AGGCC
CSSIW

Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

'Above and Beyond'

National review of *domiciliary care* in Wales

October 2016

Contents

1 Introduction

This report sets out the findings of the national review of care provided to adults in their homes (domiciliary care) carried out by Care and Social Services Inspectorate Wales (CSSIW) between August 2015 and March 2016.

Our review aimed to:

- assess the type and scale of domiciliary care provided in Wales; and
- identify what is working and what is not.

Our review aimed to understand the relationships between the following people and organisations and how they depend on and affect each other:

- people who are receiving care in their homes.
- care workers providing care to people in their homes. (In this report, 'care workers' means carers who are paid to provide care, not unpaid family members who provide care.)
- care providers arranging care and
- local authorities commissioning domiciliary care.

We considered the different approaches to commission and procure care in Wales and the benefits and challenges of these approaches. The report makes suggestions to improve practice and shape the regulations and guidance that are being developed to support the new Regulation and Inspection of Social Care (Wales) Act 2016[1].

Our review asked the following main questions.

- How do local councils and health boards commission domiciliary care services?
- What is working well and where could arrangements be improved?
- How do domiciliary care agencies organise the care they provide?

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[1] Welsh Government (2016a) *Regulation and Inspection of Social Care (Wales) Act.* Wales: Welsh Government.

- What quality of care do people receive?
- What are care workers' pay and conditions like and what challenges do they face?
- What quality-assurance systems are in place?

We explored domiciliary care from the perspective of four main groups:

- people and their families;
- care workers;
- care providers; and
- care commissioners.

2   Executive summary

This national review set out to test a simple hypothesis: that the way domiciliary care services are commissioned and procured has a direct impact on the experiences of people who receive care. The reasoning is that commissioning influences the way domiciliary care agencies respond when arranging the delivery of care which affects the way care workers are engaged in the work and how they are expected to provide care.

To a large extent, the hypothesis is proven. There are obvious connections.

Care and support that is arranged for a set length of time with fixed tasks (a 'time and task' basis) is more likely to result in inflexible, rushed care, especially when call times (visits) are short. From inspecting councils and holding focus groups, we found that care purchased at low prices tends to lead to more problems with recruiting and keeping care workers. This is because care providers are not able to offer attractive pay and conditions. This in turn reduces capacity, which means with fewer care workers to provide the care, there is more pressure to squeeze calls in. This makes the difficulties worse, because care workers who are placed under stress are more likely to leave. Providers are then more likely to hand back contracts and care packages because they don't have enough care workers to meet demand.

On the other hand, when there is good cooperation and mutual understanding between commissioners and providers the arrangements for providing care are more secure. Care is more likely to be reliable and person-centred when it is arranged on a more flexible basis, when it is fairly paid for and when people receiving it have a high level of control.

We also found that the level of skill in running individual domiciliary care agencies affects the quality of care people receive, regardless of what rates are being paid. We saw this in our inspections, in feedback from care workers who had moved between agencies and in feedback from people who had received care and support from more than one agency. No matter how care is commissioned, a small proportion of domiciliary care agencies are poorly managed and organised. This leads to unreliable care, poor continuity of care (people not seeing the same care workers) and poor communication.

However, the analysis in this review goes much further.

The review underlines how important relationships are to people who receive care and to their care workers. At its best, domiciliary care is centred on relationships. People told us it is not just about tasks or times – social and emotional well-being are as important as physical well-being. People with care and support needs can be lonely, isolated or extremely vulnerable. They need to have trust and confidence in their care workers. So do their families, who are often crucial to the overall support arrangements that people depend on.

The review found that most people, most of the time, are happy with and appreciate the care they receive. This is remarkable considering how systems around traditional domiciliary care are designed. This finding is replicated in other studies and surveys elsewhere. It reflects the commitment of frontline care workers and those back at the office who, in the face of rapidly changing hour by hour requirements are busy trying to make sure people get the visits they need.

However, this review also found that a small proportion of people experience poor care. In particular, this is about poor care worker continuity and unreliable visits.

Our review found that despite poor pay and working conditions, most care workers are very motivated. They are naturally caring and concerned for the people they support. They often go 'above and beyond', doing things that are 'not on the list' or staying on and giving care in their own time.

The review found that domiciliary care is an extremely complex operation. The scale is huge: some 14 million hours of care are being commissioned each year in Wales at a cost approaching quarter of a billion pounds. These figures do not include the large amount of care that is paid for privately, provided directly by councils or care purchased using direct payments. There are many different types of care providers, from very small micro-businesses[2] to large international companies, and from charities to local councils.

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[2] In areas of the UK where the idea of micro-businesses is being developed, this refers to care providers employing less than 8 people, commonly one person or a sole trader.

The review found that arrangements for purchasing care in councils and health boards are extremely varied. This comes at a very high cost in terms of potential care and support capacity, duplication and inefficient administration. The review also found that care workers employed by councils are on more favourable terms. It is accepted that council-run services are significantly more expensive than those run by the independent sector.

The review found that there is a serious lack of care and support capacity and the market is very fragile. This lack of capacity comes at a high cost for individuals, their families and public authorities with increasing pressure on delayed transfers of care from hospitals in some local authority areas. The current approaches are not sustainable.

The review shines light on two factors that are driving some of the behaviours in the system.

- General workforce shortages. This results in calls being 'crammed in', especially at peak times of the day. In turn, call times are shortened or 'clipped'.

- Overzealous application of procurement and finance rules. This can result in a tendency to drive down prices in the short term, punitive contract terms and a need to account for every penny spent.

The review also shows that what is essentially a simple ask, 'Can I have some help at home?', becomes very complex when more and more people are involved in the chain of making decisions and providing care. The transactional costs of this very busy, high-volume, dynamic market must be very high for public authorities purchasing care and those who are providing it. Commissioners make the whole business and cost of arranging domiciliary care more complicated and opaque by using a very wide range of contracts, fee arrangements, payment systems and monitoring systems. This is unhelpful and cannot continue. However, feedback we have received suggests that there is pessimism about achieving consistency and resistance to rationalisation or standardisation. It will take strong, decisive leadership to bring order to this turmoil.

The review also highlights that the Welsh, United Kingdom (UK) and European Union (EU) governments all have a very influential role in setting the context in which domiciliary care is provided through:

- more direct policy and legislative changes (e.g. Health and Social Care regulation, direct payments) and
- through indirect changes (such as the national living wage, funding for training, and EU procurement and employment rules).

Some of the recent decisions are having a huge impact on the sector. For example, the decision to stop funding for vocational (work-based) training in 2014 for people over 25 in Wales was mentioned repeatedly by people we talked to because the care sector depends on attracting middle-aged workers.

It is therefore important that the consequences of any changes are fully thought through in relation to the social care sector and the connections are made by all involved.

As we take forward the Social Services and Well-being (Wales) Act 2014[3] there are opportunities to move towards a more person centred outcomes based approach. However the question is whether the application of current procurement and financial rules will allow new approaches to flourish. It is not possible to have new thinking in only one part of a system.

Everyone involved in the provision of domiciliary care has a part to play. We found that when people, especially commissioners and providers, work together to find solutions based on mutual interest and understanding, the outcomes are more likely to be realistic and achievable. This has to be the starting point. That said, we propose the following areas for consideration.

The task before Welsh Government is to create the conditions where:

- a high-quality health and social domiciliary care workforce can grow and be sustained; and

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[3] Welsh Government (2014a) *Social Services and Well-being (Wales) Act.* Wales: Welsh Government.

- the business of domiciliary care can flourish.

The Government can do this in the following ways.

- By supporting the National Commissioning Board in driving forward alignment between regional partnership boards and commissioning bodies with the use of standardised and simplified tendering and contract arrangements and the development of a standardised approach to contract monitoring and assurance arrangements. These arrangements should include ethical commissioning principles for the workforce and supporting the development of outcome-based contracting systems that give incentives for encouraging self-reliance and providing continuity of care.

- By supporting Social Care Wales in delivering an integrated health and social care workforce strategy that focuses on strategic recruitment, training and development. This must include a review of funding for training for this sector and opportunities for creating apprenticeships in health and social care. Without a clear strategy there is a significant risk that the future requirements for registration of care workers will reduce the number of people working in the sector and compound the current problems

- By using the Regulation and Inspection of Social Care Wales (Wales) Act 2016 to underpin providers' responsibilities for their staff.

- By reviewing the cap on charges to make funding available to pay for care at reasonable rates.

- By supporting the development of efficient and compatible information and communications technology systems in Wales and

- By encouraging the development a Welsh-branded domiciliary care franchise to support smaller and new domiciliary care businesses.

This will be a challenge in the current period of austerity. However, there is a real danger that if we don't invest time and resources in bringing order to the system now, costs across the health and social care system will rise significantly in the future. We are already seeing this. Simplifying and standardising processes will

make some parts of the system more efficient and may save some money, but it will not be enough on its own. More money needs to be made available in the system so that in years to come there is a resilient, competent workforce.

> 'The government increasing the minimum wage/living wage but not increasing funding for domiciliary care is presenting a challenge. I fear that this will cause a lot of problems in the industry and I do worry that there will be a big problem in health and social care as a whole. Many care packages are being offered to agencies at the moment but no one is able to take on these packages due to the same issues. Care brokers are ringing over and over again to try and place these packages but to no avail.' (Provider)

The tasks for regional partnership boards, local government and local health boards are to:

- put the principles of the Social Services and Well-being (Wales) Act 2014 into practice, especially for well-being outcomes and integrated (joined up) care;

- ensure a reliable, high-quality local workforce supply and

- develop more consistent and efficient approaches to commissioning, procurement and assurance across councils and health boards.

This can be done in the following ways.

- By promoting the use of flexible, outcome-based services and moving away from 'time and task' systems. The internal tensions between tendering and invoicing requirements and the provision of flexible, person-centred care and support must be resolved. Each commissioning authority should identify an officer who is responsible for commissioning care and support and has the authority to have overall responsibility across social services, procurement and finance departments.

- By embracing standardised and more efficient ways of working, in line with guidance from the National Commissioning Board.

- By encouraging more people to use direct payments by paying a realistic rate, providing effective support and negotiating favourable terms from the sector for people using direct payments;

- By greatly simplifying the decision making and delivery chain to engage potential providers at the earliest stage in shaping care packages, in line with people's wishes and in any reviews. In particular, they should pay attention to handovers after six weeks' reablement provided by councils' own in-house services.

- By ensuring care and support packages are reviewed in a timely way, are person centred, and care and support packages are increased or reduced promptly when necessary;

- By ensuring services are commissioned based on the long-term sustainability of the service, not price.

- By making local arrangements to link domiciliary care agencies to local health and social care services and community networks.

The National Commissioning Board is already taking forward some initiatives to introduce better ways of commissioning across Wales. Domiciliary care is big business and involves high levels of public spending. Putting in place more simplified, standardised, efficient and sustainable ways of providing care will need strong leadership and support from chief officers, elected members and health board members.

The tasks for independent domiciliary care providers are to:

- make sure care is based on high-quality relationships;

- follow the principles of the Social Services and Well-being (Wales) Act 2014, especially to support people to become more self-reliant;

- find ways to build relationships of confidence and trust with people who use services and, importantly, those who commission them; and

- make their internal processes as efficient as possible.

This can be done by in the following ways.

- By focusing relentlessly on making arrangements and structuring teams to provide continuity of care workers and making sure adequate travel time is included in schedules.

- By making sure that when visits are delayed there is good communication, especially with people who are likely to be anxious.

- By making the best use of information and communications technology systems.

- By developing reliable and meaningful assurance systems that people using and commissioning services can be confident in.

- By developing innovative new arrangements to follow the principles of the Social Services and Well-being (Wales) Act 2014, encouraging self-reliance and the involvement of local community services.

- By providing ethical working conditions and effective support for staff.

These areas for consideration are broad and at a high level. They should be considered alongside some of the more detailed suggestions set out in the review.

Looking to the future

This review considers how arrangements were working in 2015–16. However, the world is constantly changing and the provision of health and social care is destined to change significantly in the coming years. When developing any strategy, we should expect to factor in the following changes.

- There will be significant changes in the demand for care. This includes changes in the complexity and amount of care needed and to people's expectations of the care they receive.

- There will be significant changes in the workforce available. This includes changes in the demography of the workforce, their expectations and the influence of the wider economy. Leaving the EU could be very significant, particularly especially in relation to personal assistants and private carers – the 'hidden' domiciliary care workforce. This could increase demand on the traditional sector.

- The Social Services and Well-being (Wales) Act 2014 will change the culture of care and support in Wales and alter people's expectations and provide potential for increased integration between health and social care.

- There will be increased levels of 'medical' intervention being undertaken by domiciliary care workers and the emergence of contracted community-based nursing services.

- There will be more opportunities to use telecare, telehealth and telecommunication. These could reduce the need for 'monitoring' visits by care workers and support providers in their work.

- More digital technology will be used, not only to reduce back-office costs but also to enable people to source care. There are now Apps being used in the UK for people to source carers directly and their use is likely to grow exponentially as has happened in other areas (e.g. taxis).

- The development regional commissioning arrangements.

- Arrangements for social care and NHS funding are likely to change. Pooled budgets for residential care (from 2018) may be considered for other forms of care.

These factors need to be carefully examined and understood. The strategy for domiciliary care should make the most of the opportunities and identify any threats. Indeed, it should influence change by helping to shape the future and create the conditions in which high-quality domiciliary care and support can flourish.

3 Background

3.1 The domiciliary care sector

The provision of domiciliary care, also known as 'home care', is well established. However, there have been substantial concerns about its ability to grow and survive in the long term, its quality, care workers' pay and conditions, and the systems for commissioning and providing domiciliary care.

We found that councils in Wales commissioned 13,266,981 hours of domiciliary care for 2014–15. This is in line with the 13,185,254 hours of domiciliary care reported to the Welsh Government[4] for home care provided by councils and independent agencies. Based on information from two health boards, it is likely that an additional 20 per cent of domiciliary care is commissioned by the NHS. In a typical seven-day week, councils commissioned a total of 214,317 hours – an average of 9,742 hours each. On average, each council in Wales commissions care for more than 900 people a week. Information from providers suggests that around 15 per cent of domiciliary care is privately purchased. Some providers rely wholly on either commissioned or privately funded care, while others have a mix of both.

On 31 March 2016, 426 agencies were registered with Care and Social Services Inspectorate Wales to provide domiciliary care in Wales. This number has increased slightly from 422 agencies registered for the two previous years. There were 618 domiciliary care managers registered with Care Council for Wales[5]. This is a small increase since the previous year, although fewer managers were linked to a registered service. Of these managers, 596 had current employment in domiciliary care. Nine managers were known to be managing more than one domiciliary care service.

We recorded 673 concerns about domiciliary care agencies in 2015–16. This increased slightly from 638 concerns in the previous year. Although there is no real

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[4] StatsWales (2015) *Home care by local authority.* Available at www.wales.gov.uk

[5] Care Council for Wales (2016a) *The profile of the domiciliary care managers in Wales 2016: a report from the Care Council for Wales Register of Social Care Workers*. Cardiff: Care Council for Wales.

comparison between domiciliary care services, the rate of concern (1.6 per agency) is very similar to that of care homes. In general, services are broadly compliant with current regulations. In 2015-16, we issued 124 non-compliance notices (0.3 notices an agency), which is slightly fewer than the 139 notices we issued in the previous year. In 2015–16 the level of more formal enforcement action against agencies was low compared with the level for residential care homes.

3.2 Why we carried out this review

This review was prompted by the following concerns.

- Television documentaries on the quality of care experienced by people using domiciliary care services.
- Concerns about care workers' pay and conditions and investigations by Her Majesty's Revenue and Customs into care workers not being paid the national minimum wage.
- Concerns expressed about new methods of procurement being introduced in which individual packages of care were being tendered on line ("placing my Granny on eBay").

The Minister for Health and Social Services at the time was keen to see evidence in respect of the prevalence of short call times and the use of zero-hours contracts in Wales. These became particular areas of focus for this review.

In the wake of serious problems in some areas, notably Powys, commissioners were also very interested in improving the sustainability and quality of domiciliary care.

3.3 How we carried out our review

There are already some excellent research papers and publications about domiciliary care, but often these look at just one aspect of domiciliary care. We wanted our review to look at the whole system with fresh eyes from the following four perspectives:

1) People who use care and support at home.
2) Care workers who give care and support.
3) People in organisations that provide care and support.

4) People in organisations that commission it.

We wanted to learn from things that were working well and identify solutions that recognise the dependent relationships among all the main partners involved.

We felt it was important to understand the partners' roles and responsibilities, their successes and difficulties, and the interdependency and impact on one another. To gain this deeper insight we wanted to hear from people who were using domiciliary care. After discussing this with providers and inspectors, we designed a survey that could be completed on our website. Inspectors also gave out copies of the surveys while inspecting domiciliary care agencies and when talking with people and their families.

We were interested in the quality of care people received and the outcomes of the care arranged for them by the provider agency and care workers. We talked to three 'focus groups' of older people and their families to test out emerging themes which came out of the survey responses.

We also wanted to know how care arrangements for care impacted on care workers exploring their pay and conditions and the challenges they face. We designed a survey for care workers to complete on our website. We also gave out questionnaires and interviewed staff while inspecting provider agencies.

We wanted to look at recruiting, retaining and managing a workforce to keep a business going as part of providers' business operations and management practice. We wanted to hear about the quality-assurance systems they have in place, their business challenges and their relationships and connections with commissioners. We also wanted to explore the approaches providers take to the quality of care. To do so, we used an enhanced methodology for our inspections, which allowed us to focus on specific aspects of quality; for example, person-centeredness, respecting people's wishes and care worker continuity. We asked domiciliary care providers to fill in a survey and asked for their views while carrying out enhanced inspections in the review period. Providers who responded to the survey and were interested in contributing further to the review joined us at one of three regional workshops. These workshops allowed providers and commissioners to meet to identify specific challenges and share ideas and successful ways of working.

All 22 councils in Wales responded to our survey and many took part in our regional workshops. We also carried out six inspections: we chose two councils from each CSSIW region and spoke with commissioners and staff. During these council inspections we met members of local domiciliary care provider forums. As part of each inspection, we looked at the files and experiences of six people who were receiving care. Where possible, we visited people and their families at home to deepen our understanding of the situation in each council area.

We used focus groups, our stakeholder reference group and some individual meetings to explore specific issues in more depth.

3.4 The future of the sector

There are a number of opportunities to make improvements in future. We have worked closely with Care Council for Wales, which has been commissioned by Welsh Government to produce a five-year strategy for domiciliary care in Wales. We have also been working closely with the National Commissioning Board, which is considering national commissioning and outcome based frameworks. We are also looking at opportunities to reshape how domiciliary care is regulated by developing regulations and codes of practice to accompany the Regulation and Inspection of Social Care (Wales) Act 2016.

Under our recently introduced legislation, (the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015[6]), all sectors need to work together to improve the well-being of people in Wales. They envisage longer-term solutions, including early intervention and prevention, to ensure health and social care services are sustainable. The role of domiciliary care will be crucial in achieving these ambitions.

The following chapters of our report provide evidence and feedback from the perspectives of people and organisations involved in domiciliary care. We then analyse some of the relationships and pose challenges and suggestions.

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[6] Welsh Government (2015) *The Well-being of Future Generations (Wales) Act 2015.* Wales: Welsh Government.

4 What people using domiciliary care told us

4.1 Our approach

We start our journey with what people who use services and their families told us. We received 283 surveys from service users and their families and we spoke to 224 people while we were inspecting councils and regulated services[7]. We also met with older people at three focus groups, where we had open discussions around four themes:

1) what matters to older people receiving domiciliary care;

2) what is working;

3) what isn't working; and

4) their suggestions for improvement.

It is interesting that 56 per cent of people who filled in the survey said they live on their own and 14 per cent do not have family and friends to help or support them.

Of the people who said they were receiving care and support:

- 17% were between 18 and 64 years old; and
- 83% were 65 or older.

Of the total, 43 per cent of these people were over 85.

When asked about funding their care:

- 42% of people said they pay for some of their care;
- 30% said they pay for all of their care; and
- 28% said they did not pay for any of their care.

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[7] There were more responses to the survey in the council areas and agencies that encouraged people to respond. However, the messages were repeated and consistent with the points made in the focus groups.

4.2 The main messages

- In general, people are very happy with the care they receive and are very grateful.

- People really value the relationships they have with their care workers.

- People recognise that care workers are under pressure and in a rush, and they feel concerned for them.

- In general, people receive the care they need and are confident in the skills of their care workers.

- People recognise that care calls cannot always be provided on time, but they say good communication is critical if there is a delay or if their care worker is changed.

- Seeing the same care workers (continuity of care workers) is the most important thing for people who use care services.

However, we also found several examples where the care provided was poor and where people were generally unhappy. From the surveys and our inspections, we estimate that 5 to 10 per cent of people are receiving an unsatisfactory service. The main things that people are unhappy about are:

- lack of reliability;
- poor timekeeping;
- poor communication; and
- inconsistency of care workers.

We also had detailed qualitative feedback from our focus group discussion, which has helped us to understand the experiences, wishes and concerns of people who use services and those of their families.

4.3 What matters most to people receiving domiciliary care

- Consistency of care workers.

- Social contact.

- Being able to choose their routines (for example, bedtimes) and the 'people who look after us'*.*

- Communication: 'knowing what is happening' (Focus group).

- Being able to communicate easily with care workers.

- Having information about what services are available and the costs and fees: 'it's all very confusing, people are left helpless' (Focus group).

4.4 What is working

- Care workers do care about the people they help.

- Some care workers are very committed. People are *'moved by the dedication of the staff ... even coming in the snow!'* (Focus group).

- Health and social care being joined up in some areas.

4.5 What is not working

- The quality of care varies from one agency to the next.

- Evening and weekend calls are unreliable.

- Care workers are rushed because their travel time is not being considered.

- Care arrangements are not being joined up between agencies: 'Domiciliary care workers are out of the loop' (Focus group), 'the left hand does not know what the right hand is doing' (Focus group).

- Consideration of the needs of dementia and sensory impairment: there is 'disorientation when there are a high number of care workers' (Focus group).

- Providing continuity - People don't always get to see the same care workers.

- 15-minute calls.

- Care workers are not available when people need them: 'people are put to bed early when they want to go to bed later'(Focus group)

- 'People experiencing long periods of isolation' (Focus group).

4.6 Suggestions made by people we spoke to

- Allocate certain care workers to certain people.

- Have joint information systems between agencies.

- Have some sort of team debrief to share information between key agencies, including care workers.

- Councils should employ staff if they want to provide domiciliary care

- Recognise the importance of social contact: 'care must go beyond physical attention' (Focus group).

4.7 Emerging themes – what we found

We identified a number of factors which affect the quality of care and support that people receive.

1) Receiving care and support.

2) Relationships.

3) Communication.

4) Timing of calls.

5) Punctuality.

6) Choice and control.

7) Consistency of care.

8) Being helped to be independent.

9) Dementia support.

10) Welsh and other languages.

11) Care workers.

12) Quality assurance.

The following sections set out more details about these main findings.

4.7.1 Receiving care and support

The surveys and many of the care packages we looked at during inspections showed clearly that for most people, domiciliary care works well. In response to the statement 'I receive good quality care and support', 70 per cent of people said 'always' and 27 per cent said 'most of the time' ('mostly true')[8].

Figure 1 – I receive good quality care and support
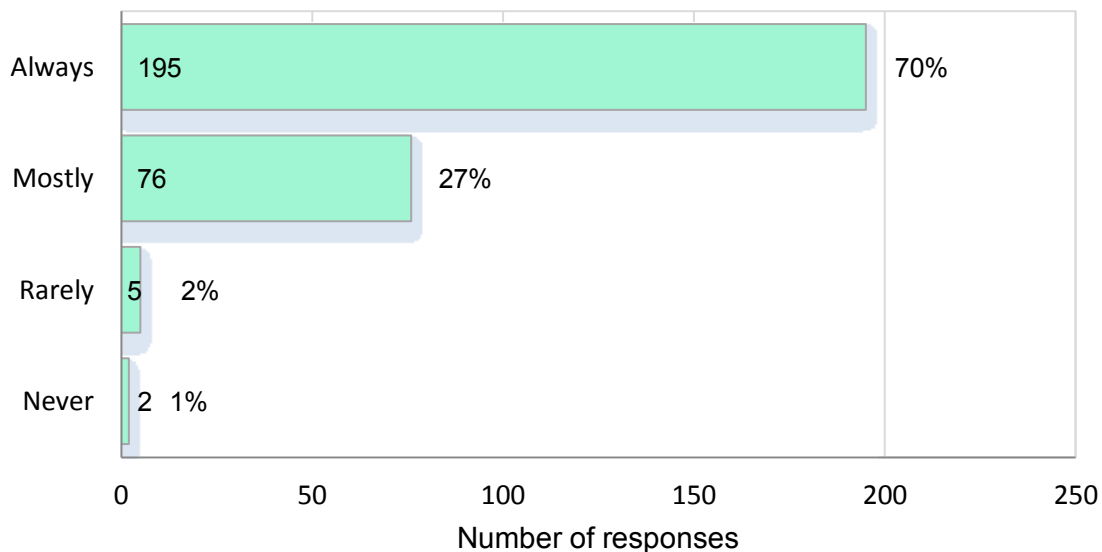
During inspections, people told us:

'We count ourselves blessed; it works very well for us, the care workers are exceptionally kind'

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[8] In this report, the charts give a breakdown of the categories as a percentage of the total number of responses. They also show how many people answered each question. We have not included any responses left blank. Chart percentage values have been rounded up and the total may exceed the expected value.

'I am well looked after, the agency goes beyond'

4.7.2 Relationships

People's relationships with their care workers are a very important theme in the survey responses and in our inspections. In the eyes of people receiving care and support, the relationship with their care worker can be much more important than completing the care tasks. Many people who receive care and support in their own homes are lonely, and very strong bonds develop between care workers and the people they care for:

'I hear banter and laughter from the care workers when supporting Mum' (Inspection)

'I have someone to talk to during the day' (People survey)

Similarly, for families, particularly daughters and sons, there is a strong sense of entrusting the care of a loved one to another person.

'Our care workers are friendly and reassuring. We are glad to know someone is caring' (People survey)

'Care workers are part of our family' (People survey)

'We have taken to most of the staff but not taken to two' (Inspection)

'They're a good crowd' (Inspection)

Two other important themes are:

- the need to match care workers to people who need care and support and their families; and
- having time to develop relationships during calls.

In response to the statement 'People who care for me have time to talk to me during their visit', 68 per cent said 'always' and 26 per cent said 'most of the time'.
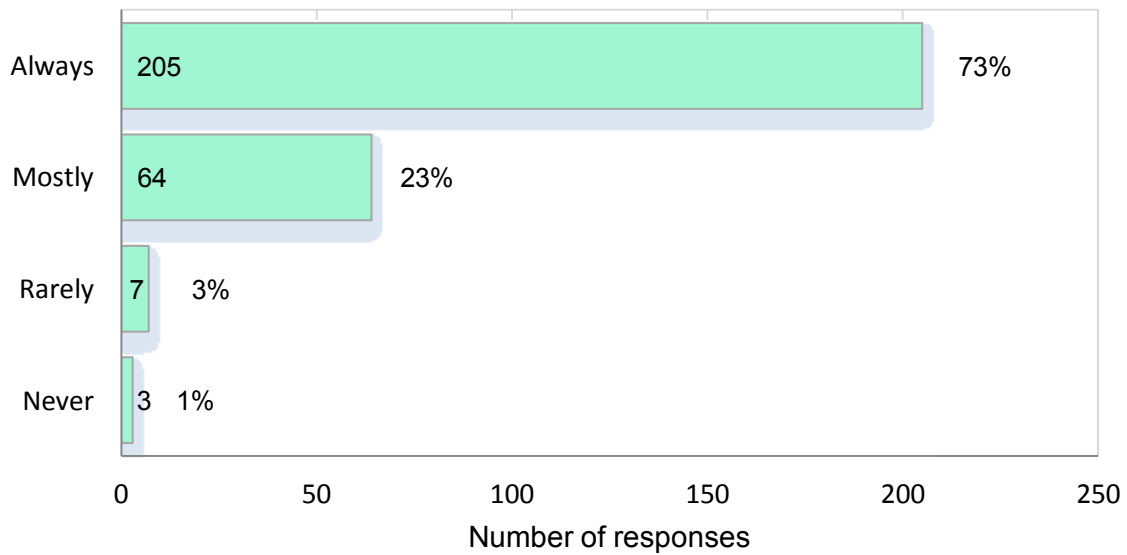
Figure 2 – People who care for me have time to talk to me during their visit
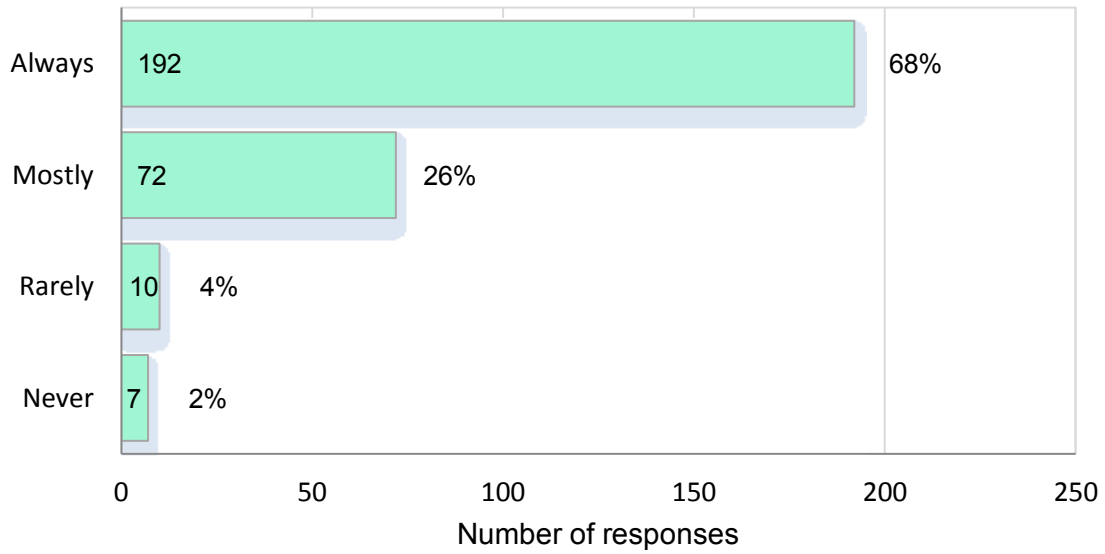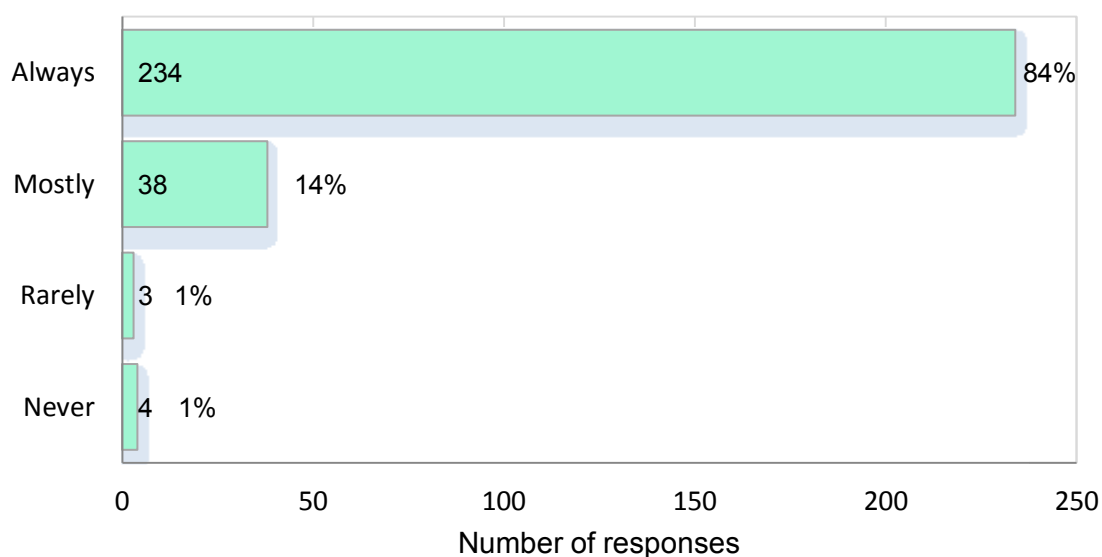

In response to the statement 'People who care for me listen to me', 73 per cent said 'always' and 23 per cent said 'most of the time' ('mostly true').

Figure 3 – People who care for me listen to me

People also said that care workers showed them respect and treated them with dignity.

Figure 4 – People who care for me show me respect and treat me with dignity

4.7.3 Communication

However, not everything is positive. People using care services and members of their families have raised serious concerns about how the quality of the care provided by different agencies varies. This is about how reliable calls and communication are, which appears to reflect the organisation and planning arrangements back at the office.

'My relative has a new care package for the last six months, split by two providers. Alzheimer package first thing in the morning is excellent and tailored to her exact needs. Other calls are meal calls by another provider and sometimes this does not work as well, sometimes rushed which is difficult. Before this the care package was appalling, unreliable, uncaring and untrustworthy. It took many months for social services to rectify. Gone over to a combination of direct payments and care paid for by the local authority which so far works better' (People survey)

'I use two companies; the first is an excellent example of good practice, well trained pleasant staff who arrive on time. The office communicates well if there are any changes and will try to accommodate me if I have any need to change my time, allowing me to lead an independent life. Unfortunately the second company shows poor practice, which makes me anxious and takes away my independence' (People survey)

'No communication from care workers, often late – often do not show up at all – always have to be directed – never follow the care plan already mapped out – never use initiative, e.g. if I have dropped something don't pick it up without being asked – do not clean up after me e.g. toilet after bowel movements – they are always moaning about travel times and how hard it is for them – never stay full length of time. I feel I have NO dignity e.g. stripped off unceremoniously and washed' (People survey)

Previous studies by the Welsh Institute for Health and Social Care[9] indicated that 96 per cent of care is provided by informal carers (relatives and friends) and 4 per cent of care is provided by domiciliary care agencies. More importantly, the study concluded that the ability of informal carers to provide care was often very dependent on the reliability and quality of agency care. This was also very clear in our findings.

One person told our inspectors how she was affected when the care an agency gave to her mother became very erratic and how she now has her life back following the appointment of a new, more reliable agency. She explained that the repeating pattern of late and missed calls left her in a state of severe anxiety. She dreaded every day, fearing for her mother's safety. The uncertainty left her feeling constantly agitated; she said 'it was a living nightmare'. She told us she was diagnosed with anxiety and depression, which led to her being prescribed antidepressants and taking sick leave. This affected her income. She was distracted and unable to respond to the needs of her teenage children, which led to arguments and family tensions. The poor care provided by the agency affected the whole family. She said that appointing a new, more reliable agency has given her life back. She can trust the agency and knows they will tell her if there are any problems.

Another family carer told us a similar story. Her mother has dementia and doesn't respond well to strangers. The care provider keeps sending different people to give

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[9] Welsh Institute for Health and Social Care (July 2012) *Home care in Wales: views and experiences of older people, report of findings for the Older People's Commissioner for Wales*. Wales: Welsh Institute for Health and Social Care; University of Glamorgan.

care. They sent some thirty different care workers in one fortnight, despite a previous agreement that care would be provided by a team of four. As a result, her mother gets distressed and incidents keep happening. The agency then calls her at work to sort out the problems and calm her mother. She says it is 'very unfair' and feels very upset to see her mother so distressed. The problems have been going on for some time and have affected her relationships with her husband and her employer. She has been offered direct payments, but she explained that she already spends a lot of time supporting her mother and does not have the time to sort out arrangements to use direct payments. The family already adds to the council-funded package by buying additional care directly themselves (which she says works well). She said that she is made to feel that she is the problem for complaining when it is the agency that has not given the care it has been contracted to provide. The stress has been overwhelming and is seriously affecting her own health.

Reliable calls are particularly important when people have dementia. Another family carer told an inspector:

> 'It's been horrendous. I work the rest of the week. I've asked if I can cut my hours to take care of him… told I am not trained well enough because health fund his care. I am not nursing background but the care workers are not either. He punched me in the face, doesn't mean it. Care workers tried to take him out but none of them have got the strength or passion because it's very difficult' (Inspection)

Our evidence suggests that there are two ends of the spectrum. When packages become established and there is good communication, relationships develop and trust builds. However, when the care is unreliable and erratic, confidence and trust break down and the impact on the person receiving care and support and their wider family can be devastating.

4.7.4 Timing of calls

The timing of calls is an important theme that we tried to understand in the review. The general feeling in user surveys and focus groups was that people would value longer calls, although they accepted that time is a scarce resource.

Discussion in our focus groups confirmed that people who use care services see 15-minute calls as undesirable. They are seen to encourage a task-based approach to care on 'a get in, get on and get out basis'. People also pointed out that 'if the care workers are unfamiliar they have to spend the 15 minutes learning the ropes so the care is not given'. They also said that '15 minutes is not enough' and 'people don't even get 15 minutes'.

In response the statement 'People who care for me stay for the expected time', 68 per cent said 'always' and 27 per cent said 'most of the time'. But interestingly, in our inspections, we found that some people were quite happy with the call lengths even though the records showed that calls had been 'clipped' (shortened by more than ten minutes on each call).

The question of monitoring call lengths came up in one of the focus group discussions. People asked how well these are monitored:

'Our council pays for 30 minute calls but people don't do 30 minutes'

'Who is monitoring call lengths? No one seems to be.'

**Figure 5 – People who care for me stay for the time expected**
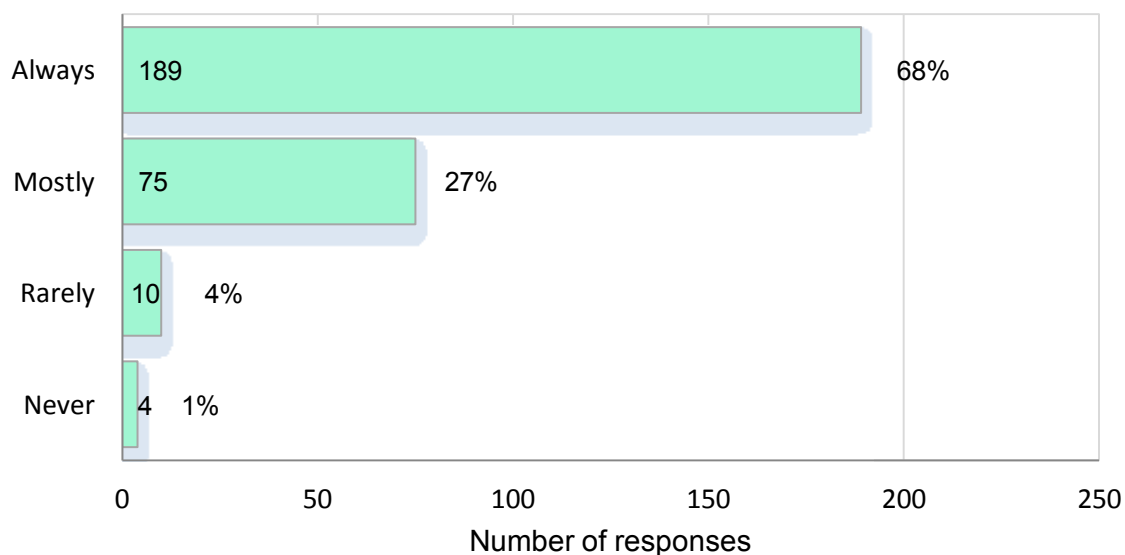
People made many comments about care workers being rushed. People had empathy for the plight of their care workers, and showed some positive recognition and tolerance of poor timekeeping. We even heard of a situation where family

members had asked their elderly parents why the care workers had not prepared their meal and washed up. Their parents said that the care workers were so exhausted when they arrived that they were happy to let them have a rest and a cup of tea instead of doing the tasks needed.

In response to the statement 'People who care for me are rushed and have to leave early', 11 per cent said 'always' and 15 per cent said 'most of the time'.

**Figure 6 – People who care for me are rushed and have to leave early**
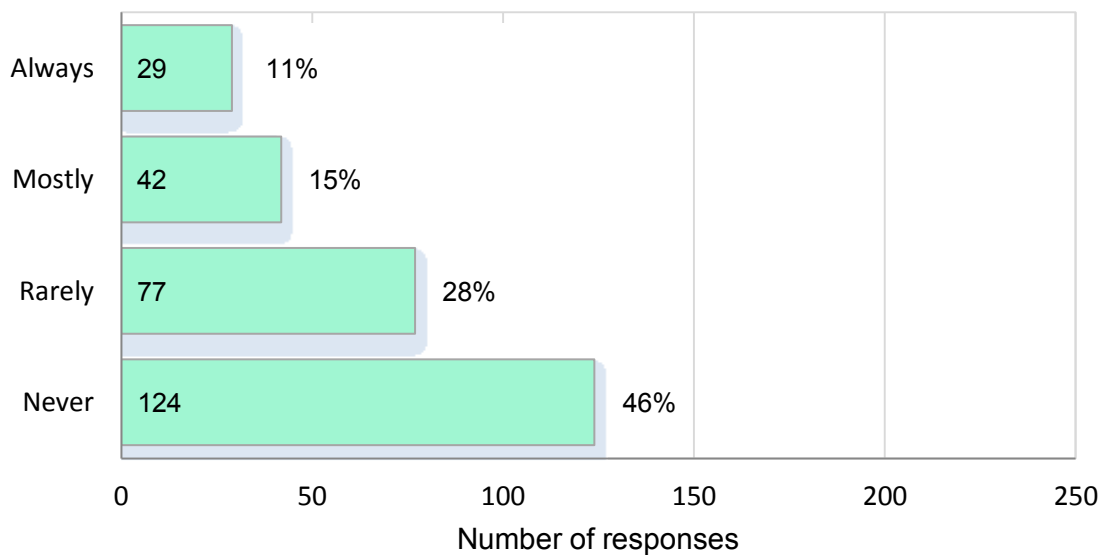
'My aunt and uncle were very happy with the care. There was good continuity, nice people, but always in a rush' (Focus group)

People told us that in most cases there was enough time for the care workers to give the help needed. However, we had feedback that in some cases councils had reduced the length and number of calls.

'They reduced night calls with no input from the family' (Inspection)

Figure 7 – People who care for me have enough time to help me

	Number of responses	
Always	183	66%
Mostly	74	27%
Rarely	14	5%
Never	7	3%
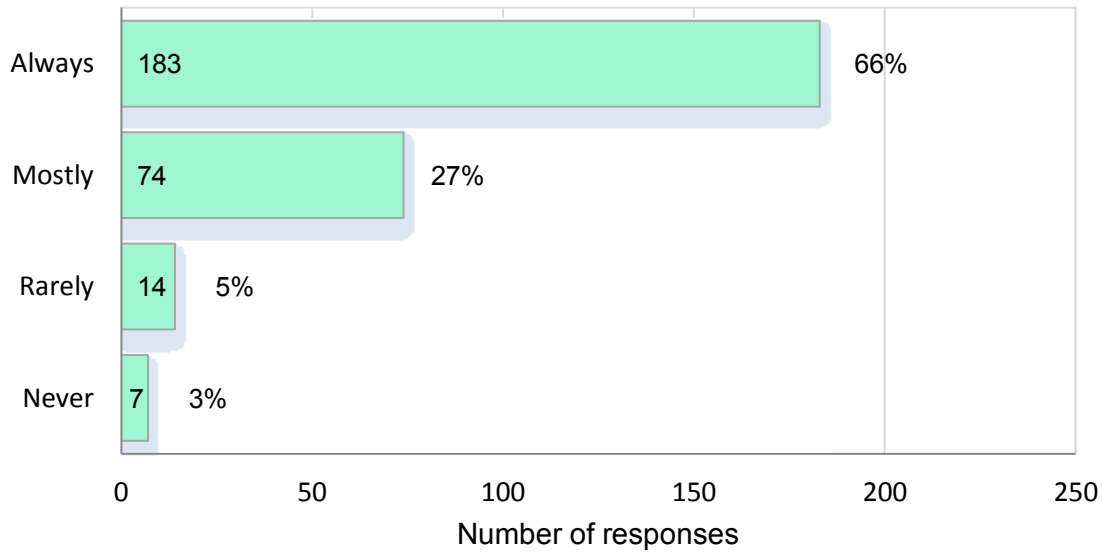
4.7.5 Punctuality

We also considered the punctuality of calls. On the whole, people told us that care workers arrive on time for most calls.

**Figure 8 – People who care for me arrive on time**

	Number of responses	
Always	132	47%
Mostly	131	47%
Rarely	11	4%
Never	4	1%
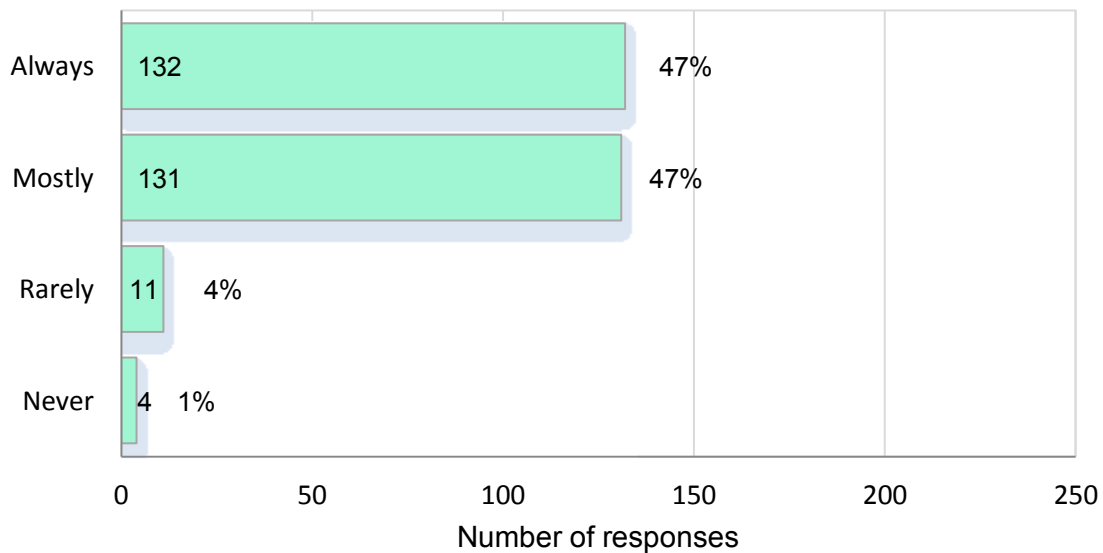
People receiving care and members of their families did not expect care workers to arrive at the exact time they were due. They fully appreciated that care workers have to be flexible to meet the needs of people in previous calls and that traffic and other

problems can make them late. However, some people have needs that must be met at a specific time. These 'time critical' calls may be for taking certain types of medication or being supported to keep hospital appointments. For people with dementia and those who are prone to anxiety, care workers not arriving on time causes them severe distress. Our survey results and feedback during our inspections suggests that if there are changes or delays, good communication is critical. Around 20 per cent of people said some providers performed poorly on this.

Figure 9 – The agency keeps me informed about any changes to visiting times or care workers
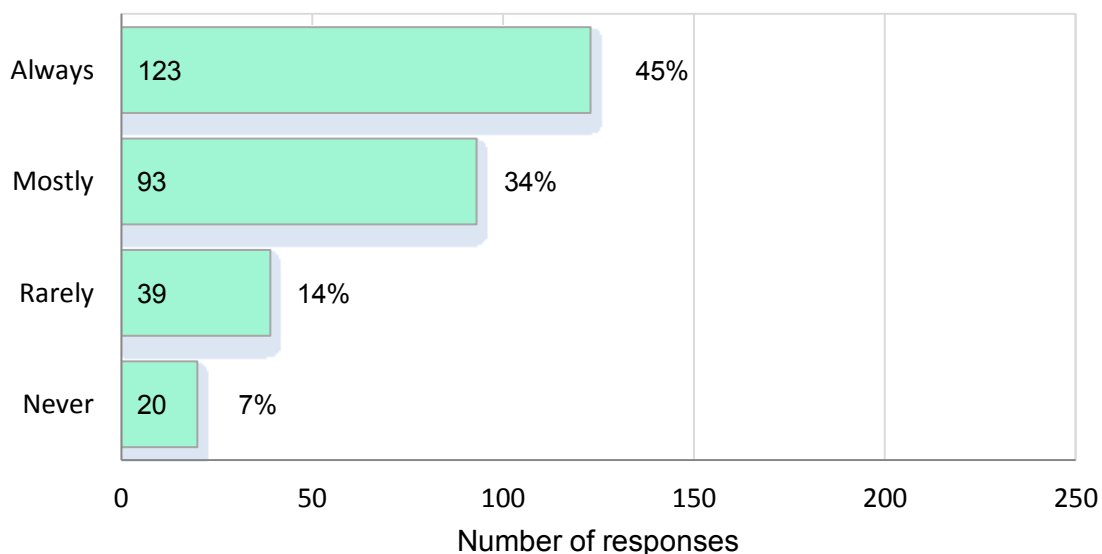
'No missed calls; have been late once or twice; ring to let me know if they are going to be late' (Inspection)

'… erratic care when regular care worker is not available. Communication and recording practice diabolical. Office base seems chaotic. Lack of integrity from office staff and management' (Inspection)

'Calls are frequently late or changed without any communication, I have waited up to two hours to be got up and have missed appointments. Sometimes I do not get to bed until midnight as so few staff working' (People survey)

4.7.6 Choice and control

In general, we found that most people, most of the time, felt they had choice and control over the care being provided. People mentioned that it is important to support people to keep up their normal routines, such as bedtimes: 'Choice of care routines, for example, bedtimes, is very important' (Focus group).

Figure 10 – My care is provided in the way that I wish
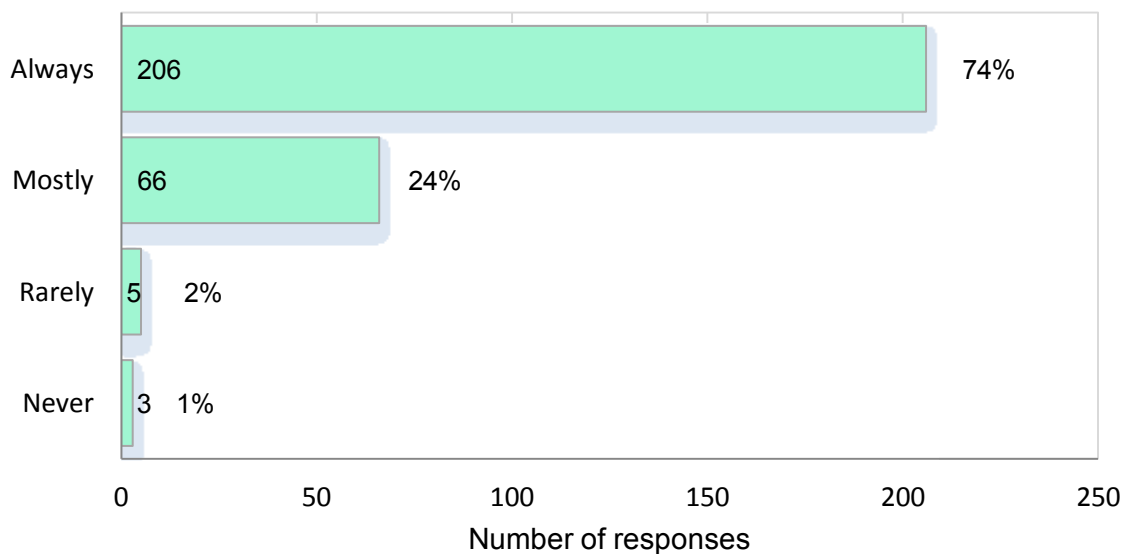
People gave their views during our inspections:

'Agency did best to accommodate times requested'

'I have mixed feelings; I do not always feel in control'

'Yes, I can honestly say they have taken our wishes into consideration. Anything that's not right is always rectified quickly'

'Agency really listens to me; the manager and the staff know me well and provide a very flexible service'

Flexibility was also seen as important, as people's needs might change on the day. So was the ability to do things that might not be stated 'on the list' if they were important to the person receiving care and support.

'Care packages are too general and do not offer a personal approach. They are too rigid with no flexibility. Sometimes you cannot predict how long a call will take. One day it might be 15 minutes, the next an hour' (People survey)

'Feel looked after, and look after my dog' (People survey)

'Care workers do more than the plan indicates' (Inspection)

'One agency in Bargoed offers real choice, age group and gender of care workers, they will even take you to the cinema' (Focus group)

The idea of choice and control was discussed at the focus groups. It is more complicated than it may first appear. People made the point that finding out what a person's wishes and needs are can mean much more than accepting what they are saying at face value. It is a process of exploration and negotiation.

'Older people will always tend to be very grateful. They do not like to complain, they fear they will lose the service or be put in a home, do not want relatives to know in case they make a fuss. They do not like to make demands and will understate their needs, therefore care workers need to be proactive and anticipate people's wishes and needs' (Focus group)

For some people, their ability to express their wishes may be very limited, and some people are very vulnerable. It is very important that care workers can respond to people 'in the moment, considering non-verbal as well as verbal cues.

'They care for my husband who has limited communication and they respond to his body cues well' (Inspection)

It can be challenging for care workers to give people choice and control when they are very resistant to the care they are being given even though it is in their best interests. One example given was a man with dementia who was very confused and aggressive and would lie in urine and faeces and fight off care workers with his stick. Another was a lady who needed to be washed but resisted help.

'Older people are very vulnerable; imagine being in a night dress and stripped off for a wash' (Focus group)

'People being cared for can be uncooperative and very aggressive' (Focus group)

Relatives recognised these issues and said that providing care and support is not straightforward; it needs to be flexible. It is essential that care plans are written together.

'Professionals just came along; I had no real input. Someone just came along and told me what they were doing' (Inspection)

4.7.7 Continuity of care

As we have already said, relationships are very important for people who receive care and support and for their families. Continuity of care (making sure people see a care worker they know) is essential to any domiciliary care service. This is less of an issue in supported housing arrangements, where specific care teams support groups of people on a planned, stable basis.

Of the people who filled in the survey, 12 per cent told us that they rarely or never received care from someone they knew.

Figure 11 – I receive care from the same care staff I already know
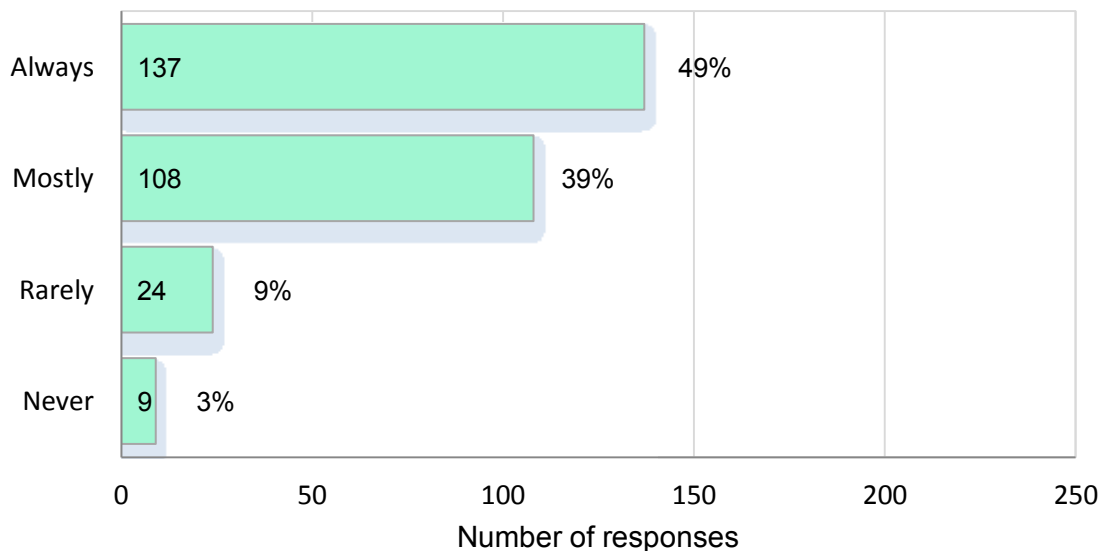
When agencies get this right, care is judged well:

'We see the same care workers throughout the week. Care workers are wonderful' (Inspection)

'My mother is very pleased with her care workers. They show her respect, kindness and care. I think it is very important that Mum has the same care workers each week. It builds trust and friendliness!' (People survey)

People in the focus groups described how fearful and anxious people can be when complete strangers arrive to provide what can be very intimate care, such as washing. Having to accept such care from strangers was seen as a betrayal of a person's dignity.

When talking about a relative who was bed-bound, one member of the focus group said: 'there were constantly changing care workers, strangers just coming through the door'.

Other comments included:

'I do not know who is coming through the door' (Inspection)

'A person became distressed when confronted by male care workers they did not know. They were supposed to have two female care workers' (Focus group)

'Elderly people like to know exactly what is going to happen and don't like changes. They would prefer a small group of known care workers' (Focus group)

'I have had 30 different care workers in one month, most of whom have not looked at the care plan' (People survey)

One person said that continuity of care is an important area that someone should be made responsible for. They suggested that provider agencies should be given incentives to reward continuity.

4.7.8   Being helped to be independent

Helping people to do things for themselves involves patience and time. In the survey, people told us that care workers helped them to do things for themselves.

Figure 12 – People who provide my care help me do things for myself
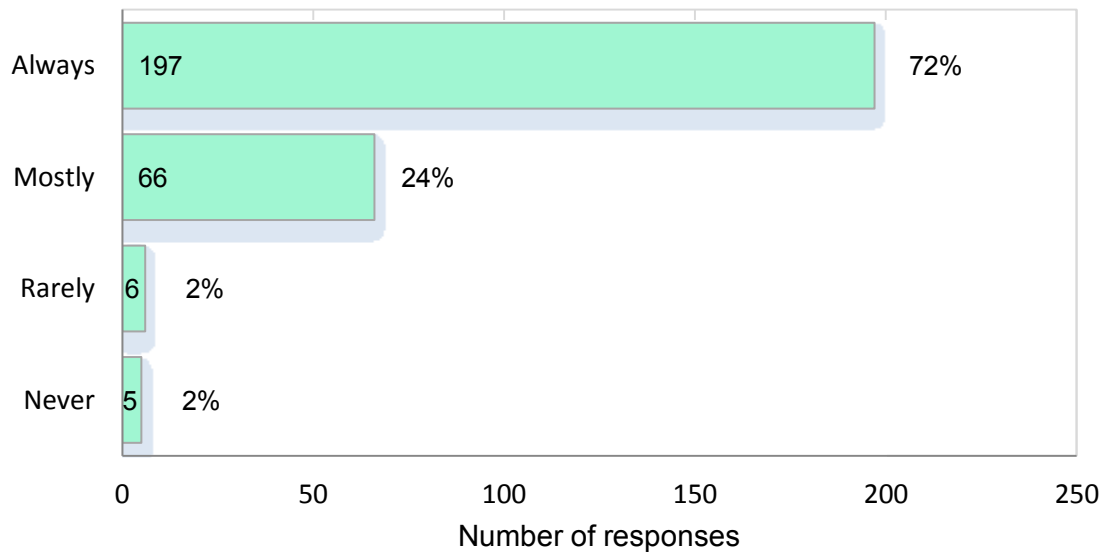
During our inspections one person told us how care workers supported her over time to be able to have a shower independently. In addition:

> 'The care workers talk to her, involve her in the kitchen when they are preparing her meals as much as possible.'

> 'She can do less than she could, but they encourage her independence to do what she can'

However, we wonder, given the time pressures on some calls, if this is what happens in reality. In one of the focus groups, people pointed out that how difficult it is to balance the benefits of supporting people to do things for themselves with the need to ensure people are safe. This is particularly important for frail elderly people, people who have mobility problems are at risk of falling, and those who have dementia.

> 'Sometimes we do too much for people. That's not life. People need to do things for themselves, need to take risks' (Focus group)

These are not easy matters to resolve.

4.7.9 Dementia

In our inspections and focus groups, people highlighted the particular challenges and risks of providing care and support for people with dementia. From the point of view of families, having a relative with dementia heightens anxiety because there are higher risks and more uncertainty. Having reliable domiciliary care brings some order and reassurance to what can be very stressful situation. Unreliable care makes the situation and stress much worse for families.

‘It has been a total nightmare’ (Focus group)

Familiarity is critical when caring for someone with dementia. Without it, people with dementia experience increased confusion and anxiety, which may lead to frustration and misunderstanding. Caring for someone with dementia without appreciating the perspective of that person and how dementia may be affecting their understanding or emotional state can lead to serious incidents. Care workers need to have a good understanding of the background of the people they are caring for and which approaches will work.

We found that for some people with dementia, having reliable calls and set care routines (to the tiniest detail) is crucial in reducing confusion and creating a sense of order in what is being experienced as a chaotic world. One example we heard of was the importance to someone with dementia of having *a cappuccino in a specific cup* – not an instant coffee in any cup, which would have no meaning for them.

Families can be very embarrassed about dementia. They do not always want to share their problems with services. They may feel responsible for their relative's behaviour towards others, including care workers. In one moving account, a carer who experiences a high level of violence from her husband told us she would never approach an agency because it was unfair to expect care workers to cope with her husband's behaviour. She felt that it was her burden to bear. Supporting and working with families can be as important as caring for the person with dementia.

4.7.10 Welsh and other languages

Our surveys identified 30 people (11 per cent) who described themselves or were described as Welsh-speaking. Eight were able to receive their care in Welsh. Most people didn't seem to mind whether their care workers spoke Welsh or not and said they were happy to communicate in either Welsh or English.

> 'Some of my care workers are Welsh speakers. I don't mind if care workers speak Welsh or not' (People survey)

> '[Having Welsh-speaking staff] is not an issue. Some care workers ask Mum to teach them, which is lovely' (People survey)

However, in our focus groups, relatives gave examples where speaking Welsh had made a real difference to the quality of the care and to people's relationship with their care workers. In one example, relatives found the care workers 'talking to and singing to [their mother] kindly in Welsh. It was lovely to see and made my mum so happy'.

> '[Conversing in Welsh] opens the door' (Focus group)

In one focus group, people expressed concerns about the ability of some foreign staff to communicate in either Welsh or English.

4.7.11 Care workers

People receiving care and support and their relatives were very positive about care workers and the contribution they make. In the survey, 99 per cent of people told us that staff are always or mostly kind. A similar proportion said they trusted their care workers.

Figure 13 – People who provide my care are kind

Always 228 82%
Mostly 47 17%
Rarely 2 1%
Never 2 1%

Number of responses
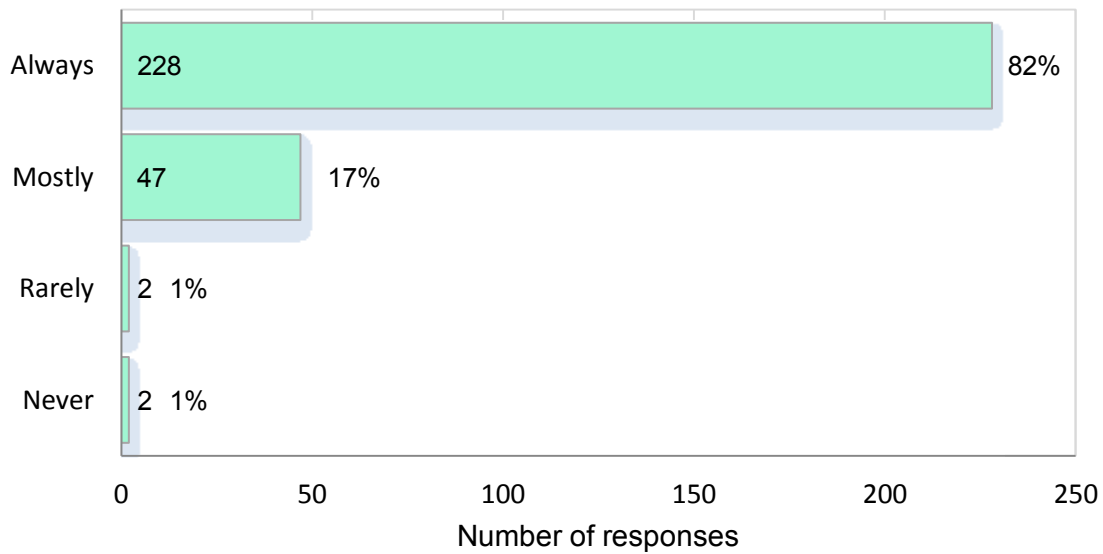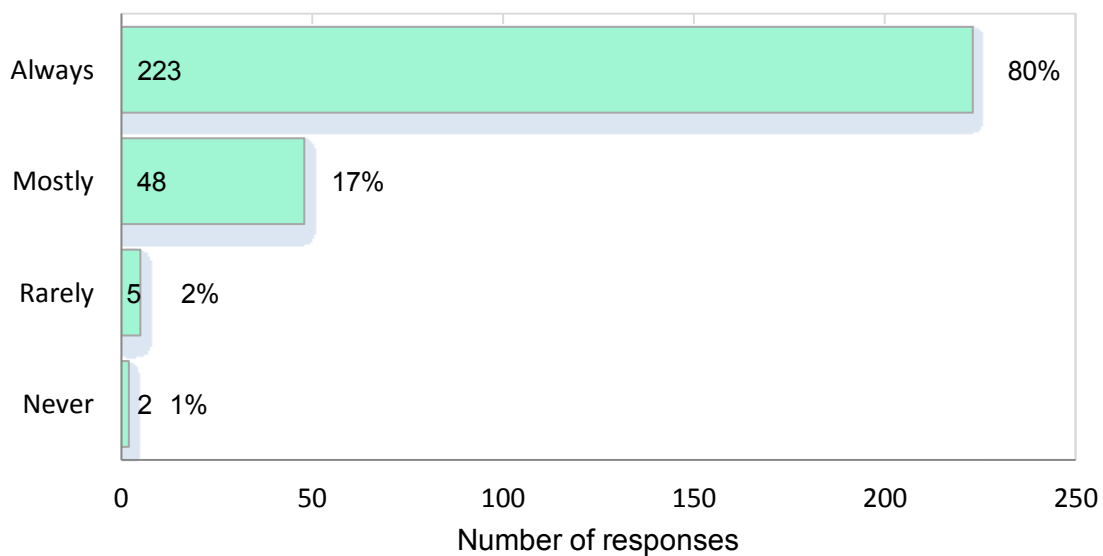
Figure 14 – I trust the people who care for me

Always 223 80%
Mostly 48 17%
Rarely 5 2%
Never 2 1%

Number of responses

'All the care workers are lovely; we are very lucky' (Inspection)

'Care workers can turn a dismal situation into a happy one' (Inspection)

We found that people had a lot of empathy with and tolerance towards care workers. They were aware of the pressures they are under and their poor pay and conditions.

'They have their hands full' (Focus group)

'Wages are poor' (Focus group)

'Staff are often stressed and crying when they arrive late at night and I feel I am in danger being hoisted as they are too tired' (People survey)

As to be expected with such a large, diverse workforce, not all care workers were viewed in the same positive light:

'About six care workers are nice, the rest are a bit slovenly, a slap dash attitude, "let's get it over and done and get out"' (Inspection)

'Most of the care workers are good but I have complained about three' (People survey)

Being able to choose or match care workers was seen as very important. It was especially important for women to be able to choose the gender of care workers: 'they sent a man, a very nice man, but she was terrified' (Focus group). In another example, a provider offered an elderly lady a young male carer to help her to shower. At first she was very reluctant, but over time she was quite happy with the arrangement. In our discussions, men seemed to be happy to be cared for by women.

We also received many comments about the age and maturity of some care workers. One issue was that younger care workers are not able to cook meals that older people are familiar with. Another was their ability to complete household tasks. One person in a focus group told us about an old lady in a wheelchair who was trying to tell a young carer how to set and light a fire: 'the carer was hopeless and the fire never got going!' (Focus group).

The issue of personal relationships and professional boundaries was brought up in our discussions. People we spoke to recognised that people who receive care and support and their care workers can become very attached. They saw attachment as inevitable and important for some people who are lonely.

'For many, the care workers are the only person they will see in the day; therefore, care must be given in a humane way' (Focus group)

However people raised the issue of people becoming too attached; the vulnerability of people receiving care and support.

> 'Care workers can take advantage. They offer to do shopping and short-change them, add their own things to the shopping list' (Focus group)

The issue of personal boundaries was highlighted during our inspection of one agency. A grateful elderly couple gave two care workers Christmas cards. When the care workers got home, they found that the couple had put £20 in the envelopes and written a message to say how much they appreciated the care. The care workers failed to tell the agency or return the money. When the manager found out two weeks later, the incident was reported as financial abuse. The agency carried out an investigation and both care workers were sacked. In their act of generosity, the elderly couple lost their two valued care workers. Because the care workers accepted the gift and didn't report it, they lost their jobs and will find it hard to work in domiciliary care again.

People said they feel that registering care workers on the professional social care register of the Care Council for Wales is a good thing. They recognised the importance of codes of conduct for care workers. They also felt that fair pay and conditions could reduce the risk of exploitation of the people being cared for. Agencies would have more choice when recruiting and care workers would be less tempted to exploit the people they care for. One example given was being paid for travel time. People also felt that the culture of the organisations employing care workers was important in encouraging positive relationships:

> 'Care workers must be treated with humanity by their employers so they can in turn offer humanity for the people they care for' (Focus group)

People were very concerned about the future and keeping staff in their jobs. Again, they felt that providing good pay and conditions was critical to this. A number of people were very appreciative of care workers from abroad, care workers from Eastern Europe and Africa were particularly mentioned. However, the following point was also made:

'If economies abroad recover, people from abroad will go back. Where will we get our care workers from then?' (Focus group)

People felt that those providing care were well trained. They had confidence in their skills. However, people told us that training in dementia and mental illness needs to be strengthened. They also told us that, occasionally, untrained office staff cover calls.

Figure 15 – People who care for me are well trained and know what to do
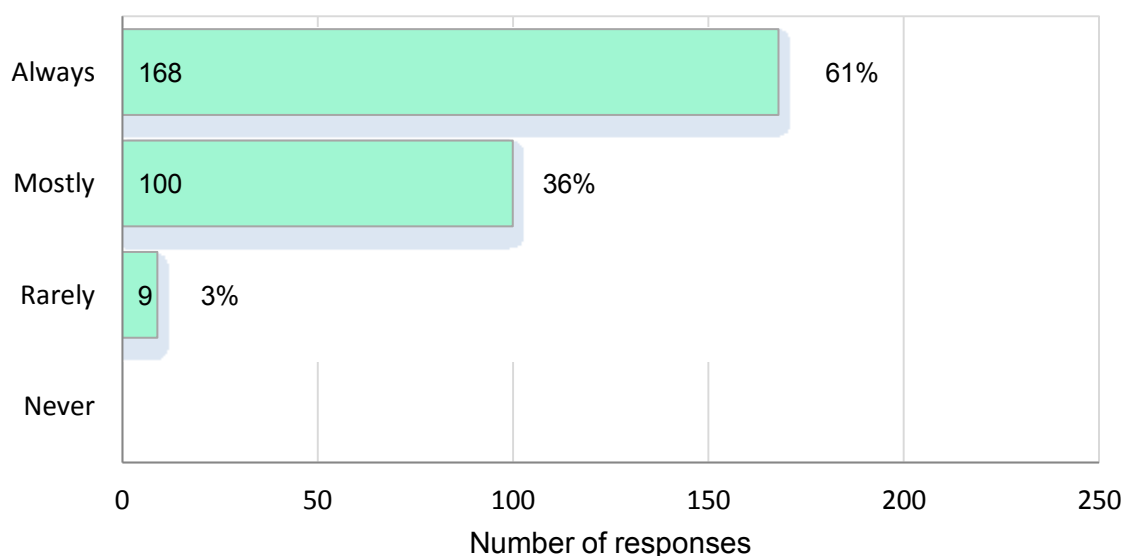
In one of the focus groups, people stressed that training is an excellent way of valuing staff, 'especially if you cannot give them money. Gives staff a sense of value and self-esteem'.

People in the focus groups were aware how very difficult care work is. They knew how physically demanding it can be and that manual handling can be a real challenge: 'some people are too big to handle safely'. They said care work can be unpleasant and messy *('cleaning bottoms'*). They told us that these aspects and other realities of care work tend to be overlooked but should be spoken about.

They stressed the importance of choosing the right staff: 'this is a vocation'.

4.7.12 Quality assurance

We wanted to find out how involved people and their families were in the quality-assurance arrangements for domiciliary care and how well agencies responded to their concerns and complaints. From the feedback we received, agencies could do better in this 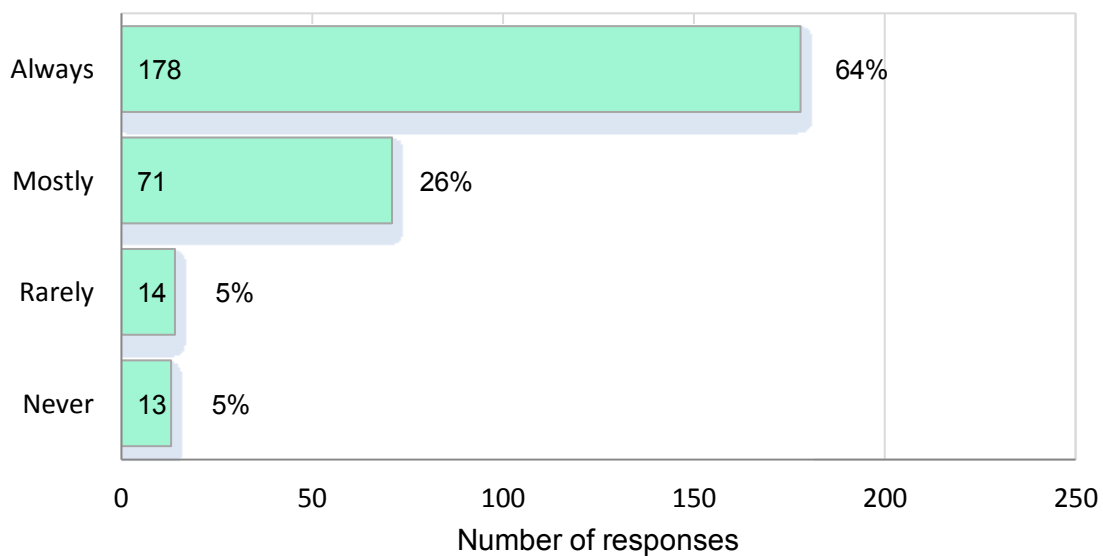area. Over 25 per cent of people said they were never or rarely asked for comments about their care, and 10 per cent were not confident that things would be put right if they complained.

Figure 16 – The agency ask for my comments about the care I receive

Response	Number	Percentage
Always	139	51%
Mostly	60	22%
Rarely	43	16%
Never	31	11%

Number of responses
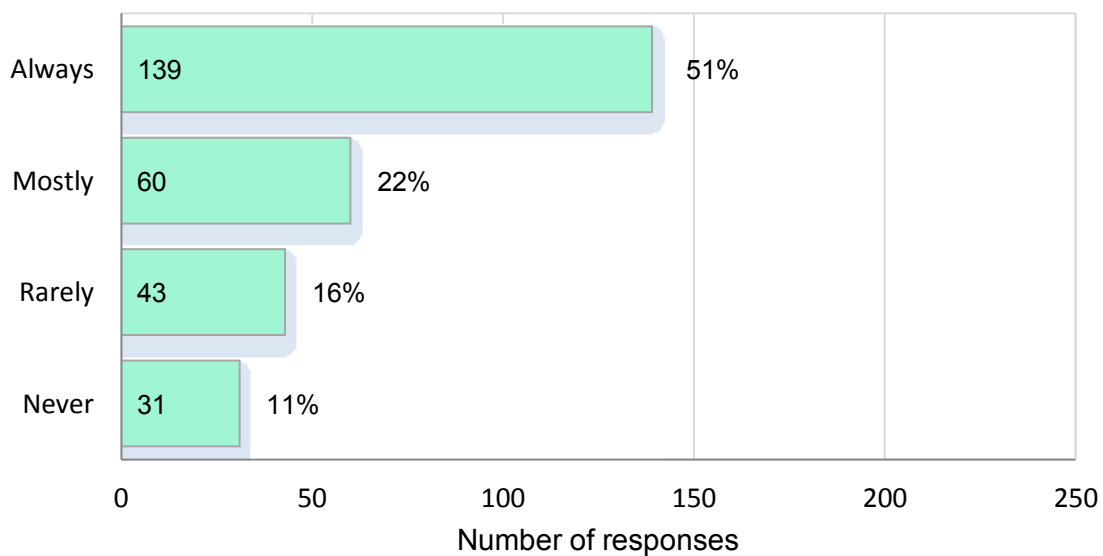
Figure 17 – If I raise a concern or complain I know things will be put right

Response	Number	Percentage
Always	178	64%
Mostly	71	26%
Rarely	14	5%
Never	13	5%

Number of responses

From the comments we received, some agencies seem to be better at responding to concerns and complaints than others. In our inspections we found some people know the office staff by name and feel able to make contact and discuss issues. However, one focus group reminded us of the importance of knowing who to speak to and how to get feedback from 'the office'.

> 'There are fewer complaints than for care homes. This is because people don't know who to complain to or have the ability to speak to those they need to' (Focus group)

5   What care workers told us

5.1   Our approach

We received survey responses from 213 care workers and spoke to 196 staff during our inspections. We did not arrange focus groups for staff. This is because the Centre for People and Performance at Manchester Metropolitan University Business School (commissioned by the Welsh Government) was already running focus groups with care workers and managers to find out what affects the recruitment and retention of care workers. Their researchers joined our three focus groups for providers and commissioners and shared the findings from their focus groups. Their report, *Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care* (WG 2016b)[10], contains powerful and detailed descriptions of the issues facing domiciliary care workers and managers in Wales. The report should be read alongside our review.

Almost 75 per cent of care workers who responded to our survey had been working for their provider agency for more than a year. In addition, 82 per cent were planning to stay in domiciliary care work for more than three years. Twenty-six workers (12 per cent) said they were confident Welsh speakers.

A significant number of care workers said they provide care in more than one council area, and one care worker worked across six areas. Of the staff who responded to our survey, 84 per cent worked for providers in the independent or voluntary sector, and 16 per cent worked for councils.

We focused on three themes:

1) what care workers like about the job;
2) what they don't like about the job; and
3) what changes care workers would suggest.

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[10] Welsh Government (2016b) *Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care*. Manchester Metropolitan University Business School. Wales: Welsh Government.

5.2 The main messages

Our findings are very strongly aligned to those of Manchester Metropolitan University Business School, the Burstow Commission in *Key to care*[11] and UNISON in *Time to care*[12].

- The strongest and most important message is that care workers gain deep satisfaction and pride from improving people's quality of life. They enjoy building relationships with the people they care for.

- The work can be emotionally demanding and stressful, especially managing time pressures and meeting the expectations of managers and families.

- Care workers feel the pay and conditions are poor and do not reflect the demands and complexity of the work they do.

5.3 What care workers like about the job

- Making a difference by improving people's quality of life and helping them to be independent.

- Being appreciated.

- Having relationships. Care workers enjoy meeting new people and talking and listening to the people they care for.

- Achieving goals.

- Variety: getting out into the community.

- Being part of a team.

- Flexibility and being able to work around family commitments.

- Supporting family carers.

[11] Koehler, I (2014) *Key to care: report of the Burstow Commission on the future of the home care workforce*. London: LGIU.

[12] UNISON (2013a) *Time to care: a UNISON report into homecare*. London: UNISON, the Public Service Union.

5.4 What care workers don't like about the job

- Being taken for granted.

- Time pressures when doing the work: rushed calls and not enough travel time.

- Having to cover other calls (for example, to cover sickness).

- Lack of continuity with people being cared for: not being with them from the start to the end of a service.

- The working conditions: poor pay, unpaid 'dead' time between calls, job insecurity, long hours, a poor work-life balance and unpredictable work patterns.

- The stress of having to make last-minute changes at home (for example, arranging child-minders).

- Poor organisation and management and poor communication from the office.

- Unrealistic pressure and expectations from managers.

- Not having team meetings.

- Not having a career structure.

- The emotional demands of being a care worker: seeing people upset and dealing with confrontation caused by things beyond their control, such as changes in care plans.

5.5 Changes care workers told us they would make

- Better pay and conditions.

- More discretion for care workers on call times, especially for people whose needs are complex and for more vulnerable people.

- Abolish 15-minute calls.

- More continuity and consistency when working with service users.

- Better business management, including supervision and support from managers and day-to-day communication.

- Better training.

5.6 Emerging themes – what we found

Care workers said that the following factors were important for providing care and support.

1) Job satisfaction.

2) Meeting people's needs.

3) The timing of calls.

4) Continuity of care workers.

5.6.1 Job satisfaction

We met and heard from many care workers who are really committed to their work. They gain a great deal of satisfaction from what they do and enjoy the relationships they have with the people they care for and support.

Figure 18 – I enjoy my work

Always 134 63%
Mostly 77 36%
Rarely 1
Never

Number of responses
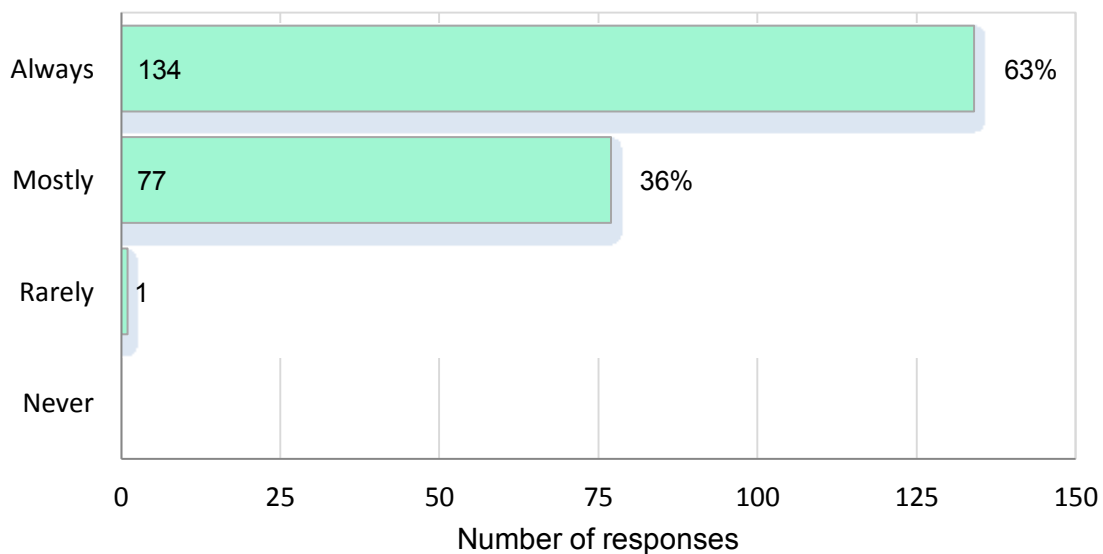
We were given several examples of care workers staying on to help and spend time with people, even though they were not being paid. In one example, an elderly man told one of our inspectors that his care worker had stayed after the calls were due to finish to help him to use the iPad his daughter had given him. He was delighted and it brought him a great deal of joy; he was now spending time looking at images of things he remembered and visiting old family holiday destinations on Google Earth.

In our staff survey, care workers told us what they like about their job:

'I like visiting service users, chatting to and supporting them with their daily needs, trying to make a positive difference to their day'

'I love meeting new people; learning about them, they all have a story to tell, getting new service users to accept us in giving them a helping hand'

'Sharing with them their goals and achievements, building relationships and watching their skills and confidence develop'

'We provide a service that allows people to remain in their own homes and have more choice and freedom than they would in a nursing home'

'Helping support family carers in these demanding roles; knowing that both carers and the cared for look forward to my visits, the continuity and reliability of the service, giving carers free time'

In our inspection, one care worker added:

'We have a variety of people to care for, which is really interesting'

Around 12 per cent of care workers said they find the work difficult all the time or most of the time.

Figure 19 – I find my job difficult
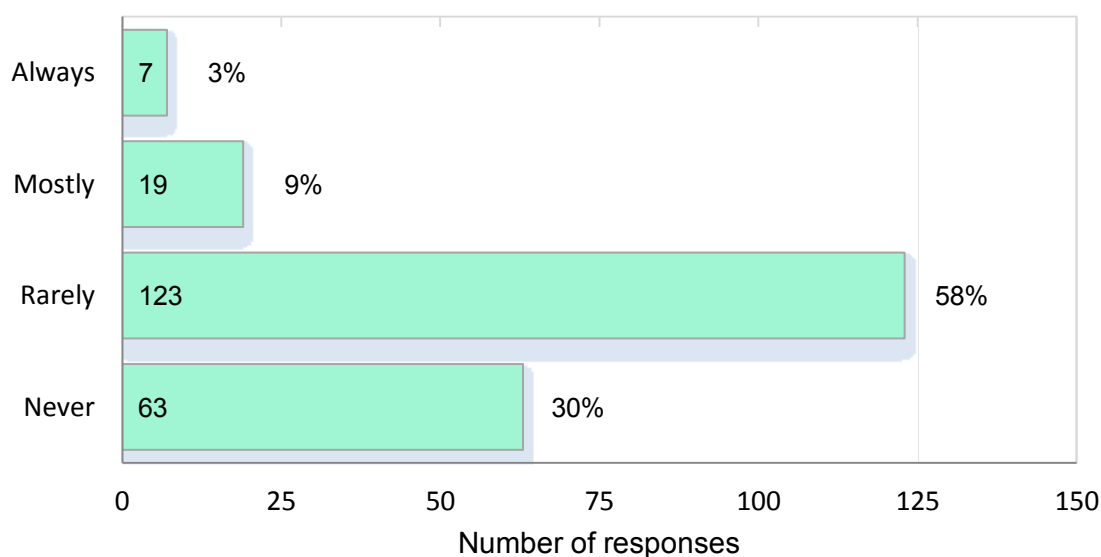
It was clear from our review that many tasks that care workers do are physically demanding; for example, moving people. Some tasks also involve intimate care, such as helping and cleaning people who are incontinent, helping people who have mental health issues, and helping people who may resist care or may be aggressive towards care workers. However, these negative aspects of care work were not mentioned in any survey responses. It would seem that care workers accept them as part of the job.

In our survey, we also asked care workers what they did **not** like about their job. A large proportion of the 213 who replied said 'nothing', or 'I love my job'.

Almost 55 per cent of care workers who did report something mentioned the pressure of the work and having to rush between calls. Many of their comments about the emotional impact revealed how upsetting the work can be.

Table 1 – What care workers do not like about their job

Issue	Number of times the issue was mentioned	Comment

Rushing; pressure	28	Stress of running late; not enough time on calls; short calls (15 minutes).
Emotional impact	25	Especially people dying or being lonely.
Travel time	18	Not being paid; time spent travelling.
Office organisation	17	Paperwork, communication, last-minute changes.
Pay	14	Low; no extra at weekends. Long shifts.
Long days	8	Fifteen/ twelve hour shifts. Exhaustion.
Late nights/ early mornings	4	Safety mentioned.
Zero-hours contracts	1	Because I cannot get a mortgage.

One care worker we spoke to said she had been working in domiciliary care for a year and was planning to give up. She had moved from being a learning assistant for children with special needs and had been looking forward to working with elderly people in the community. She told us her reasons for leaving were that half the people she provided cared for were really lovely and appreciative, but the other half were not. She dreaded making some of the calls. She spoke about one client in particular who was 'spiteful', very critical and demanding, and found fault with everything she tried to do. The care worker also said she found it hard to manage personal boundaries. She said:

'They think you are their friend and try to exploit the relationship and get you to do things which are not part of the care plan.'

Care workers also mentioned problems with managing the relationship with family members and the difficulty of meeting their expectations.

'Family members, certain ones, can be challenging at times but I tend to get on with everyone' (Inspection)

Care workers see domiciliary care as more than just a job, and their work affects them emotionally. Some told us that they felt anxious when leaving people on their own who might be very lonely or vulnerable. They also spoke about the emotional impact of seeing family members give poor care and seeing someone they have been caring for deteriorate or die. Sometimes a care package ends suddenly and care workers are left with feelings of loss and sadness.

> 'It's one of the hardest jobs I think caring, and people don't realise it' (MMUBS 2016, page 82)

> 'Sometimes the stress and emotions can be tough to deal with' (Staff survey)

5.6.2 Meeting people's needs

Figure 20 – I am given up-to-date information about the needs of people I care for
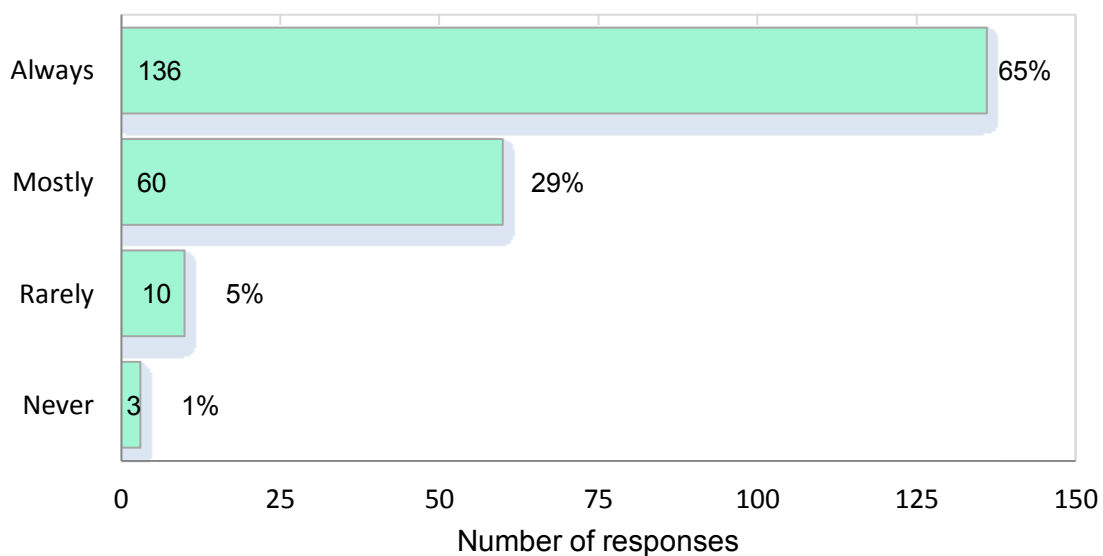
Most care workers felt that they were well prepared and able to meet the needs of the people they care for. Care workers recognised the importance of care plans but said they were not always up to date. They said that the daily care records did not include visits by other professionals (such as district nurses), which might affect the needs of the person receiving care and support. Some told us they had good relationships with primary healthcare and could ring the surgery.

We found that introductions were important. Most care workers recognised that there is more to the job than doing tasks: understanding *how* a person wants care to be provided is as important as *what* care they need. Care workers made the following comments made during our inspections:

> 'Always required to familiarise yourself with the care documentation prior to visiting new service users'

> 'We know people and can help them in ways they like'

> 'We often have to ring the GP for service users and we have a good relationship with them'

> 'Trying to meet district nurses at the same time can be difficult'

Our inspections found that care plans received from social workers are broken down into tasks. They do not reflect outcomes and are not reviewed frequently. This means care plans are often out of date and do not meet people's needs. Care workers expressed some dissatisfaction with the care plans provided by social services either for being too task based, being unrealistic or out of date.

> 'Social workers should shadow us; they don't see what we do in the time they give us, there are other things care workers have to do – the person's home needs tidying, the dog needs to be let out in the garden; as a care worker you can't just leave it' (Inspection)

5.6.3 Timing of calls

In response to the survey, care workers said that they were on time for most of their calls.

Figure 21 – I am on time for my calls
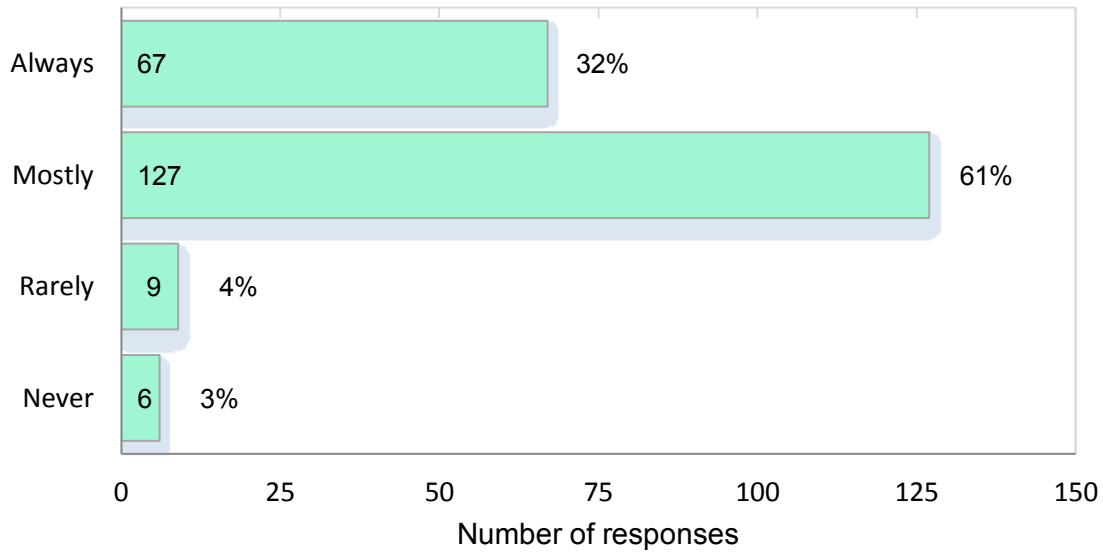
However, a common complaint was that insufficient or no travel time was being allowed for and as a result calls were late or had to be cut short in order to complete the schedule of calls. In the study by Manchester Metropolitan University Business School, care workers described the stress placed on them having to complete a wide range of care tasks in a short call time when they are already running late. Care workers made similar comments in our survey.

Figure 22 – I have enough time to travel between calls
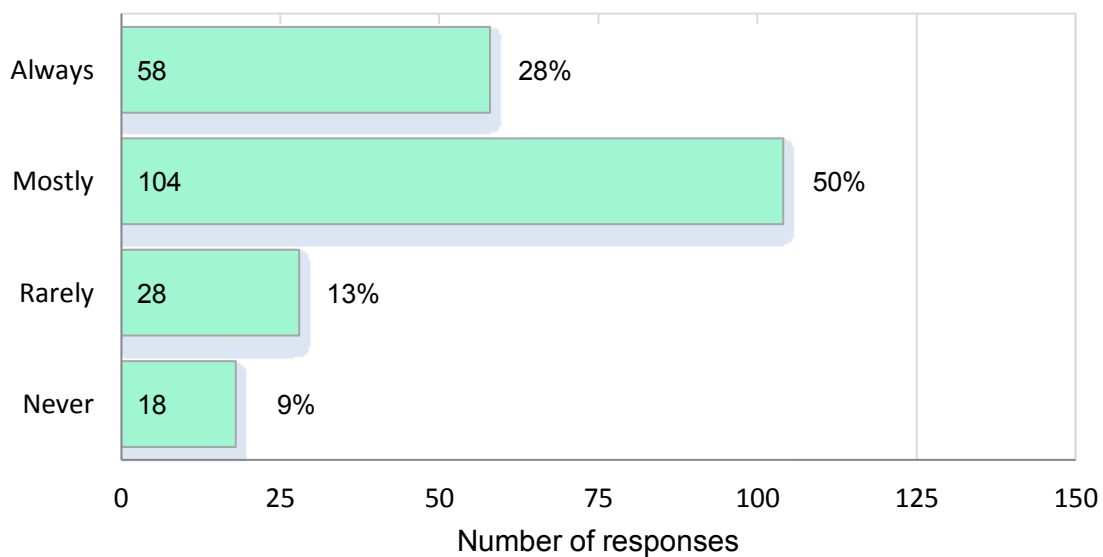
Figure 23 – I have to cut my calls short
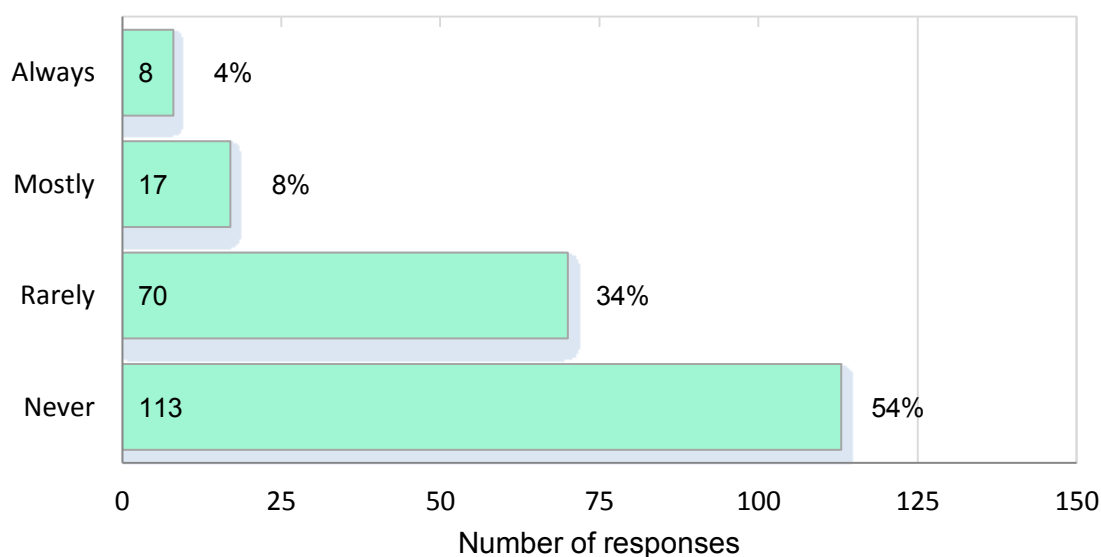
Our findings and the feedback we received are consistent with those in the UNISON report (2013, page 6), which found that 46 per cent of care workers said calls are often arranged in a way that means they have to rush and leave early.

> 'I don't enjoy that on occasions there is not enough travel time between each call which makes me feel pressured and the need to rush. I also feel on occasions that I am not given enough time to complete the tasks required during the call' (Staff survey)
>
> 'Not enough time. Not enough travelling time – I have to rush and cut calls' (Inspection)
>
> 'Our mileage is set as the crow flies using a computer package rather than factual knowledge about the area including which roads will be congested at particular times; e.g. schools' (Inspection)
>
> 'Times do not allow for traffic at busy times' (Inspection)

Care workers also told us that they felt the allocated call times were often insufficient which impacted on the quality of the care provided and how much time care workers could spend talking to people during their calls.

Figure 24 – I am given enough time to complete the things I have to do
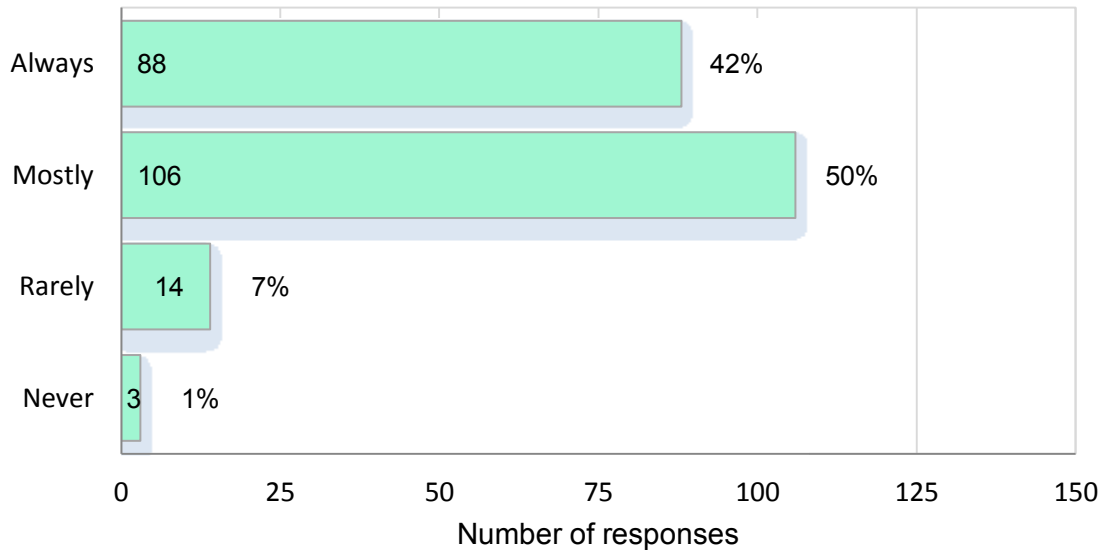
Figure 25 – I have time to talk to people I visit
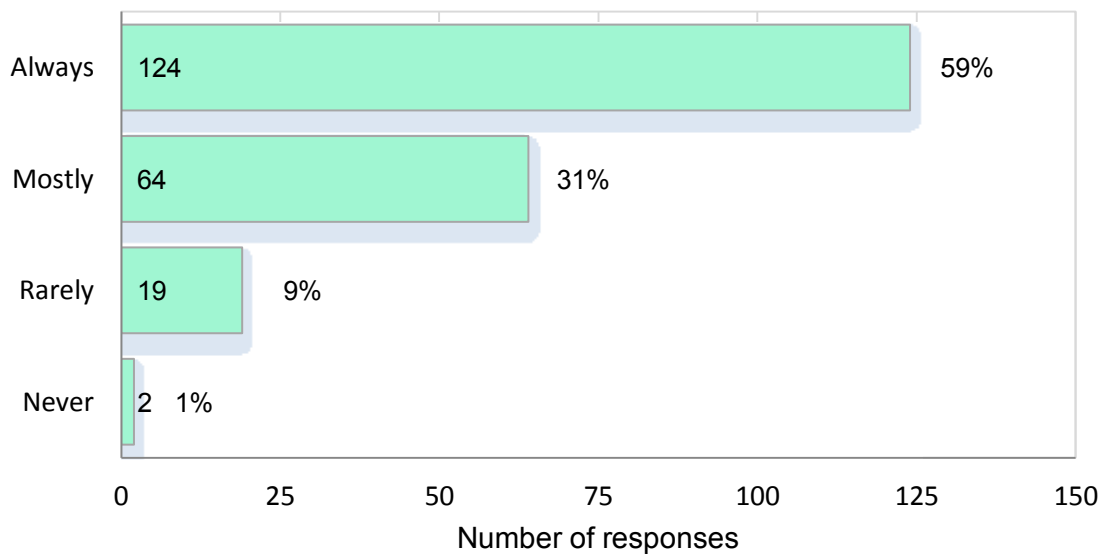
'Pressure of time and next and next! It's never as "people centred" as the care company makes out' (Staff survey)

Care workers were not in favour of 15-minute calls and talked about the pressure that short calls create. It is clear from the following feedback in our inspections that 15-minute calls are often being used for personal care, not just to prompt people to take their medication or check how they are doing.

'Quite a few 15-minute calls; I am meant to put people into their pyjamas and make a cup of tea in 15 minutes – really struggle to do it'

'Lunch; sandwiches and drinks because that's all there is time to do!'

'I have some 15-minute calls, usually to get someone dressed or welfare check or to check medication has been taken'

5.6.4 Continuity of care workers

Of the care workers who completed the survey, just under 30 per cent told us that they were asked to visit people they did not know.

Figure 26 – I am asked to visit people I do not know
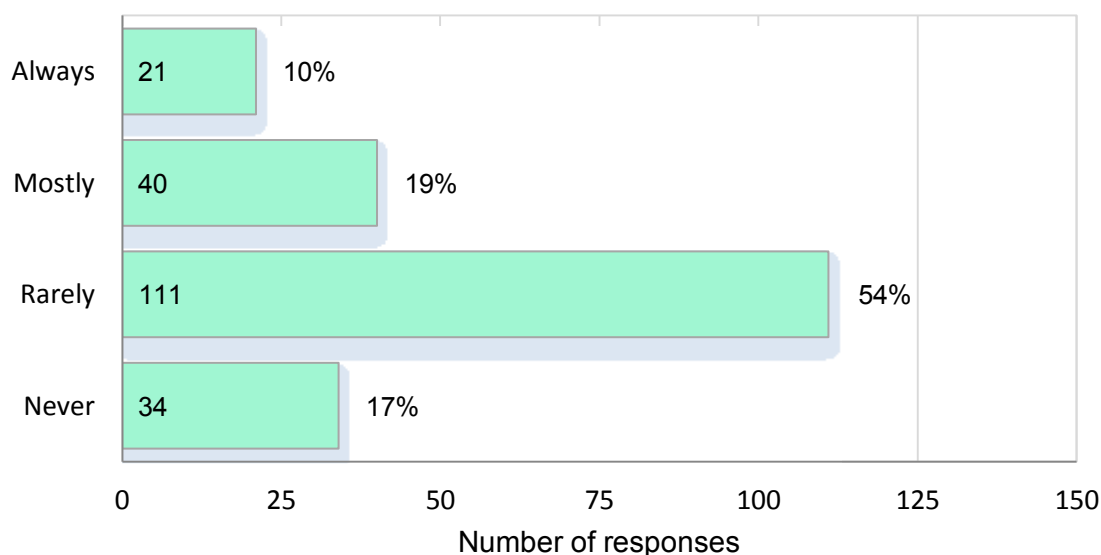
Our survey findings above are similar to those of the UNISON study *Time to Care*, which found that 37 per cent of care workers reported that their clients often get different care workers. Care workers value having a consistent relationship with the people they care for. One care worker mentioned that it is valuable to be able to monitor people over time, from call to call, to identify any changes. In their survey responses, care workers also recognised that having strangers coming to the house can have a negative effect on people and that consistency is important when caring for people with dementia:

'Usually work with the same clients, they have dementia, there's a lot of work and it is important to provide consistency'

'People who are double handers[13] get better continuity of care'

During our inspections, care workers said that some of their co-workers did not see the same people frequently enough to be able to judge how they were:

'the care records said "appeared well" – they couldn't confidently say that… they didn't know them well enough'

Safety was also a concern:

'Users leave the door open and due to a lack of continuity they don't know who is walking through their door; it must be very frightening for them' (Focus group)

5.7 Business operation and management

We considered how the following aspects of business operations and management affect the role of care workers:

1) Leadership.

2) Scheduling calls.

3) Support and supervision.

4) Training.

5.7.1 Leadership

It was very clear that different companies offer very different employment experiences to their care workers and that organisational efficiency back at the office is very important. Care workers need to feel valued and supported. They also need to know what they are doing so they can plan ahead and make family arrangements. Because of the pressures in the system, it is not uncommon for care workers to be working shifts of 12 hours or more. They often have periods of downtime between

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[13] People who need two care workers to help them.

calls during the day when they are not paid. They cannot use this as personal time because the gaps are too short to travel home or go shopping.

> 'Gaps on some runs; care worker has to sit outside and wait until care is due as there is not enough time to travel back to the office. Care workers feel runs could be better organised and they could input into the planning process' (Inspection)

> 'Split shifts are poor as no thought is put into rotas; results in care workers leaving' (Inspection)

5.7.2 Scheduling

It is very important to care workers that their time is scheduled efficiently and that they are told as soon as possible about any changes. Our survey results and feedback from inspections suggest that last-minute rota changes (that is, changes on the day or the night before) are fairly common and that some agencies are better organised than others.

Figure 27 – I know my schedule for the following week
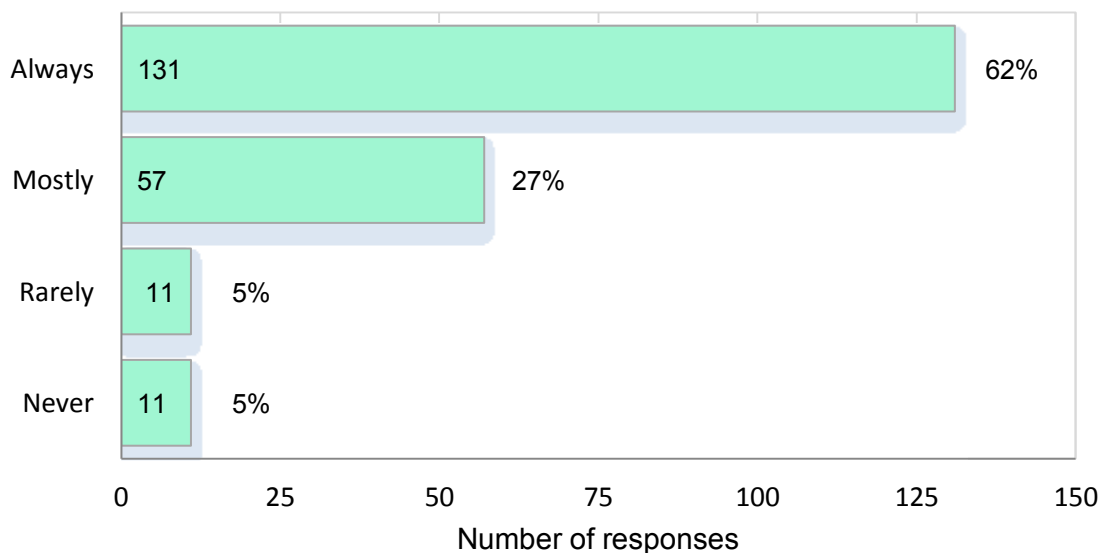
Figure 28 – I am asked to change my rota at the last minute (on the day / night before)
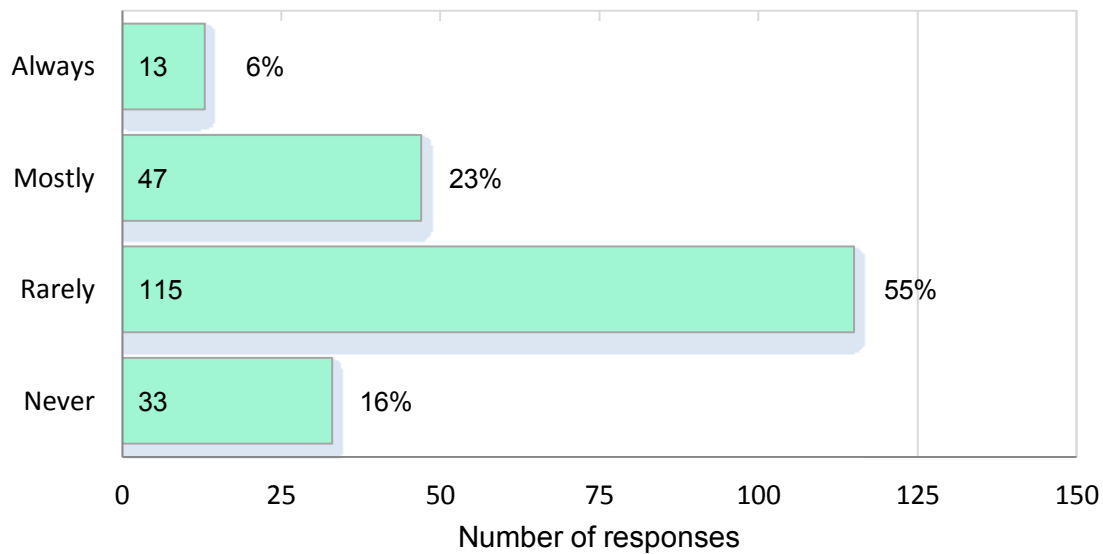
During our inspections of domiciliary care agencies, care workers told us:

'One care coordinator makes last-minute changes without prior consultation; there is pressure to take additional calls'

'We are frequently asked to pick up extra calls, would be better if we were given consistent calls in a given geographical area'

'We are given mobiles to access rotas, can work excessive hours as frequently asked to do extra shifts. Messages don't always get through; when a second carer is coming it may not be clear who is turning up to support you'

However, we also received some positive comments:

'We are informed of changes, office runs well, good notice for changes, other previous office more disorganised'

'Monthly rota reviewed at least a week before the end of the month. If there is a new client we'd be called to read the paperwork and a nominated person would take us on the first call. Clients receive copies of the rotas at the same time.'

One care worker commented during an inspection discussion that consistency is easier to maintain when they work consistent hours and have well-planned care schedules.

> 'I work a consistent number of hours with a good run, which gives good continuity for staff and our users'

5.7.3   Support and supervision

Around 18 per cent of care workers told us that they did not have regular meetings with their managers. However, over 90 per cent said they got good support from the office when they rang for advice.

Figure 29 – I have regular meetings with my manager
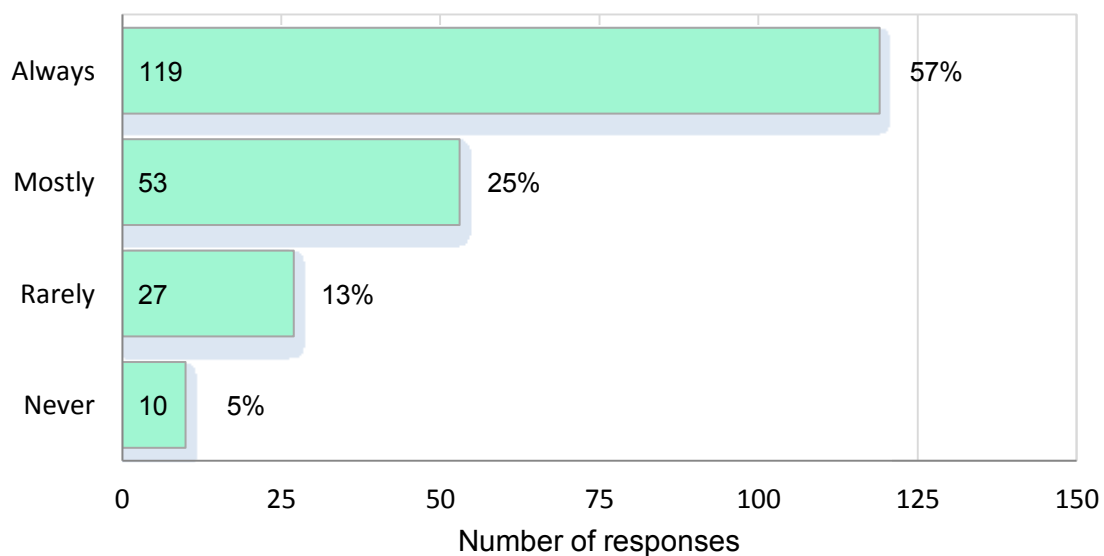
Figure 30 – I get good support from the office when I ring for advice
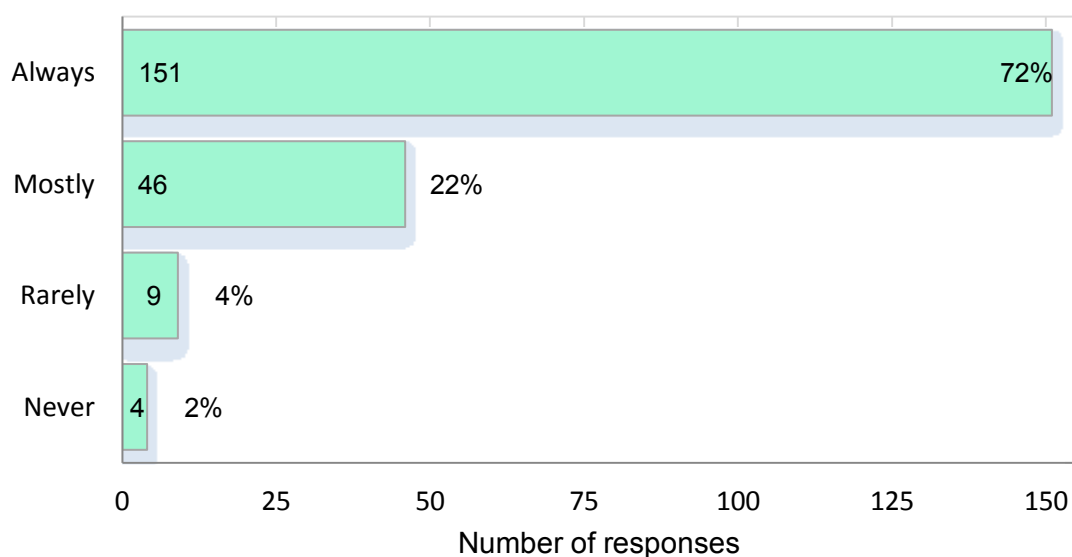
Care workers seem to recognise two types of support and supervision. One of these is about coping and managing day to day, and the other is more general appraisal. We found that care workers think it is important to have good backup and access to advice and support from the office staff and this influences their decision to stay with a particular provider agency. During our inspections we heard:

'This is a good company; I have worked for them for 22 years'

'Our operations manager is responsive if we have issues with rotas and hours of work'

'Good support from the office; any queries, just ring management'

'On-call / out-of-house support is of good quality'

'I was told on interview to share any concerns and that I should not go home worrying about something. I have done this and I feel valued; the agency is very supportive'

'Can come in at any time, especially at weekends, there is always someone available'

Staff supervision tends to be informal and often happens dynamically, 'on the run' and in 'the field'. In particular, care workers value supervision from people who are 'hands on' and know the job. They told us during our inspections:

> 'Nice to have feedback, especially from my supervisor as she works in the field and knows the service users'

> 'We have regular supervision in the field, not in the office'

> 'We get spot checks to check we are on time and do what we are supposed to do'

> 'Regular spot checks and supervision, care workers feel this gives more meaning to discussion in supervision, as it is related to day-to-day work'

> 'Supervision is great. I look forward to mine; never felt in a position where I have been pressured'.

5.7.4 Training

A high proportion of care workers said they felt they were well trained. A large number also said that new care workers were trained before they started doing care work.

Figure 31 – I feel I am well trained and am confident to complete the tasks asked of me
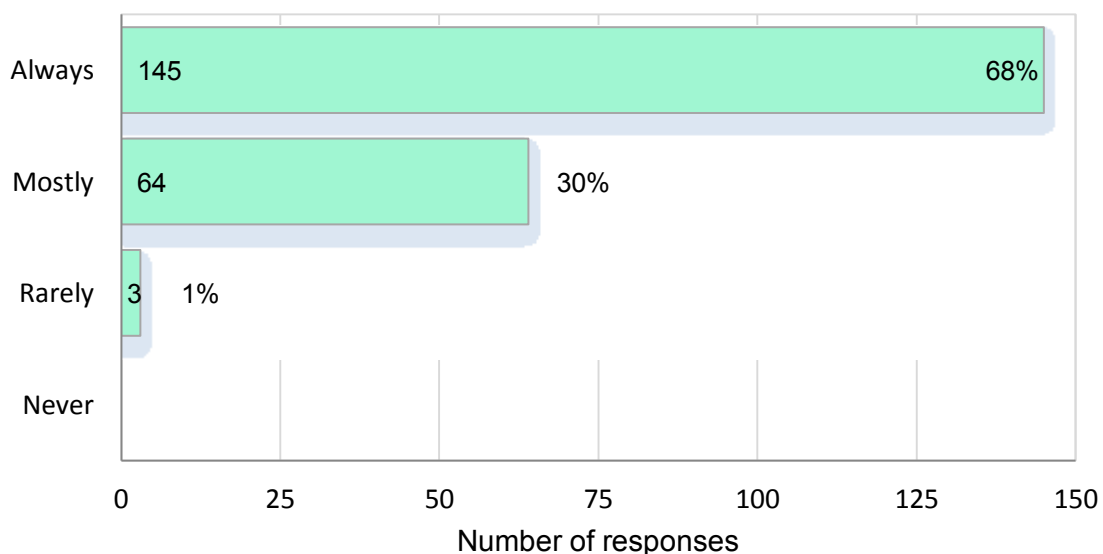
Figure 32 – New staff who join our agency are properly trained before they go on their visits
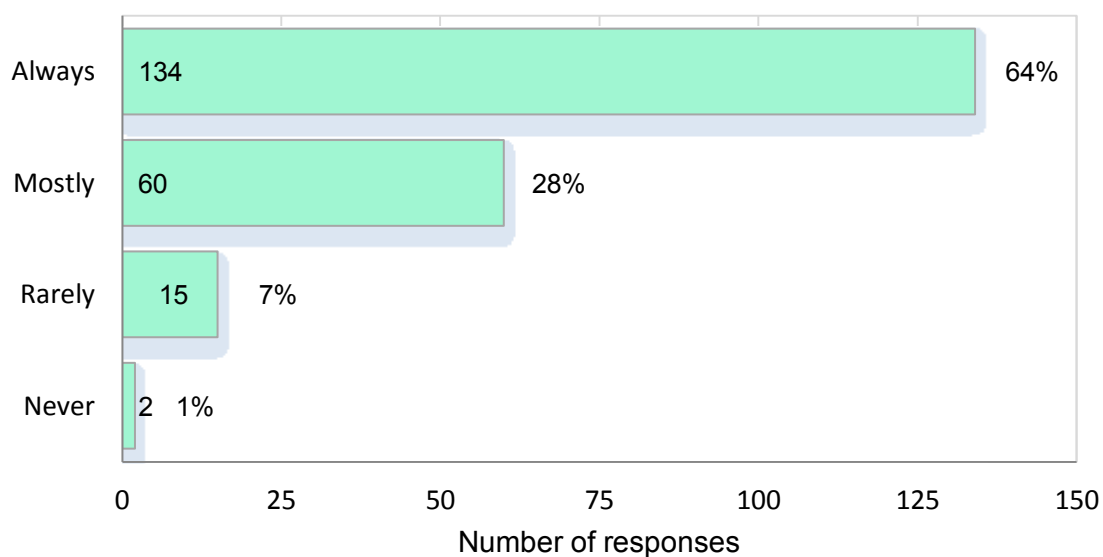
A large number of staff who responded to our survey said they are properly trained before they go out on calls. This mirrors the UNISON study Time to Care, which found that 72 per cent of staff said they received regular ongoing training and 59 per cent said they received specialised training on more complex needs.

Of the 207 responses to our question about professional qualifications, more than two thirds (68 per cent) of care workers said they had a professional qualification. Of these, 134 people went on to describe their qualification, with almost nine out of ten stating they were qualified with National Vocational Qualification 2, Qualification Credit Framework 2 or above. During our inspections, care workers told us:

'Lots of training – I enjoy it'

'Good induction, shadowing, good teamwork and support'

'I have to pay for the training if I leave within 12 months'

'Encouraged to ask for any training'

'Care coaching course arranged so I can be trained to support and guide new care workers'

5.8 Pay and conditions

Care workers gave us their views on:

- their contracts; and
- travel time and travel expenses.

5.8.1 Contracts

On the whole, pay and conditions for care workers are poor compared with other jobs, given the expectations of the work, the long antisocial hours and the level of responsibility involved. Care workers feel that what they do is not valued in the pay they receive.

> 'I feel the money doesn't reflect what we do' (Staff survey)

Of the respondents who took part in our survey, 48 per cent are paid on zero-hours contracts. This is in line with 42 per cent found by UNISON. We found that care workers have two points of view about this. Some like the complete flexibility that zero-hours contracts give them, especially because it helps them fit their work around family commitments and school holidays. Others would prefer more stability and the benefits of being on a formal contract for a set number of hours. One person mentioned that this would enable them to apply for a loan or mortgage. During inspections, care workers told us:

> 'Zero-hours contract suits me'

> 'No day off for three weeks; zero-hours contract'

> 'On zero hours but get consistent work'

On the other hand, contracted hours were also seen to have their limitations too although they appear to be applied differently in different agencies.

> 'Want more hours but can't go over contracted hours'

> 'Have contracted hours but regularly go over them' (Survey)

One person commented that they were not paid for overtime and thought they should be.

5.8.2 Travel time and travel expenses

Of the care workers who responded to our survey, 54 per cent were not paid for travel time. Again, this closely matches the UNISON findings (58 per cent). This has significant implications for people being paid the national minimum wage or national living wage, as they may find themselves being paid below the legal threshold.

> 'A lot of travelling time – sometimes hanging around in the evening' (Inspection)

> 'Staff not paid travel time unless it exceeds three miles between calls, which is rare, not paid for fuel, not paid if they remain at calls beyond the allocated duration' (Inspection)

Most of the care workers in the survey (88 per cent) said they use their own cars to travel to calls, although 12 per cent said that they had a car provided by the agency. One quarter of care workers said they were **not** paid any mileage rate. Of the staff who were paid and gave a figure, the average rate was 26p a mile.

> 'This does not cover the wear and tear on your car but better than nothing. I can do 20,000 miles a year just for work' (Staff survey)

6 What people providing domiciliary care told us

6.1 Our approach

We began by holding several meetings with two provider associations (United Kingdom Home Care Association and Care Forum Wales) to understand the provider market and co-design a comprehensive national survey. This enhanced our knowledge of how agencies work and their specific concerns and pressures. The survey had a remarkable response rate of 215 providers: 83 per cent of those we spoke to as part of our review and 50 per cent of all registered providers in Wales.

We had open and structured discussions with providers at three project stakeholder meetings and three regional workshops with providers and commissioners. To follow up on specific points, we had individual meetings with some providers. We held more meetings with providers and managers to focus on day-to-day management.

Also, we held focus groups with providers as part of our six council inspections. We talked to providers and managers during our 70 enhanced regulatory inspections of provider agencies across Wales. We brought together the data and narrative findings from the inspectors' records.

To gather evidence from inspections that we could compare, we used 'grading descriptors' ('excellent', 'good', 'adequate' and 'poor') to grade nine aspects of domiciliary care provider agency performance. These included:

1) how far people's wishes are taken into account and how much control they have over the care they receive;

2) how person-centred care planning and provision is;

3) whether calls happen at the right time and for the right length of time;

4) scheduling;

5) continuity of care workers;

6) support and supervision;

7) staff training;

8) staff pay and conditions; and

9) quality assurance.

We developed the grading descriptors and definitions with advice from the United Kingdom Home Care Association, Care Forum Wales and our own inspectors. Inspectors made each judgement by considering a range of hard data sources (staff training or records) alongside feedback from users, staff and managers. Of the 70 inspections we undertook as part of this review, we were able to use descriptors for around 62. However, this varied slightly depending on the evidence available (e.g. no electronic call monitoring system available).

6.2 Provider profile

215 provider agencies took part in our survey. Because some provided narrative answers to questions that asked for numbers, the information that follows is our best interpretation of the data we received.

6.2.1 Number of staff employed

Of the 215 agencies that responded to the survey, 210 provided information about staffing. The total number of staff employed by these 210 agencies was 14,452. On average, each agency employed 68.2 staff. The lowest number of staff employed by an agency was 1 and the highest was 846.

Of the 14,452 staff employed, 12,525 (87 per cent) were involved in direct caregiving. On average, each agency had 59.6 staff that provided direct care.

Figure 33 – What is the total number of staff that your agency employs?

Number of staff employed:

Number of staff employed	Count	Percentage
Over 100	37	17%
76-100	17	8%
51-75	35	17%
26-50	53	25%
0-25	70	33%
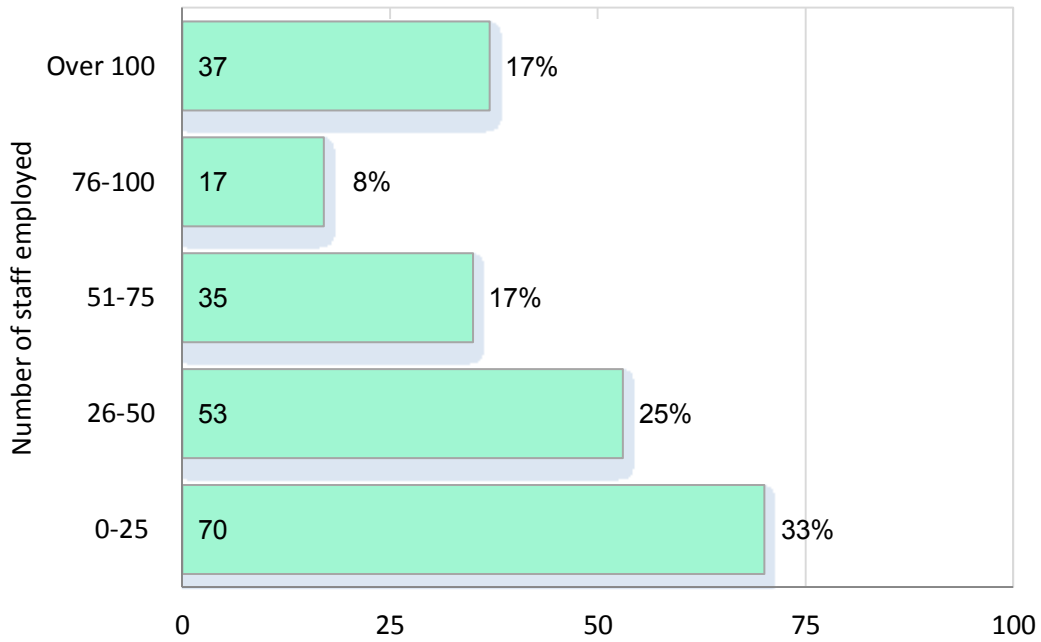
6.3 Amount of care provided

We asked providers how many hours of care they provide in a typical seven-day week, and 206 providers responded. They told us that they provided a total of 299,361 hours a week. The average was 1,453 hours a week. The lowest number of hours a week provided by an agency was 9 and the highest was 18,112.

Figure 34 – In a typical week, how many hours of care do you provide?
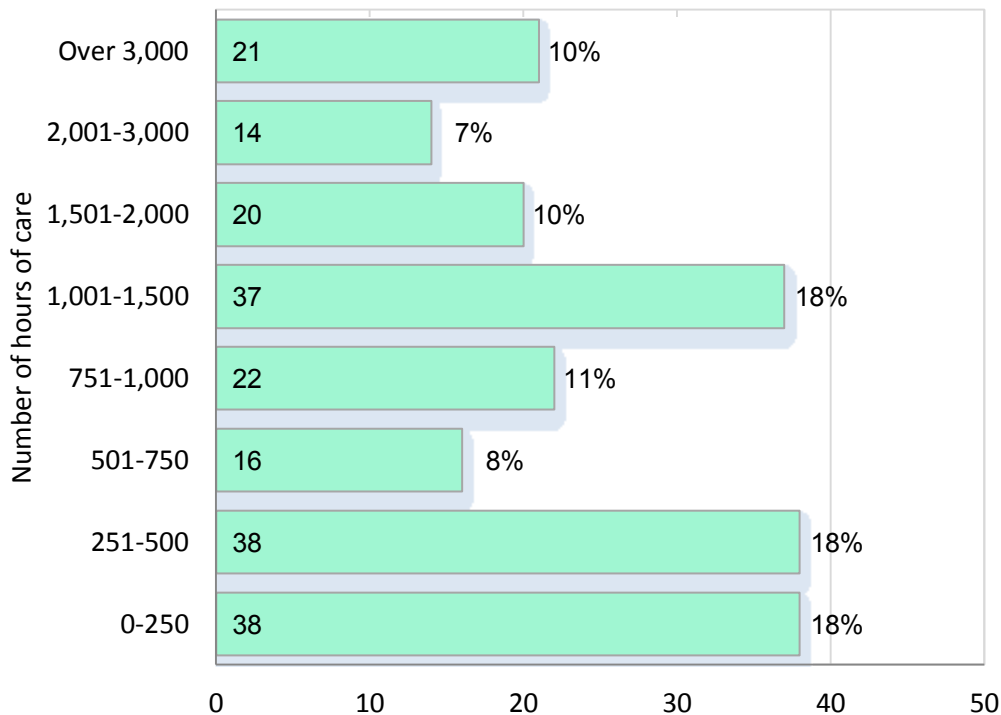
When asked how many people they cared for in a typical week, 208 providers said they cared for a total of 17,950 people. The average number of people cared for by each agency was 86, and this ranged from 1 to 1,200 people.

We also asked agencies how many new care packages they took on each week (as at June 2015). Altogether, the 199 providers who responded told us they took on 1,572 new packages of care in a typical week. This ranged from 0 to 118 packages for each agency.

Figure 35 – In a sample week, how many new care packages of care did you take on in June 2015?
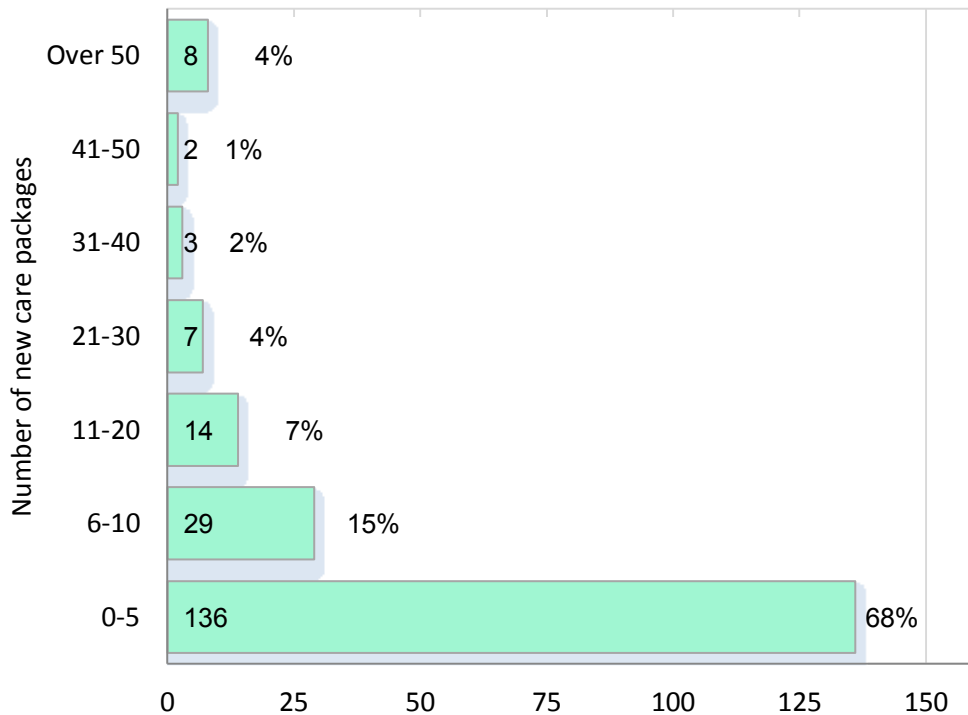
6.4   Range of agencies

There is a very wide range of domiciliary care agencies in Wales. The United Kingdom Home Care Association (UKHCA) warned us of this when we were constructing the survey questions. They told us not to assume that registered agencies work to any preconceived model of operation.

This was very clear from the survey responses to our questions about scheduling. Around one quarter of respondents (51) said they did not do 'scheduling' and described themselves as not being 'traditional agencies'. These respondents include a wide range of service providers, such as other types of extra care, floating support, night services, specialist hospice care, micro-businesses for very small numbers of private clients, nursing services, specialist local services for children with disabilities and 24/7 live-in services. There were also a number of large providers who operated 'hybrid' agencies offering quite different services from the same agency, for example both traditional domiciliary care as well as extra care / housing support.

Among the 90 per cent of services that said they were independent, their size, ownership and structure varied considerably. Many are private providers, including:

those owned by medium-sized companies operating a number of agencies (some in England);

- single-company agencies that are part of very large holding companies; and
- local smaller private companies, some of which are operated independently as part of a wider franchise.

The sample also included very small companies owned by one or two people who provide the care directly themselves.

The largest group of independent agencies in our sample (40 per cent) described themselves as small family-run businesses.

Table 2 – Different types of providers

Description	Percentage of providers
Small family-run	40%
Run by charities, some large and UK-wide (e.g. Crossroads), others small and local (e.g. Caerphilly Care for Carers)	19%
Part of a local company	11%
Part of a large / holding company	12%
Part of a housing association	2%
Part of a franchise	7%

The remainder (around 10 per cent) of service providers who responded were agencies run by local councils. Most of these provide reablement services, but some provide a range of services.

Figure 36 – Typical maximum and average hours of care provided in a typical seven-day week
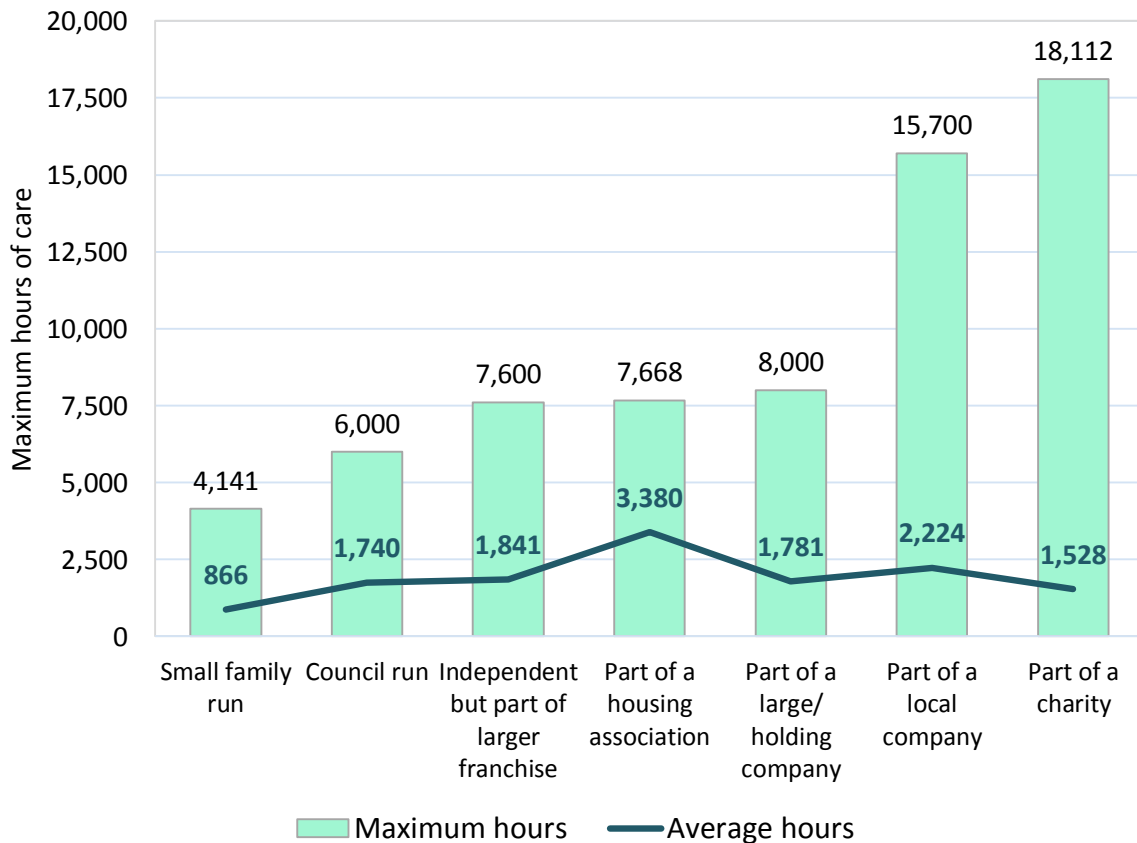
The business models and sources of income varied considerably; some agencies are solely dependent on public contracts, some solely on private and a range of relative dependency for those who had a mix of public and privately funded work.

Figure 37 – Typical maximum and average hours of privately funded care provided in a typical seven-day week
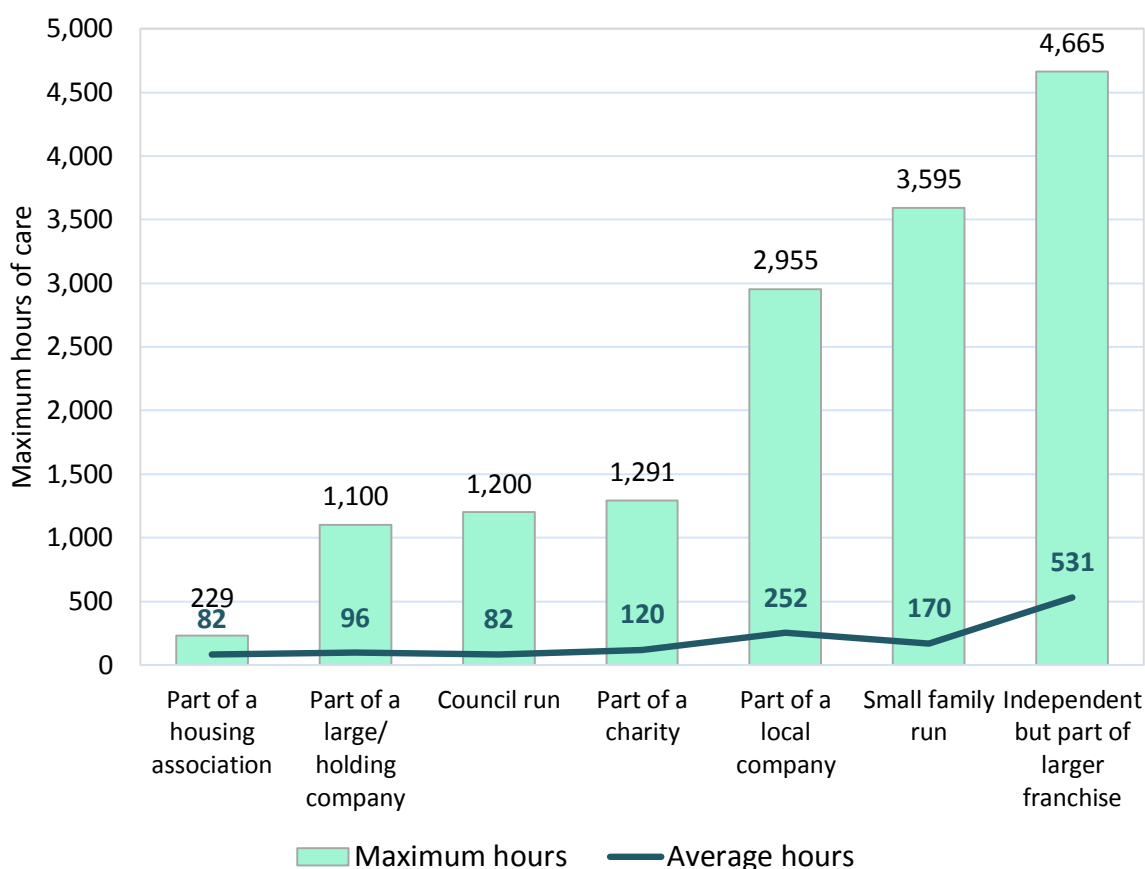
The important lesson for commissioners and for us is that there are many different service and ownership models within 'domiciliary care'. We are also aware that there are many other types of services which are not formally registered. These include:

- organisations that support people on direct payments who use personal assistants;
- employment agencies that recruit live-in carers; and
- organisations that offer support that cannot be registered, like sitting services.

This presents major challenges for market development and reporting on the market, and registration and inspection.

Our current registration structure does not reflect this wide range of ownership and type of provider. It would be hard to find terms that accurately or easily distinguish between the different types of ownership and styles of operation. This is something to consider carefully under the arrangements for the new Regulation and Inspection

of Social Care (Wales) Act 2016, especially when new services will have to register (such as care and support provided in prisons).

The range of activities carried out also skewed some of our results. Some of the questions we asked (for example, about scheduling or working with commissioners) did not apply to some agencies.

Although we focused on 'traditionally' commissioned services that offer care packages to people living in their own homes, we also noted some characteristics and learning points from other types of agencies.

For example, some housing support agencies:

- have a stable, long-term contracts and a stable client base;

- do not plan care on a 'time and task' basis – instead have dedicated staff teams allocated to a small number of settings and clients providing care and support in line with person-centred plans;

- have staff working shifts not calls and spending little or no time travelling;

- have stronger links to multidisciplinary teams and the NHS, including multidisciplinary assessment (especially for people with learning disabilities or mental health problems);

- have lower volumes of people needing care and support and less turnover. This results in proportionately fewer assessments and introductions made by the service;

- give staff higher levels of often specialised training (for example, positive behavioural support and active support);

- have different, more simplified internal management structures, allocation systems and financial reconciliation systems; and

- use different monitoring and quality-assurance systems (for example, no missed or late calls).

There are many obvious advantages to this approach. Such models could be used to provide more flexible domiciliary care services to people across communities, rather than simply procuring services for each individual.

6.5 The main messages

- There is a very diverse range of registered agencies.

- Providers are concerned about the quality of the care they give. They often feel that quality is compromised when contracting with local councils.

- Providers are very anxious about the future, especially about rising costs and the national living wage.

- Providers' main concern is to recruit and maintain a reliable, competent workforce.

- The bureaucracy around commissioning, contract monitoring, regulation and financial reconciliation is a heavy burden for providers. The fact that different councils use many different systems makes this burden even heavier.

- Providers do not believe that current fee levels offered by councils allow them to offer services that can be sustained and expand in the long term. Providers are becoming more and more cautious about the work they take on. Many are cherry-picking clients and choosing not to bid for contracts. Some providers are handing contracts back.

- Providers are feeling challenged by people's rising levels of dependency and vulnerability. Added to this are the increasing expectations of commissioners, people using services, and the families of service users. Domiciliary care is becoming much more complex in nature than it used to be.

6.6 What matters most to providers

- High levels of customer satisfaction.

- Having a sustainable business with a realistic income: being paid a fair rate.

- Having enough members of staff and making sure they are good, reliable and flexible.

- Being listened to and working together with commissioners.

- Building efficient 'care runs'.

- Trying to optimise staff availability to times of peak demand and over holiday periods.

- Being paid on time.

6.7 What is working

- Relationships with 'commissioners'. This seems to be based on personal relationships with brokerage (the people who negotiate individual placements).

- Privately contracted work.

- Domiciliary care that is linked to supported housing (care provided by dedicated teams).

- Flexible time bands.

6.8 What isn't working

- Tendering processes, especially where it is a 'race to the bottom'. Tendering is onerous and not transparent.

- Assessments and handing over work, especially when expectations have been raised with people and their families and cannot be met;

- Delays in reviewing care packages to increase funding when needs intensify and to reduce care packages when people needs decrease which would release care worker capacity;

- 15-minute calls.

- Poor integration of health and social care and with health and social care.

- Workforce capacity both in terms of having enough people available and ensuring the workforce has the right skills to provide the care needed.

6.9   Suggestions made by providers

- Agencies should do the care and support planning.

- Joint assessments by commissioners and providers .

- Use a 'trusted assessor' role.

- Have a link social worker for a provider agency.

- Banning 15-minute calls.

- Provide funding for Qualification Credit Framework training for care workers who are over 25.

- standardise and simplify contract monitoring and inspection – have *'one system'*.

- Standardise performance monitoring information requirements

- Introduce single systems for payments.

- Introduce flexible time bands and call lengths.

- Remove the charging cap on personal contributions to increase the number of private customers.

6.10 Emerging themes: what providers told us and what we found on inspection

6.10.1 Providing care and support

To explore provider agencies' perspective on the quality of the care and support they offer, we considered the following eight areas.

1) Choice, control and the delivery of person-centred care.

2) Relationships with professionals.

3) Timing of calls: late, missed and shortened (clipped) calls.

4) Continuity of care.

5) Welsh language.

6) The number and type of complaints and referrals to adult protection services.

7) Quality assurance.

8) Monitoring and regulation.

6.10.2 Choice, control and person-centred care

Our inspectors judged that 61 per cent of agencies were either good or excellent at giving people choice and control over the service they receive. They judged that 15 per cent of providers were poor in this area. The findings on how far agencies provided person-centred care were similar. This is not surprising, as the two go hand in hand.

Figure 38 – Taking people's wishes into account (inspector assessment)

Excellent ▢ Good ▢ Adequate ▢ Poor ▢
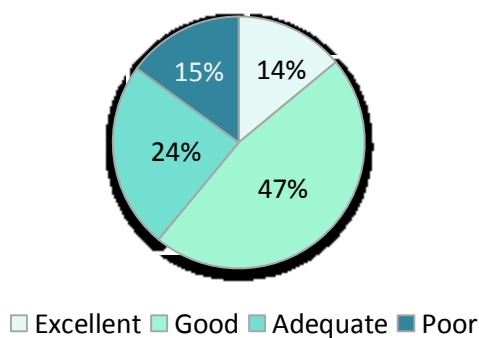
Figure 39 – Person-centeredness (inspector assessment)

☐ Excellent ☐ Good ☐ Adequate ■ Poor
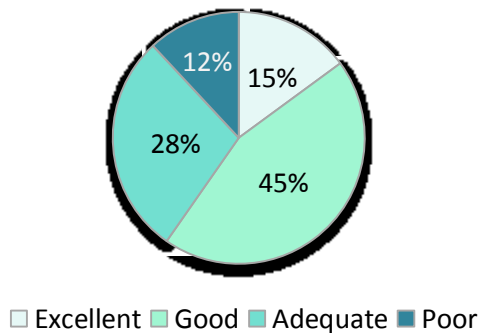
In our survey we asked providers to describe how they:

- accept new packages of care;
- carry out assessments;
- design and offer care packages; and
- confirm those care packages.

We had a huge response to the question. It quickly became clear that when care is commissioned by local councils the plan is usually already prescribed in detail. The provider accepts the plan without meeting the person needing the care package. The times have already been set and added to rosters. Care workers will have already been chosen based on who is available and who else needs support in the same geographical area (so that planned 'runs' are as efficient as possible).

While the provider often develops the service delivery plan in a meeting with the service user, the basic structure of the care package (such as the tasks to be done and the time slots) are already set and contracted for. There is little room for manoeuvre; expectations have been established.

Providers told us that care managers have to play games to work around service users' needs while fitting the criteria set by councils to have the package funded.

> 'The council stopped "shopping calls" and "cleaning" calls but care plans now refer to "monitor food" and "keep the house clean"' (Inspection)

'Care managers will overstate personal care needs to get household tasks included. You can't prepare a meal if no one has bought any food and you can't provide personal care in a house that is dirty or unsafe' (Provider interview)

However, there is scope for better practice. Examples include when the agency and the care manager visit the person who is seeking care together and when there is an opportunity, to introduce care workers.

'Works well when coordinator / manager goes out on first assessment visit with care manager' (Inspection)

'Manager takes every new staff to all calls to introduce them before they start providing care for the agency' (Inspection)

It was clear from the survey responses that some agencies take a different approach. Those providing care on a privately funded basis take time to match care workers to the people requesting care and support. The result is that the agency and the person seeking care and support can have an open, unfettered discussion about what the person wants and needs and how and when this will be provided.

One agency provides care and support on a private basis only, which includes people using direct payments:

'Our calls are a minimum of one hour. Our services are tailor-made, customised packages of care. Our primary focus is on the quality of staff, if you can get that right, people will receive good care and support. You need to be able to trust staff; they are the ones out there delivering the service. We expect them to do whatever the client wants, walk the dog if that is important on the day. We don't distinguish between the different types of help people want, it is what matters to them whether it's collecting prescriptions, making beds, caring for a pet or providing personal care. We spend a lot of time meeting our clients, understanding their wishes and determining which staff might be best placed to support them. We take a lot of care to match our care workers with new clients and we offer a personal introduction before the service commences' (Provider)

Another commented:

'We will be introducing someone who will become a very significant part of another person's life' (Provider)

6.10.3 Relationships with professionals

Our inspectors found that in general, providers' relationships with NHS services, particularly district nurses, are positive and reflected what people told us.

'Good relationships between users, families, health and social care professionals – district nurses, CPNs (Community Psychiatric Nurses), GP, OT (occupational therapists), day services. Evidence in files that communication is good and respectful, care records evidence staff follow other professionals care plans e.g. OT / district nurse and carers contact other professionals when need arises'

'Good information sent from health board including district nurse care plan and a former agency's care plan; others sent anonymised pen pictures'

'Good multiagency working (care workers, physiotherapy, provider and local authority) resulted in care package reducing from double to single care workers'

Providers had positive things to say about their relationships with brokerage staff. They made fewer comments about relationships with social workers, although some providers told us it was difficult to contact social workers: 'often no allocated social worker, even for complex cases' (Inspection). It appeared from the feedback we received that social work turnover and vacancies have a very disruptive effect on the co-ordination of care packages.

6.10.4 Timing of calls

Receiving care at the right time or to fit in with daily routines is really important to people who have care and support. It is also important that the care is not rushed and there is time for conversation. We found a huge variation in providers' approaches to logging and monitoring calls. How providers defined, monitored and recorded missed and late calls also varied widely. The vast majority of agencies reported that they had recorded no or few missed or late calls.

Our judgements of agencies suggested that two thirds performed well (graded 'good' or 'excellent') on call times but almost 10 per cent performed poorly.

Figure 40 – Timing (inspector assessment)

☐ Excellent ☐ Good ☐ Adequate ■ Poor
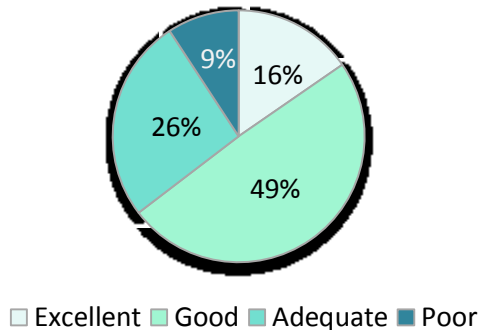
During our inspections we examined the call records for 2,884 calls. We found that:

- 7% were too early, with care workers arriving more than 30 minutes before the planned call time;
- 5% were late (more than 30 minutes after the planned call time);
- 3% were missed;
- 17% were clipped (shortened by more than 10 minutes each visit); and
- 7% were 'very clipped', where the call lasted for less than half of the planned time.

According to the provider survey, 74 per cent of providers believe staff always stay for the planned time and 23 per cent believe staff stay for the planned time most of the time.

Figure 41 – Our staff stay for the allocated time when undertaking visits

Always: 156 — 74%
Mostly: 49 — 23%
Rarely: 1 — 0%
Never: 4 — 2%

Number of responses
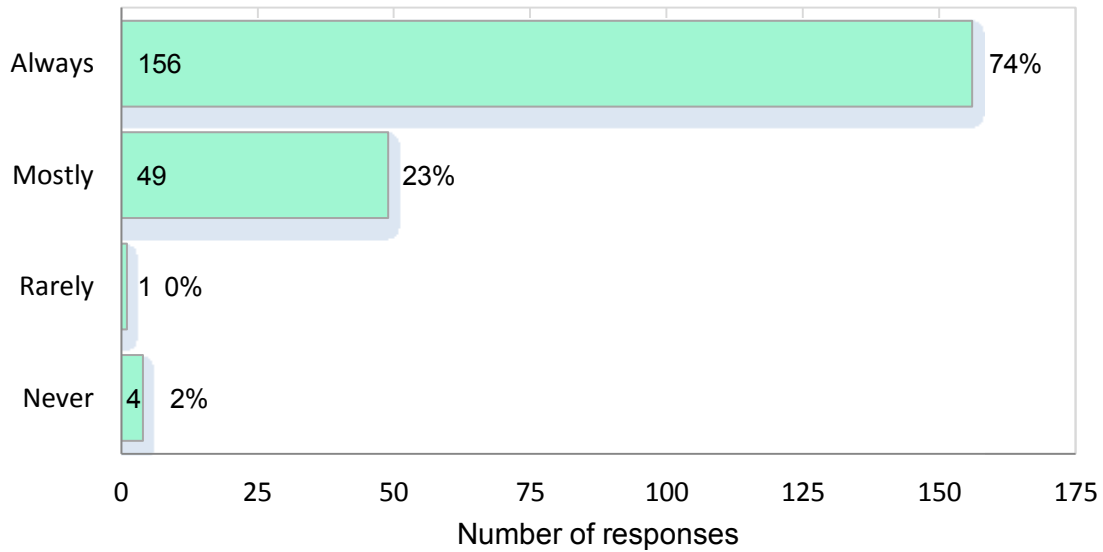
However, 17 per cent of providers said the time that councils and health boards allowed for calls was rarely or never enough.

Figure 42 – The times allocated by the councils/health board are about right

Always: 20 — 10%
Mostly: 153 — 74%
Rarely: 30 — 14%
Never: 5 — 2%

Number of responses
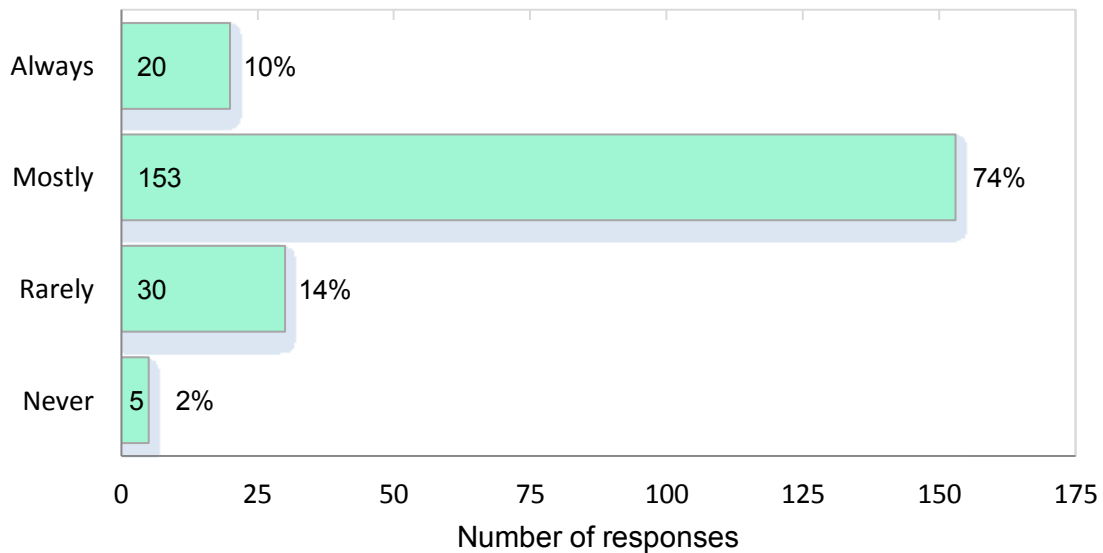
Some managers spoke of their 'constant fighting' with commissioners for more time with service users.

6.10.5 Continuity of care

Continuity of care workers is one of the most important quality issues for people who receive care and support. According to providers' responses to the survey, they believe continuity is good.

Figure 43 – People receive continuity of care from care staff they know
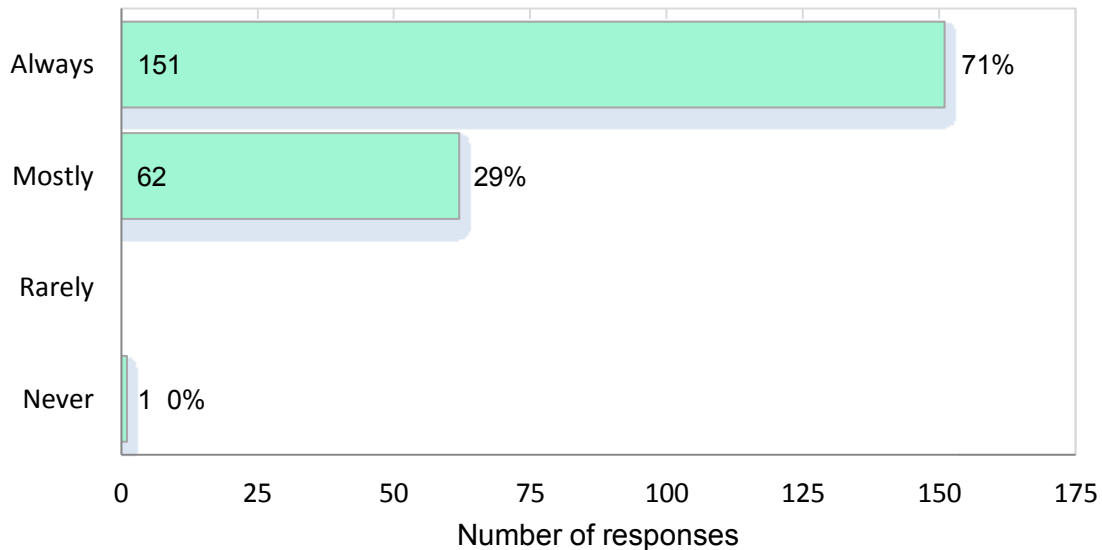
During our inspections we rated 71 per cent of agencies good or excellent for continuity of care, but we also found that 19 per cent were poor.

Figure 44 – Care continuity (inspector assessment)

□ Excellent □ Good ■ Adequate ■ Poor
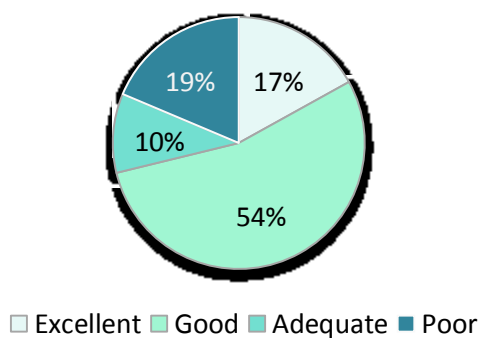
This discrepancy between provider perceptions and CSSIW findings may be the result of sampling, but it is more likely to be because different standards are being applied. When running services day to day, many provider agencies may feel they

are doing quite well given the challenges they face. However, in reality the level of continuity is not that good.

Providers recognise that relationships are important. They said it was common for people to refuse a replacement care worker when their original care worker was on leave or could not attend for some other reason. A nurse-qualified provider emphasised the importance of continuity, observing that when people with dementia receive care from staff they are familiar with they are more likely to take their medication.

During our inspections, we found evidence that some providers will regularly introduce a new care worker to people receiving a service as a way of making sure people don't become too dependent on certain care workers. Some providers said they need to regularly introduce new faces in care teams to be able to give people continuity of care when their usual care worker is on annual, maternity or sick leave. They also talked about the need to maintain professional relationships. Some providers spoke of an emphasis on the continuity of quality and maintaining consistency in the delivery of care rather than the identification of specified care workers to deliver it. However, when we spoke to people receiving care and support they often referred personally to individual care workers who made a difference in their lives.

6.10.6 Welsh language

We asked providers if they are able to provide care in Welsh. The results for the survey suggest that 36 per cent would really struggle to do so and that only 17 per cent were in a position to do so all the time.

Figure 45 – We are able to provide care in Welsh
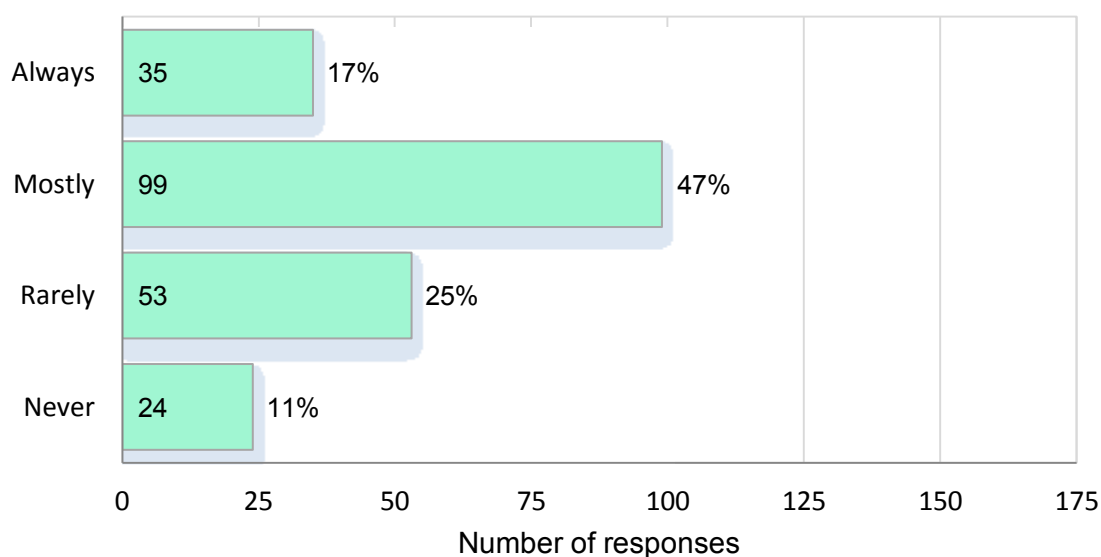
During our inspections we found an example of good practice in one agency in South West Wales. Here, people who are Welsh speakers are linked to staff who speak Welsh, including when undertaking an initial assessment.

6.10.7 Complaints and adult protection

As an indication of service quality we looked at how many complaints were made about care provided by provider agencies and how many adult protection issues there were.

The provider survey told us that agencies seem to receive a very low number of formal complaints given the complexity and volume of the work. Many problems seem to be sorted out informally and over the phone.

- 108 agencies (51%) reported that they received no formal complaints in the past year.

- 87 (41%) said they had received five complaints or fewer.

- Three agencies reported higher numbers of complaints (47, 62 and 86).

From some of the comments we received, it was clear that we couldn't rely on all the responses from agencies. We also found that internal recording systems may not be

reliable. For example, some agencies commented, *'none that are recorded'*. Some said they could not give a figure for complaints, which is concerning.

The most common causes for complaints were:

- personality clashes – not liking the care workers;

- invoicing and disputes over bills;

- missed calls and timing problems;

- problems with the continuity of care workers; and

- confusion over call times (often caused by poor communication with other agencies).

For adult protection referrals, 116 agencies (just over half) said they were not involved in adult protection referrals in the previous year. Of the agencies that had, 69 said that they had been involved in three referrals or fewer. The comments we received told us that a large number of the referrals were not substantiated and many referrals included those made by the agency about issues relating to risks posed by others, for example family members, not the agency's own conduct. The comments noted a number where referrals in relation to staff conduct had not progressed to adult protection strategy meetings but were passed back for the provider agency to deal with.

6.10.8 Quality assurance

We were keen to know how well domiciliary care services assured the quality of their services. The responses we received showed clearly that many agencies, even the larger agencies, could not provide basic performance information about their services. For example, they could not tell us how many calls were late or missed or how many complaints they received. This is partly because many agencies use diaries rather than electronic call-monitoring systems, which means there is no easy way to collect and analyse information. However, electronic call-monitoring systems have their own limitations. For example, systems where the care worker has to swipe the care plan with their mobile phone or ring the agency to log the start and finish of

the call can lead to arrival times not being logged. Also, they don't take into account the time it takes to be let in to the person's home and greet them. This is even more of a problem with short calls.

In the survey, most providers told us they used customer surveys once or twice a year. Some did spot checks on calls, some did paperwork audits and others did reviews as a means of getting feedback from people receiving care and support. We saw positive examples of agencies carefully analysing survey responses (which also included staff surveys) and using the results to identify areas for improvement. However, it would seem that quality assurance is an area that could be developed and better standardised.

During our inspections we found quality assurance to be poor in one in five agencies.

'Not all agencies conduct the annual quality-assurance review in a manner that would be informative to them and to their continuous improvement. There was a lack of clarity about the purpose and function of this process and how it should be undertaken – that is, to inform their own business' (Inspection)

Figure 46 – Internal assurance (inspector assessment)

□ Excellent □ Good ■ Adequate ■ Poor
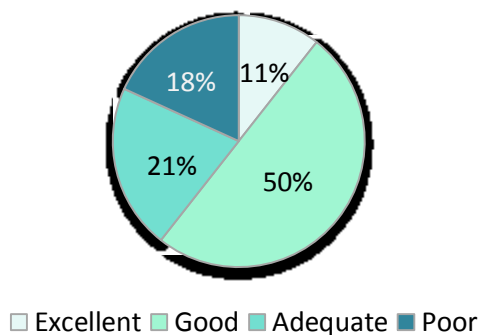
We found some examples of good practice:

'One support worker is allocated to lead on each user feedback; keeps file up to date, ensures consistency' (Inspection)

'Excellent quality of care reviews undertaken with mixed methodologies by provider and thorough report produced, three to five pages of care records audited

monthly, timesheets audited weekly, views of users, staff and other stakeholders included with provider analysis of quality including lessons learned' (Inspection)

'Provider produces three-monthly quality monitoring reports including analysis of care documentation and discussions with service users and staff' (Inspection)

Naturally, in smaller, local agencies registered providers and managers are very hands on, are likely to know all the staff and many of the service users, and deal with 'commissioners' every day. In larger agencies their focus, especially that of responsible individuals, is broader and strategic. This raises questions about the qualifications and training registered managers need in relation to good business and organisational skills, and the requirements for 'registration' for responsible individuals under the new Regulation and Inspection of Social Care (Wales) Act 2016 especially for the larger agencies.

'Our business is under enormous pressure due to volumes and staffing'
(Provider interview – big agency with more than 200 staff)

6.10.9 Monitoring and regulation

Providers told us that a large burden was being placed on their businesses by:

- different councils having different arrangements for monitoring performance;
- duplication in monitoring performance across councils; and
- extra requirements from CSSIW.

Providers said they would welcome a more efficient approach.

Two thirds of providers reported that they always found inspections helpful.

Figure 47 – I find inspections by CSSIW helpful
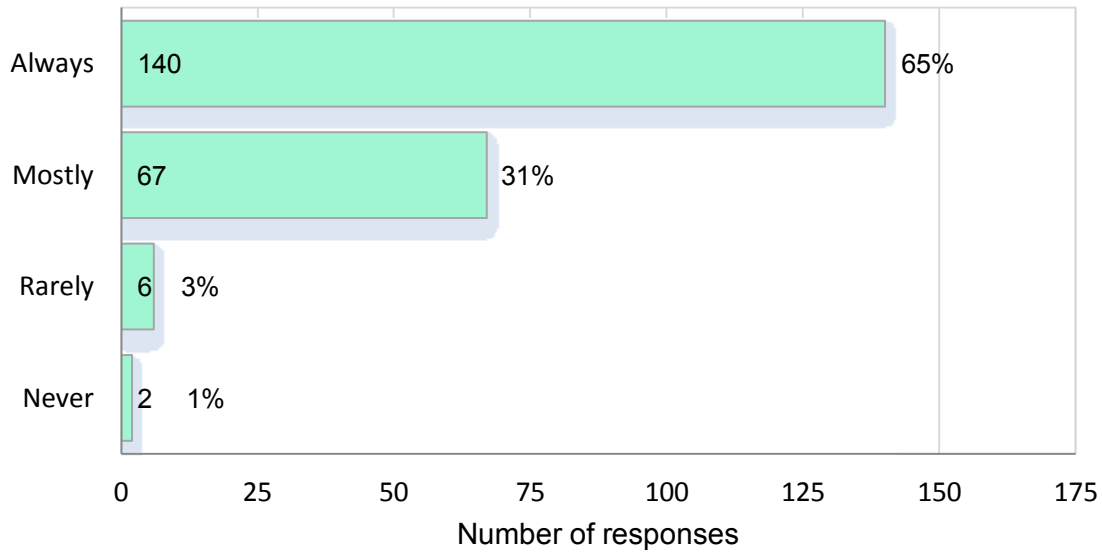
Providers also told us that the inspections were not intensive enough and didn't cover the things that mattered most.

> 'Inspectors don't understand agencies and have no experience of running an agency and don't know what to look for. They are not in a position to recognise outstanding features in good agencies' (Provider)

Several agencies commented on the survey that they welcomed feedback after monitoring visits from councils. Providers told us that the frequency and intensity of these visits varied widely. Some providers had not been visited by the council for many years, while others had visits every three months.

> 'Contract monitoring – not seen anyone from contract monitoring in six years' (Provider)

> 'Regular contract monitoring is useful' (Provider)

> 'We make the changes that they [local authority] recommend in their monitoring reviews ASAP' (Provider)

Providers told us that service monitoring by outside organisations is a burden, partly because of the differences in expectations. Providers who work with more than one council often have to provide different performance data in different formats for

different councils: some want it every month, some every three months. Inconsistent standards among commissioners create more duplication.

> 'Poor commissioner understanding of the day-to-day operation of a domiciliary care agency leads to inefficient practice; unrealistic expectations e.g. care workers being required to attend more than one medication training course to meet expectations of neighbouring local authorities' (Inspection)

Providers recommended that commissioners and regulators should share information more and work together to reduce duplication.

6.11 Business operation and management

To understand how providers' business operations influence domiciliary care, we considered:

1) recruitment;
2) pay;
3) travel time and travel expenses;
4) other pay-related conditions;
5) staff turnover;
6) zero-hours contracts;
7) incentives;
8) support and supervision;
9) training;
10) scheduling;
11) 15-minute calls; and
12) franchising.

6.11.1 Recruitment

Surprisingly, providers' survey responses showed that in general they were confident that they were able to recruit good staff. The problem was recruiting enough staff. It would appear that there are people available who would make good care workers, just not enough of them.

Figure 48 – I can appoint staff I think will make good care staff
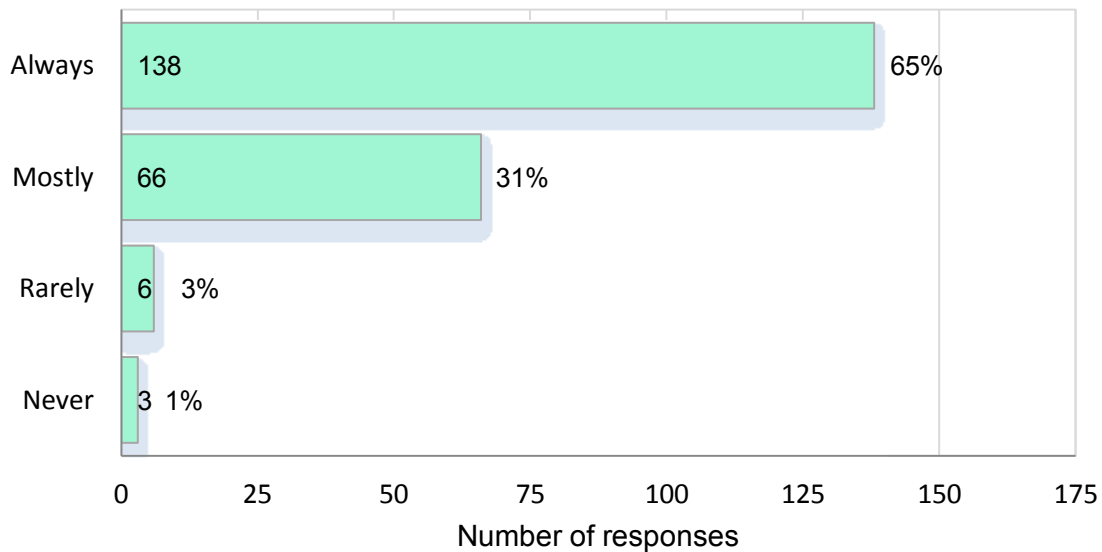
Figure 49 – I can recruit enough staff to meet demand
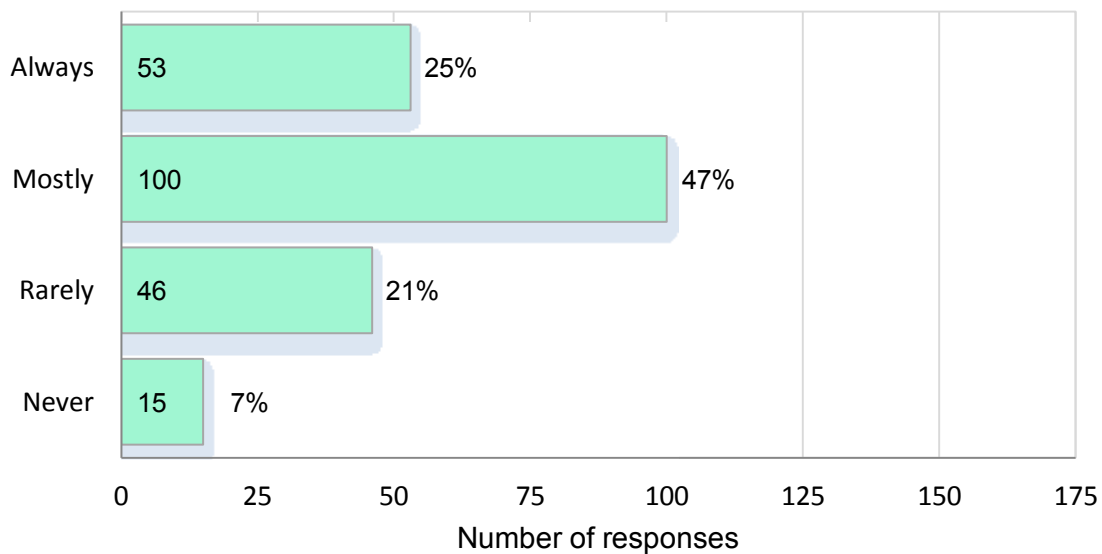
Wales now has its lowest ever level of unemployment and the lowest unemployment rate in the UK. Virtually every provider we spoke to mentioned the problem of recruiting staff: 'We are all fishing in the same small pool'. Providers were at pains to find new recruitment methods, rewarding existing staff for recruiting friends and family was not uncommon.

On the other hand, one provider told us recruitment was not an issue: 'every day I receive CVs to consider'. Another provider pointed out that although his agency

prefers experienced care workers, younger staff are not covered by the national living wage and there was potential for age discrimination as they would be cheaper to employ.

6.11.2 Pay

During our inspections we tried to assess the pay and conditions that providers give to care workers. It is difficult to put a value on pay. However, we based our assessments on what we understood were average rates at the time rather than on what could be considered fair rates for this type of work. Given this condition, we assessed 55 per cent of agencies as good or excellent, and 13 per cent as poor.

Figure 50 – Pay and conditions (inspector assessment)

☐ Excellent ☐ Good ☐ Adequate ■ Poor
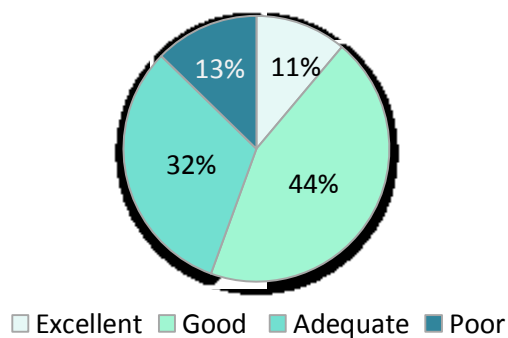
Of the 147 providers who answered our survey question on hourly rates, we found that, at the time:

- 68 (45%) paid £6.50 to £7 an hour (£6.70 was a very common rate, and the lowest was £6.52);
- 67 (44%) paid more than £7 and up to £7.50 an hour (£7.20 was a very common rate);
- 7 (6%) paid more than £7.50 and up to £8; and
- 5 (4%) paid more than £8.

The highest hourly rate mentioned was £10.50 or more for health support workers providing home-based hospice care. (Care workers have to be completely flexible about their availability.)

We also found that:

- some agencies pay more at weekends and on bank holidays – an extra £1 to £1.18 was mentioned;

- some agencies pay different rates depending on the length of the call (one example was £4.10 for half an hour, £5.10 for 45 minutes and £6.70 for an hour);

- care supervisors and seniors tend to be paid 50p to £1.50 an hour more than care workers;

- some providers pay extra rates for staff with Qualification Credit Framework 2 or 3 – usually 10p and 25p an hour, respectively; and

- some providers pay different rates for client time and travel time (one example was £8.08 for client time and £6.35 for travel time).

Seven agencies (including four councils) not included in the figures above paid salaries, not hourly rates. These ranged from £13,500 to £16,929 a year.

Council hourly rates tended to be higher: around £8.40 or more.

6.11.3 Travel time and travel expenses

Of the 215 agencies who answered the survey question on travel time and expenses:

- 105 (around 50%) did not pay for travel time; and

- 32 (around 15%) did not pay a mileage rate. Those who did pay a mileage rate usually paid between 35p and 45p a mile; the lowest was 12p a mile.

All councils paid for travel time, and all but one paid a mileage rate. The most common mileage rate was 45p a mile.

Forty-one agencies in the survey (around 20 per cent) provided cars for staff to use.

6.11.4 Other pay-related conditions

During our inspections, we also noted agencies that:

- gave staff a tunic or jacket but took payment for this out of their wages each month;

- did not pay staff to attend team meetings;

- made staff pay back the full cost of their Disclosure and Barring Service check if they left within six months (the amount they had to repay reduced gradually up to 12 months); and

- did not pay staff for five days' induction training but made staff pay the agency £100 if they left within three months.

6.11.5 Staff turnover

From 209 surveys we found that:

- around half of providers have a staff turnover of less than 10%;
- 88% have a turnover of less than 30%;
- 12% have a turnover of more than 30%; and
- 9% have a turnover of more than 45%.

This survey suggests that in reality, turnover may be lower than the rates that are often quoted: 32 per cent (CCW 2015)[14] and 30 per cent (UKHCA 2015)[15].

Table 3 – staff turnover

Staff turnover rate	Number of providers with this turnover rate	Percentage of providers with this turnover rate
0–5%	66	31%

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[14] Care Council for Wales (2015) *Workforce development report*. Cardiff: Care Council for Wales.
[15] United Kingdom Home Care Association (2015a) *An overview of the domiciliary care sector*. London: UK Home Care Association.

6–10%	44	21%
11–20%	55	26%
21–30%	24	12%
31% plus	20	10%

Turnover rates in the 20 council-run services were significantly lower, with 80 per cent saying it was less than 5 per cent.

In our focus groups, providers spoke about their experiences and fears of competition in the workforce market: 'we lose a lot of staff to the local authority, NHS and residential care'. The new Aldi supermarket opening in Wrexham had a significant effect, and providers are now concerned about jobs being created at the new prison. In another region, a health board recruiting for healthcare assistants on better pay and conditions led to the domiciliary care sector losing a number of staff.

Providers said that they had some loyal care workers who had been with them for a long time, but other staff would jump between agencies for as little as 5p more an hour. In our focus groups providers told us that new recruits were often not interested in the work or in staying.

'Typically new staff stay for six months. After that they are trained enough to take on more physical tasks like cleaning bottoms. Confronted with that, they leave.'

'People are sent by 'jobseekers' to tick the box, they have no real interest in domiciliary care work.'

'Youngsters don't stick around. Research suggests that people using the NHS prefer to be cared for by someone close to their own age range.'

'Staff turnover and retention are a challenge in an area traditionally not seen as a long-term career option or used only as a stepping stone to a real career in nursing or social work, workforces rewarded by the tax credit system for

part-time low national minimum wage work and little financial incentive to the same for full-time work or to take on further or vocational education.'

One provider noted that staff turnover goes in phases. People who are saving money and gaining experience before starting a university or college course leave in September. Holiday periods are difficult where staff have family commitments while children are off school. This can trigger people leaving.

During one of our inspections we were told that that one group of care workers all left at the same time after a personal dispute between managers and staff. This resulted in a lot of care packages being handed back to the council.

Inspecting another service highlighted a link between high staff turnover and complaints. The service had a poor recruitment process, failing to get references from previous employers and letting staff start work without a cleared Disclosure and Barring Service certificate. This failure to ensure quality led to seven staff being sacked in two weeks – two of these for missing calls.

6.11.6 Zero-hours contracts

Of the provider agencies that answered the survey question, 109 (just over half) used zero-hours contracts. For 52 agencies (25 per cent), *all* their care workers were on zero-hours contracts.

Five (20 per cent) of the 20 councils used zero-hours contracts.

We also noted the experience of two agencies who had tried to transfer their care workers to more secure contracts:

> 'Although our care workers have been offered guaranteed hours, they have all chosen to remain on zero-hours contracts.' (Survey)

> 'Expression of interest sent to all staff in respect of working contracted hours, only 9 of the 76 staff accepted so majority remain on zero-hours contracts.' (Survey)

6.11.7 Incentives

We found that providers were trying out the following ideas to offer incentives and improve working conditions.

- Awards for 'carer of the month' and 'best new carer'.

- Best team, which is voted for by service users.

- Drinks paid for at the Christmas party.

- Cash bonuses.

- Monthly draws.

- Free AA breakdown cover.

- Working patterns of four days on and three days off (this appeared to work).

6.11.8 Support and supervision

We found that support and supervision was good or excellent in just over half of services, and in 12 per cent we judged it as poor.

Figure 51 – Support and supervision (inspector assessment)

Excellent Good Adequate Poor
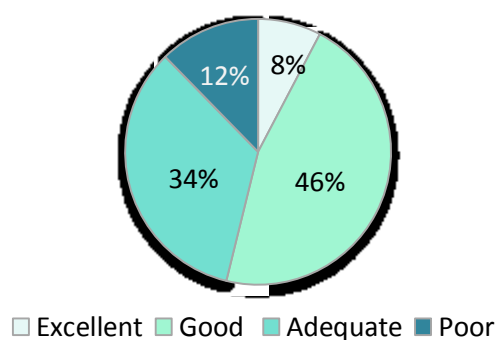
There is a mismatch between the expectations set out in the national minimum standards and those of inspectors. Inspectors expect to see more formal office-based 'one-to-ones' and supervision provided on a day-to-day basis. Providers suggested that a more flexible outcomes-based approach should be considered to reflect the fluid nature of supervision in agencies:

'Complementary methods such as coaching, mentoring, quality-assurance checks, buddying etc. should be recognised' (Inspection)

'Registered manager works hands on, observes staff and advises' (Inspection)

'CSSIW don't consider work-based supervision, which takes place during our spot checks' (Provider at a focus group)

'Requirement to record formal "one-to-one supervision" presupposes an approach which does not reflect reality. Much supervision happens in a fluid way, bits here and there in passing as required' (Provider)

One provider commented that supervision is important for helping care workers to maintain professional boundaries in their relationships with people they care for. Managers told us that care workers can need constant support and that managers have to intervene when care packages are causing problems. During our inspections, providers also highlighted the need to support care workers to manage challenging behaviour.

Providers mentioned the importance of keeping up morale. Some agencies display thank-you cards in the office, and others are keen to involve their staff in improving the business.

Providers recognise the value of team meetings. However, turnout is often low because care workers are not always paid to attend.

6.11.9 Training

We found that training was good or excellent in just over half of the agencies we inspected, but it was poor in 16 per cent. Most agencies give new staff one week's induction training followed by a 12-week probation and training period. In the survey, around one third of providers mentioned using the Care Council for Wales induction framework, and it is likely that others have used it too. Some agencies provided specialised training; for example, on epilepsy, stoma care, catheter care and stroke awareness. Most agencies used some sort of matrix system (often based on a spreadsheet) to highlight who needs to attend particular training courses within the year.

Figure 52 – Training (inspector assessment)

Excellent Good Adequate Poor
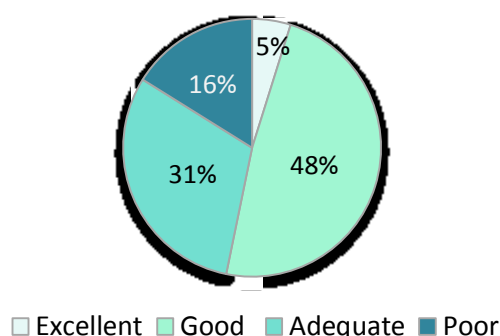
A constant concern expressed by providers is the withdrawal of training funding for staff over 25.

> 'It's a priority to have Qualifications and Credit Framework (QCF) funded for over 25s. At £1,000 a shot it's expensive, ten new carers is £10,000. That's money I have not got' (Provider at a focus group)

Providers recognise the value of training. It helps staff to 'feel valued and positive about their role'. Some agencies give staff incentives to take up training. For example, one agency said it pays staff 25p more an hour for each National Vocational Qualification they do. Other provider agencies value the learning that care workers can share with one another

> 'Our company promotes peer networks between care workers. They like to share their stories. This is very good way for reinforcing training and offering support. Care workers really value it.' (Provider at a focus group)

We also received the following feedback from providers (through the survey and during inspections) about problems with training staff:

'Social Care Development Workforce Partnership (SCDWP) courses are being pitched at too high a level and not at the level staff work day in day out. Needs to be practical'

'booking system for our council-run training is diabolical and a lot of training is cancelled'

'we have a lack of shadowing opportunities; DVD used for training or e-learning, which is not always suitable'

'small agencies; much more difficult to release staff for training'

'very difficult to get training on more medical needs; neither district nurses or health board provide it.'

6.11.10   Scheduling

We found that the arrangements for rostering staff were good or excellent in around 57 per cent of agencies and poor in 17 per cent.

Figure 53 – Staff rostering (inspector assessment)

☐ Excellent ☐ Good ☐ Adequate ■ Poor
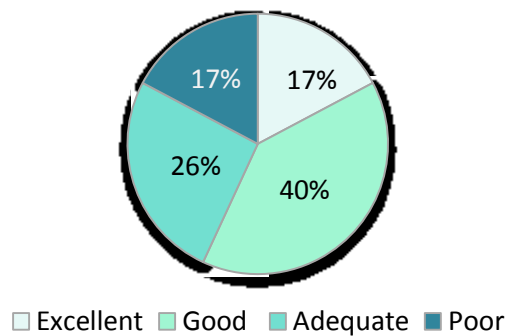
In agencies where scheduling care was not working, there were significant inefficiencies and problems with planning, quality and understanding workforce capacity. When inspecting providers we found:

'Poor rota organisation was linked to very high turnover of staff directly related to poor organisation of agency, lack of oversight by manager'

'Agency continued to accept packages that they were unable to cater for resulting in safeguarding issues'

'Rotas can only be achieved by call clipping; 24/163 scheduled calls in one day had not had allocated travel time'

'Rotas unrealistic or no travelling time – in reality calls shortened or run very late'

However, the survey responses suggested that most providers believe they factor in enough time for travel.

Figure 54 – Enough time is allowed to enable staff to travel between visits
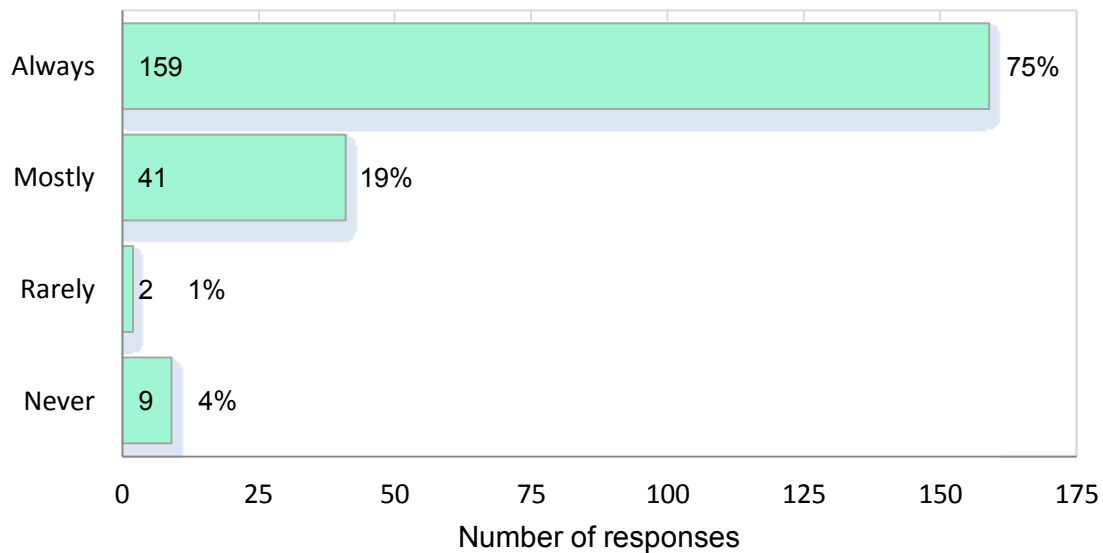
Where rostering worked well, it reduced travel time and costs:

> 'Calls arranged in clusters or zones to aid timing, and in some cases account for no travel expenses paid' (Inspection)

In our focus groups, providers told us that social workers had made commitments to families that no agency had the capacity to fulfil, especially at peak times of the day. This put providers under pressure to squeeze more calls in and cut travel time.

> 'User and family expectations not met, frequent variance in time agreed by social worker and ability to be delivered by agency. Provider states social worker tells user/family that call times will be sorted out in a few weeks when this cannot happen' (Inspection)

Providers (and some staff) also told us that some people to ask care workers to leave early because they prefer to have their house to themselves or don't like unnecessary interference in their lives.

Providers also told us that the variety of call times that councils use is not necessary and adds needless complications to planning. For example, one council asks for 15, 20, 30, 40, 45 and 60 minute calls.

Scheduling care and rostering staff are essential for making sure the right care workers, with the right skills, arrive at the right time to provide the care and support that people need. However, it is a very difficult task because there are so many variables. For example, people receiving care and support might not need a visit on the day it has been planned if they are in hospital, have visitors or are being cared for by relatives. On the other hand, a person's needs may have increased and they require an additional or longer call.

Added to this are the many problems that can happen on visits. Examples include difficulties getting let into someone's home, someone being ill, someone falling and needing an ambulance, or someone with dementia not wanting to receive care on the day.

Care workers may be unwell, they may have family and childcare emergencies to deal with or their car might break down. Factor in weather (snow is a major issue in many parts of Wales), road closures, accidents and car parking and you can appreciate the huge challenges facing care coordinators every hour. On top of this, care workers on zero-hours contracts may decide not to work at certain times.

One inspector said there is 'inconsistency in delivery during holiday periods when sickness and unauthorised leave occurs or staff leave the agency with no notice'.

Making sure care workers have care runs that keep travel time to a minimum is critical to their pay and conditions and to keeping the agency viable.

We have included some providers' comments in detail below because they give a real insight into the different approaches and the factors they have to balance and take into account.

'However, staff will have already provided information about their availability. We operate a work scheduling database system. There is a master copy of the rota where the staff have their regular calls in place. We endeavour to

ensure no more than four care workers visit any one particular client, although with larger care packages, e.g. 28 hours per week, more care workers may be necessary. If a client or their carer does not respond well to a member of staff, we will discuss the issues and introduce another care worker. All care workers receive their rotas and contact the office if a) they are unable to cover a particular call, b) they require more information about a client, or c) they do not understand what is required of them. Travel time is outside calls and this is reflected on the rotas. We estimate the time between calls by using AA Route Planner. If staff are unable to complete the journey within our estimated time, we quickly extend the travel time to reflect a more realistic journey to ensure the client receives the true allocated time and care. If staff are likely to be 15 minutes or more late, they are required to contact the office and we will inform the carer or the client as appropriate…'

'We use an internet-based system to schedule visits. The initial set up of a new service user is time-consuming to enter the details and ensure that all visits are correctly allocated to the ideal carer. We are very happy with the system we use and find it works very well for our needs now that we have grown to 30 service users. Our contract permits our carers to arrive at each visit up to 15 minutes early or up to 15 minutes late – so we effectively have a 30-minute window for our arrival time which helps our care team to manage their time and ensure that their round of visits runs smoothly. Our travel time is minimal between most visits as we cover three small patches and carers' rounds are clustered to the same area – usually the area where the carer actually lives. This also helps to keep our staff happy as they are not travelling very far to work.'

'We use an electronic system to allocate staff to clients. The client is usually put on the system straight away but if rotas have already been issued a handwritten rota is devised for the first week of care and all staff allocated are informed by manager or admin staff. Managers develop rounds using the knowledge of the seniors working in the areas so that clients that are close to each other are placed on the same round. This means staff do not waste time travelling long distances between clients. When new clients are taken on they

have to fit into these rounds as one of the criteria to be taken on. Whenever possible staff are allocated to their first and last client which is near to their home to keep travelling to a minimum. If there is distance between clients then managers allocate this into the rota so that travelling time isn't taken from the next client.'

'Electronic systems are used to roster and monitor the whereabouts of staff. Travel time for reablement staff is added to the rotas, generally 10 minutes per visit, depending on the area. Staff are generally allocated to small geographical areas but due to the short-term nature of the service, daily changes to rotas and the need to respond quickly to referrals, staff may be required to travel across the council care and extra travel time is then added to the rota to ensure staff are not rushing from visit to visit. Rotas are initially set for visits lasting 15, 30, 45 or 60 minute calls according to the presenting information but staff provide feedback on individuals' progress, or lack of, and rota visit timings are adjusted according to this feedback. Staff take as long as it needs to take to complete each visit. Extra-care staff work within a building and so do not need travel time as they can move from one flat to another very quickly.'

'We are currently in the process of introducing travel time between calls. We approach scheduling by looking at the preferred times and the location of the service. We try to marry this into a run, so that there is minimal overlap and staff needing to go back on themselves to reach services.'

'Calls are scheduled in the required time slots. We have an understanding that the times could be 30 minutes early or late but we aim to arrange with the service user if the times are altered / someone has been delayed due to a change in a service user's condition. Travel time is allowed on average after every three calls to allow time to catch up depending on the distance between calls / school traffic / road works'.

In the survey we received a wealth of detailed feedback from 'traditional' agencies about their approach to scheduling and rostering. More and more agencies are using information and communications technology, which is becoming increasingly

sophisticated. Around half of the providers who responded to the survey use a variety of software.

A few agencies use manual systems or their own spreadsheets to design rotas. Most agencies use commercially developed tools, and many providers use the same ones. The most basic tools create simple schedules of care. The more sophisticated systems, which some providers are using, can also do the following.

- Factor in travel times between calls.

- Link to satellite navigation systems to give travel directions to care workers and provide the agency with real time location of where their care workers are. This helps providers estimate call times, contact service users and bring in extra care workers if needed.

- Create invoices.

- Calculate wages and allow for holidays.

- Cross-check training skills and highlight training needs.

- Predict future staffing needs, including numbers and skills.

- Link to call-monitoring systems and tasks in the care plan.

- Identify replacement care workers who the person receiving care already knows.

- Regularly collect feedback from service users on progress towards outcomes and the quality of their care.

- Predict and calculate care worker continuity.

- Provide performance information on call times, missed calls and late calls.

Providers are using very diverse planning systems, but they are placing most emphasis on linking planning systems with electronic care planning documents. The responses we received made clear that different providers are operating at very different levels of complexity.

Electronic scheduling systems can create efficiencies but as some providers told us they come at a cost. One provider told us that one of the councils his agency contracts with just over the border in England is insisting that agencies use only one system so this can be aligned with the council's own system. The potential benefits are that invoices can be checked and payments made automatically and that the council can monitor the day-to-day performance of the agency. However, the extra cost, which is based on an annual fee for each service user and is paid by the provider, is such that the provider has very reluctantly withdrawn after 24 years of working with that particular council.

This poses a challenge across Wales if different councils require different systems from the same provider who may also face different demands across the UK. However there is merit in standardisation – using systems with basic functionality that can talk to each other.

6.11.11   Fifteen minute calls

The evidence from our inspections of agencies is that a number of councils commission 15 minute calls and these are used not just for monitoring/ medication visits but also personal care, some of which is quite demanding. It was also clear that a number of providers did not provide 15 minute calls or had decided to stop accepting 15 minute calls but were being placed under enormous pressure to do so.

Providers explained that, from their point of view, 15-minute calls do not make efficient use of care worker time. This is because they reduce the time available for giving care – as a proportion, care workers spend more time getting into someone's home, travelling from one call to another and doing administration for the visit. Fifteen-minute calls also place a cost burden on the agency: a call still has to be arranged, recorded and invoiced for, no matter long how long it lasts. Also, staff have to be paid a higher pro-rata rate to avoid falling below the national minimum wage because of the increased down-time between calls.

Providers had the following to say about 15-minute calls.

'Only problem with commissioner is despite saying no, the 15-minute calls will still be put in there is always a concern that if the 15-minute calls are rejected the whole package would be given to someone else'

'LA commissions 15-minute calls but we are reluctant, will do so for medication checking / meal preparation but will charge for 30 minutes'

'We ceased 15-minute calls resulting in one LA ceasing to contract with us'

'I feel pressure to accept 15-minute calls'

'Routinely commissioning impossible 15-minute visits. Compromises safe and dignified care'

'15-minute calls; feel pressure to accept them e.g. of 15 minutes to toilet, prepare lunch and meds'

'Council keep pushing out 15-minute visits for what are complex care tasks e.g. meds and dressing'

From providers' responses to our survey we found that:

- no providers said they did not provide 15-minute calls, although 80% said that between 0 and 5% of their calls were 15-minute calls;

- 6% of providers said between 5% and 10% their calls were for 15 minutes;

- similar percentages of providers said that between 10% and 20% or between 20% and 30% of their calls were for 15 minutes; and

- 2% of providers said that over 45% of their calls were for 15 minutes.

6.11.12   Franchising

Of the agencies in our sample, 7 per cent were run as franchises. We were keen to understand the benefits and challenges of franchise arrangements.

Franchising is where a business is given a contract to operate an agency under a brand, such as Care Watch or Home Instead. The agency has to pay a management

cost (around 5 to 7 per cent). The agency also has to pay for other customised or branded services (for example, bespoke call-monitoring systems, training packages, employment documents and financial systems). Franchises tend to guard their reputations fiercely. They are selective about who they allow to use their name and have rigorous internal quality control systems.

People we spoke to said they value the support they receive from their franchisers. They said that, especially for people who are new to the business, it is a safe and supportive way of building up a new agency and reduces the chance of making mistakes. They feel that the costs of being part of a franchise are usually offset by the marketing advantage of being part of a brand. However, providers also commented that franchisers tend to be very England-centric and the guidance they offer does not reflect the context of working in Wales. This is especially relevant to regulatory requirements, which tends to be solely based on the expectations of the Care Quality Commission.

6.12 Working with commissioners

We explored the following aspects of working relationships between agencies and commissioners.

1) The relationship between providers and commissioners.

2) Information provided when assigning care packages.

3) Reviewing care packages.

4) Fees and tendering.

5) Approaches to contracting and commissioning.

6) Zoning.

7) Direct payments.

8) 'Time and task' commissioning.

9) Outcome-based commissioning.

10) Payments.

6.12.1 The relationship between providers and commissioners

It was surprising to find that most providers have very positive relationships with 'commissioners', given the tension over fee settlements and the pressure on providers to take on work. This clear in the survey scores and the detailed narrative responses, which often referred to excellent or very supportive relationships with commissioners.

Figure 55 – I have a good relationship with the councils / health boards I contract with
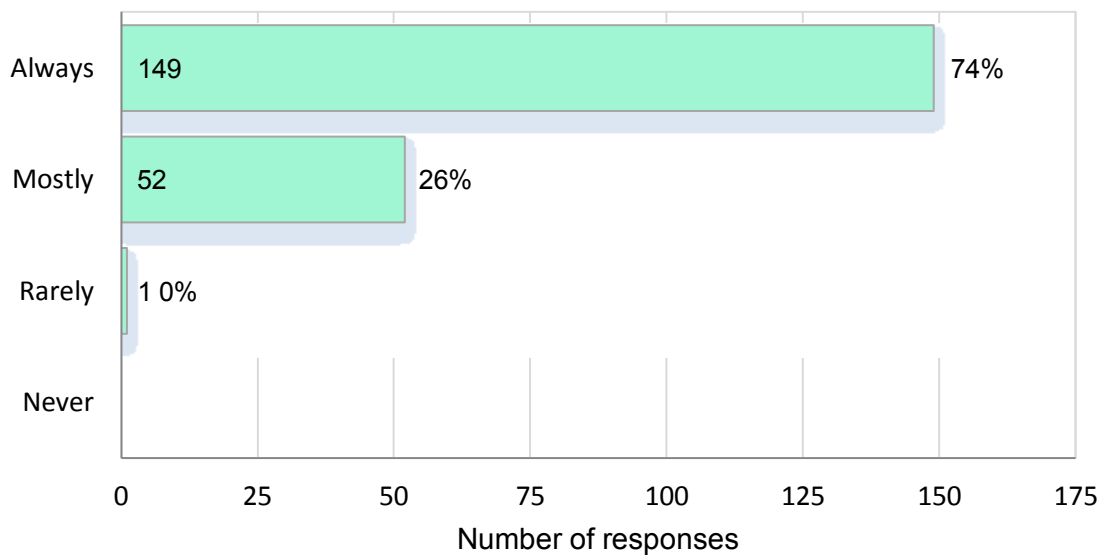
Figure 56 – Councils / health boards allocate the work among providers fairly
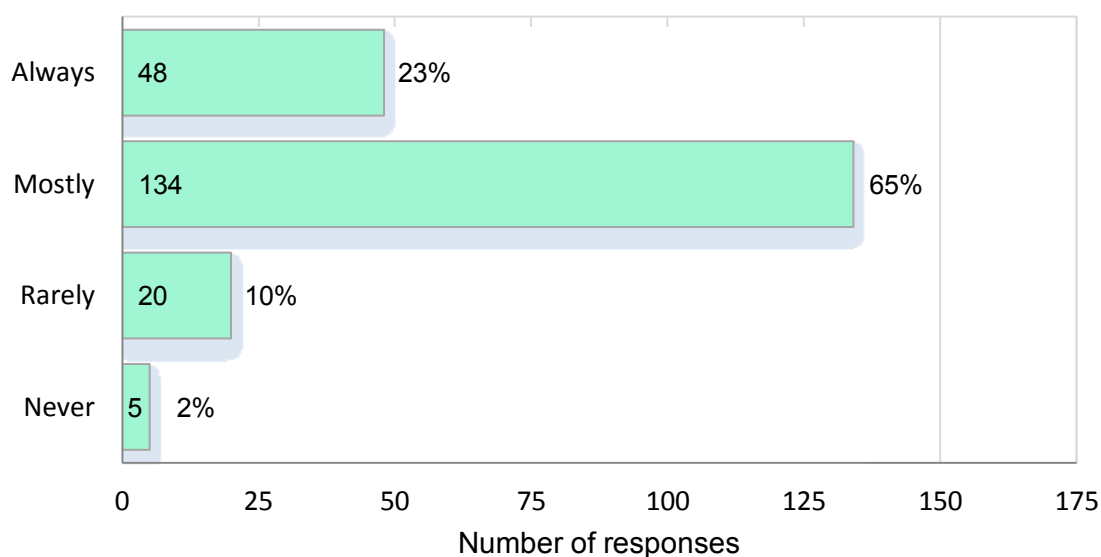
Several providers mentioned their meetings with commissioners. However, some were frustrated that some councils did not hold regular meetings or that meetings were cancelled or postponed. Providers also said they had good relationships with adult protection teams, who they felt able to contact for advice and support.

Having said this, the many comments make clear that providers tend to see 'commissioners' as the people they do most day-to-day business with (usually people from brokerage, social workers or contract monitoring) rather than those who truly commission services.

There was evidence of strain and pressure in relationships. Several providers said they felt pressurised and bullied to take on work. One provider told an inspector she nearly lost her business because she was forced to take on work she knew she couldn't fulfil. She said the stress this brought to her and her staff and the damage it did to their reputation because of late and missed calls was not worth it. She would now rather take the risk and lose the contract with the council.

Figure 57 – I am put under pressure by the council / health board to take on more
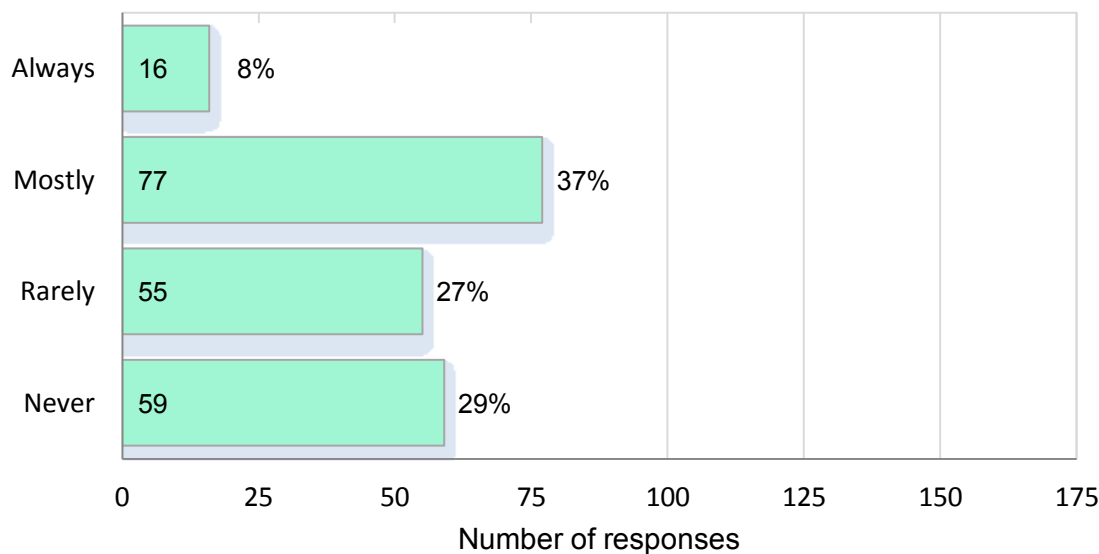
Providers told us:

'There is enormous pressure to take extra visits and packages'

'Commissioners can be short on the phone – don't give the agencies credit for knowing – soul destroying – I was always taught to work as a team – it doesn't happen'

'When you are challenged by the council to take on more packages, you need to stand firm on decisions'

'We are willing to be flexible but not to cram calls'

Our inspections confirmed that agencies were often 'placed in [an] impossible situation, being asked to pretend they can service visits when they can't, just to get them off care managers' books' (Inspection).

6.12.2 Information provided when assigning care packages

As part of this review we wanted to explore how care packages are handed over from care commissioners to agencies. Our theory was that many of the issues around providing care stem from the way in which care packages are put together

and brokered. We were particularly keen to understand if commissioners were giving good-quality information to agencies.

The results shown in the figures below suggest that providers cannot always have confidence in the information they are given or that they will be kept up to date.

Figure 58 – The care plans I receive from councils / health boards are reasonably accurate
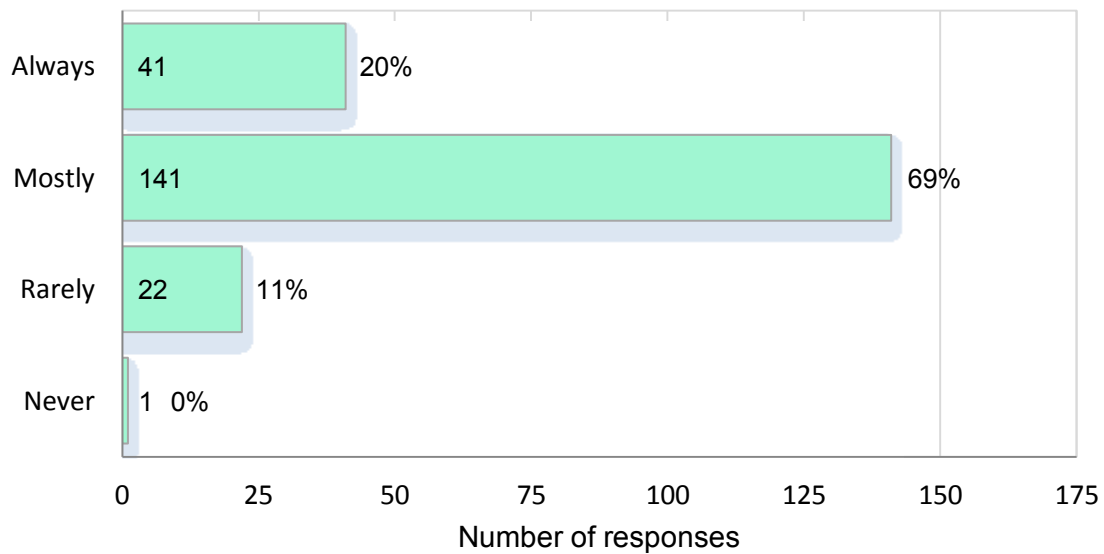
Figure 59 – Councils / health boards keep me informed of changes to the care plan
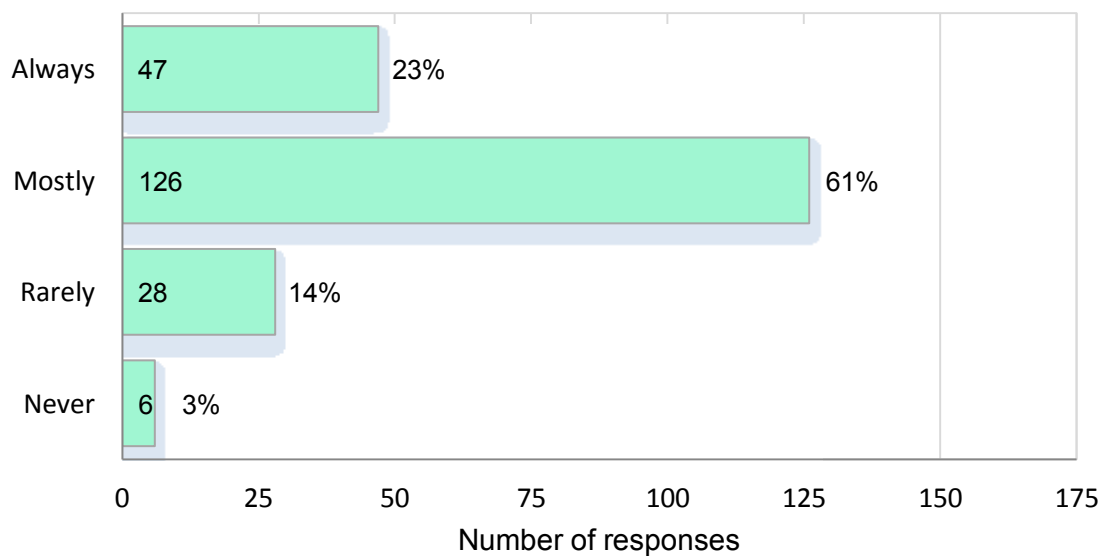
These findings were confirmed in our inspections:

'Some reports of good quality information from commissioner and assisting in developing a good service plan. A large number of reports of limited information given about potential users, only name and address, unable to assess at this stage if the provider can meet need. Results in wasted time for provider and user, particularly if the user has a condition that the agency staff is not trained to support'

'Provider requests timetable of care in advance of meeting a user but this is not always provided by council, some information on user wishes from council but information not always accurate causing upset and wasting time for all parties and delaying the care package being fulfilled if the agency cannot meet the actual requirements of the user'

'Quality of local authority care plans varied – some better than others some with very limited information just say "personal care" or "needs prompt", some can be in depth'

6.12.3 Reviewing care packages

Reviews cause anxiety for providers. There are three areas of concern.

The first is that packages are cut without any discussion with the provider. Given how much contact the provider has with the person receiving care and support, the provider should be in a strong position to provide helpful information. Our inspectors noted:

'Council cutting packages on review provider rarely involved in reviews'

'Care workers' views never sought as part of LA review; provider never invited to participate; provider conducts own six-monthly reviews'

'Council does not include provider in their reviews'

The second concern is the common problem of getting a care package reviewed and revised when a person's needs change and they need much more support (for example, after a stroke). During our inspections, providers told us:

'Needs increase but council won't increase hours until there has been a review. This means people either don't get the care or are unsafe or agency loses significant money. Council holds payments until reviews are done'

'Variances application – can take up to four weeks, hard for them to get out to review'

'Case closed to SW input once package allocated, time-consuming to get case reopened therefore impossible to request an OT assessment – threatening to pull out brings results variances in packages not accommodated and must be fought for – fighting for this all the time.'

However, during our council inspections we also received positive comments:

'Many providers report LA is responsive if reviews are requested and commissioner responds well when user needs change'

'Management make the call if the care workers can't complete their tasks and the call needs more time, some LAs just authorise the additional time; they don't come out to check, as there is trust'

The third area of concern is the overall lack of reviews being completed by councils.

'Provider felt lack of respect by social worker; agency needs to do own reviews due to the infrequency of LA reviews'

'inconsistent invitations to reviews, some providers chasing LA to carry out reviews'

'Care files audited by provider found 90 per cent LA reviews out of date; provider wrote to advise the LA' (Inspection)

6.12.4 Fees and tendering

In individual interviews, providers told us:

'I don't deal with local authorities. It's the Devil's work. Therein lies the path to insanity and bankruptcy'

'We can all talk aspirational but it has to be paid for'

Providers were very clear that the current rates being paid by some councils are not high enough for providers to survive in the medium and longer term. They said that the fees they get do not allow them to pay care workers a fair rate for the work they do or attract care workers into the job. They also told us that the tendering processes vary widely across councils and are very complex, technical and time-consuming. When we explored the detail of the contracts in our discussions with providers, some contracts appeared to be one-sided, with several penalty clauses passing all the risk and costs to the provider.

Figure 60 – The rate paid by councils and health boards for the work required is reasonable
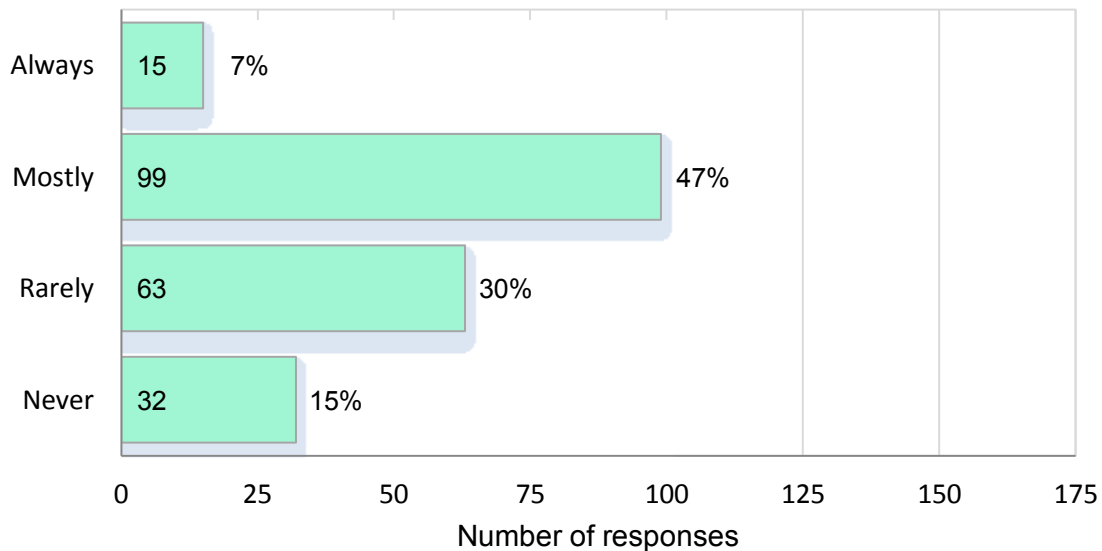
Some providers told us that they did not go for certain contracts because they read the small print and found that the risk was all on the provider. For example, prices were set for three years or there were no guarantees of any work: 'Who do they think we are?'

Providers told us that some contracts were being offered and agreed on at eye-wateringly low prices that did not make sense (£13 per hour and under). They said the costs were unsustainable. We heard more than once of companies known in the industry as 'cash cows' – providers who take on contracts with a view to 'bleeding the profit' for two years and then pulling out and handing the contracts back.

One provider told us that some larger companies make a low bid to win the contract but have no intention of seeing the term of the contract out. Instead, they get out before costs escalate and reduce their profits.

> 'They have no regard for [the] council's desire to build a sustainable market or their own organisational credibility as they move off to another locality. These providers should be tracked – questions should be asked as to why providers pull out or hand back packages to learn lessons'.

In confidential discussions during the review, people told us about medium-sized providers who had won fairly big tenders only to re-examine the costs and realise that they were not sustainable. These providers were planning to hand large contracts back.

One provider told us that the frequent changes in commissioning practice made business planning difficult in the medium and long term. He explained that he needs stability, a clear vision and an understanding of potential demand to be able to plan his business.

We received the following comments in survey responses from providers.

> 'The tendering process isn't very fair. I feel sorry for smaller providers who have not got the financial skills to provide breakdowns of all the costs. It's all too complex'

> 'We try to put in a sustainable, fair price; and then lose out. One large, five-year contract we just bid for has just been taken on at just over £13 an hour. Doesn't stack up. The burden to drive prices down is on the provider which simply results in low pay'

> 'One council has just put its rates up by 6 per cent to £12.54 an hour for 2016; no enhancement for short calls. There is less time to bear the additional costs related to the call, e.g. travel, back office etc.'

> 'We were going to bid to [name omitted] council but did not. No guarantees, there no point in taking the risk in setting up. You need an absolute minimum of 600-700 hours a week to establish an office'

'One example: In a recent bidding process 12 providers were invited to tender following pre-qualification questionnaire. Supposed to be 50 per cent price, 50 per cent quality but in reality it rests on the price. It's a six years plus two plus two contract. Very difficult to set a price over those timescales when the profit margin is so thin'

'Good relationships with people in procurement but too many systems in Wales, it's too woolly'

'We didn't go for the tender, we weren't prepared to take on packages that big, we're not a huge company and it would have been a huge strain and we wouldn't have wanted to fail'

'Receive offer from council and must respond in 24 hours or next provider on the list is offered the care package. Financial penalty if no capacity and provider must pay the difference in fees with the provider who accepts the package is then expected to take on the package once they have capacity resulting in lack of continuity for the user.'

Providers told us that feedback is important in the tendering process.

'Communication could be better – If our bid is unsuccessful we don't hear back; would like to know why we were not successful. If successful sometimes it takes a day sometimes a week to hear back from brokerage'

Likewise, one provider suggested that it would really benefit commissioners to ask why providers choose not to bid or withdraw from the tendering process.

6.12.5 Approaches to contracting and commissioning

Domiciliary care work is contracted between commissioners and providers in many different ways. We explored some of the benefits and problems that can arise from a provider's perspective. It is complicated, because there are many variations in how some of these approaches are applied and commissioners often combine different approaches, such as 'block contracts topped up by spot'. We have explained these approaches in the following sections.

However, several providers told us that the formal systems do not work and are often bypassed.

> 'The council has a brokerage system but it doesn't really work. More often they phone us with urgent packages, which we will accept if we have the capacity.' (Survey)

a) Spot contracts

Traditionally, 'spot contracts' are used to buy individual care contracts for each person. The price is either negotiated for each package of care or agreed in advance as part of a framework agreement. There is no guarantee of work for the provider, but with demand in the system so high and supply so short, this is less of a concern to providers at the moment. Providers can consider each package of care and decide if it is something they are able to take on and if doing the work would be cost effective.

> 'Spot contracts place less pressure on our agency to take on calls'

> 'It all depends on the quality of the information given to the provider about what care and support each person needs and where they live'

> 'They place contracts by postcode. In rural areas this can mean plus or minus eight miles. You go in blind and having accepted a package and finding it is in the middle of nowhere you can't give it back or renegotiate the fee'

We had positive feedback from a provider who told us that the health board uses spot contracts flexibly to top up existing contracts when extra care or visits are needed.

b) Dynamic purchasing

'Dynamic purchasing' is a system where spot contracts are placed on a computer system and approved providers bid for specific packages of care. When this was introduced in Cardiff, people were sceptical. However, providers now value the transparency and fairness the system brings. We have also found, though, that many contracts are placed outside the dynamic purchasing system on a spot basis.

Providers told us about the 'Matrix (now rebranded as Adam)' dynamic purchasing system in Cardiff:

> 'Generally works well but no increase over the four-year period, I am concerned companies can make decreasing bids to win the package. The amount of information required to be entered in the bid does not match the limited information provided by the LA. Example: where council did not advise the providers that the package was a temporary; a lot of work for a four-day package'

> 'The Cardiff system creates a bidding war, does not focus on quality and creates significant work for agencies given the amount of information they have to provide particularly as council doesn't always describe people's needs clearly. I have been told to subcontract as Cardiff regard agencies in breach of contract if they try to hand packages back'.

> 'I have seen more work coming to me since my quality score improved'.

c) **Block contracts**

In theory, a 'block contract' is when commissioners buy a set number of hours each week, which they can then use as needed. When used in this way, block contracts give providers some certainty about how much work they will have and allow them to recruit and retain care workers. In the past, block contracts were often used to buy residential care. They are used more often in domiciliary care linked to supported housing.

In our inspections of councils and our discussions with providers, it became clear that practices varied widely and some contracts could not really be called block contracts. In several cases they seemed to be used to try to guarantee supply to the council without guaranteeing any business to providers. They also included heavy penalties.

We received the following comments from providers following our survey.

> 'Now we have a contract for 1,000 hours a week. But we only get paid for what they purchase, perhaps just 600 hours. If we are offered work and

haven't used the 1,000 hours up we have to take it, no matter how difficult or expensive the work is to provide, and if we don't we face a penalty charge. If someone we are providing care to goes into hospital, we don't get paid BUT we have to keep the slots available in case they come out of hospital. That can mean keeping staff who are not being paid on standby. If we don't we face a penalty charge …'

'Old block contracts do exist but there is no guarantee. You only get paid for what is used. No risk to commissioner, it is all passed to the providers'

'We are under pressure to accept all packages allocated to us and we face a financial penalty if we are unable to deliver them'

'Huge variation between councils; terms are not adhered to, hours are not paid, penalties are applied. Length of contracts years ahead with no guarantee of annual uplift during the life of the contract' (Inspection finding)

The issue of not receiving fee increases (uplifts) was particularly exasperating to providers.

'We haven't had an uplift from our council for four years'

'Supposed to be a price review every two years; doesn't happen and they never even answer'

d) **Subcontracting arrangements**

Only seven providers in our sample said they subcontracted work to other providers. Only eight did work on behalf of other providers.

Subcontracting adds a cost to the provider chain and, in general, there is little incentive for providers to get involved. The feedback we received suggests that providers are not interested because the inherent risk and complications outweigh the small gain.

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6.12.6 Zoning

More and more councils are moving to tendering based on 'zoning'. This allows providers to concentrate their efforts in a patch and build more efficient care runs. One of the risks of this approach is that the council becomes very dependent on a single or small group of providers, which could cause problems if those providers decide to withdraw or cannot provide a reliable service. There are potential problems for providers too. Focusing their businesses on patches can narrow their operational base and their ability to recruit staff. One provider explained that there are particular problems in rural areas of Wales.

> 'Zoning has its challenges: you need a patchwork quilt, a combination of rural and urban work to balance the risks and costs'

During one of our inspections a provider complained that being restricted to zones seriously limited opportunities for expanding the business. She felt that this made her business less able to survive and grow in the long term.

We noted that one agency working in zones has a care worker in each local area, who is paid to provide cover at short notice. Their local offices are open on Saturday and a duty manager is on call out of hours. This arrangement allows contingency arrangements to be put in place.

6.12.7 Direct payments

During our review we heard from several providers who give care to people who use direct payments. Sometimes this arrangement was put in place after repeated problems with care that was brokered by the council.

> 'We provide private care. A lot of people come to us when the care provided by the council has broken down and they have gone onto direct payments. The local council only pays £11.73 an hour for direct payments which means a family may need to pay a top up of £8 an hour. But they are happy to do so to ensure that their relative has a quality service and it is still much cheaper than the alternative of residential care. It means people can remain well cared for at home which is where they want to be. One solution would be for

councils to increase the rates for direct payments and encourage more people to make their own arrangements' (Provider)

6.12.8 Time and task and outcome-based commissioning

Traditional domiciliary care is purchased on a 'time and task' basis. This is where the care is prescribed, setting out in detail what needs to be done on each visit within set time slots.

In general, providers feel that this is not the best way to provide care and support. It is inflexible and can lead to an approach that is not personalised. However, as one provider put it, 'at least you know what is expected'.

Increasingly, commissioners are considering outcome-based approaches. This is where care packages are based on desired outcomes and blocks of hours that can be 'banked' and used more flexibly. One provider that has experienced a range of different approaches welcomed this initiative but said commissioners found it hard to move away from 'time and task'.

Other providers said:

'Cost envelope commissioning[16] is good, it provides flexibility but you cannot run the two systems (i.e. time and task) in parallel' (Provider)

'Task-based gives security; is very difficult to be outcomes focused when it isn't commissioned or judged by inspectors that way. Needs trust; who in reality sets the outcome? What is an outcome? Often aspirational at best, not meetable, realistic or measurable' (Provider)

6.12.9 Payments

In discussions and feedback, providers raised the issue of delays in receiving payments. Payment delays can place businesses at serious risk. People told us about situations when local authorities have had to make loans to care agencies to keep them in business while delayed financial payments were sorted out. The arrangements for invoicing can be very complicated, especially given the volumes

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[16] Provider is given a price range rather than a fixed price.

concerned and changing patterns of care delivery for individual people. Councils and health boards do not have the same approach, which makes things worse for providers because they have to use different systems and provide different evidence for different commissioners.

> 'Some providers spoke of adequate invoice and billing processes but others spoke of invoices being delayed particularly where there were changes. Again variability with impact significant. High transactional activity noted by some providers where changes and verification of invoices takes time'. (Council inspection)

> 'Payment delays result from emergency or temporary increase in hours although confirmed by commissioning, the payments are sometimes later queried which delays payment and requires the agency to chase up the payment.' (Council inspection)

> 'Payment is often late, we have to send reminders' (Provider)

> 'Invoices submitted weekly but changes hold everything back. Issues are passed from pillar to post credit notes are written and invoices re-billed.' (Provider)

> 'Need to chase up payments issue for us as a small company' (Provider)

> 'Local Health Board is good with payments, one council is good, another has a history which is shocking more than 50 per cent of invoices passed 50 days – we had to get a large overdraft to pay wages because we are not paid timely' (Provider)

One provider told us that some councils are introducing and insisting on payment and reconciliation systems using purchasing cards (known as 'P-cards'). This provides a more automated banking system for payments but it comes at a cost to the provider: 4% interest for the card provided by one bank, and other systems have a cost of 1.85%. Although they are low, these extra costs for providers reduce what are already slender margins.

6.13 Challenges

In our survey and in our focus groups, we asked providers to comment on the day-to-day and longer-term challenges they faced. There were some common themes.

a) **Day-to-day challenges for providers**

- Just 'keeping the show on the road' – making sure enough care workers are available to cover all the calls.

- Staff sickness.

- Recruiting and retaining staff: 'people are not willing to work for peanuts'.

- Keeping up with paperwork.

- Dealing with pressure to take on more work.

- Making sure the tenders and individual packages that they bid for or accept are sustainable in the face of possible costs.

- Getting increases in funding when a person's needs increase.

b) **Long-term challenges for providers**

- Keeping the business viable in the face of rising costs.

- The impact of the national living wage.

- Uncertainty about the impact of new regulations.

- Higher expectations of commissioners and families.

- Making sure care workers have the skills to deal with ever more complex needs.

7   What people commissioning domiciliary care told us

7.1   Our approach

We began by designing a national survey with council commissioners and provider associations. All 22 councils and 2 of the 7 health boards (Cardiff and Vale University Health Board and Aneurin Bevan University Health Board) gave us very detailed evidence for which we are very grateful.

We selected six councils (two in each region) for an inspection to help us understand how they approach commissioning and how effective these approaches are in providing domiciliary care. We have published individual reports on these inspections[17]. We reviewed commissioning documentation, interviewed staff and tracked five care packages from assessment through 'brokerage' to day-to-day delivery. In doing so we considered the views and outcomes of the people receiving services. We also explored providers' experiences at local forums. In our analysis, we tried to link the findings from our regulatory inspections of domiciliary care providers to commissioning practice.

We also talked to a wide range of commissioners at our three stakeholder group meetings and at three regional focus groups. We took account of both our and Wales Audit Office's inspection of Powys County Council's commissioning arrangements and the useful lessons that the council has learned. We followed up particular lines of enquiry by visiting councils again, attending workshops, and interviewing members of staff with responsibility for commissioning and care management.

7.2   The main messages

- Commissioning domiciliary care is a huge task in Wales. The complexity and scale of this task is rarely properly appreciated. It involves substantial expenditure, approaching a quarter of a billion pounds of public money each year in Wales. The sector employs thousands of staff and supports thousands of vulnerable people in their own homes. When domiciliary care goes wrong, the risks to life, health and well-being of people using the services and their

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[17] http://cssiw.org.uk/our-reports/national-thematic-report/2016/160626-national-review-of-domiciliary-care/?lang=en

families can be significant and the costs to other parts of the health and care system can be high.

- There is serious pressure in the system because there is not enough capacity to meet demand. This is especially true for older people's care and support.

- Commissioners recognise that 'time and task' commissioning models have limitations and are not compatible with the culture of care and support expected in the Social Services and Well-being (Wales) Act 2014.

- Many commissioners are considering outcome-based commissioning and are looking for a way to use it. They are anxious to get it right but are concerned about avoiding costs rising or services failing. A small number of councils are developing this approach.

- Poor relationships and conflicting priorities between social services and central procurement (a council department that deals with council contracts and is not part of social services) are often a barrier to providing more flexible, person-centred care.

- A very wide variety of approaches to commissioning and procurement are being used, including different contract structures and different fee-setting and monitoring arrangements. This is inefficient and makes commissioning unnecessary complexity.

- There is a lot of innovation and there are some very good examples of care and support provided at a local level. However, there are concerns about the cost of some of these schemes and whether they can continue in the long term. There are also doubts about how some of these models could be scaled up or applied more generally.

7.3   What matters most to commissioners

- Making sure people can get the care and support they need: being able to meet demand.

- Keeping control of costs and keeping within budgets.

- Not falling outside of procurement rules.

- Service quality and reliability.

- Making sure care is supplied to avoid delayed discharges of care from hospitals.

- Avoiding people becoming dependent on funded care and support in the long term, where possible.

7.4   What is working

- Most care and support is allocated to ensure care is provided, most of the time.

- Many people are happy with the care and support that is commissioned.

- In general, there are good working relationships between frontline 'commissioners' and providers. Both are very committed to get it right for people.

- Many frail and vulnerable people are being supported to live at home.

7.5   What is not working

- There is not enough capacity in the system to meet demand, especially at peak times of the day.

- Several providers are handing back whole contracts and packages of care. This can happen without warning and is a source of anxiety for commissioners. When it happens, it is stressful for people receiving care and support and for their families.

- Internal relationships between central procurement and finance officers in some councils.

- Some providers are delivering poor-quality care.

- There is a lack of trust by some commissioners, especially in relation to some private companies.

- Commissioners are not able to place some care and support packages, especially more complex care, 'double-handed calls' and care in more remote rural communities.

7.6 Suggestions made by commissioners

- Commission care at a regional level through the new regional partnership boards.

- Remove or change the current fee cap on charges.

- Provide help and guidance with developing outcome-based approaches to commissioning.

7.7 The scale of domiciliary care being commissioned in Wales

7.7.1 Volume of commissioned care

From the responses to our survey, we estimate that local authorities commission over 13 million hours of domiciliary care each year. Based on what two of the seven health boards in Wales told us, health boards may commission another 20 per cent. This does not include:

- Domiciliary care purchased through direct payments; or
- Domiciliary care purchased privately as either whole packages or 'top-ups' to care arranged by commissioners or
- Domiciliary care provided by councils.

The following table gives some idea of how much care is commissioned in Wales.

Table 4 – Amount of care commissioned by councils and health boards

Number of agencies commissioned at any one time	

Average per commissioning body	21
Median[18]	17
Range	3–56
Number of hours commissioned in a typical seven-day week	
Average per commissioning body	9,742
Median	10,326
Range	4,832–29,691
Number of people receiving commissioned care in a typical seven-day week	
Average per commissioning body	909
Median	933
Range	325–4886
Number of new contracts issued in a typical seven-day week	
Average per commissioning body	16
Median	13
Range	3–52
Number of hours of care people receive in a typical seven-day week	
Average per commissioning body	12.7

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[18] The middle number in a list of numbers.

Median	13
Range	9.4–28

Table 5 – Domiciliary care provided directly by local authorities ('in-house') (17% of care provided by councils in Wales)

Number of hours provided from in-house Service in a typical seven-day week	
Average per council	2,034
Median	1,917
Range	0–8,000
Number of people receiving in-house support in a typical seven-day week	
Average per council	179
Median	188
Range	0–542

7.7.2 Urban and rural commissioning

Based on the ratios provided by each individual council, councils told us that, typically, 80 per cent of the domiciliary care they commission is provided in urban areas and 20 per cent is provided in rural areas.

Ceredigion County Council had the highest rate of rural commissioning (80 per cent). Bridgend County Borough Council, Carmarthenshire County Council and Gwynedd County Council all commission around 40 to 45 per cent in rural areas. Powys County Council (despite its large geographical area) and Monmouthshire County Council reported only around 15 per cent rural commissioning. This is probably because these counties have several large population centres.

Councils covering large compact cities and some old industrial centres reported little or no rural commissioning (The City of Cardiff Council, Newport City Council, Blaenau Gwent County Borough Council and Torfaen County Borough Council).

7.8 Emerging themes – what we found

We identified the following themes in relation to commissioning.

1. Responsibility and internal relationships.

2. Leadership, change and transition between contracting arrangements.

3. Approaches to commissioning and procurement.

4. Fees and fee-setting.

5. Payment systems.

6. Contractual requirements for care workers and subcontracting.

7. Arrangements for assessing, allocating and handing over care packages.

8. Arrangements for monitoring providers.

9. Challenges.

7.8.1 Responsibility and internal relationships

The variety of responses we received during this review prompted us to reflect on the following questions in relation to councils. (The same may apply to health boards.)

- What do we mean by 'commissioning'?

- Who are the commissioners?

- Where in an organisation does commissioning happen?

- Who is ultimately responsible?

We found that many providers tend to see brokerage, local social workers and contract monitoring officers as the 'commissioners'. These are the people they have dealings with on a day-to-day basis.

However, the arrangements for commissioning and procuring domiciliary care are very complex. They vary from council to council depending on the structure of its social services departments and central procurement department.

The first task in commissioning is to analyse and plan in order to understand:

- the needs of the local population;
- how people want their needs to be met; and
- how providers and the council can best meet that need.

This enables a commissioning strategy to be developed which sets out a broad approach to managing supply and demand into the future and the basis on which services will be purchased. This level of thinking normally happens in social services. A head of service or a 'strategic commissioner' leads the process.

The next step is to secure services. To do this, commissioners:

- develop detailed service specifications based on the commissioning strategy; and
- offer possible providers the opportunity to apply for consideration.

If they are suitable, providers can then tender for the work. If they are successful, they will be awarded a contract. Central procurement services are usually responsible for this part of the process.

Once a contract has been awarded, individual packages of care can be arranged based on that contract. This is normally done by a brokerage team, which is often part of a social services department but can be part of central procurement services.

The final step is to settle invoices and make payments for the work undertaken. The invoicing and payment systems may be managed by social services, a separate finance department or central procurement. Invoices need to be checked and paid, and contributions from people receiving care and support need to be invoiced and

collected. Given the amount of domiciliary care, its dynamic nature, and payment rules and contribution thresholds, this process can be very complex.

The main focus of central procurement and finance departments is to make sure the council:

- complies with procurement rules when it awards contracts;
- achieves value for money; and
- treats its suppliers fairly.

Central procurement is more dominant in some councils than in others. It may curtail or reshape the approach that social services have set out in a commissioning plan. This can be a source of conflict.

During our council inspections, people told us:

'Social services commissioners are bullied by central procurement; you need to be strong to stand up to them'

'There is a state of constant tension between central procurement and social services'

'How do you seek to reconcile the needs of people who need care and support with procurement directives?'

'Central procurement are driven by a mantra to achieve efficiencies and reduce costs. In social care we have driven the costs down so far that services are failing and the costs to the wider system and to people who need care and support are escalating. Central procurement don't see that. They are both short and narrow sighted'

In interviews, people said:

'As a senior officer in social services I would welcome the opportunity to clarify who is ultimately responsible for commissioning'

'Procurement staff will point to EU Regulations and often interpret these in a very black and white manner leading to formal onerous tendering processes. I

think it's fair to say that once these processes are complete it's then left to the social services departments to implement the new contracts and deal with any difficulties that emerge'

During our inspections and workshops across Wales, we found considerable variation in the relationship between corporate procurement, finance departments and social services between councils. We made the following observations:

- In some councils there are stronger relationships between social services and corporate procurement. This leads to a better understanding of purchasing care ('rather than furniture'), advice and guidance being provided, and more flexibility in developing and awarding contracts.

- In some councils, central procurement officers are aware that a new approach is needed because of the Social Services and Well-being (Wales) Act 2014.

- In one council, corporate procurement tried to assist social services commissioners, but roles and responsibilities were unclear There was no detailed planning or scrutiny.

- In several councils, procurement departments were working strictly to procurement rules. They were accounting for every penny for the council through financial transactions supported by 'time and task' models and electronic call monitoring.

- Procurement officers are not 'managed' by the Director of Social Services and often report to a council's section 151 monitoring officer (person legally responsible for council finances). This means there is a high level of financial focus. Some councils expect all unspent money to be recovered – this is a direct barrier to outcome-based commissioning approaches, such as "time banking".

- Some councils will not risk leaving the provider to manage the money for fear of not being accountable for council money. However, this approach is at odds with other services procured. For instance, grants are paid to organisations in the third sector, which then manage the money until they

provide their end-of-year reports setting out their spend. An example of this is block contracts for sitting services for people with dementia.

- Some councils have a centralised commissioning team that sits within corporate services and do not have any social services commissioning officers. This makes it more challenging for the Director of Social Services to change the culture and approach to commissioning.

The arrangements in North Wales are an example of the variance.

- All six councils in North Wales have brokerage within social services. However, their contract management functions differ – some are in corporate or central procurement and some are in social services.

- Invoicing and payment systems differ. Some are wholly in social services and some cover corporate finance and social services. Some brokers check off invoices and recommend that a contract manager authorise them. Other brokers are not involved and the task may fall to a financial assessment officer.

- Tender specifications are developed either separately in social services or as a joint project, generally led by social services with colleagues from procurement as expert members of the team.

- When functions are separated across 'commissioning and planning' and 'contract management', there is often a debate about who is responsible for preparing the specification. In North Wales this usually falls to commissioning and planning officers, with input from contract management staff or colleagues in procurement. The specification is then signed off by the budget holder.

- There are some positive arrangements. For example, in one council the corporate procurement manager has a background in social services and a full understanding of commissioning.

7.8.2 Leadership, change and transition

a) Leadership styles

We found that a variety of leadership styles are used in social services when developing strategies for commissioning domiciliary care. These are set out below.

Visionaries: 'Visionaries' feel inspired by the opportunities brought about by the Social Services and Well-being (Wales) Act 2014. Some have been energised by external consultants, such as Vanguard who have caused them to reflect on the fundamental values and objectives of the services they're trying to run. They tend to focus on the experience of people receiving care and support, and they are prepared to challenge all assumptions and think deeply about what is important and what has value. They are prepared to take risks and step outside the norm. They have to put up with some suspicion and criticism from others. They tend to think more broadly and at a community resilience level. Leaders in Monmouthshire and Carmarthenshire County Councils are examples of visionaries.

Strong shapers / interventionists: 'Strong shapers' or 'interventionists' are analytical. They are prepared to rethink and change how services are delivered, but they do so by moving between more conventional approaches to contracts. Their main goal is to create efficient, good-quality, cost-effective supply chains. They will make big decisions and take risks, and they are prepared to remodel contracts and introduce new forms of contracting, such as dynamic purchasing, outcome-based contracting, zoning, and outsourcing in-house resources. Leaders at The City of Cardiff Council, City and County of Swansea, Neath Port Talbot County Borough Council and Wrexham County Borough Council are examples of strong shapers.

Fixed or continuous observers: These people tend to accept the status quo. They may be anxious about taking risks and make only small changes to existing arrangements such as terms and conditions or introducing more efficient back-office arrangements.

None of the leadership styles described above is particularly right or wrong. They all have their merit, depending on local conditions, political expectations and pressures. However, the energy and management capacity needed to make big changes and

deal with the consequences and political fall-out is enormous and needs to be considered when taking forward large scale change. Making changes can have very significant and heartfelt consequences for people receiving care and support. A change in provider or a sudden loss of capacity in the market can put people receiving carer and support at considerable risk when visits fail to materialise.

b) **Change**

In discussions, senior officers made it clear that they are often constrained by the political views of elected members, especially in the use of fee settlements with private care providers. There is often significant inertia and there are difficult barriers within the system, such as:

- a lack of political and corporate will to support large-scale change;

- the overall culture within the council workforce; and

- resistance to change by providers.

The importance of supporting change at all levels was highlighted during our inspections:

> 'Social workers have had to endure many changes without the necessary training and support. More work was required for them to understand what outcomes are…' (Inspection)

c) **Transition**

In the past few years, we have been aware of the very significant impact that making changes can have on people. Examples include the City of Cardiff Council retendering in 2011 and introducing dynamic purchasing in 2014–15, Powys County Council retendering in 2014–15, and Neath Port Talbot County Borough Council outsourcing its domiciliary care services in 2011–12. Managing any major change and controlling risk is complex. It needs careful attention to detail to avoid unintended consequences.

The important lessons from the transitions we have observed are:

- provider agencies that are expected by councils to expand quickly to take on significantly higher numbers of hours often fail;

- do not take independent providers for granted – they will leave the market if they are not treated fairly; and

- do not take the workforce for granted and presume that care workers will move to new providers under the Transfer of Understandings (Protection of Employment) Regulations (TUPE). It doesn't happen in practice.

Providers are very concerned about risk, especially when commissioning models transfer risk from commissioners onto them. This appears to be common practice.

Providers are also very concerned about extra costs. What might seem a minor administrative change or cost per 'care package' to a commissioner can have significant cost implications for providers when applied to a high number of calls or people. Providers will pull out of contracts or stop trading if they feel the risks are too high to justify any potential rewards.

Most care workers do the work because they enjoy their work. They have relationships with the people they care for and, in good provider agencies, they value being part of a team or a wider "family". Care workers may think twice about continuing in domiciliary care when they have to face moving to new, often larger organisations; saying goodbye to people they have cared for over many years; or face reduced pay when employment protection expires.

However, with good planning – and, importantly, strong engagement with providers – it is possible to make significant changes:

> 'I thought the transfer to the new commissioning model of domiciliary care was going to be much more difficult, but despite some teething problems, we have emerged not as "battle scarred" as we anticipated' (Inspection)

7.8.3 Approaches to commissioning and procurement

a) Rates of commissioning

It is interesting to consider the rate of hours commissioned per head of population across council areas. We analysed information local authorities reported about the hours they commissioned (per week) against a representative (proxy) figure for the number of people likely to need help from a domiciliary care agency. The representative figure was based on the total number of people aged 65 or over per council who need help with at least one self-care task, the number of people with dementia and the number of adults with a moderate or severe learning disability[19]. Our results are shown in the diagram below.

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[19] Daffodil (2016) *Projecting the need for care services in Wales: Self care, Dementia, LD – Moderate or severe*. Welsh Government. Available at www.daffodilcymru.org.uk

Figure 61 – the rate of contracted domiciliary care a week for people over 65 who may need services

Area	Rate
Aneurin Bevan UHB	0.14
Cardiff & Vale UHB	0.16
Isle of Anglesey	0.57
Flintshire	0.58
Denbighshire	0.59
Gwynedd	0.61
Bridgend	0.61
Powys	0.66
Conwy	0.67
Wrexham	0.67
Rhondda Cynon Taf	0.69
Ceredigion	0.69
Carmarthenshire	0.75
Newport	0.77
Caerphilly	0.81
Swansea	0.83
Merthyr Tydfil	0.86
Neath Port Talbot	0.91
Torfaen	0.92
Monmouthshire	1.04
Pembrokeshire	1.22
Blaenau Gwent	1.35
Cardiff	1.44
Vale of Glamorgan	1.45

Legend: University health board / Local authority

Rate of contracted domicilliary care

The results are similar when using sample data for the share of hours of care provided in a sample week to people over 65 (StatsWales 2015). However, rates vary considerably. The highest rate (by The City of Cardiff Council) is almost four times that of the lowest provision (by Merthyr Tydfil County Borough Council).

Figure 62 – Proportion of client hours provided in a sample week in 2015 to people over 65, by local authority (Stats Wales)
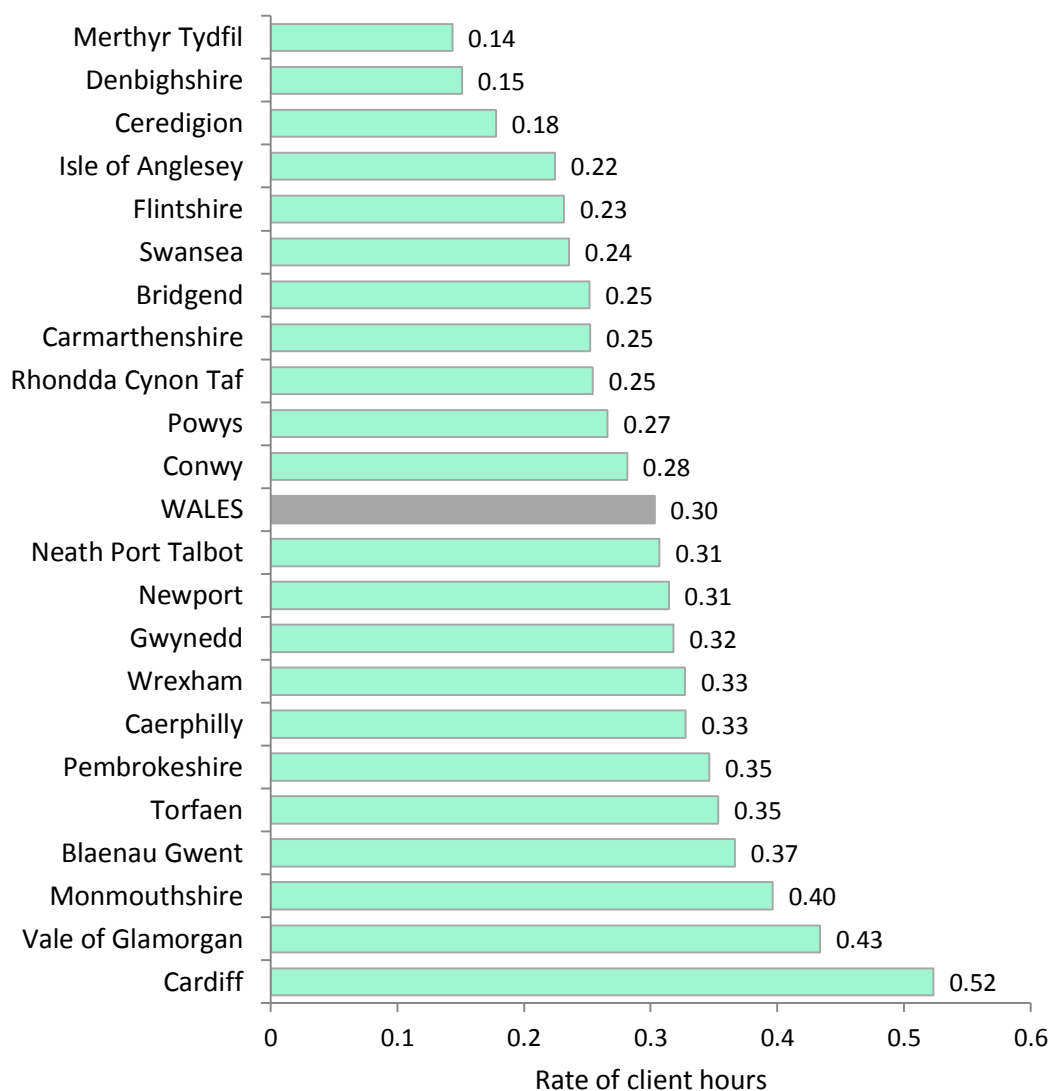
We need to do more to understand the variation across councils. However, the differences may be related to:

- the proportion of people in each council area who pay for their own care;
- the overall balance between care provided to people in the community and care provided in residential care homes;
- the size of the care packages being purchased; or
- the thresholds being applied.

However, when developing any commissioning strategy it is essential to undertake a rational analysis, including comparative data, to forecast rates of potential procurement.

b) **Procurement models**

We asked commissioners how they approach commissioning and procurement. At the time of the review, many councils were reviewing their existing arrangements and trying new models or planning to change them in the future.

Procuring domiciliary care is complex. Several different models are used across Wales, and different councils apply terms like 'block' and 'spot' quite differently. Added to this, commissioners may take different approaches for different types of need; for example, using one approach for supported living and another for traditional domiciliary care. Some even use different approaches in tandem to 'top up' individual people's care packages or to provide care over and above a block contract.

Most councils use 'call off' framework agreements, where they accredit a provider as part of a scheme and offer work on set terms as it arises. Six councils have created patches (or 'zones') as part of a framework agreement in order create potential efficiencies and save money by reducing travel times. Some work with only one or two providers within each zone. In theory, this makes things more efficient for the provider. However, it also increases risk if the provider fails as a business or withdraws from the work. This has been a serious problem in Wales and in other parts of the UK. Carmarthenshire County Council has mitigated this risk by adding more providers to framework agreements as a contingency.

Some councils use variations of block contracts where a provider has to offer a set number of hours each week but the council does not guarantee or pay for the total number of hours. The provider has to pay a penalty if they cannot provide all the block hours. This approach aims to give the council some guarantee of supply. However, although it is useful in more 'steady state' services where the number of hours needed doesn't change very much, like supported housing, it is losing favour in traditional domiciliary care.

Several councils use spot contracts, where they put individual packages out to tender, often on a website. A more sophisticated computer-based approach called 'dynamic purchasing' has been developed, which allows providers to compete for contracts for individual service users. One interesting feature of dynamic purchasing is that it cuts out the day-to-day involvement of central procurement in tendering exercises. The City of Cardiff Council uses this system and we looked at it in detail as part of our inspection. On balance, it seems to have worked well in placing the majority of care packages, makes the system more transparent, and provides a way of assessing and recognising quality. It also helps providers to optimise their costs, for example by concentrating on particular areas or types of care, allowing them to use resources more efficiently. However, it has not increased capacity and the hourly cost of care has risen. The approach has merits, but needs active market development (for example encouraging new providers to cover specific areas) and refinement to control pricing. An information and communications technology supplier told us that in other parts of the UK, providers have operated as 'cartels' to play the system to drive up prices.

Torfaen County Borough Council has a different version of dynamic purchasing, which it aims to use for all care contracts in the long term. Neath Port Talbot County Borough Council plans to use dynamic purchasing in the future.

When deciding the best approach, commissioners have been mainly concerned about value for money (cost and quality) and guaranteeing supply. Those contracting traditional domiciliary care have focused on 'time and tasks' prescribed on an individual basis. This has been very much ingrained in the mindset of commissioners and providers alike, and it is the most common approach in Wales. However, commissioners and providers recognise the limitations of this approach. The main limitation is its lack of flexibility to respond to people's wishes and needs as they arise on the day. Having said this, although people have criticised the approach and it is not person-centred, it has endured. This may be because it forms the basis of a 'contract for work' that commissioners and providers understand and can trade in: in theory, they can measure the work and pay for it. It is an approach that meets the needs of finance officers.

Some councils in Wales are now moving towards an outcomes-based approach. Councils give providers a number of hours over a week or month that they can use as needed to achieve outcomes or goals for the person receiving care and support. Unused hours can be 'banked'. This approach has been pioneered elsewhere (notably in Wiltshire) and, although it is attractive, it does have problems. Two councils in Wales are trying this model, most notably Carmarthenshire County Council where we undertook an inspection. We went back to Carmarthenshire County Council to look at the progress it had made and carried out a detailed review of the supporting documents and contract arrangements to understand how it was working.

Carmarthenshire County Council had given considerable thought to the scheme and to building relationships with providers, and has carefully developed the documents that support the model. The council introduced the scheme in July 2015 and they are still developing it. It is too early to assess the longer-term costs and benefits of this approach, but the initial findings are positive and on inspection we heard examples of people receiving a more flexible service and becoming more independent. The documentation and "rules" are proving complex and the challenge ahead is to develop an approach which is simple and flexible to administer yet provides assurance and financial accountability for both commissioners and providers alike.

7.9   What we learned from our council inspections

We selected six councils to inspect.

Table 6 – Procurement models

Council	Activity
City and County of Swansea	Was undertaking a 'whole systems change'. Keeping a traditional 'call off' contract but tendering providers to work alongside its integrated hubs where health and social care services work together.
Carmarthenshire	Was introducing outcome-based commissioning for

County Council	geographic zones.
The City of Cardiff Council	Had introduced and was refining dynamic purchasing.
Monmouthshire County Council	Has a programme called 'turning the world upside down' which involves introducing strengths-based assessments and care and support services in local communities.
Wrexham County Borough Council	Had signalled its intention to move to outcomes-based commissioning (yet to begin) and had retendered into zones.
Denbighshire County Council	Was in the process of reviewing its approach in the face of capacity and sustainability issues.

During our council inspections we tried to use gradings to evaluate user experience and the approach to care planning and commissioning and to look for any links between the two. This proved impossible because most of the councils we visited were in the process of changing their approach. We have published reports on our website for each of the inspections.

We learned the following things from the inspections.

- The main factors that affect the experience of the person who needs care are how provider agencies are run and whether they can provide continuity of care. Commissioners can create better or worse conditions to support providers in achieving this.

- When fee levels are too low, providers cannot recruit or keep care workers. Some of the councils paid particularly low rates, which led to providers becoming disenchanted, services potentially becoming unsustainable and commissioners becoming concerned about the lack of capacity.

- Although tendering is said to be based on quality and price, in practice it seems to focus on price: 'Quality has taken a back seat with regard to commissioning of domiciliary care' (Inspection). The process some councils use to award contracts seems to be flawed. As mentioned earlier, providers told us they believed that some of the contracts awarded are not viable and have been handed back already or may be handed back in the near future. Contracts should be awarded based on sustainability, not short-term cost savings.

- Geographical zones have advantages (such as less travel, easier networking, more consistency and lower costs). They also have drawbacks, including the risk of depending on one or two providers operating in an area. Imposing such a model can seriously limit a provider's ability to grow, which makes services less sustainable.

- The short calls that some councils use lead to poor, rushed task-based care and more time spent travelling.

- Giving providers accurate assessments of what care is needed and good-quality care plans is important if they are to plan and arrange a service. Training for social workers is important in this. We found evidence of some good multidisciplinary practice at a local level.

- Local networks for people using care and support and domiciliary care providers are important. Linking care workers to professional and community networks (like the locality hubs in Swansea) adds value to the service.

- It is possible to develop mature, open and strong relationships with providers by involving them in shaping plans and services.

7.9.1 Commissioning 15-minute calls

From our commissioner survey we found the following.

- Three councils did not answer the question about 15-minute calls. Of the 18 councils that did, 11 said they use 15-minute calls.

- The data from these 11 councils is hard to analyse, as some gave ranges or numbers of people (the survey asked for a percentage based on a sample week). The figures suggest that for councils that do commission 15-minute calls, the average (as a percentage of the total number of calls in a sample week) is approximately 15%. One council said that between 40% and 70% of the calls it commissioned were 15-minute calls.

Figure 63 – Percentage of 15-minute calls commissioned
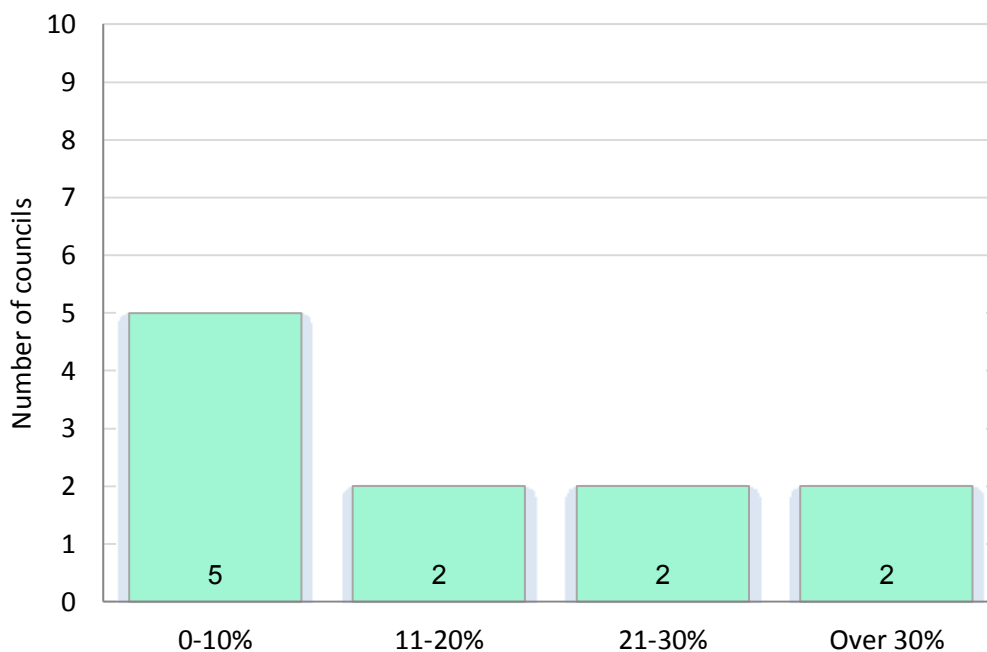
- Of the seven councils that did not routinely use 15-minute calls, four did not commission any 15-minute calls and three commissioned almost none (less than 1%). Two councils had recently stopped using 15-minute calls.

- Neither of the two health boards that responded used 15 minute calls.

It is difficult to reconcile the fact that on principle some councils will not use 15-minute calls (or have recently stopped using them) but others are using them routinely. Despite councils stating they only use 15-minute calls as 'monitoring visits' or 'medication prompts', our survey and inspections provided strong evidence that many 15-minute calls are being used for personal care (dressing, washing, preparing meals and support with eating and drinking).

'Care arrangements outlined three visits a day, seven days a week for 15 minutes each call – the first call of the day was to "prompt medication, encourage to have a substantial wash, assistance with hot water in bowl, towel dry, assist to dress, prepare breakfast and hot drink and empty commode"' (Inspection)

'Lunch time carer called whilst on visit to prepare meal – this is a 15-minute call that appeared too short' (Inspection)

7.9.2 Fees and fee-setting

'The pressure on prices does not appear to drive providers out of the market but rather to affect employment conditions for care workers' (The King's Fund cited by UKHCA 2007)[20].

'They want to change the world but don't want to pay for it' (Provider during council inspection).

a) Fees paid

The *Homecare Deficit* report, written by the United Kingdom Home Care Association (UKHCA)[21] and published in March 2015, gives a helpful, detailed analysis of the average fees paid by Welsh councils, weighted by volume of hours purchased. This data was based on a series of Freedom of Information requests to councils. Although there are disclaimers, it seems a credible starting place. The study indicated the average weighted price for Wales in 2014–15 was around £14.39 an hour. At the time of the UKHCA survey, only two councils were paying above the UKHCA minimum price for homecare, which was £15.74 at the time.

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[20] The King's Fund (2005) *Understanding public services and care markets (working paper)*, cited by United Kingdom Home Care Association (2007) *A fair price for care*. Sutton: United Kingdom Home Care Association.

[21] United Kingdom Home Care Association (2015b) *The homecare deficit: a report on the funding of older people's homecare across the United Kingdom*. London: United Kingdom Home Care Association.

Average price paid for older people's home care during a sample week in September 2014 (UKHCA 2015, page 41)
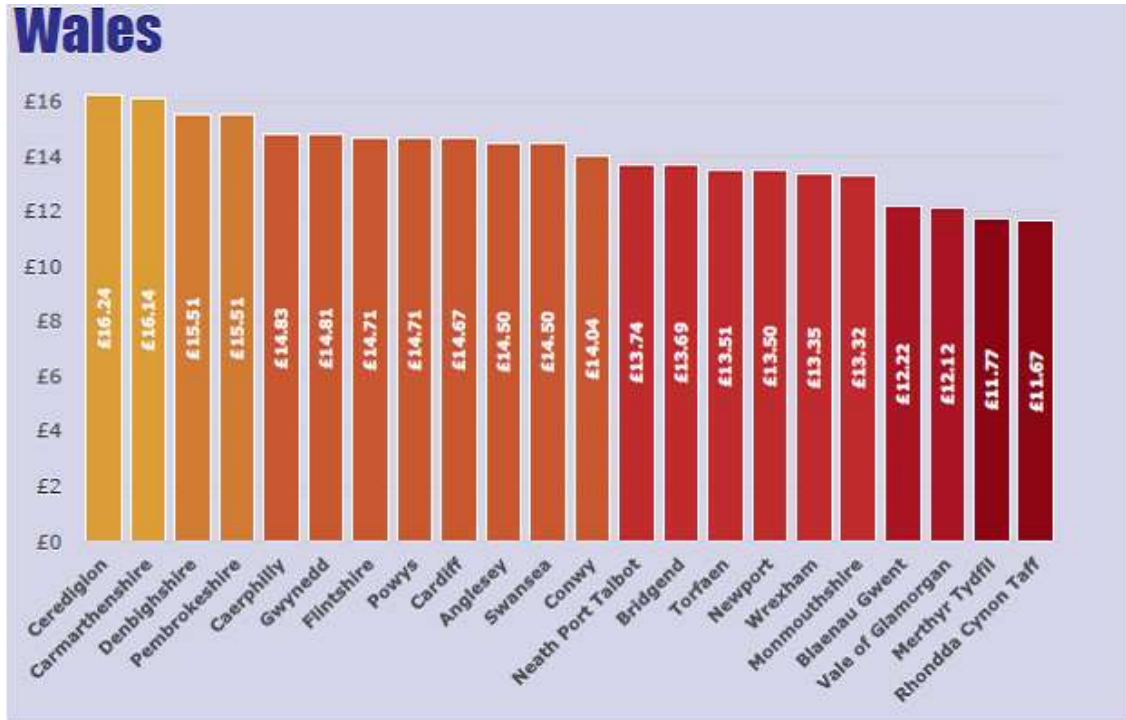
The variability between council rates is immediately apparent. Two councils pay average fees of less than £12 an hour, and two were paying more than £16 an hour. Likewise, the lowest prices paid ranged from £9.16 an hour to £15 an hour.

However, Wales compared favourably with other government regions of the UK and was ranked third out of 12.

Average prices paid for older people's homecare during a sample week in September 2014 (UKHCA 2015, page 17)
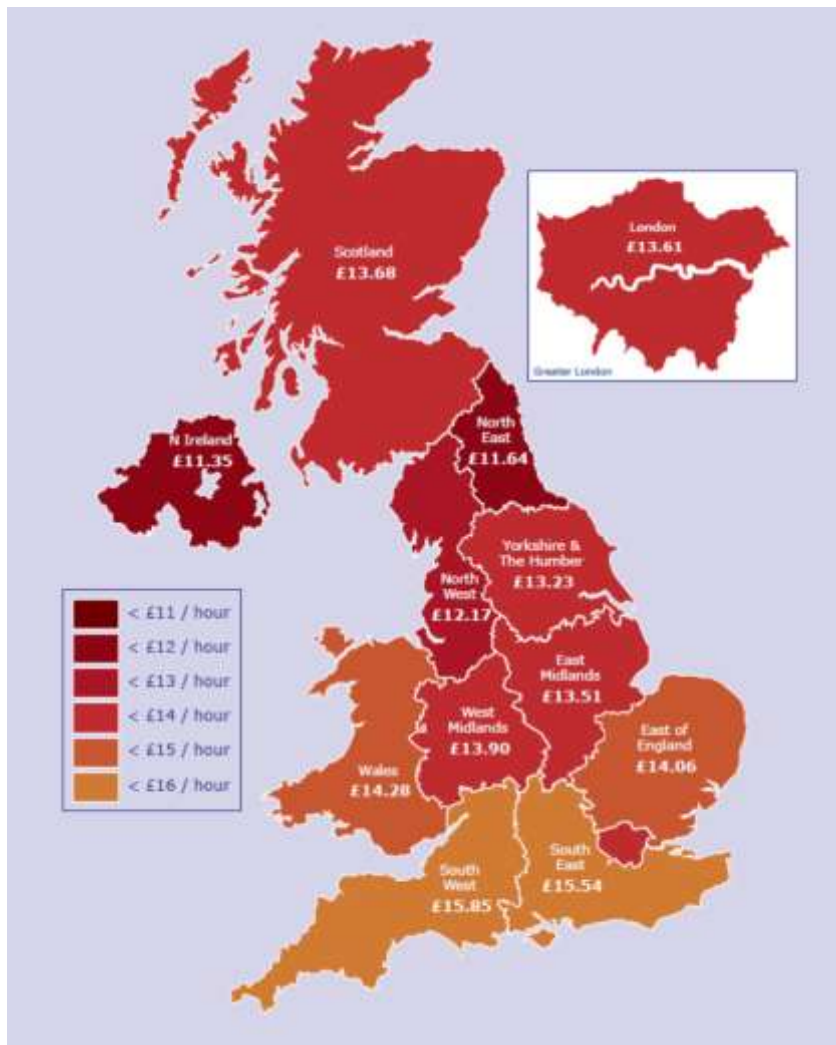
In this review we focused on the lowest rates paid in Wales, but we did collect data on the highest rates. Analysing the highest fees is more problematic, because the highest fees are likely to be paid for a small minority of very complex care packages and do not reflect the overall situation. From the surveys of the 22 councils in 2015, we found that seven paid minimum rates of less than £12 an hour and six paid more than £14 an hour.

Table 7 – Minimum hourly rates

Minimum hourly rates	
Average	£12.77

Median	£12.00
Range	£9.82–£15.00

Table 8 – Maximum hourly rates

Maximum hourly rates	
Average	£16.79
Median	£17.20
Range	£13.15–£25.80

b) **Approaches to setting rates**

We asked councils to summarise their approach to setting rates. It became clear that practice varied widely.

There were eight approaches, which could be blended or applied in various ways depending on the type of contract (such as for traditional domiciliary care or supported living). These were as follows.

1) Open-book analysis.

2) 'Fair price for care cost' models.

3) Historical pricing: used as benchmark with a yearly increase to reflect any rise in costs.

4) Open tendering / competition – with the lowest bid tending to win.

5) What was affordable: dividing the council budget by the number of hours expected to provide an indicative rate.

6) Dynamic purchasing with no set price, where providers bid for each care package.

7) Dynamic purchasing with floors and ceilings on minimum and maximum prices (being introduced).

8) Individual price setting: often used for complex care packages that are difficult to place outside the main system.

It was very clear that councils were following very different approaches and philosophies to setting prices for traditional domiciliary care.

Below, we have set out councils' descriptions of their approaches to fee-setting. We have taken these comments from our commissioner survey.

Table 9 – approaches used to setting rates

Different council approaches to fee-setting
'Does not set rates, the market provider sets their price. Lowest hourly rate accepted was £9.82 in line with people who have direct payments and personal assistants. Setting a minimum rate allows smaller cooperatives to compete in the domiciliary care market.'
'Encourages providers to review rates in line with workforce capacity ie National Minimum Wage, travel costs, pensions etc.'
'Rates reviewed annually and provider pressures considered when agreeing respective rates the following year.'
'Rates set on an individual basis where providers unable to agree a rate or fail to limit suggested increases.'
'New pricing model introduced allowing provider to factor in costs of visit (travel) and cost of care being delivered.'
'Considers emerging pressures on providers ie living wage, pensions and need to factor in sustainable profit margin.'
'Rates agreed different ways via framework tender process in the north of

council and a spot contract process in the south, rates negotiated with providers based on cost effectiveness and financial sustainability.'

'Council sets a minimum and maximum rate, with emphasis on quality not price (80/20 weighting).'

'Annual review of fees sets price. Standard hourly rate of £14.50 at present across the board.'

'Negotiates with individual providers and looks to pay what the market suggests.'

'Providers set their own rates by submitting a single hourly rate for care at point of application. This rate is applied irrespective of complexity of package of care, time of call(s), duration of call, day of year and is to include travel time etc.'

'Historically the setting of rates (maximum) has been based on the average of the unit cost charged by the provider (at the time).'

'Operates an open-book approach to fee-setting so that each provider has a fixed fee inclusive of mileage/travel that reflects the actual costs. Accounts information, ledger extracts and a cost calculator template are required as part of the evidence gathering and usually council will meet with providers to discuss and agree a rate.'

'Rates for domiciliary care are set following a full and open procurement and tender process. The procurement process means that the rates are set in open competition by the providers themselves.'

'Has an indicative fee structure and providers respond to this by setting their own fees which are usually less.'

'Rates are set via the tender process and determined by the provider.'

Has been working with three of its larger providers to understand their views on the real cost of care, taking into account changes to the national

minimum wage and other national directives. 'There is a real challenge for us to balance the financial resources we have available, the need to deliver further financial efficiencies and the need to pay a realistic cost for care'.

'Extending the domiciliary care framework agreement for a period of two years from April 2014, the council agreed a new rate for that full period subject to any…factors which might impact upon costs.'

'Discuss the current rates on an annual basis and what our budget can allow for the following year. However in September 2016 this will change as the council are implementing a dynamic purchasing system to broker the care where the service providers will submit their rates for individual care packages.'

'Tender invited prices from the providers against a service specification. Evaluation of prices includes both quality and price and providers ranked accordingly on framework.'

On top of this range of approaches, councils often tender in separate geographical areas and for separate types of service. This is happening more and more often.

Several commissioners said they may start to use regional cost models in the future. Based on what councils told us, interest in dynamic purchasing models seems to be growing.

Furthermore, councils do not always apply these 'hourly rates' pro rata. Some councils pay different rates for different lengths of call: 15, 30, 45 or 60 minutes.

Both health boards we surveyed said they use council rates as the benchmark. They agree any extra fees for more complex needs on an individual basis to reflect higher skills needed.

This huge range of approaches means wide variation in not only prices but also in the rules being applied. Some councils set a fixed, published rate. Everyone knows the rate and providers can choose to enter the market and model their businesses

with that knowledge to hand. This is inherently fair. In another council area, each provider is given a different rate based on their costs and overheads. This means that providers can be doing the same work but are paid different rates because their costs differ. Rates may also vary based on what is perceived as a provider's quality score. Some councils pay providers more for more complex packages of care, and others do not.

Added to the varied pricing structures, there are very complex arrangements and contract rules for 'block', 'call off' and 'spot purchases', including penalty clauses. There are also very different arrangements for invoicing and payment. This is daunting for any provider. It puts businesses at risk when they are trying to forecast incomes or write a business plan for a bank to secure funding. Given the high numbers of calls and the low profit margins, it is not surprising that some businesses have failed financially. Neither is it surprising that providers are withdrawing from contracts or becoming more cautious about growing their businesses, especially as they are also uncertain about staff costs and the impact of new regulation.

> 'The fee position is not workable as the continued expectation that we will bid lower than the indicative fee levels to get the work is only resulting in us not being able to recruit, and a number of providers pulling out altogether' (Provider during council inspection)

We heard of one council which, having set its prices after a major retendering exercise, faced the possibility of several providers leaving the market. The council had to increase its fees. This example calls into question how effective tendering arrangements are.

We also heard of numerous instances where care managers or brokers had to place contracts outside the formal tendering arrangements.

c) **Annual fee uplifts**

We have not collected information about fee increases for 2016–17. This will be an important year because paying the national living wage will increase costs. Providers have reported that many councils have increased fees by around 2 per cent to 3 per cent, and one council increased theirs by 6 per cent (but from a very low starting

rate). However, some providers told us that councils have not increased fees at all. Providers told us in workshops that before now there had not been a fee increase for several years. Four years was mentioned often, and one provider mentioned six years.

In one of the dynamic purchasing models, the fees negotiated were originally set for four years with no prospect of any increase. This has now changed to reflect the unprecedented cost pressures on providers.

7.9.3 Payment systems

We asked councils to summarise their approach to payment / reconciliation systems and what information they need from providers to settle accounts. From discussions with providers, we know this can be complex and that late payments and disputes over invoices can lead to very serious cash-flow problems. The responses from councils made clear how complex this can be, as the information they ask for varies widely. Our main findings are as follows.

- Over half of commissioners need weekly invoices, but several work on a monthly basis.

- Some commissioners ask for very detailed evidence of the actual hours of care provided so they can match this up with the care plan. Some need information on every individual call, for each client. Others ask only for variances (i.e. additional work not specified in the contract), and one council samples 10% of call logs.

- Some councils link payments to evidence provided through electronic call-monitoring systems. If a care worker tries to make a visit and cannot get in, the agency might not be able to claim that cost.

- Most councils pay within 28 days. One pays within 10 days, but some withhold payment if there is dispute over calls (not uncommon).

- Some councils make payments through a third party (such as a company operating dynamic purchasing software).

- Councils use the information sent by providers to invoice people who receive care. They also have to consider if the weekly cost is above or below the £60 cap for fees to work out what to charge the service user.

- There was no evidence of any payments being made against outcomes delivered. They were all based on time.

Some commissioners mentioned that the system needs to be simplified.

Table 10 – payment systems

Different commissioner approaches to payments
'At the end of a care week (Monday to Sunday) the weekly service receipts are submitted by the providers. They confirm the number of units of service delivered and the system automatically calculates the bill based on the unit cost defined in the service agreement. The provider then confirms they have delivered the service as per the service receipt, and submits to the council. The council reviews the service receipt and either approves or rejects it. Each Wednesday, Matrix Finance run the invoicing process generating an invoice to the council for the value of all services delivered as per approved service receipts. Council then pays a consolidated payment to Matrix and Matrix in turn, pays the providers in line with the 21 day payment terms in the contract.'
'The authorisation to pay a provider is in the form of a service placement that is entered onto our management information system. The provider submits invoices that include client's name, date of care and cost of care, the individual's contract register and the overall spreadsheet is checked to ensure that the invoice submitted is correct.'
'Providers are required to complete a return on a weekly basis informing of the amount of hours each service user has received. Providers are required to submit an invoice. The hours recorded on the invoice are cross-referenced to check that it is no more than the assessed need (contracted hours) that is recorded within the client service record on the social services database. Invoices are, in the main, submitted weekly in line with the weekly return. If

the invoiced hours are more than the assessed need then queries with relevant staff and provider are undertaken to resolve any issues. Payments, once approved on the system, are released in the next payment run. Payment runs are twice weekly.'

'Providers are paid based on their planned call durations and clients are re-charged based on their actual call durations (up to the £60 per week, Fair Charge cap).'

'Payments are made based on actual hours delivered, four-weekly in arrears, and processes have been aligned across all providers. To receive payment providers must complete an electronic invoicing template which also feeds in to the service user invoice system. Ten per cent of all timesheets are audited against the invoice return and also a further check of the activity by one carer per agency is undertaken.'

'Council accepts weekly invoices from providers which are accompanied by a spreadsheet confirmation of actual hours delivered in that week. Reconciliation is made against a provider database that compares commissioned or planned hours and actual delivered. Systems are not automated at this time but requires staff time to reconcile and enter data. Invoices are paid on a weekly rolling basis.'

'Providers invoice with a breakdown of hours provided per week per individual. This is reconciled against the contract. Payments are made weekly. This data also informs the service user bills.'

'Information required from providers in order to settle invoices: print out from electronic call-monitoring system showing duration of call, actual duration of call and staff name attending call. Cross-referenced to staff timesheets.'

7.9.4 Contractual requirements

a) Employment conditions

Of the 22 councils we surveyed:

- 14 do not include employment conditions in their contract requirements;
- three are considering including employment conditions; and
- five do include employment conditions, but the extent of these varies.

Neither of the two health boards include employment conditions in their contract requirements.

In Pembrokeshire, the council asks providers to include in their hourly rate all costs for staffing, travel, bank holiday and weekend premiums, and management and ancillary costs. Providers are required to train staff in working hours and cover the cost of the training. The council does not specify the type of employment contracts that provider agencies should use (that is, contracted hours).

Carmarthenshire County Council has included several employment conditions in its tendering process. Providers must offer all staff a contract of at least 12 hours a week and must include travel time for care workers in the visit costs.

Providers working with Wrexham County Borough Council must meet at least stage 2 of UNISON's *Ethical care charter*[22]. A nearby council is considering doing the same.

Commissioners have different opinions on whether or not to allow providers to use zero-hours contracts. As one council noted, there is always a demand for domiciliary care services so providers don't have any difficulty in offering work to their employees, even though they do not guarantee hours. 'Some staff have reported that they prefer the flexibility of a zero-hours contract, however it is recognised that zero-hours contracts do not offer any stability to staff' (Survey).

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[22] UNISON (2013b) *Ethical care charter*. London: UNISON.

b) **Allowing subcontracting between providers**

In our survey, seven councils and one health board said they allow subcontracting between providers. The other health board and 15 councils said they do not. The problem with subcontracting is that responsibility for both quality and fulfilling the contract becomes very unclear from regulatory and contractual points of view. It also adds costs in the chain and can be unprofitable for providers.

In some cases, subcontracting is allowed only in specific circumstances; for example, when contracts are being transferred or to cover unexpected sickness. There are usually conditions, such as the provider must tell the commissioner beforehand or must subcontract work only to other accredited providers.

Those in favour of subcontracting argued that it was better than missing calls. They also said that providers could use subcontracting to manage peaks in demand and capacity issues while recruiting or inducting new care workers. One council's contract stated that the subcontracting agency still has full responsibility for the work done by any subcontracted agency. However, this may not be realistic in practice.

Some councils were very clear that they felt subcontracting care was not acceptable. In the survey, one council noted:

> 'Subcontracting can be very problematic in terms of the service users' needs/ wishes and their consent. Management issues, such as employees who may be on different payment grades fulfilling the same duties, staff being poached, responsibilities for adherence to care plans, reporting procedures, information sharing protocols, ensuring relevant training …'

Another said:

> 'We do not permit subcontracting ... we feel this dilutes the relationship between provider/commissioner'

Another respondent said that providers should employ their own care workers to meet the demand for care packages:

'A neighbouring authority used the subcontracting of 40 per cent of individual service providers' contracts which proved to be highly problematic, leading to the destabilising of their domiciliary care market.'

One person told us that, in their experience, providers did not want to subcontract work and did not have the skills needed to do this successfully.

One of the health boards identified that a small number of complex care packages were provided by specialist domiciliary care providers through a direct contract. Arrangements for 24-hour contingency care may mean an agency has to use qualified nursing care support through another agency if there is a crisis.

7.9.5 Arrangements for assessing needs, allocating and handing over care contracts

We asked councils and health boards to tell us briefly about their approach to assessing individual needs and placing individual contracts of care.

From their responses, we found the following.

- A small number of councils actively promote direct payments as an alternative to commissioned care.

- Many councils provide six weeks of reablement before considering ongoing domiciliary care. This is to encourage people to rely on themselves or 'right size' the care package;

- Sometimes social workers pass care plans straight to brokerage, but usually they need to get a manager's approval. In some councils they need to go to a 'resource panel' to agree that the care is eligible for funding. We did not explore how many packages are approved, reduced or rejected.

- Most councils said they use 'fair access to care' criteria and apply the 'substantial / critical' threshold[23].

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[23] Welsh Government (2002) *Creating a unified and fair system for assessing and managing care: taking forward improving health in Wales and building for the future.* Wales: Welsh Government.

- A few councils mentioned 'integrated assessments' (involving both health and social care).

- A few councils involve potential providers in the assessment process.

- Some councils talked about assessing 'outcomes', one said they were moving towards conversations about 'what matters', and another said they were taking a strengths-based approach (this is based on what the person could do, not what they can't do).

Table 11 – Approaches from different councils to assessing, allocating and handing over care

Examples of different council approaches to assessment, allocation and handover
'Council uses a five-factor framework assessment approach focused on personal well-being outcomes, barriers to achieving outcomes, personal circumstances, strengths and capabilities, risk to meeting well-being outcomes. More complex assessments included integrated specialist assessments. Applying a holistic approach to well-being. Through the community resource team clients undergo a six-week re-enablement period to maximise independence and deliver on well-being outcomes, most no longer need any managed care.'
'Integrated assessment process and contract care based on good working relationship with the providers and matching to individual needs.'
'Assessment based on eligibility criteria, outcomes identified in care and support plan, flexible care provided based on overall total hours a week and total visits each day of the week. Provider works in partnership with care user to deliver responsive service.'
'Integrated assessment framework, applying criteria of critical and substantial risk, support offered via direct payments option or commissioned via dynamic purchasing brokerage system.'

> 'Each individual receiving a service will meet eligibility criteria, all recommendations for care are approved by weekly resource panels.'

> 'All people newly referred for help with personal care are assessed using the Targeted Intervention Service's holistic assessment tool, which considers an individual's function, environment and surrounding support.'

> 'The care manager undertakes an assessment to determine the level of support required and completes a care and support plan. This is then discussed in the domiciliary care panel to seek authorisation to proceed to commission the service. Once authorised, the care manager completes a commissioning record which is e-mailed to the approved framework provider to commission the service, if they are able to respond to the package, this is then e-mailed back to the care manager as an official record that the package has been commissioned, the level of support required and cost, who the provider is and start date.'

> 'Social workers will carry out an assessment of a person's needs using a strengths-based approach and following this if they need at-home support they then determine whether they look to secure a contract via the brokerage system or whether a particular provider would be best suited to meet a person's needs.'

> 'Care managers carry out a needs assessment and record the details of the required care on a care and support plan, the intake team provide up to the first six weeks of care in order to right-size the package through enablement for the longer-term care package commissioned through a brokerage system.'

The health boards appeared to fund domiciliary care through Continuing Healthcare[24] based on full, joined-up assessments.

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[24] This is care funded wholly by the NHS where needs are most complex and the person may otherwise be cared for in hospital.

In the survey we asked about whether care plans accurately reflect the needs and wishes of people receiving care and support. In response, 23 of the 24 council and health board commissioners said this was 'mostly true' and one council said 'always'.

Concerns about handing over care packages from reablement to domiciliary care services were expressed several times during this review and during one of the council inspections:

> 'Expectations set up by the reablement service led to a disappointment for users when transferred to the independent sector. The quality of the reablement service delivery plans are inconsistent which could lead to further confusion on transfer of care packages' (Inspection)

As part of the review we spoke to care managers and social workers, who told us about the challenges they face when doing assessments. They feel under pressure because they are caught between the needs of frail, vulnerable people and a system that demands that they "jump through hoops and frame needs" to demonstrate that people are eligible for care. One person described the experience as constantly feeling "squeezed".

7.9.6 Monitoring arrangements

a) Monitoring contracts

We found that arrangements for monitoring contracts vary widely among councils. Many commissioners who responded to the survey referred to having 'robust processes' and some have invested much more time and staff hours than others. Every commissioner does something quite different.

Some councils do "contract compliance" visits twice a year, some visit once a year, some visit every two years and some use a risk-based approach and make visits if they receive concerns or data suggests the service may be experiencing problems. Four councils do not make contract compliance visits. As one provider told us, "our council has not visited for at least six years".

Commissioners sometimes tell providers they will be visiting and sometimes don't. One council said the depth and frequency of visits were proportional to the size of the agency.

From what we learned from providers and by looking at some contract monitoring reports, visits seem to focus on regulatory issues and compliance. They include examining policies, procedures and staff and service-user records. The visits do not focus on outcomes for people using services. Providers said that some people doing contract monitoring visits had a no idea about running a domiciliary care agency and often had a background in administration not social care. Providers described commissioners using a rigid approach to monitoring: 'box ticking'. We saw one contract monitoring report that required that 'all possible risks should be identified and controls put in place'.

Some commissioners told us they use monitoring data from providers (on carer continuity, missed calls and late calls). However, some of these councils were not able to tell us the rates of missed or late calls, which is concerning. Information on missed and late calls tended to be based on reports from providers. Self-reporting relies on good monitoring systems, which some providers clearly do not have. Several councils said they use data from electronic call-monitoring systems. Some councils have to rely on information that providers have collated from paper diaries kept in people's own homes. In an inspection we carried out before this review, we found that the data the provider passed to the council was completely different from the performance we saw on inspection. This was not deliberate; it was down to the agency's poor record keeping and a lack of ability and capacity for collation and analysis.

Some councils undertake surveys of people using domiciliary care, some visit service users, some gather feedback from care reviews and some do spot checks at times of scheduled visits to assess the quality of care being provided. One council told us that they shadow care workers during shifts.

Some councils use information to give providers a score on quality, which attracts a premium rate. One council said they use a provider 'self-assurance questionnaire' as part of their scoring method for the online bidding system.

A few councils have monthly or meetings every two months with individual providers to discuss performance. Providers made positive comments about these meetings.

Two councils said they liaise with CSSIW, but none referred to analysing providers' own quality-assurance systems. There were no examples of using feedback from reviews of service users' care and support needs.

It was clear that most councils have good intentions. However, they have all set off in very different directions, sometimes without any clear thought about the purpose or value of what they are seeking to achieve by monitoring contracts. This means providers have to give very different evidence to different councils. This creates unnecessary additional burden for providers. They told us it is a real problem, adds to their costs and was a disincentive to working across council boundaries.

b) **Working definitions of late and missed calls**

We were keen to find out what definitions commissioners use for late and missed calls when monitoring contracts. From the survey responses, we found the following.

- Some commissioners said that definitions should be based on what the person receiving care considers to be a late or missed call and whether the time of the call is very important; for example, because of a medical condition.

- One commissioner said that whether the lateness is communicated is relevant to the definition; for example, if a care worker is stuck in traffic and rings the service user to say they are going to be late.

- Definitions have less meaning when time bands are being used, although the trigger for a call being 'late' could be at the end of the time band.

- Monitoring call times is not appropriate in outcome-based care and sends the wrong message about what is an appropriate measure of care quality.

The 17 councils and one health board that defined 'late calls' used the following definitions.

Table 12 – late calls

Late call: Number of minutes after start time	Number of councils using this definition
10 minutes	2
15 minutes	3*
30 minutes	11 (including health board)
90 minutes	1**

*One council had two definitions of late calls: 15 minutes for time critical calls where punctuality is very important and 60 minutes for non-critical.

**One council used a single definition of 90 minutes to cover missed and late calls.

The 17 councils that defined 'missed calls' used the following definitions.

Table 13 – missed calls

Missed call: Number of minutes after start time	Number of councils using this definition
60 minutes	6*
90 minutes	2
120 minutes	2
No one turning up	7**

* Two councils that defined missed calls as 60 minutes after the start time also specified 30 minutes for time critical calls.

** One council defined this as 'no one turning up within the time band'.

We asked councils to give us the numbers of late and missed calls recorded between April 2014 and March 2015. Only five councils were able to provide this information.

Table 14 – late and missed calls

Late and missed calls (Based on five council responses)	Late	Missed
Average	45.0	61.5
Median	53	34
Range	6–184	4–352
Did not say	14	14

We were very surprised that only five councils could give information about this, especially as several councils said that they used the trends in late and missed calls as part of their quality monitoring and risk profiles. Most of the other responses we received said 'no data', which suggests that either councils had problems retrieving the information or there was no information.

c) **Protection of vulnerable adults (POVA) referrals**

We felt that activity may help to judge quality. We asked councils how many POVA referrals they received across commissioned domiciliary care providers between April 2014 and March 2015.

Table 15 – POVA referrals

Referrals	Number
Average	63.3
Median	28
Range	11–333

We need to treat this information with a great deal of caution, as it is clear that different councils have very different systems for recording data. A few councils were able to give detailed information about adult protection referrals, such as how many went forward to an investigation and how many were then upheld. One council recorded 333 referrals. This was a large council and only 24 referrals went forward for investigation.

Most councils did not record separately referrals about the 'agency' and referrals about the 'household'. Deciding what should be referred to POVA is also an issue: some councils treat missed calls as neglect rather than a performance issue, and others view poor staff behaviour as a conduct issue rather than a reason to make a POVA referral. Clearly, each case needs to be considered individually, looking at how much harm has been said to be done or how much risk is posed.

In our experience, the number and type of referrals made can be significantly skewed by one or two failing providers. They are not a reflection on the wider sector.

The most common adult protection concerns included financial abuse, neglect (for example, not providing catheter care or not preparing meals), medication issues and missed calls.

d) **Complaints**

We also asked councils about the number of complaints they received about commissioned domiciliary care between April 2014 and March 2015.

Table 16 – Complaints

Complaints	
Average	12.7
Median	14
Range	0–80
Didn't say	1

Given the amount of work commissioned, the number of formal complaints to councils about domiciliary care is low. The common themes include:

- late and missed calls;
- the attitude of care workers; and
- continuity of care workers.

e) **Commissioners' views on the quality of care commissioned**

We wanted to know what commissioners think about the quality of the care given by the sector and their relationship with providers. The findings from our survey suggest that commissioners think that most people get the right care at the right time and are generally happy with the care they receive.

The findings from our focus groups support this. Commissioners said they appreciate the contribution of the domiciliary care sector and empathise with the pressures, financial problems and recruitment issues they are facing. They told us that most providers seem to perform quite well; it is a small proportion that give commissioners serious cause for concern. In the survey, some commissioners acknowledged that there are problems with the continuity of care workers. There was more marked acknowledgement that providers do not alert councils about late and missed calls.

7.9.7 Challenges

In our survey and in our focus groups we asked commissioners to comment on both their day-to-day and longer-term challenges. The common themes are shown below.

- Providers' ability to meet demand at peak times and holidays.

- Providers' ability to respond to new requests quickly.

- The capacity of providers fluctuating, especially in rural areas (one care worker leaving can have a significant impact).

- The availability of staff, especially male staff.

- The supply of care workers, especially in remote rural areas.

- Not enough continuity or consistency in the service provided because of staff turnover and recruitment problems

- Providers not communicating with people receiving care; for example, if they are running late.

- Managing the expectations of service users and families, 'especially around time slots'.

- Transferring care packages from reablement.

- Gathering service users' views to help shape commissioning.

- Not enough capacity within commissioning and contract monitoring teams.

- Different electronic call-monitoring systems being used – 'collating time-recording information is very time-consuming'.

- Making sure providers allow enough travel time between calls.

- The difficulties with commissioning care in rural areas: 'rurality' and 'all that comes with it'.

- Developing local, sustainable providers and avoiding over-dependence on larger, national companies.

We also asked commissioners what the biggest long-term challenges are in commissioning and contracting domiciliary care. Their responses were very rich in content and were consistent across all commissioners.

a) **Demand**

Commissioners are daunted by how much demand is increasing and becoming more complex, especially for frail older people and people with learning disabilities. They also mentioned rising expectations and the need to manage these to keep them realistic and achievable.

b) **Supply**

Commissioners are extremely concerned about the fragility and sustainability of the current independent domiciliary care market. They mentioned that the number of providers in the market place is falling and smaller providers are being bought out by larger companies. They said that actively managing the market is a challenge – in reality, they have little or no control.

Commissioners also talked about the cultural change providers need to make in embracing the Social Services and Well-being (Wales) Act and find new ways of working.

'One of the greatest challenges is the radical transformation of the existing domiciliary care.'

Another challenge is 'building a relationship with the sector to foster shared risk taking to reduce dependency and promote independence'.

c) **Workforce**

Developing a high-quality, well trained and caring workforce that can be maintained in the long term is a very significant concern. Commissioners mentioned the issues of keeping staff, the transient nature of care work and the ageing workforce. They mentioned the problems of long-term workforce planning and forecasting and how far this rested with providers, commissioners or Welsh Government. Questions they asked included:

- Is this the responsibility of all or some of these groups?
- How do people work together the achieve this?
- Where is the money going to come from?

One commissioner noted:

'The introduction of an outcome-based approach is likely to be a significant challenge, particularly in regards to the culture of care workers. It is anticipated that some care workers will be unable to

adapt to a very different way of working and the current training will not be adequate within the new approach.'

Another identified the need to deal with the problem of workforce capacity at peak times of the day and in holiday times. Because this is such a big issue, it would seem to need a *strategic* workforce related response.

d) **Money**

It is not surprising that the issue of budget cuts featured very strongly in commissioners' responses. They were also very anxious about the effect of the national living wage and other cost pressures caused by providing better terms and conditions for care workers.

e) **The law and culture change**

Commissioners were very concerned about how the requirements of the two new Acts (the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016) will affect the sector and their own work.

Many said they are moving towards an outcome-focused commissioning model but needed to know how best to achieve this. In our focus groups, commissioners said they are struggling to see how outcome-based commissioning can work in practice and are worried about the risks.

> 'Commissioning for outcomes is going to need to be "sold" to corporate colleagues very skilfully as the expectation to account for every penny increases (I'm certainly experiencing that here). The concept of flexible commissioning and provider freedom around duration of calls won't be understood by all, either corporately or politically' (Inspection)

> 'The challenge of developing a whole-system approach from assessment and case management, brokerage, providers and reviews to move to an outcome-based approach which is person-centred i.e. move away from time and task based approach' (Commissioner survey)

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f) **Managing performance**

Commissioners were concerned about managing performance in an outcomes-based world; they said that monitoring the work under the new arrangements will be challenging. They need a 'clear set of outcome measures to help move towards outcome-focused commissioning'.

g) **Technology**

One commissioner asked about whether there are any national approaches to electronic call monitoring and whether all commissioners will have to use it. The commissioner wondered how electronic call monitoring by providers will be used to manage relationships with providers in the future. This is an important theme and is worth exploring further. In our survey, many commissioners told us that most or all providers had good information and communications technology for organising care. Three said this was rarely the case. Our experience from inspections suggests that there is a lot of variety in whether information and communications technology is used effectively.

The Social Services and Well-being (Wales) Act 2014 requires a significant change in culture and approach. It is clear from the responses we received that some councils are already moving towards a more person-centred approach based on strengths and outcomes. The most challenging part of implementing the Act will be to truly reduce demand and long-term dependency by increasing the role of community support and encouraging and supporting people to become more self-reliant.

However, if the pressure to use and allocate resources stays high, and funding continues to be limited or reduced, domiciliary care will still need to be rationed and some of the behaviours in the system like call clipping and call cramming are likely to continue.

8 Analysis and suggestions

We have tried to understand how different aspects and experiences of the domiciliary care system fit together by looking at different perspectives. To do so, we have brought together what people told us and what we found in our inspections. We have also considered some of our findings alongside those of other reviews.

The world of domiciliary care is not easy to explain, as the different parts are very interdependent.

We have broken the analysis down into the following areas.

1) What matters to people receiving care and support – relationships and continuity, timing of calls and care and support.

2) Commissioning – structures and tendering, approaches, monitoring and assurance.

3) Workforce development – workforce strategy, motivation and support for care workers, recruitment and career development, training, working conditions and other roles.

4) Business development – market analysis, franchising and information and communications technology.

5) Other issues – the Regulation and Inspection of Social Care (Wales) Act 2016 and impact of the cap on fees.

8.1 What matters to people receiving care and support

8.1.1 Relationships and continuity

People told us that their relationships with their care workers are as important, if not more important, as the tasks that need to be done or the length of the call. It is the experience and quality of a visit that makes a difference to people's lives. This means that arrangements for providing domiciliary care must create the most opportunities to provide good, relationship-centred care.

Of the people who answered our survey, 82 per cent said care workers were always kind and another 17 per cent said that care workers were kind most of the time. Good relationships have mutual benefits and it is clear from what care workers told us that relationships are very important and rewarding for them too. However, this review has emphasised the risks and challenges of developing such significant relationships and the importance of understanding the need for boundaries. Some agencies rotate' care workers to avoid people becoming too dependent on one person, and Care Council for Wales has published guidance on making professional boundaries[25]. The relationship between a care worker and a person using the service may appear to have much in common with a friendship or other personal relationships. However, it is a professional relationship with a specific purpose – to improve the well-being of the person using the service.

This issue may benefit from more discussion. It should be part of each care worker's induction, support and supervision, and it should be talked about openly when introducing or reviewing care packages.

In this context, it is not surprising that continuity of care workers is the single most important issue mentioned by people receiving care and support and by their families. The survey results suggest that most of the time, people receive care from someone they know. However, during our inspections we found many examples where poor continuity was having a significant impact on people receiving care and support and on their relatives.

By comparing people's perceptions and those of care workers, we found that continuity of care is only guaranteed around 50 per cent of the time. For around 10 per cent of people, it is common to receive care from care workers they don't know.

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[25] Care Council for Wales (2016b) *Professional boundaries: a resource for managers*. Cardiff: Care Council for Wales.

Figure 64 – Continuity of care
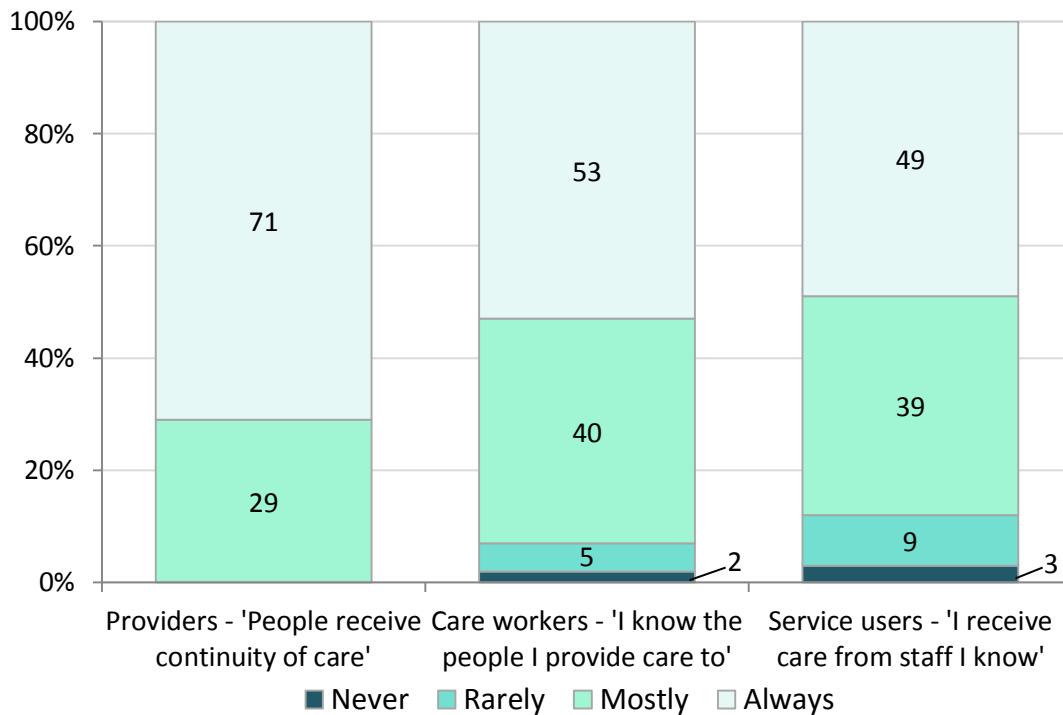
8.1.2 Call times

Call times, punctuality and call lengths are often at the centre of the debate about the quality of domiciliary care, especially in media reports. However, they are blunt instruments for assessing care quality accurately, and focusing too narrowly on them can be counterproductive. It is the experience and the outcome of each call that matters to people, not its exact length. Call lengths seem to be more of a concern for commissioners, who want to make sure the council gets what it contracts and pays for.

People and their families understand that calls cannot always be on time and that care workers sometimes have to spend more time with someone else, which makes them late for other calls. A more realistic approach, not promising too much or proposing times that can't be achieved, helps to avoid disappointment and frustration. Providers and care workers told us it is challenging to manage people's expectations when social work assessments have led them to expect visits at times that are not realistic.

Care workers and people receiving care often told us that calls were rushed and that care workers were under pressure. Six per cent of people said care workers rarely or never had enough time to talk to them and 10 per cent of care workers said they rarely or never had time to talk to the people they visit.

We wanted to know what is causing this pressure and whether calls are being rushed or shortened (clipped). There was a general agreement that for most calls, care workers stay for the time they should. Our surveys and inspections also made clear that not having enough travel time is the main reason for calls being rushed.

The chart below shows the percentage of providers and care workers who think enough travel time between visits is always, mostly, rarely or never allowed.

Figure 65 – Enough time is allowed between visits (responses from providers and care workers)
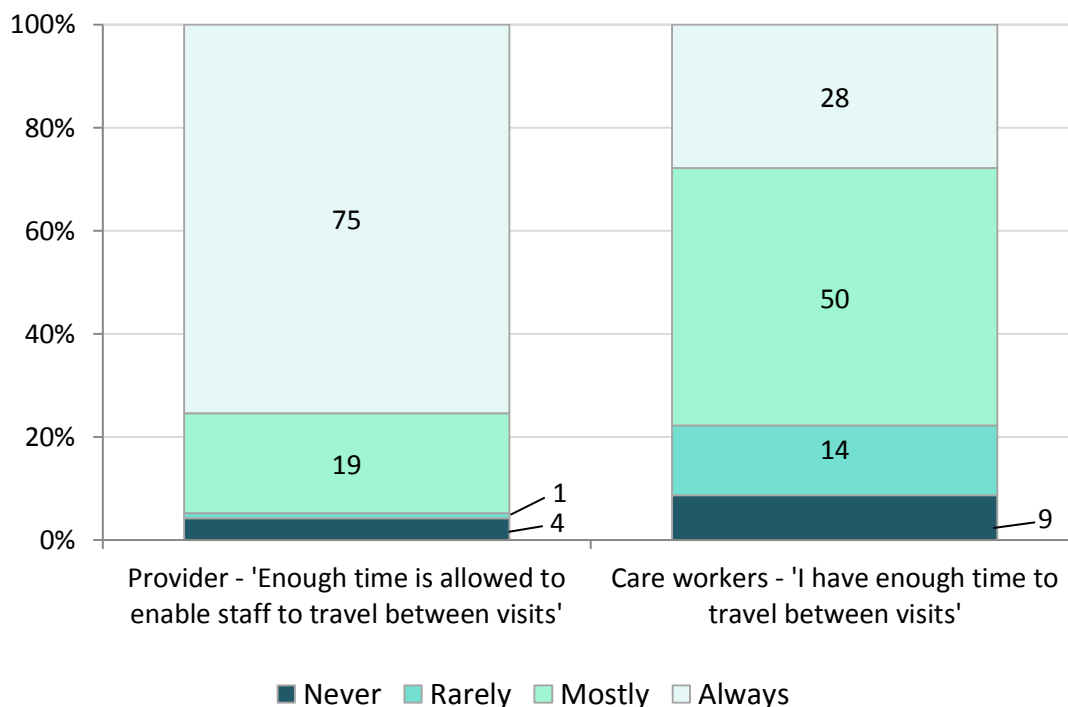
The chart below shows care workers and service users' views on the length of calls and whether they are cut short. This information is based on their survey responses to questions on call lengths.

Figure 66 – Staff and service users' views on call lengths
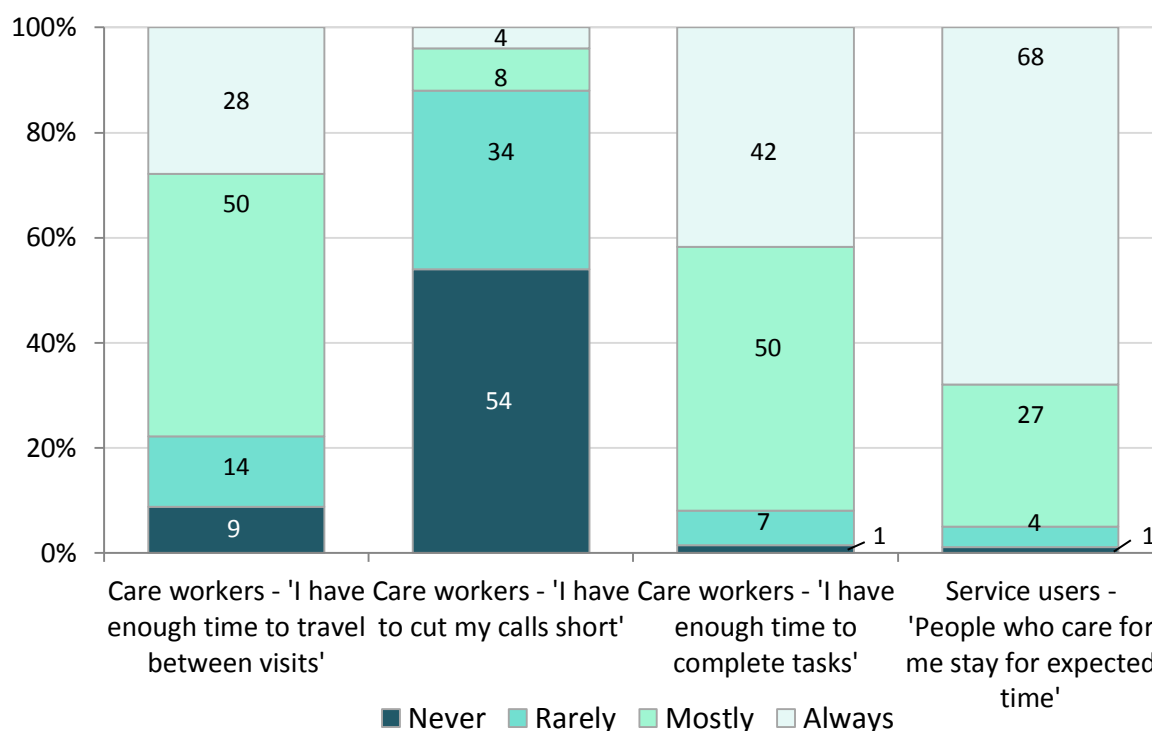
By analysing the 2,884 calls we reviewed while inspecting domiciliary care providers, we found that 17 per cent of calls were 'clipped' (10 minutes less than the planned time) and 7 per cent were 'very clipped' (shortened by more than half of the planned time, including 15-minute calls which were clipped by more than 7-and-a-half minutes). But we also found that 6 per cent of calls lasted longer than planned. This was based on records in 43 of the 70 agencies we inspected. The other 27 (nearly 40 per cent) did not have accessible, detailed records on call times and were unable to say if calls were on time, late, missed or clipped. We would expect any well-run domiciliary care agency to be well sighted on call times as part of quality monitoring.

Providers, commissioners and people receiving care all told us that they don't like 15-minute calls. They seem to cause dissatisfaction, lead to rushed visits and make care workers feel under pressure. They also reduce the amount of time spent caring because there is more travel time between calls and they 'increase the administrative cost' of each call.

Table 17 – 15-minute calls provided and commissioned

Percentage of 15-minute calls provided or commissioned in a typical 7-day week	Number of providers in each percentage band	Number of commissioners in each percentage band
0% or no response	0	8
0–5%	171	9
5–10%	13	1
10–15%	5	1
15–20%	6	2
20–25%	0	2
25–30%	11	0
30–35%	0	0
35–40%	5	0
40–45%	0	0
45–50%	2	0
Over 50%	2	1
Total	**215**	**24**

Commissioners have mixed views about 15-minute calls. Some councils have decided that 15-minute calls are not acceptable, but others are continuing to use them. Some councils claim that they use 15-minute calls for monitoring only, but the evidence from our inspections shows that this claim is suspect.

The decision about how long a call should last should be made by the care worker on the day as part of a flexible approach to care rostering, rather than being set by 'time and task' commissioning. Short calls may be appropriate on some days for some people as part of a flexible approach.

Some councils use or have considered using assistive technology, telehealth and telecare to avoid the need for short calls, for example for welfare checks or medication prompts.

The data is complicated, but our analysts have estimated that between 5 and 10 per cent of commissioned calls are likely to be 15 minutes long.

One of the larger electronic call-monitoring companies (CM2000) helpfully gave us the following information on recorded call lengths. This is based on a sample in 2015 of three quarters of a million 15- and 30-minute calls across the UK.

Table 18 – sample of recorded call lengths (2015)

15 minute calls		30 minute calls	
Call length	Percentage of calls	Call length	Percentage of calls
0 to 5 minutes	5%	0 to 10 minutes	3%
More than 5 minutes but no more than 10 minutes	18%	More than 10 minutes but no more than 20 minutes	13%
More than 10 minutes but no more than 15 minutes	53%	More than 20 minutes but no more than 30 minutes	64%
More than 15 minutes	24%	More than 30 minutes	19%

The caveat with electronic call monitoring is that time might not be recorded at the start of the visit when care workers are meeting people, dealing with their immediate needs and getting to a phone or care record to log in. Because of this, it is unlikely that recorded call times capture the whole call length.

Although there is understandable concern about short calls, our review and the CM2000 study have highlighted that a significant number of calls are longer than planned. CM2000 found that 20 to 25 per cent of calls last longer than planned, and we found that 6 per cent of calls last longer than planned. The difference may be explained by the scale of the study by CM2000 and the use of electronic monitoring data only.

Councils do not pay for care that goes over the number of hours set out in the contract with the provider nor are care workers normally paid. In our consultations and focus groups, we found that it is not unusual for care workers to work longer than planned, in their own time, for which they received no pay. Commissioners and providers working on a 'time and task' basis do not seem to want to recognise call times that last longer than planned. This means the extra time is nearly always provided at the care worker's expense.

The fact that many calls go on for longer than planned should be recognised and explained, especially when concerns are raised about clipped calls.

Our survey highlighted several reasons for clipped calls, some of which we had not expected. These are as follows.

- Little or no travel time included in schedules. As discussed earlier, this was the main reason given. When we looked at care worker schedules as part of our inspections, we often found calls scheduled back to back.

- Previous calls taking longer than planned.

- Not enough time planned for the call, especially when councils commission 15-minute calls.

- Traffic and parking problems.

- People asking care workers to leave early or not needing calls (for example, if visiting family members were providing care). Providers and staff told us that this was not uncommon.

- Time lost while being let in.

- Time lost while logging in to telephone and other electronic monitoring systems.

Monitoring the length of call times provides several benefits. It helps with:

- charging for care;
- planning staffing resources;
- adjusting care packages;
- monitoring the performance of care workers; and
- measuring quality (when considered alongside other measures).

However, too much emphasis on keeping to call times reduces flexibility. Some councils allow for call time to vary (for example, 5 minutes shorter or longer for a 30-minute call).

Punctuality is another very important issue for people receiving care and support. However, providing care on time to people with different and complex needs at the busiest times of the day is a huge challenge. In our discussion forums, we found that people's expectations about timing were often set during the care assessment, before the care package is brokered and an agency identified. There needs to be a flexible approach to make sure:

- as many care workers as possible are available;
- travel time is reduced as much as possible; and
- an appropriate care worker is matched to the person needing care and support.

Expecting a care worker to arrive at a set time is unrealistic, so several councils and providers have started using time bands (for example, 'early morning' or 'late morning'). For people who have appointments to keep or medication to take at

certain times, timing is very important. However, for many people, a time band is more realistic and acceptable.

Our survey results confirm that care workers and service users alike think care workers arrive on time most of the time.

Figure 67 – Punctuality

In our review of 2,884 calls during inspections, we found:

- 85% were on time or less than 30 minutes late or early;

- 5% were 30 to 60 minutes late;

- 7% were more than 30 minutes early; and

- 3% were more than 60 minutes late (classed as missed calls).

Until we spoke to people, we hadn't appreciated that for many service users and their families, early calls are just as much of a problem as late calls.

We also noted (from survey responses and our inspections) that for lonely people and some people with dementia, reliable calls are a source of 'order' in an uncertain world and give them reassurance. Some people find it difficult to tolerate lateness because of their emotional needs, not their physical needs. People told us that some people 'clock watch' and get very agitated and anxious and start to ring relatives if the care worker is more than five minutes late, even though they may not be in any danger.

Reassuring people early and communicating with them well are essential for reducing anxiety, and some agencies are better at this than others.

As mentioned earlier, we found a huge variation in how providers and commissioners define late and missed calls. Although there are arguments for more sophisticated approaches, given the current limitations of many providers' recording systems we suggest that a simple, standard definition:

- any call more than 30 minutes after the end of a time band is 'late'; and
- any call more than 60 minutes after the end of a time band is 'missed'.

8.1.3 People being in control and receiving the care and support that matters to them

People also told us that they often need help that isn't on the care plan and appreciate it when care workers are flexible. Care based on tasks that are tightly proscribed and limited to what is considered 'eligible' is not what people want. It is important to people that care workers can do what matters to them on the day. This is also more likely to encourage self-reliance.

It was encouraging to find in our survey that 74 per cent of people using domiciliary care said they always receive care in the way they wish (24 per cent said 'most of the time') and 72 per cent said they are always helped to do things for themselves (24 per cent said 'most of the time').

With the introduction of the Social Services and Well-being (Wales) Act 2014, we are entering a new world where social workers and care managers are expected to have conversations with people about what matters to them, rather than doing

conventional assessments. The emphasis is on outcomes and helping people to rely on themselves. People we spoke to recognise the deep challenges of balancing the need to take an approach based on outcomes for people and the need to specify a service that can be signed off by a manager and brokered.

From our discussions with providers, conversations about 'what matters' are exactly what happens when they set up care packages for privately funded clients. The care provided is based on what the customer wants, and the customer truly has control in shaping a service that suits them. From the feedback we received, care managers and social workers have to think about 'eligibility' and are often limited to identifying tasks they know the council will fund. Some providers told us that the care plans they inherit from brokerage are sometimes inaccurate and irrelevant – they have to start from the beginning to discuss and agree their 'service delivery' plan with individual people. In our survey, 11 per cent of providers said that the care plans they receive are rarely or never accurate, but every council believed that care plans are a true reflection of people's needs and wishes most or all of the time.

It became clear in our discussions that the care provided is not just related to a person's needs – it also depends on what an agency can offer.

At the heart of setting up a successful service is the need to consider options for match what a person wants and when to the care workers who are available. When deciding who might be the best person to provide care, providers need to think about:

- who might be best from a relationship point of view;
- what skills they have;
- whether they speak Welsh; and
- where they will be travelling from.

This is what 'the old [council] home care organisers were very good at!' (Focus group)

The decision or 'hand off' chain connecting people who want care and support and those who provide it must be kept as short as possible – an early, direct conversation between provider and user is best. The problem with some of the current tendering and brokerage systems is that to offer work across providers

openly and fairly, the first assessment and scoping has to be done without providers being involved.

> 'The more people who become involved the more care becomes industrialised' (Consultant)

We were interested in a new model assessment involving providers in care planning which is being used in Caerphilly and in the experience of care providers who have been contracted as 'trusted assessors' in England to undertake the initial assessments and set up care packages.

The obvious solution is to take out the 'middle man'. The problems of having intermediaries with different priorities became very clear in our discussions with several service users who said they had started using direct payments because they were not satisfied with what the council had arranged for them. They told us that the care they arranged through direct payments is much more successful, but the rates provided by the councils can be much lower so the family has to pay 'top-ups' of around £5 to £8 an hour. Some people told us they do not have time to take on the burden of arranging direct payments, as they were already overwhelmed by providing care themselves.

We received many reports of poor handovers from reablement to domiciliary care providers, especially for:

- assessments;
- information (which was rarely shared); and
- managing the handover in relation to call times.

This clearly needs attention.

8.1.4 Suggestions

- Change the perception, expectations and behaviours relating to domiciliary care. Make outcomes and relationships the priority, and challenge a narrow focus on call monitoring. This will mean making an effort at every level, including giving explanations to the public and the media.

- When monitoring performance and quality, focus on the experiences of service users and the continuity of care workers.

- To improve continuity, arrange for care to be provided by small teams that cover specific geographical areas.

- Only give a time slot for calls where timing is very important. Whenever possible, use time bands (for example, 'early morning' and 'late morning').

- Consider having flexible call lengths (for example, 20–40 minutes rather than 30 minutes), using time banking, and planning fewer but longer visits.

- Do not commission 15-minute calls. Short calls put pressure on care workers and are inefficient, as they reduce the amount of time in the day spent on caring. Some councils do not allow 15-minute calls or have stopped commissioning them, but others still use them for medication or monitoring and a few still use them for personal care. The Regulation and Inspection of Social Care (Wales) Act 2016 prohibits 15-minute calls unless there is a specific reason to justify them.

- Have a common, simply defined standard for late and missed calls and use this proportionately alongside other measures to monitor performance.

- Commissioners should expect (and pay for) care workers to be given enough travel time and providers should build it in to costs and schedules.

- Produce care plans together rather than handing them down. Always involve the person, their family and the agency providing the care:

- Focus care plans on outcomes and allow for flexibility. Don't base them solely on a set list of tasks.

- Set a realistic rate for direct payments and provide good support. Negotiate favourable terms for people on direct payments.

- Always consider matching care workers to the people they will provide care for, considering preferences and personalities.

- Introduce care workers to the people they will be providing care and support for before their visits begin.

8.2 Commissioning

In this section we consider:

- the broad commissioning structures;
- how the work is divided up;
- how fees are settled; and
- how contracts are monitored.

8.2.1 Structures and tendering

The scale and complexity of commissioning domiciliary care became clear during this review. The huge variety in how things are done across Wales reflects the internal dynamics within councils and the personalities and beliefs of those who are in control.

The relationships between central procurement, finance officers and social services staff vary considerably. So does understanding about EU procurement rules and due diligence in financial accounting. We have not examined EU procurement law in detail, but we have been advised that EU procurement rules can be used flexibly for social care and to support innovation. However, this is not how some councils are behaving.

The cost to the public purse of doing things in so many different ways must be enormous, with each council working separately and investing time in developing systems and going out to tender. Even in north Wales, where there is a regional commissioning hub, only a few councils said they use the north Wales framework that has been developed. Our evidence from talking to providers is that this variation puts providers off coming forward to work with councils and significantly adds to the burden and cost of sustaining different tendering and accounting systems.

With the future of local government reform uncertain, this issue needs urgent and concerted action. The new regional partnership boards should have an important role to play. Processes must be simplified and standardised. However, in some of our conversations with key individuals we found there is very significant resistance to this – there is a strong desire to 'keep local' and deep pessimism about whether any national or regional approach can be achieved.

We have taken an active interest in the development of the Caremore approach in Wales. Caremore is funded by the Welsh Government and aims to streamline and reduce costs in NHS and local authority commissioning for learning disability and mental health services. The approach has expanded quickly and applying it to domiciliary care is being considered. Caremore negotiates and monitors all contracts in Wales for the learning disability and mental health sector, including contract specifications and fees based on a fair price for care. The approach is proving to be challenging and there are criticisms, but it is streamlining systems. What we learned from discussions suggests it has unearthed significant cost inefficiencies. This could teach us about the challenges and benefits of having a national commissioning structure for Wales and how a national approach could override and impact upon the commissioning and procurement arrangements within councils and health boards.

We are also interested in how dynamic purchasing, which is based on individual tenders for care, bypasses traditional commissioning structures.

It is clear that how commissioning and procurement is done affects the quality of care provided.

- Tendering that results in low prices makes for poor, unsustainable care. This was particularly clear in our council inspections. Several councils have seen care packages fail or providers hand them back.

- Focusing mainly on accounting for time taken and tasks completed leads to rigid care that cannot be changed on the day, with care workers 'breaking the rules' to do what matters most to people receiving care and support.

- Tendering that relies on an agency being able to grow suddenly and quickly has a high risk of failing and calls being missed.

Feedback from providers suggests that, in reality, tendering that is based on a 60% / 40% quality scoring system does not consider the quality element. This raises important questions about how these are designed and scored and whether they are fit for purpose. At the time, one system we considered depended more on how skilful the provider was at writing a submission than on any objective measure of past or future performance. Providers told us that, in their experience, commissioners often award contracts based only on price, no matter what systems in the tendering process measure quality.

In general, Wales pays higher rates for domiciliary care than the rest of the UK. Rates vary widely across Wales, and some contracts are run at well below what is seen as a realistic price for care. We are aware of the work being done in North Wales with the United Kingdom Home Care Association (UKHCA) to develop a pricing model and we recommend that minimum thresholds are applied.

We can make the following observations.

1) **Time horizons**: Commissioning is about developing a market that can grow and survive in the medium and longer term – not short-term procurement, which is how some commissioners seem to be behaving.

2) **Working together**: Commissioners and providers have to trust each other. They should work together to understand the market in its widest sense (including workforce supply, people using direct payments and people buying care privately) and its challenges and opportunities. Commissioners and providers should share responsibility for developing solutions and improving capacity based on shared interests. In our inspections we found that when this works well, commissioners and providers are willing to embrace change. When it does not, there is suspicion and resentment on both sides.

3) **Stronger assurance**: Commissioners use a 'time and task' model for care because they believe care can be measured, but in reality it can't. Traditionally, the time and task approach assures commissioners that care is being delivered and councils are getting what they are paying for. To move forward, we must change the culture of assurance and bring in new systems that are robust, trustworthy and meaningful.

From our evidence, peak times (especially mornings) and holiday periods are a particular challenge for capacity and care worker availability. This is to be expected, given most people's routines and the more complex tasks at the beginning and end of the day. Rather than accept the problem as inevitable, it should be tackled as a strategic priority. They should consider solutions like different pay rates, targeted recruitment for certain times of the day, and alternative tasks that domiciliary care agencies could do during quieter times of the day. One provider suggested falls-prevention work as an example.

8.2.2 Approaches to commissioning and procurement

There is no single, simple approach. Everyone is working with a lower and more difficult financial budget and the workforce available is limited.

We know that new models, such as outcome-based commissioning and dynamic purchasing systems, are being tried and promoted across the UK, but these do have some problems.

> 'Contract terms need to be transparent and easy to understand to include clarity of outcome measures, the implications of failing to meet targets and the frequency of payments'[26]

We can make the following observations.

1) **Contracts**: It seems reasonable to use 'call off' contracts based on framework agreements to buy most care in urban areas. However, it is not reasonable to use framework agreements with penalty clauses that pass the risk to providers. Fees should be fair and include costs for travel time.

   Commissioning traditional domiciliary care is very complex. There is a high demand, people have varied and complex needs and expectations, and the patterns of demand can change unexpectedly. Care has to be provided across different geographical areas, alongside other services and in line with the general strategies of the council and its partners. On the supply side, this

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[26] Bolton, J (2015) *Working for well-run evidence-based public care: emerging practice in outcome-based commissioning for social care* (discussion paper). Oxford: Institute of Public Care, Oxford Brookes University. Page 5.

review has highlighted that there is a very wide range of agencies with very different levels of sophistication and capacity.

2) **Zoning**: This approach should be considered, but carefully. Its advantages are that it reduces travel time, which makes providing care more efficient. It also concentrates care worker capacity and provides more viable ways to cover business expenditure. However, this often comes at the cost of greatly reducing the number of suppliers. It also limits providers' potential to grow and sustain their businesses. A wider, patchwork approach should be considered, for example blending across urban and rural areas with more than one provider working in each. Where strict zoning is used, commissioners must make contingency plans and consider reserve provider capacity.

3) **Floating support**: In more rural areas, a broader service model similar to floating support (for example, a team of workers covering a number of specific locations) rather may be better than a model of domiciliary care based on individual people.

4) **Delivery chain**: There should be a radical review of the assessment and delivery chain so providers and people receiving care and support negotiate the arrangements for their care. Concepts such as 'trusted assessors' should be explored.

At the time of writing, for most traditionally brokered domiciliary care the process is linear. The commissioner acts as a barrier between potential providers and people who need care and support.

Figure 68 – Linear process of commissioning domiciliary care
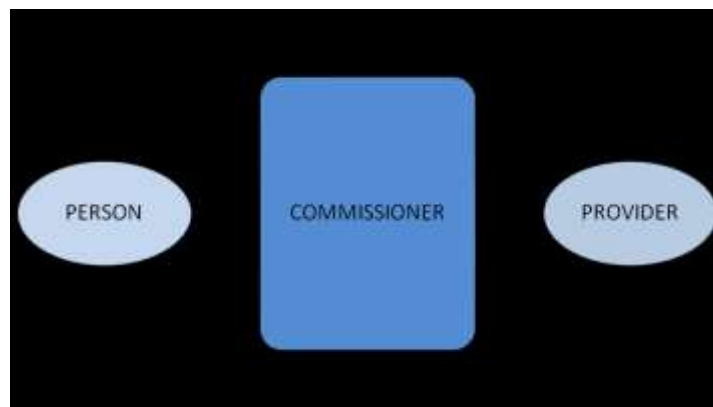
The process needs to become more integrated, creating as many opportunities as possible for people needing care and those providing it to work together.

Figure 69 – Integrated process of commissioning domiciliary care
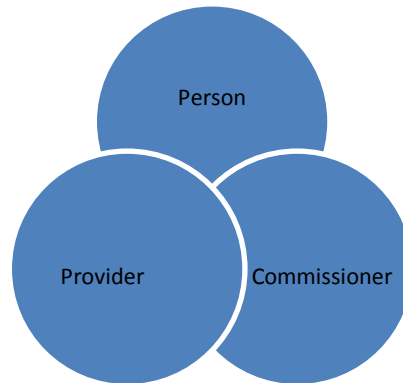
5) **Decoupling 'time and task'**: The idea of controlling costs by defining and measuring tasks and recording time spent is not person centred. It belongs to factories and a world of 'piece work'. It does not promote flexibility or efficiency. It should be replaced by an outcome-based approach where care and support are provided more flexibly and care workers are empowered to change the care they give on the day. As suggested previously, time does need to be factored in and recorded, but with more flexible slots within time bands (such as 20–40 minutes for a call, not 30 minutes). Opportunities to 'bank' and save hours across several people's care packages should be considered; in other words, people are entitled to a service, not a number of minutes.

6) **Outcome-based commissioning**: At its heart, outcome-based commissioning is about freeing up care workers to do what matters most to people to achieve their goals, be it more independence, or living as well as possible despite becoming more frail or being at the end of one's life. The challenge is how to set out, reward and manage the performance of outcome-based care without creating complex bureaucracy. It has to be kept simple and it has to be defined and led by people using the service. It needs trust between everyone involved, especially between commissioners and providers, and between providers and the care workers they employ. From

discussions and from paperwork shared with us, we are aware that some councils in England have been developing outcomes approaches and are struggling to work with people to define outcomes and then measure agencies' performance in achieving them. The Institute of Public Care is working to produce guidance for councils in Wales considering different models for commissioning outcome-based domiciliary care.

8.2.3 Monitoring and assurance

Some agencies have strong systems for monitoring their performance, but we were surprised by how weak some of the arrangements are.

We were also very surprised by the very different arrangements each council has for monitoring contracts. The arrangements were all well intended, but it is a burden to providers when different commissioners want different information.

Unexpectedly, we found that several agencies welcome and value monitoring visits. In particular, they value ongoing review meetings with commissioners.

As part of any national framework, we should take an agreed approach to monitoring contracts. This approach should be consistent with and integrated with inspection and regulation. We noted that some councils insist on providers having electronic call-monitoring systems; this seems very reasonable for agencies except for very small, specialised or floating support agencies.

The new service-based framework for registration provides new opportunities to monitor agencies in different ways – at a whole service level rather than an individual agency level. This should be explored by CSSIW.

8.2.4 Suggestions

- We need definitive advice on how to interpret the EU procurement rules and UK Procurement Regulations 2015 in relation to commissioning health and social care. The Welsh Local Government Association or National Commissioning Board may be well placed to provide this advice.

- There needs to be a strong impetus towards standardising and simplifying commissioning and procurement by using national pricing models and frameworks.

- When tendering, give significant weight to financial and workforce sustainability. The issue of quality scoring needs to be examined and challenged.

- Commissioning for an area may include a range of approaches to meet different types of need and serve people in different locations. We suggest emphasising outcome-based approaches. The National Commissioning Board is well placed to help develop outcome-based practice and to review the success of models being tried in Wales.

- Throughout Wales, there should be a standard approach to monitoring agencies and collecting information from them. Consider having 'lead commissioners' who are responsible for monitoring agencies in a region or nationally on behalf of commissioning councils or health boards.

8.3   Workforce

'Making care work a career of esteem, where a living wage is paid, staff are trained and recognised as valued workers who contribute a huge amount to society will inevitably come at a price, but the cost of doing nothing will be even greater.' (Key to Care, Burstow Commission)

Key to care (Koehler 2014) and *Time to care* (UNISON 2013) contain powerful descriptions of the day-to-day life of care workers and set out some detailed findings and recommendations, which are reinforced by this review.

8.3.1   Workforce strategy

a) Responsibility for workforce strategy and development

During our focus groups and our meetings with providers it became clear that there is no common understanding of who is responsible for workforce strategy and development in the sector. Training was given as an example.

The framework for co-investment in skills: taking collective responsibility for skills investment in Wales was published in November 2014[27]. The framework aimed to change the balance of responsibility for investing in skills between the Welsh Government, employers and individuals from April 2015 by giving employers more responsibility and reducing dependency on government funding for training. As a result, Welsh Government funding is only available for apprenticeships at Qualification Credit Framework (QCF) level 3 and below for people under 25. This makes employers responsible for apprenticeships and training up to level 3 for employees over 25.

Providers told us again and again that the impact of this policy has put them in an impossible position. Funding a QCF level 2 qualification costs an agency around £1,000 for each worker. Agencies tend to employ older people, because they are more likely to stay in the job and are mostly preferred by elderly people. However, they now have to fund any vocational training themselves. Adding fee settlements, the introduction of the national living wage and the introduction of pension costs, there is little or no money available for training at this level. Staff turnover, as well as other agencies, care homes and the public sector 'poaching' qualified staff, does not give providers much incentive or room to invest in accredited professional training.

In the current financial climate, the share of professionally qualified staff in the sector is likely to fall over the coming years as the decision to stop funding for over 25s takes more effect. If qualification requirements are attached to workforce registration (which seems likely), it will be very challenging to achieve the Welsh Government's ambition to register the workforce unless there is significant investment. Where this responsibility lies for developing and sustaining a health and social care workforce for Wales is still unclear.

Clearly, strong leadership and direction is needed and Social Care Wales is well placed to provide this. It requires urgent, integrated long-term planning to reduce the risks as far as possible and make clear what the expectations and responsibilities are at all levels: the Welsh Government, regional partnerships, local councils and providers. If providers are to bear the burden of paying for training as set out in the

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[27] Welsh Government (2014b) *Framework for co-investment in skills: taking collective responsibility for skills investment in Wales*. Wales: Welsh Government.

co-investment strategy, it will be particularly important to test whether realistic funding is being built into costing models by commissioners. It will also be important to monitor the take-up of professional training, whether this is going up or down, and the income streams available for training.

8.3.2 Motivating and supporting care workers

Perhaps the strongest and most heartening finding of this review is how deeply care workers value their work. They genuinely care and want 'to make a difference' to people's lives. We need to make sure we provide conditions where care workers can achieve this ambition. To compromise a care worker's values by putting them under pressure to shorten calls or keep to set tasks is deeply dissatisfying for them and a source of stress and frustration.

The other main finding is that, like many people, care workers like to belong to teams. They value support and thrive on being recognised for their work. It is the day-to-day 'on the job' support that matters most. The formal expectations of staff supervision in the current approach to regulation have less value and relevance in domiciliary care and are based on supervision models used in other sectors such as traditional social work.

8.3.3 Recruitment and career development

This review found that the number of hours people worked and their long-term commitment to domiciliary care varies widely throughout the workforce.

Of 208 care workers who responded to our staff survey, the majority (82 per cent) told us they were planning to continue to work in domiciliary care for more than three years.

Table 19 – How long care workers plan to stay in domiciliary care

Length of time	Number of care workers	Percentage of total
Less than a year	11	5%

1 to 3 years	27	13%
More than 3 years	170	82%

We did not explore the ethnic background of care workers in this review. However, from comments made by people using care services, we know there is a broad mix of ethnic backgrounds among care workers and many care workers come from Eastern Europe.

Feedback from providers suggests that the workforce can be divided into:

- younger people (under 25), who are not planning to stay in the sector for very long; and
- older people (including retired people), who are looking for a second career and plan to work for several years in domiciliary care.

The career overlap between this sector and other health and social care sectors is also clear. As such, it is worth looking at domiciliary care as part of wider opportunities in health and social care instead of separately.

Providing career paths and training opportunities for such a diverse workforce is a challenge, so we may need to have different strategies for different parts of the workforce. On the whole, people think that registering care workers and giving them professional status is a very good idea. However, they are concerned that:

- this may force willing, caring but less academic workers out of the sector; and
- unless training for over 25s is funded the potential workforce could shrink.

8.3.4 Training

The survey results suggest that people using and commissioning services think care workers are well trained and able to meet the needs of the people they care for, most of the time. This is also reflected in the staff survey.

Figure 70 – Training

However, during our inspections we judged that 17 per cent of agencies performed poorly in staff training and did not give their employees training in the basic skills. On the positive side, we judged just over half of the agencies 'good' or 'excellent' because they were organising a wide range of training, including training on more complex aspects of care.

We also found that the tasks care workers are doing are becoming more complex, sometimes quite 'medicalised'. Heath boards are commissioning more domiciliary care (possibly as much as 20 per cent of all domiciliary care commissioned) to support people with complicated long-term conditions and people who need palliative (end of life) care. Our discussions and the survey responses revealed that domiciliary care can include:

- catheter care and PEG feeds; and
- supporting people with complex learning disabilities, dementia, terminal illnesses and mental health conditions.

Some providers said it was difficult to find more advanced training and to know what training was best. They said that some district nurses are reluctant to provide training. Looking to the future, we expect that more joined-up working between domiciliary care and health and social care will be needed to support people with long-term health conditions. Any workforce strategy needs to consider this. For example, should domiciliary care workers be trained in phlebotomy? Is there merit in developing a community nurse assistant role at QCF level 3? Some domiciliary care services in the UK employ nurses and are considering providing care through community-based multidisciplinary teams.

Older people mentioned the current lack of joined-up working in our focus groups. In our surveys, care workers and the two health boards told us that when people need complex care, there is strong team of NHS staff and domiciliary care agencies.

8.3.5 Working conditions

'I feel care should be made a profession and care workers should be rewarded better. As we can only afford to pay just above the minimum wage I don't feel the best people are working in care. I would like to be able to pay my care workers a minimum of £10 an hour. (Provider survey)

'I feel higher wages would attract better staff. Staff turnover is a problem. I find this is mainly due to staff not being paid for travel time. They can be out a lot longer in the day than they are actually paid for.' (Provider survey)

A large share of care workers who we spoke to or who responded to our survey said they love their jobs and find domiciliary work very rewarding. This is despite low pay and poor working conditions; for example, not being paid for travel time or not being paid between calls. We found that several were working very long hours – more than 12 hours in a day in some cases. Some talked of 'exhaustion'. The recurring challenges of the work include:

- having to rush;
- feeling under pressure;
- the emotional impact of the work;
- time spent travelling; and

- last-minute changes and communication with office staff.

People receiving care and support were aware of the pressures on care workers.

We judged working conditions as 'poor' in 10 per cent of the agencies we inspected. This judgement was based mainly on their contractual arrangements.

In our inspections we did find some agencies that had tried to use better working patterns. For example, one provider had moved to four days on, three days off to deal with the exhaustion care workers were experiencing. The provider said this was working well.

Zero-hours contracts are controversial. Around half of the staff who completed our survey were on zero-hours contracts and around half of the agencies used them (but not necessarily for all their staff). In *Time to care*, UNISON concluded that:

> 'Zero hours do not serve the interests of either client or homecare workers (in almost all instances) and their use should be strongly discouraged in this sector'.

UNISON came to this conclusion because zero-hours contracts make it less likely that people needing care will get the same care worker on a regular basis, which 'negatively impacts on the worker's finances, morale and work-life balance' (page 38).

Also, care workers on low wages and zero-hours contracts have 'little predictability of income and future work, so it may be hard to budget ahead' *(*Koehler 2014, page 5).

The Manchester Metropolitan University study for the Welsh Government reflected a more balanced view, reporting that care workers are 'divided' in their opinions. Although care workers feel some insecurity about future work, given the amount of work on offer there is no real problem: 'You get the hours because they're there; never been without'. Others told researchers it is 'all or nothing ... as soon as somebody goes into hospital we lose four calls a day and then it affects us a lot' (Welsh Government 2016b, pages 88–89)*.*

Interestingly, some staff who had moved to permanent contracts (for example, 40 hours) a week were only being offered and paid for 27 hours if that was all that was available. Some were paid for their contracted hours, but others were paid only for the hours they actually worked.

The United Kingdom Home Care Association (UKHCA) produced its own question and answer paper on zero-hours contracts in 2014. They told us that agencies use a range of contracts that may be referred to as zero-hours contracts, each with different entitlements, rights and terms and conditions. Their paper, *Zero hours contracts: some key questions*[28], makes two important points.

- In a world where there is a lack of long-term commitment from commissioners and there is uncertainty about the length of contracts, providers cannot take the risk of employing staff on permanent contracts and potentially having to make redundancy payments.

- Demand for domiciliary care fluctuates throughout the day, with peaks in the morning, at lunchtime and at bedtime. Unless providers can find enough work to fill the periods of low demand, then at best guaranteed hours would have to be concentrated on the peak times of the day. It would be difficult to create a '9-to-5 style contract' given these patterns of demand.

Our own review made clear that many workers like the flexibility of zero-hours contracts. We were surprised that when some agencies have offered permanent contracts they have seen very low take-up by care workers. This has also been the experience of UKHCA members more widely. The problem is more for the provider, because they cannot guarantee how much work their care workers will take on and when they might want to work, especially during school holidays. The main advantage of permanent contracts mentioned by care workers is that they make it easier to secure loans and mortgages.

At the time of our review, we were aware that the Welsh Government was leading other initiatives on zero-hours contracts and that the Public Services Staff Commission was holding a consultation. It is a complex matter which our review

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[28] United Kingdom Home Care Association (2014) *Zero hours contracts: questions and answers*. Sutton: United Kingdom Home Care Association.

suggests rests on the specific details of the zero-hours or permanent contracts being used.

8.3.6 Other roles: managers, care coordinators and supervisors

Carrying out our review made us more aware of the importance of office staff. These employees work hard every day to keep the agencies running, make sure calls happen, and balance the demands of people needing care and support with the care workers available. Sometimes they even have to rush out and cover calls.

We have not devoted much time to this group of staff, but their performance is very important. It will be essential to involve them if domiciliary care services move towards outcome-based care and to take forward the cultural shift that is needed under the Social Services and Well-being (Wales) Act. We believe that more discussion is needed to understand the skills, training and support needs of this group of staff.

8.3.7 Suggestions

- As part of its proposals for a five-year strategy for domiciliary care in Wales, Social Care Wales will develop a workforce strategy that makes clear the responsibilities of everyone involved. It will also have to consider the possible effects of leaving the EU.

- Given that there seem to be two different profiles of people entering the profession (younger people and older people), the workforce strategy, recruitment activities and development activities should target these groups separately to understand and meet their needs.

  o For younger people, domiciliary care work should be offered as a positive career choice and as part of a broader journey into health and social care work. Two-year health and social care apprenticeships should be considered.
  o For older people, who may be returning to work and often have other responsibilities, flexible working and part-time patterns should be promoted.

- The impact of registering the workforce should be assessed by Social Care Wales so that any risks can be understood and reduced.

- Working conditions for care workers should feature in providers' assurance systems, contractual and monitoring arrangements and regulation, and inspection activity.

- Before taking any action on zero-hours contracts, consider the need to give people a choice.

8.4 Business development

8.4.1 Market analysis

We did not carry out a detailed analysis of the domiciliary care market in this review. This is because the current registration system does not record the influence of large UK-wide companies, which have bought up many agencies in Wales but continue to trade them as local, separate businesses. We are aware that some of the larger UK umbrella companies have been traded on the stock market and have been bought up by investment companies. This very dynamic and complex situation calls for a detailed approach and an understanding of the UK market as a whole.

We have met a wide range of providers in our focus groups and inspections. We found that in Wales there are still many small companies, often family-run providers, which provide local services. Some companies need to have private clients to make sure they do not risk having to close when councils review their commissioning to save money by having bigger contracts with larger providers. Some of the smaller providers do not have efficient back-office systems, do not have good control over costs and do not make use of information communications technology.

8.4.2 Franchising

We were interested in the positive experiences some providers have had when starting up companies as part of a franchise. Many local small businesses providing domiciliary care and other local third-sector organisations would benefit from being part of a dedicated Welsh domiciliary care franchise that understands the context

and regulatory framework of providing care in Wales. We believe this is a significant opportunity for business development.

The Welsh Government could support the development of a Welsh-branded franchise through an established independent or third-sector provider, which would support new and smaller providers and 'micro businesses' (a company with a single employee, for example) through mentoring, back-office functions and quality-assurance systems to help them provide high-quality local services, especially in more rural communities. Once seed funding or support has been provided, this could be a wholly independent franchise generating income from a percentage fee based on turnover.

We are also aware of local projects (for example, Solva and Pembrokeshire) and the use of 'community catalysts' in Somerset (people who create networks within communities with a view to developing community-based services) to support micro-businesses in domiciliary care. These initiatives could be used to develop care and support services in more rural communities.

8.4.3 Information and communications technology

We wonder if Business Wales could work with these smaller providers to make them more resilient and help them share and improve back-office functions.

In the review we found that the sector is using a significant amount of information and communications technology and it is becoming even more sophisticated. Used well, it could significantly reduce transactional costs, improve planning and monitoring, and give assurance. Given the very high volumes of complex transactions that take place, there is huge potential for information and communications technology to make domiciliary care more efficient, especially by reducing back-office costs.

As ever, there is a danger of systems becoming too complicated and encouraging behaviours that are logical rather than person-centred. We think there should be:

- a digital strategy for domiciliary care in Wales; and

- an opportunity to share best practice and support providers to use information and communications technology.

We also found that there are problems with systems working together, especially council payment systems and provider internal systems. We should plan for the future together to avoid investing in systems that won't be able to talk to each other.

8.4.4 Suggestions

- The National Commissioning Board, with support from us, should lead a forward-looking market analysis to identify trends in operations, ownership patterns and the possible risks and opportunities.

- Through Business Wales, the Welsh Government should explore setting up an independent domiciliary care franchise for Wales, *Gofal Cartref Cymru*, possibly as a social interest enterprise.

- The National Commissioning Board should consider including a digital area of work in their programme.

8.5 Other issues

While carrying out this review we were also mindful of:

- regulation and inspection arrangements in the future; and
- the fee cap (or limit) that has been introduced so people and their families can get support with paying for domiciliary care.

8.5.1 Regulation and inspection

The new Regulation and Inspection of Social Care (Wales) Act 2016 and the new regulations, code of practice for inspections and service standards to be developed for 2018 give us a unique opportunity to rethink our approach to regulating and inspecting domiciliary care.

We also need to consider which services should be formally regulated and how they should be treated. However, there are exceptions written into the Act, such as

services providing support and recruitment services to people employing personal assistants.

Inspecting domiciliary care is not easy. The care takes place in people's own homes and inspectors do not necessarily have the right to visit. They also have to be careful about handling personal data, which can include people's addresses and contact details. Also, as we have found in this review, the size of agencies and how they are run varies widely. Other UK regulators are struggling with this issue too.

We believe our current regulations and standards are narrow and ineffective. In particular, they do not focus enough on scheduling, internal quality assurance and the well-being of staff, which lie at the heart of the quality of a service.

When developing any approach, we need to make sure that regulation and inspection:

- focuses on what matters to people;

- focuses on the things that make the most difference to service quality;

- is effective in dealing with shortfalls;

- encourages improvement;

- encourages providers to be responsible;

- takes account of the different types of agencies providing domiciliary care;

- responds to new service models, such as nursing care; and

- is efficient and not a burden.

In our survey, two thirds of providers said they found the current inspection arrangements helpful. We did not ask why and we were surprised by this result, because we believe the current methods are not sufficient.

The problem is that although the National Minimum Standards (NMS) deal with many of the concerns that people using services have about quality, they do not line up well with the regulations that would allow us to enforce them. Also, the regulations

tend to focus on processes, not outcomes. In some areas, there are significant contradictions between the expectations being set out. For example, Regulation 14 (3) states that:

> 'The registered person shall, so far as is practicable, ensure that the personal care which the agency arranges to be provided to any service user meets the service user's needs specified in the service delivery plan.'

This is at odds with the National Minimum Standards, which under the title 'responsive services' aim to promote the outcome:

> 'Service users receive a flexible, consistent and reliable personal care service'.

The National Minimum Standards also contradict each other. For example, standard 7.1 says:

> 'The agency is reliable and dependable and is able to respond flexibly to the needs and preferences of service users which arise on a day-to-day basis, and services are provided in a way that meets the outcomes identified from the needs assessment.'

But standard 7.2 says:

> 'Staff arrive at the service user's home within the time band specified and perform the tasks specified in the service delivery plan.'

It is important that the arrangements under the new Act take a more coherent and consistent approach. They should be consistent with outcome-based commissioning and allow for when service standards are poor.

We believe that the inspection methods used in this review are a significant improvement on our current approach and that the ratings and our lines of enquiry are a good basis for future discussion. This review has highlighted specific concerns that need to be considered; for example, managing personal boundaries, care worker continuity and problems around medication training. We did not formally evaluate our approach, but we received very positive feedback from providers and

inspectors, who said the approach was more thorough. It did, however, take twice as long.

We also wonder if it is time to look again at the risks and benefits of announced and unannounced inspections in domiciliary care. We believe there are advantages to having announced inspections.

We have also been trying out the following other methods.

- When inspecting providers that run more than one agency, inspecting services across all the agencies instead of focusing on individual agencies.

- We shadowed a care worker for a day. Whilst this gives a valuable insight to the pressure and demands on the care worker, it is difficult to use this to form judgements confidently about the wider operation of the agency.

- We used a new online survey as part of this review, which was fairly successful in collecting information on how agencies are run. This could help us when designing annual returns.

We believe the regulator has to be able to distinguish between the two main types of agencies – supported living and traditional domiciliary care. They do this in Northern Ireland, although some agencies provide both of these services. We believe it is worth considering having separate standards and inspection approaches.

We will be introducing a risk-based approach to inspection in the future. Unlike care homes, agencies can change in size and the types of services they offer quite quickly. We know that agencies that grow quickly or move into new geographical areas are more vulnerable. As a result, we believe it would be useful to look again at the notifications we require from agencies so we can help to reduce the risk of failure.

The findings from this review could be used in a workshop to consider future approaches to regulating and inspecting domiciliary care.

8.5.2 The current cap on charging fees

In 2015 families paid only the first £60 a week for domiciliary care and local councils paid for any care that cost more than this. Although this policy means well, we were interested to know how it is affecting the market. This issue arose when we were inspecting Powys County Council in 2015. In their discussions with Herefordshire Council and agencies on the border, it appeared that having the cap was bringing more people into the social services system. Providers told us that they preferred working in Herefordshire because they had a higher share of private service users, who were paying a higher rate. In the survey we asked commissioners and providers about how the cap affected them and what they thought would change if it was lifted.

This is what they told us.

Commissioners

- Commissioners told us that the cap draws more people into the formal care and support system than there would be without it. This places a higher cost burden on the council, which has to pay fees to agencies and administrative costs, including arrangements to 'collect client income'.

  > 'The impact has been twofold – the number of clients now receiving support from the local authority who would previously have been self-funding has been significant and the loss of income to the council has been significant. It has been estimated that the total lost income for the council within 18 months of the implementation of the cap was in excess of £2 million' (Commissioner survey)

- Some commissioners said that this makes them less able to pay better fees to providers, because the budget is spread too thinly. In turn, this makes providers less able to survive and grow in the long term, affects the quality of domiciliary care and drives wages down.

- Some commissioners also said that people whose finances exceed the capital limit financial threshold are choosing to use high levels of domiciliary care, because they only have to pay £60 to avoid residential care. This has made

some care packages more expensive than residential care, which would be more appropriate for the person concerned.

> 'More people are choosing to remain at home with large packages of care as a lower cost option for those with resources over charging thresholds when residential care may be most appropriate option, family pressures associated with this' (Commissioner survey)

Providers

Some providers did not understand the cap, confusing it with a ceiling price set by some councils. Those that did understand it made the following comments.

- 'It restricts how many private people we have'. (numerous comments);

- It results in lower wages for care workers, which causes recruitment problems: it 'restricts us in terms of attracting quality staff'.

- 'People remain in their own homes longer than before the cap, care packages increase as the person becomes frailer, their needs are often more complex, such as dietary needs, complex manual handling and tissue viability' (Provider survey)

- Several providers said that the cap adds to their financial pressures.

- The cap limits what agencies can offer people because it restricts the agency to providing what the local authority deems as eligible care i.e. not *'"add-ons" to benefit clients'*.

- Some providers said the cap was limiting the growth of their businesses.

The cap seems to be reducing providers' income and driving down wages for care workers. However, we must consider carefully how removing the cap would affect people and their families.

9   Acknowledgements

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We would also like to thank local authority staff and managers, care providers and their care workers, and our partner organisations – including the third sector – for your time, cooperation and contributions. You have given us a lot of your time and been very open about exploring the challenges and problems you face. We really appreciate it and hope this report will help us all to improve domiciliary care in the future.

We are also very grateful to our own staff, the inspectors and area managers who inspected the agencies and councils and were willing to try new ways of inspecting, our analysts, and our communications, process and support staff who helped with the surveys and interpreting the data. It has been a lot of work and a team effort.

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11 Appendices

Appendix A: Methodology

Inspectors visited six councils for a total of four days each between September 2015 and February 2016. The councils were Cardiff, Carmarthenshire, Denbighshire, Monmouthshire, Swansea and Wrexham. At each council, inspectors considered the experience of six people in detail, reviewing the case files and speaking to people or their families (or both). We held focus groups with care managers, domiciliary care agency providers and met a wide range of council staff.

We sent a survey to all councils and local health board commissioners in Wales in August 2015.

We used an enhanced methodology to inspect 70 domiciliary care agencies. We considered the experiences of five people in detail in each inspection, reviewing their case files and talking to people or their families (or both) over the phone or in their homes.

We gave questionnaires to care workers by publishing them on our website and giving them out during inspections.

We gave questionnaires to people using services and their families by publishing them on our website and giving them out during inspections.

We sent a survey to domiciliary care agency providers in September 2015.

We held three regional workshops for commissioners and providers to identify specific challenges and share ideas and successful ways of working.

We held focus with registered managers and older people receiving services or with their families (or both).

We also held meetings with individual people, such as care providers, directors of social services, dynamic purchasing systems, commissioners and care managers.

We had three meetings with the stakeholder reference group.

Appendix B: Participants

Welsh local authorities

Blaenau Gwent County Borough Council

Bridgend County Borough Council

Caerphilly County Borough Council

The City of Cardiff Council

Carmarthenshire County Council

Ceredigion County Council

Conwy County Borough Council

Denbighshire County Council

Flintshire County Council

Gwynedd Council

Isle of Anglesey County Council

Merthyr Tydfil County Borough Council

Monmouthshire County Council

Neath Port Talbot County Borough Council

Newport City Council

Pembrokeshire County Council

Powys County Council

Rhondda Cynon Taf County Borough Council

City and County of Swansea

Torfaen County Borough Council

Vale of Glamorgan Council

Wrexham County Borough Council

University Health Boards

Aneurin Bevan University Health Board

Cardiff and Vale University Health Board

Inspections of local councils

The City of Cardiff Council

Denbighshire County Council

Monmouthshire County Council

Pembrokeshire County Council

City and County of Swansea

Wrexham County Borough Council

Focus groups

Focus groups held with:

- Welsh Senate of Older People

- Cymru Older People's Alliance

- Age Connects North Wales

- Registered managers - domiciliary care agencies

- United Kingdom Home Care Association

- Expert Reference Group for Domiciliary Care in Wales

- Q Care domiciliary care agency

- Cartrefi Cymru

- Wales National Commissioning Board

- Provider and commissioner workshops held in north, south-west and south-east Wales

Stakeholder Reference Group

- Paul Murphy, Domiciliary Care Association Wales

- Wayne Rees and Keri Llewellyn, Expert Reference Group for Domiciliary Care in Wales

- Yvonne Apsitis, United Kingdom Home Care Association

- Malcolm Perrett, Care Forum Wales

- Meryll Randell-Jones, Age Cymru

- Ian Thomas, Stephanie Griffith and Gerry Evans, Care Council for Wales

- Ian Oliver, Neath Port Talbot County Borough Council

- Amanda Philips, The City of Cardiff Council, local authority commissioner

- Chele Howard, Bridgend County Borough Council, local authority commissioner

- Claire Aston, Aneurin Bevan University Health Board, health commissioner

- Steve Vaughn, National Commissioning Board

- Catherine Evans O'Brien, Older People Commissioner Wales

- Neal Kelly, dynamic purchasing system provider, ADAM

- Nick Andrews, Swansea University

Other sources

'*In the game together – the commissioning, delivery and regulation of relationship-centred homecare*' (Swansea University, CSSIW, Health and Care Research Wales and Joseph Rowntree Foundation): an event to creatively explore relationships.

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Care Council for Wales Resource Hub.