Home Care: potential and paradox – a case study of England

Jill Manthorpe
Professor of Social Work

@scwru
PART 1: POLICY AND CONTEXT
Home care – mostly local government commissioned but not provided

Assessment by local authorities/councils (Care Act 2014)

Means-tested (payments)

If eligible – support plan to meet outcomes – if not information and advice – and pay for your own care (self-funders)

Decreasing numbers eligible for publicly funded home care as threshold for eligibility rise (not numbers)

Example: Mrs Smith – very frail, not able to wash herself or go to the toilet, cannot prepare food. Home care workers visit x 4 per day to provide personal care, also has alarm and visiting family members
A note on terminology and definitions of service

• Home care
• Home help
• Domiciliary care
• Home health care
• Does it include person providing live-in care?
Workforce note – many terms

The workforce

• Home care workers
• Domiciliary care workers
• Home helps
• Home care aides
• Personal assistants
• Support workers
• (Home) Carers – beware confusion with family carers
Tasks note

Expansion of tasks and complexities

Personal care – covering lifting, hoists, feeding, toileting, washing, dressing etc

+ overlap with practical care at home (housework)

Role substitution with nurses eg offer medication, stoma & catheter care, PEG feeding (see illustration) and information technology (IT)
Relationships note

• Phrase ‘person-centred care’ used
• Emotional labour implicit if under-recognised
• Measurable by continuity of care and satisfaction, and feeling of being treated with dignity & compassion
Costs note

UKHCA minimum price for homecare services of £15.74 per hour (=26,826 won), is calculated to enable full compliance with National Minimum Wage and the delivery of sustainable homecare services to local authorities and the NHS.

In UK National Minimum Wage = £6.50 per hour
One last note

Who is home care for?

• Meeting whose outcomes – older person or caregiver?
• Important evidence that home care supports family caregivers
Care home use declining in England – implications for home care

In England the number of permanent moves to residential and nursing care homes for both younger and older adults per 100,000 population reduced in 2013-14, compared to the previous year.

For older people there were 650.6 permanent moves per 100,000 population compared to 697.2 in 2012-13 (HSCIC 2015)

Implications for home care?
Greater disability & end of life service
January 2015 Age UK reports the number of vulnerable older people getting help in their homes has dropped by a third over the past five years to 371,000. Spend on home care has dropped since 2010/11 by 19.4% (£276,922,528) falling from £2,250,168,237 to £1,814,518,000.
The paradox of Home Care

It is seen as the answer to so many problems:

• Ageing population with increasing frailty
• Wish to age at home (cheaper)
• Job & skills creation
• Assist in hospital discharge & care home delay
• Personalised – relationship based
But home care has problems

- Poor quality – often arising from short and rushed visits = poor outcomes
- High turnover and lack of continuity of care/worker
- Job insecurity – zero hours contracts, paying for travel time, training, despite national minimum wage
- No career ladder or progression
- First job before ‘something better’
UK Media
Story 1 - 14 May 15

• ‘Keep visits to elderly brief, carer (home care worker) was told’ *The Times*
• *Routinely ordered to cut short visits (clipping)*
• *Told to leave fallen older people and call ambulance*

See also
http://www.bbc.co.uk/news/business-31869447
‘Birthday appeal for Sheffield woman, 99, goes viral’ BBC News
http://www.bbc.co.uk/news/uk-england-south-yorkshire-32720354

Serenta Home Care, which looks after Mrs Blagden, said: "She calls us her little family; we are absolutely overwhelmed by your kindness. She truly is a very special lady and you will all help to make her day as special as she is."
Evidence – not all bad!

The measure of social care-related quality of life (SCRQoL) gives an average quality of life score based on the responses to eight questions in the Personal Social Services Adult Social Care Survey (ASCS).

In 2013-14, the average SCRQoL score for England was 19.0, compared to 18.8 in 2012-13 & 18.7 in both 2011-12 & 2010-11. 76.8 % service users reported they had as much control as they wanted or adequate control over their daily lives, an increase from 76.1% in 2012-13.

In 2013-14, 64.8 % service users were extremely or very satisfied with their care and support - an increase from 64.1% in 2012-13.
PART 2: WORKFORCE AND PRACTICE POINTS
Why do home care work?

- Want to make and see a difference
- High job satisfaction, personally rewarding, feel valued
- Familiarity of location and skills
- Flexibility and proximity of work
- Fits with other responsibilities
- Work available, potential to increase earnings
- Stepping Stone to other work eg health or child care
- Not very overlooked, ‘do things my way’
Who does home care work?

• A ‘pink collar’ job – female in the main
• Often part time
• Older/midlife workers
• Local
• First step for migrants
• Advantage in England of National Minimum Data Set for Social Care
Is Home Care part of a team?

Role and responsibility of home care workers to:

- Alert if concerns?
- Monitoring?
- Communication with family & professionals
- Prevention (eg pressure ulcers)
- Recording eg medication

- Concept of care chain
Emotional labour of the work

• Role in end of life or palliative care
• Working and witnessing decline and death
• Managing own and others’ distress
• Conflict management
• Working with ‘hard to help’ – example singing while helping to dress
Home care: potential for abuse and neglect

- Evidence of higher risks of financial abuse in this setting – theft, grooming, exploitation
- Fears of higher risks from non-regulated home care eg directly employed home care workers
UK prevention of elder abuse in home care services

- Checking of criminal records (Disclosure and Barring Scheme)
- Publicity about safeguarding services
- Responsibility of employer – regulated by Care Quality Commission
System instability

• Commercial system – uneven and business turnover (very little local government or not for profit)

• Few rewards for good service (demand high)

• External threats from competitors and revised local authority contracts

• Internal pressures of staff turnover, lack of quality staff.
Policy Options 1

Regulation of home care staff (agencies are regulated)?

• Advantages: quality assurance, training imperatives, increased trust in the system, skills ladder?

• Disadvantages: cost.
Managed market?
Agreements over guarantees of work
Advantages: stability, planning, economies of scale
Disadvantages: anti-competitive, favours large providers, cost
NB some hints of this in our new Care Act 2014
Policy Options 3

Link with National Health Service (NHS)?
Advantages: integrated care whatever the location, care coordination, career pathways, quality assurance
Disadvantages: cost, lack of NHS interest
Policy Options 4

Technology?
Advantages: labour saving, manage risk, eg falls, alarms, etc., assuring, individually tailored
Disadvantages: little evidence of replacement, impersonal, cost of maintenance, over-generalised
Policy Option 5

New labour pools?
Advantages: address shortages, resolve under-employment and unemployment, labour market step up & step down
Disadvantages: tried already, eg migration, older/young (apprentices) – lack of evidence
Incentivise family to provide more home care

Advantages: known to person – bonds of relationship and duty

Disadvantages: families working, far away, other responsibilities. Hard to insist. Already happening where possible.
Policy Option 7 (one chosen)

Consumer choice (including proxies such as family carers)
People publicly funded & eligible must be offered Direct Payment (cash for care) or managed personal budgets
Disadvantages: further fragmentation, lack of monitoring, no training
Advantages: cost effective, choice, individual relationship, better outcomes?
PART 3: GERONTOLOGY
MESSAGES
Gerontology’s strengths?

Multi-disciplinary
Social model + clinical links
Multi-methods
Engagement with older people
Emphasis on impact and applicability
Theoretical understandings and developments
Home care neglect in research

• Little research on home care
• Invisible
• Not taken account of in other studies (eg do day centre users have home care?)
• Very very little on continence
Using new research developments

Measuring the outcomes of social care, such as home care
Eg ASCOT

- Control over daily life
- Personal care
- Meals and nutrition
- Safety
- Social participation and involvement
- Occupation and employment
- Accommodation, cleanliness and comfort
- Dignity
Potential to build up key research questions?

How to do this?

- Scoping studies (what is known, unknown)
- Delphi consultations

- Dynamic approaches eg James Lind Alliance methods: ‘tackling treatment uncertainties together’
Implications: messages for gerontologists

- Law of inverted evidence – much home care – little evidence
- Need to ask BIG questions – LARGE data and SMALL – multi-methods, longitudinal and experimental
- Potential to build up key research questions?
Making use of existing data

• Large scale data sets
• Archiving data
• Secondary analysis

• Through influencing funders and researchers
Conclusion: Home Care – the paradox and potential

England is an example of fragmenting, overlapping and patchy systems – with good practice surviving in many places.

The quality of work of home care affects quality of life for older people.
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Our Research

Studies from the Social Care Workforce Research Unit,

(1) Data from National Minimum Data Set for Social Care

(2) Interviews and surveys - Longitudinal Care Workers Study – with local independent managers, staff (private and not-for-profit, residential and domiciliary/home care, big and small) and users of care services and family carers

(3) On-going analyses of where care goes wrong (serious case reviews)

(4) Secondary analysis of studies of migrant care workers

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http://www.kcl.ac.uk/ssp/p/policy-institute/scwru/index.aspx