options and represent the workforce's interests. There are a number of bodies which do some of this but the industry lacks a central resource that provides easy access to information, such as that provided for health workers by NHS Careers.

Personal budgets can help to deliver choice and independence to older people but there are a number of issues that need to be addressed if they are to be successful. The following recommendations should be considered to improve the current system:

- Peer networks connecting personal budget users should be developed to support older people, by charities or local authorities for example. These proposals would require a small amount of investment and could include assistance in setting up a website or training peer network coordinators.
- A streamlined system of funding and provision of personal budgets should be developed so that the Attendance Allowance, primary health services and social care services are integrated. This would provide a higher level of flexibility and choice around where an older person spends their money.
- To ensure a more consistent approach to personalisation is taken across the city, the GLA should oversee the care market in London, ensuring that local authorities are creating an effective market in care providers and that the amount distributed through a personal budget offers adequate purchasing power to older people.

Currently, home-based care exists in a system that responds to rather than prevents the occurrence of health issues. There is little coordination between agencies and provision of reablement and intermediary care is inconsistent across London. To address these issues, we make the following recommendations:

- To bridge the gap between health and social care in a comprehensive way, a greater proportion of the NHS budget should be dedicated to preventative social care, reablement and innovative assistive technology solutions. This should be part of an effort to bring the two systems closer together in terms of how they are funded and structured so that cooperation is made easier.
- In the absence of a Strategic Health Authority for London, the GLA should be responsible for overseeing the health and care systems across the city. This will help prevent a fragmented market developing across council boundaries.
- Local authorities and health providers should use the same set of metrics to monitor outcomes and assess performance. This would help to ensure a 'whole systems' approach is taken to care across the different areas and provide incentives for consistent partnership working, reducing reliance on ad hoc, temporary projects. Monitor should be given responsibility for developing the metrics to be used and helping to embed them into health and social care providers' systems.

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