

MESSAGES ON THE FUTURE OF DOMICILIARY CARE SERVICES

**PROFESSOR JOHN BOLTON AND
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Foreword

The Institute of Public Care (IPC), Oxford Brookes University are really pleased to host the work of our Professor John Bolton and Dr Jane Townson of Somerset Care on a subject, the effective commissioning, design and delivery of outcome based domiciliary care, which has both excited and challenged a number of social care commissioners and providers of care. While many people would subscribe to a general consensus on the benefits of moving to this way of working, we are still confronted by issues of cost, the recruitment and retention of staff, provider flexibility and how to introduce sustainable innovation – elements that all contribute to the way we need domiciliary care to operate successfully in the future.

Specifically, we see that the development of an outcome focused specification is like dropping a pebble into a pond – the ripples radiate out changing all the water in the pond until it settles again. Therefore, it's the potential changes that we need to anticipate and prepare for if we want to drop that pebble.

We see the publication of this paper as coming at a crucial time in the delivery of care and support to help, where appropriate, at home and in their communities as the financial challenges in the sector look to remain into the future and that the importance of delivering outcomes is a key element in our pursuit of managing unintended demand.

In their paper, John and Jane offer the reader their own experience and suggestions on what and how needs to be explored: price, supply, demand, service design and innovation, to effectively deliver outcomes and the importance of transparency and good working relationships between commissioners and providers. We hope that you find the paper useful as a series of key messages to share, discuss and consider with colleagues and take your next step to ensuring that the future of domiciliary care, and possibly other types of support, is well and truly outcome focused.

Finally, thank you to colleagues at Somerset Care for providing the photographs in the document.

Philip Provenzano
Assistant Director
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Messages on the future of domiciliary care services

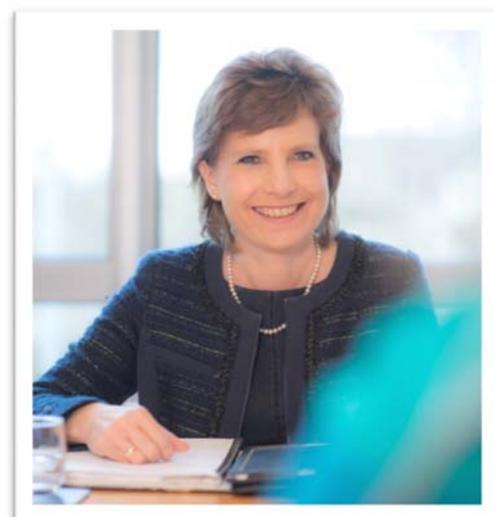
Introduction

This is a paper co-authored by Dr Jane Townson, the Chief Executive of Somerset Care and Professor John Bolton from the Institute of Public Care. The authors both have a background in the support and delivery of care. Jane leads a not-for-profit provider of care, that delivers residential care, supported living for people with disabilities, housing with care and domiciliary care across southern England. John is a former Director of Social Services and has written widely on social care and what its future might bring. This piece looks to bring together two different perspectives with a strong focus on how might we continue to help people to remain in their own homes and what might care look like in tomorrow's world.



Jane and John do not agree about everything. However, they recognise the importance of those who are providing services and those who are commissioning services having a constructive dialogue about the future of care and support for older people in their own homes. They share a belief that lack of constructive dialogue between the key stakeholders including those who are the customers has led to the current unsustainable care market in parts of the United Kingdom.

At one level the policies of the last few governments (across the United Kingdom¹) have been almost silent on domiciliary care. In the 1990s the main focus was on the role that domiciliary care could play in helping people to remain in their own homes and to live an independent life – there has been less emphasis on this, in policy terms, in recent years. The new policy framework in the 2000s focused on personalisation and personal budgets, but the policy makers have been ambivalent as to whether formal domiciliary care or personal assistants should be the model which assists people to live a more independent life. However, despite the strong push for personal budgets from successive governments, delivered through Direct Payments, most councils continue to contract with local suppliers of domiciliary care and the majority of care at home is purchased by councils in that way across the United Kingdom.



¹This paper will focus on opportunities that can be applied in any of the four home nations that have policy responsibility for domiciliary care.

There are a set of challenges that are faced by most councils in relation to the delivery of care. The national debates mainly focus on the cost of the overall service against the availability of supply. This paper considers the importance of getting the price right for both the public purse and providers but it also considers what kind of service will be right for the future.

This paper explores 7 key areas of principles and suggests that there are 4 main messages that need to be heeded by commissioners and providers of domiciliary care if the service is going to be sustainable.

The 7 areas are:

1. The costs of care
2. Improving the supply of care
3. How might demand be better managed?
4. Personalisation and menus of choices
5. A focus on outcomes
6. Innovation in Care at Home
7. Housing with Care

The key messages focus on:

1. Start with a clear understanding of the costs of the service and ensure that personal budgets can meet those costs
2. Work collaboratively on the supply of staff
3. Focus with customers on the outcomes that good care can deliver. This should mean that packages of care should operate in a more flexible way so that customers (and their carers) can choose from a wider menu of options which will enable them to remain at home.
4. Use technology to assist customers to manage the services they require.

It is an important part of this paper to suggest that there is rarely a single solution to meeting people's needs and that individuals vary in preferences and requirements. More councils are looking at how families can play a part in delivering care but where the family members are appropriately supported by supplementary care from others (this may come from paid care at home or respite care etc). There is much new work looking at how either a person's local support network can be encouraged to play an active part with the service user or how local communities can again supplement the care that is required as well as enhancing the experiences and the life opportunities of the person with care and support needs. Unpublished work from the Institute of Public Care found that the majority of older people who receive care and support live alone without local carer help available.

We would like to thank staff at the Institute of Public Care and The United Kingdom Homecare Association who have assisted us with this paper.

Professor John Bolton
Dr Jane Townson
April 2018

1 The costs of care

In this section we explore the following principles:

“Stakeholders should all be clear on the costs for delivering local services. The costs should be shared in an open way by providers and understood by commissioners”,

“Commissioners should be clear on the local care models that they will use in their area and how this might offer a choice of menu for their potential customers”

The United Kingdom Homecare Association (UKHCA) has calculated the costs of running a domiciliary care agency in the United Kingdom² and has come up with a calculation of £18.01 per hour to ensure compliance with the National Living Wage and the National Minimum Wage and to deliver a good quality service (with a much higher price for London or those paying the Scottish Living Wage or other calculations for what might be “the living wage”)³. The information and the calculations are included on their web site. For a commissioner who wishes to ensure that the provider is compliant with the applicable National Minimum Wage (and the National Living Wage), the hourly costs are calculated as follows:

Contact time	£7.78
Travel time	£1.48
NI, pensions & on costs	£2.42
Mileage	£1.40
Business Costs	£4.41
Profit / surplus	<u>£0.52</u>
	£18.01

It is important that commissioners understand the associated costs for domiciliary care. It may be possible in some urban areas to reduce the travel costs or even to reduce the business costs but any reductions are only likely to achieve a small reduction in the overall costs. The largest single cost will always be the amount paid to the worker and the associated pension and national insurance costs. The model shows this as 72% of the overall costs (including travel time and costs).

One way to confirm the costs of care is to use an “open book” accounting approach where the provider shares the information on their costs with their local commissioners. Commissioners can calculate an “average set of costs” by comparing the figures from a range of their local provision. This is an approach which is used in parts of the United Kingdom to understand the costs of residential care and which can easily be adapted to suit domiciliary care providers.

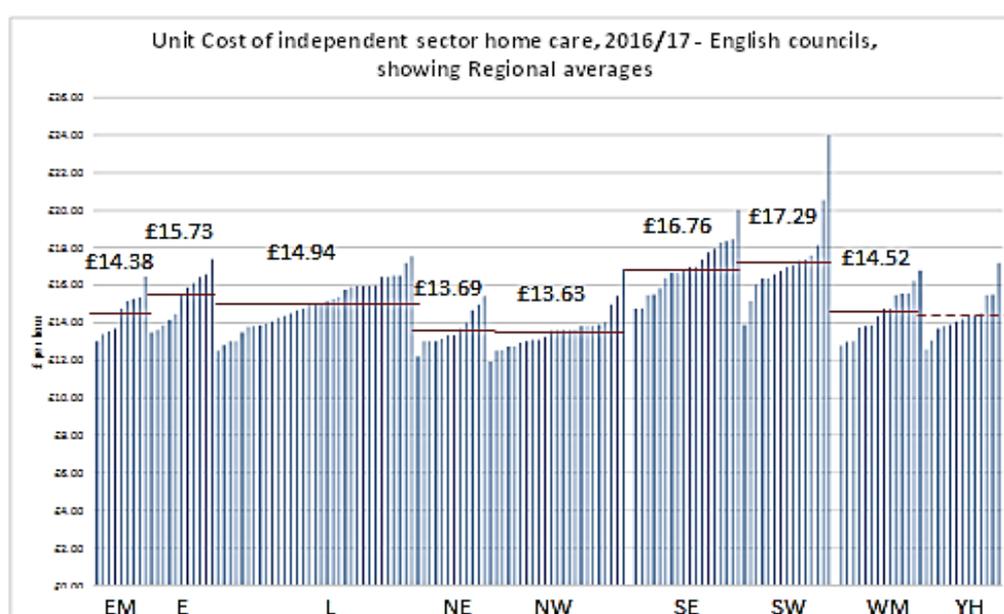
The graph below⁴ shows the reported contract price for councils in England (in 2016/17) who are paying for domiciliary care. It is clear that hardly any council meets the stated

² Basic Costing Model for the provision of social care - <https://www.ukhca.co.uk/CostingModel/>

³ The National Living Wage from the chancellor will be £7.83p on April 1st 2018

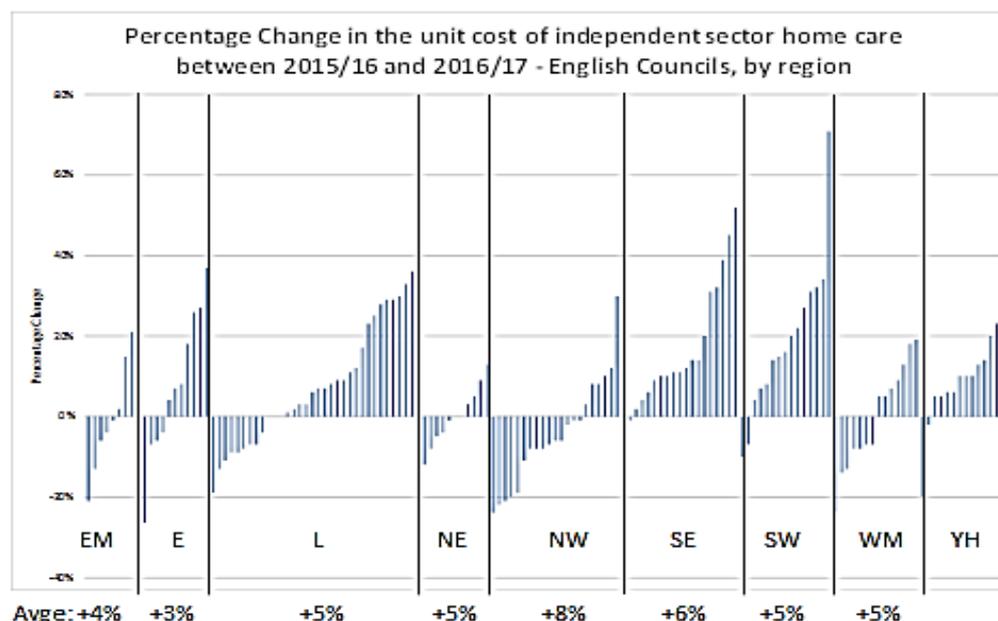
⁴ Graph produced by Rachel Ayling from National Returns.

minimum price for domiciliary care. Councils might argue that the price they pay has been set through a proper competitive process and that these are the agreed prices that providers have stated they will accept to run the service. However, given a long list of factors (i.e. recent cost pressures through increases in the national living wage, pensions, regulatory fees, apprenticeship levy and general inflation, and the fact that a number of providers are reporting that they cannot sustain their businesses at current price levels, whilst ensuring compliance with workforce and quality regulations), means that there is certainly a problem for this market. Furthermore, commissioners tend to prioritise price over quality and there appears to be little consideration of the impact of either poor quality support or the care on those receiving services, or the ultimately higher costs to commissioners of provider failure. In some parts of the United Kingdom the local authority is the main purchaser of domiciliary care and therefore has used their purchasing powers to keep prices low.



For providers of domiciliary care their main concern (in addition to the factors stated above) has been how they can effectively run their business, maintain or improve quality standards, and innovate, with very tight margins that are currently offered by councils. In fact many providers are reporting that they are making a loss on some council contracts. The price of care has become the most significant issue for them. Some providers have handed back contracts to councils as they have been unable to deliver quality services at the price the council is prepared to pay. Some providers are slowly leaving the public sector market and focusing on building their own private customers to sustain their local businesses.

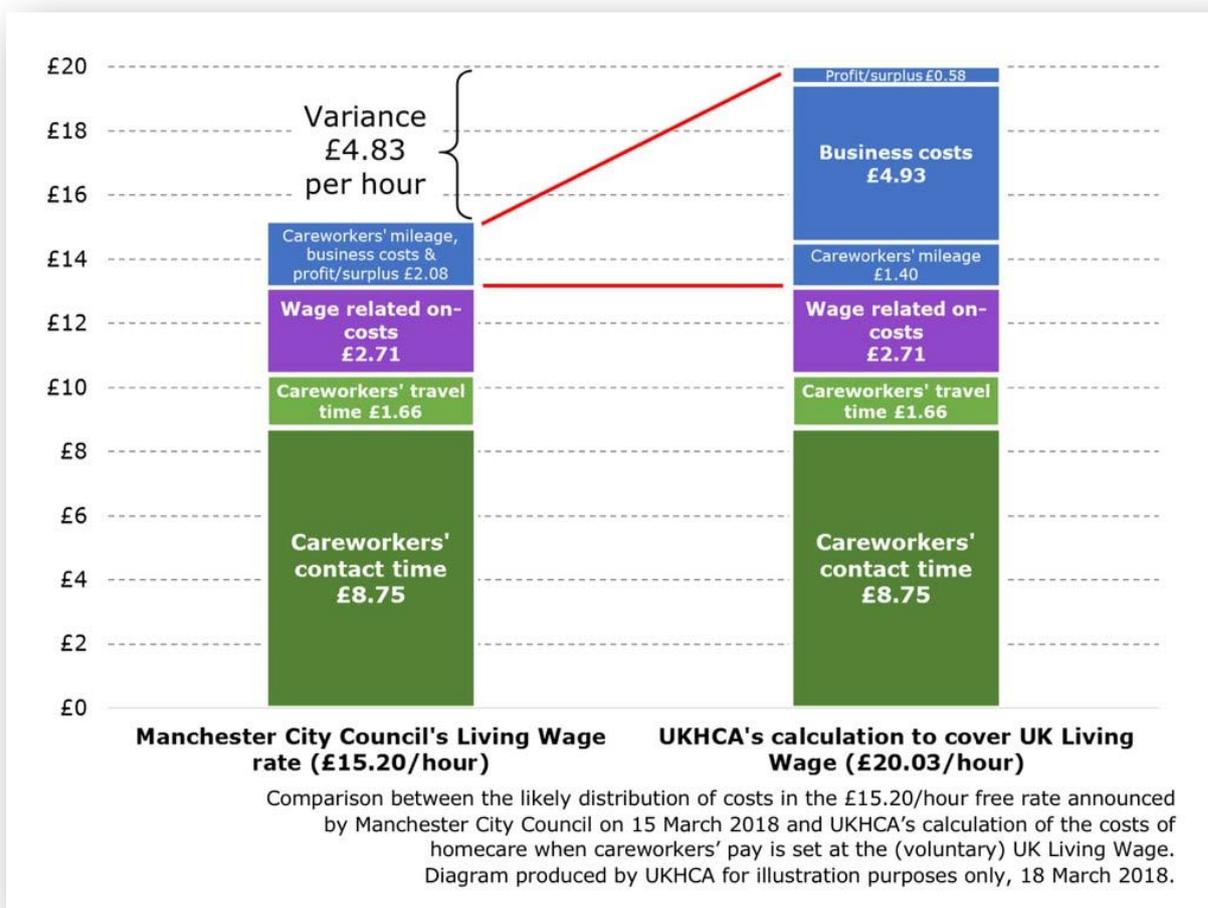
Many commentators describe this as a “crisis” in social care with financial challenges faced by councils (due to reductions in government grant) and low prices being paid to providers who cannot deliver services nor recruit the right numbers of staff.



Some councils have begun to recognise the challenges faced by providers and have started to offer significant increases in the hourly rate they will pay. But as the graph⁵ above also shows some continue to reduce the price they are prepared to pay. The best prediction is that it is likely that fewer providers will keep their businesses going unless there is an agreement to pay more for the current services on offer. One council (Manchester) is reported to be paying an increase of 17% to their providers of domiciliary care from 1 April 2018. This increase focuses on a (Manchester) living wage for the care staff of £8.75p per hour⁶. However, the council will still only be paying the providers a figure of £15.20 per hour (from a previous rate of £13.50) which means that many providers will still struggle to provide the appropriate infra-structure for the carers. If staff are paid £8.75 per hour there will be an additional £2.71 to be paid to cover national insurance and pension costs. This adds up to £11.46 per hour. This gives the company £3.74 from which to run their business and make any small profit (about £1.19p per hour less than is required according to UKHCA). This therefore does not allow staff to be either paid for their time travelling between customers or to be paid any mileage rate. This may slightly defeat the whole purpose of increasing the wage when these cost fall back on the staff member. If commissioners used the UKHCA model for costing a service then paying staff £8.75 per hour should equate to an hourly cost paid of £20.03 per hour.

⁵ Graph produced by Rachel Ayling from National Returns

⁶ The National Living Wage from the chancellor will be £7.83p on April 1st 2018.



If councils want quality services they need providers to have good quality (well paid) managers and supervisors to run the services who have good knowledge and experience of the people with whom they are working. The infrastructure of the organisations requires finance, human resources, marketing, quality assurance and governance people to ensure stability and quality of the service. The organisation must be compliant with the standards laid down by the Care Quality Commission. They need staff with permanent contracts that are paid travel time as well as travel expenses. The calculations that those who run care businesses have come up with show that in many places the cost of running a properly compliant care organisation requires over £20.00 per hour.

Generally providers report poor relationships between themselves and local councils. There are always exceptions to this but those are quite rare. Councils have felt they have had control over the domiciliary care market and have mainly focused on driving the price down and then been a bit surprised when the quality or the response from the service has not been as they expected. We have seen a decline in the numbers of providers commissioned from local authorities and in the numbers of new customers receiving care.



Some councils have tried to see if they can reduce the costs for providers by reducing the travel time of workers. They have parcelled up their contracts on a locality basis and asked providers to deliver to a particular area or district. On occasion councils have brought in new providers of care believing that they can offer a new solution but generally this has not worked for a number of reasons. Mainly because new companies have not been able to attract the volumes of staff required (staff have been reluctant to leave their previous employers or have just left the service when changes have occurred) and it has usually taken two to three years for the new arrangements to bed in. In the meantime older people have received inconsistent care.

There may be some suppliers who because of their unique circumstances may be able to deliver at a lower cost. It is the responsibility of any commissioner to be clear that they understand the reasons why this might be the case, for example, whether they are compliant with National Living Wage Regulations and other relevant legislation, and how sustainable is the business in the longer run.

There is a particular issue for the costs of domiciliary care in relation to those councils that either run these services “in-house” or through a Local Authority Trading Company in whom the council has an interest. The main service that councils continue to run in-house tends to be their domiciliary care reablement service. It has been found that in many cases the cost of running these services equates to more than £30.00 per hour (costs of over £50 per hour have been found in some councils).

The first comment to make is that it appears both contradictory and unethical if a council is not paying £20 an hour to an external provider but that it can justify paying £30.00 (or more) for its own services. Second is that many in-house reablement services offer a restricted short term service and the impact of the “reablement” is fairly limited within the

overall homecare market for their area. Third, in-house reablement services are often operationally inefficient and inflexible. Running one reablement team to cover a large rural county, for example, can result in up to 50 per cent of the time spent travelling, as well as gaps in staff rotas due to variable demand. In provider organisations, with concentration of staff in particular geographic zones, travel time is reduced and reablement workers can also cover regular home care if they have gaps in their daily schedules. This makes it even harder to justify the higher costs.

Many current suppliers of domiciliary care would welcome the opportunity to have a contract to deliver short term care with a focus on reablement and recovery if the price was set close to £30.00 per hour. The key issue for this service is ensuring that the right support from therapists is available to the external service. This has now been achieved in a number of places (see sections below).

Most councils continue to rely on traditional domiciliary care agencies to deliver the care that is required in their area. This is likely to be the case in the future. Though other approaches to delivering personal care have been developed (discussed below) none of these have been developed at a scale or consistency of supply that means they could at this stage replace the care agencies.

Barking and Dagenham

The work in Barking and Dagenham in developing a market for personal assistants is captured in the paper produced from the Local Government Association's (LGA) Efficiency and Productivity Programme¹. It describes a council looking to replace all provision of care for people in their own homes through the use of personal assistants. No other council (from the information available) seems to have gone for a similar approach. The new service (including transaction costs) was found to be marginally lower cost than the traditional services commissioned from agencies. This included a commitment to ensure that all personal assistants (paid carers) were paid at a rate that ensured they received the London Living Wage.

The approach did include the commissioning of two organisations whose role it was to recruit and support personal assistants as well as to offer the right support for service users who needed to ensure that they had all the required processes in place to act as employees. It is probably these factors (the recruitment and the employment of personal assistants) that have proved to be challenging that has meant the model has not really been developed at the scale initially envisaged by the policy makers. However across the United Kingdom there are still a significant proportion of people with care needs (mostly younger adults with disabilities) who have employed personal assistants successfully to meet their needs.

Somerset

A new approach has been reported in the most recent LGA Efficiency and Productivity report¹ that has highlighted the work in Somerset (and other places) in developing a set of community enterprises that can support the care for people in their local communities. This approach has built on previous initiatives within the council through the development of “village agents” and working with community activists and organisations to find local people who are interested in delivering care. This has created a strong network (particularly in the rural areas of Somerset) which can either supplement care from agencies or to replace that care.

This could, however, change quite rapidly if entrepreneurs with “disruptive technologies” and new approaches gain traction in the market, with no change in legislation to ensure fair competition. We are, for example, seeing an increase in “introductory agencies”, with “Uber-style” technology platforms, connecting personal assistants to clients. Most of these introductory agencies have no employer liabilities for the carers, or care regulatory accountabilities to protect the client. In this model, the client becomes the employer. It is unclear, though, how many older and disabled people who engage personal assistants fully understand their employer liability, and offer terms and conditions of employment that support and protect carers, and themselves, whilst also meeting legal obligations with regard to taxation and compliance with the National Living Wage.

There are issues to be considered for both the personal assistant and the social enterprise approach to meeting care needs. There is evidence that this is a lower cost model of delivering care, which is unsurprising as there are no costs associated with high regulatory fees. Employment costs are also likely to be lower unless councils insist on fair terms and conditions, training and development of personal assistants, which does not always appear to be the case but at present it seems unlikely that either approach can be delivered at the scale required to meet all needs. It is unlikely that these unregulated services will have all of the safeguards that some councils (or health bodies) and clients might expect from their providers of care. Of course where bodies are regulated such as domiciliary care agencies there is a price to pay for councils (and health bodies). Encouraging expansion of unregulated care providers risks further destabilising the domiciliary care market, as providers of regulated care have to bear much higher costs and cannot compete on a level playing field. It also raises questions about the purpose of regulation. *If delivering personal care is considered to require regulation, why would this regulation not apply to everyone?* We either need regulation or we do not – it makes no sense to have one rule for some and another rule for others.

There are not specific merits for each of the models described briefly above. However, it may be that particular approaches are more appropriate for different sets of needs. Where someone needs something more akin to a high number of hours of care the personal assistant model seems to be appropriate, though the risk here is whether high intensity care needs can be covered during personal assistant training, sickness and annual leave. Where there is a lower level of need the social enterprise approach can work very well. However these can also be used to meet different needs in particularly different settings.

There are emerging lessons from the way in which private funders use their resources to manage meeting their well-being, care and health needs. Those providers of domiciliary care who offer services to those who fund their own care report that their customers are looking for flexibility. They want personal care but they also want support with the things that they would like to do; sometimes lifestyle support, company, and relationship with regular carers is more important to them than personal care *per se*. All of these could, in theory, help meet people's social care needs. People who fund their own care usually rely on the domiciliary care agency to assist them in getting the right amount of care and they rely on the care agency to deliver the right care. In some places for example private providers will offer specialist care to support older people with dementia. Staff are specifically trained to assist older people and their carers as well as being able to use technology to assist them. This issue is explored later in the paper.

A council should accept that if it wants a range of domiciliary care to be available in an area it has three main choices:

- 1. It should be prepared to pay a minimum of £18.00 an hour for the service from reputable care providers (registered agencies). Or a higher amount if it wishes staff to be paid above a minimum statutory level.*
- 2. It should consider whether if it wants to develop a separate market of personal assistants who are on a voluntary register to be selected by customers to work in partnership to meet the person's needs.*
- 3. It should consider if it wants to develop a set of small social enterprises in their area which can respond to local needs.*

Whichever approach (or combination of approaches) a council chooses to take it will need to be clear that it understands the local costs of providing the service model.

2 Improving the supply of care

In this section we explore the principles that:

“Commissioners should be willing and able to work in partnership with their providers of domiciliary care to develop programmes which assist with the recruitment and retention of staff”

Partly as a consequence of the low price paid for domiciliary care those who work in the sector have poor terms and conditions of employment and recruitment and retention is a serious problem (especially when there is higher employment in the overall economy). Other factors also have an adverse impact on carer recruitment and retention. By definition, many council-funded clients have high dependency of need, and the widespread practice of commissioning of 15-30 minute visits means carers often have insufficient time to meet all their needs. This creates substantial stress for carers, particularly as they are subject to regulations which could result in prosecution and even imprisonment if violated.

Inadequate workforce capacity more generally means the carers who are recruited are repeatedly asked to cover unfilled calls, and to work in their time off; this too creates stress. Add to this having to drive miles, perhaps in heavy traffic or in unlit remote rural areas in the dark and in inclement weather. Carers are required to have strong resilience as well as a personal commitment to the people for whom they care.

Data from Skills for Care (In England) indicate that most of the staff turnover occurs in the first year after recruitment, if carers stay beyond this, they tend to stay for years, because they find the ability to help others rewarding. In many regions of the United Kingdom providers are finding it harder to recruit front line care staff. This is not unique to any single area or to particular providers. Even the providers achieving good and outstanding CQC ratings (who tend to work mostly with private customers (self-funders)) report that they are challenged to recruit the right staff with higher pay. *In order to address this, a co-ordinated approach is required between councils, (commissioners), colleges of higher education and providers.*



There are some good initiatives across the United Kingdom most noticeably the project across the South-West Region called “Care South West” which has brought all of these parties together in order to promote care as a career in both the local media and through local colleges. This is a relatively early initiative so it is hard to judge its immediate impact though it looks promising. In several places the council has led initiatives with care providers to look at areas such as the training of care staff to try and support the quality of staff and ensure a greater consistency from providers (including looking to reduce the current high turnover of staff experienced by many providers).

Other recruitment initiatives include models of apprenticeships which encourage young school leavers to trial domiciliary care as a career (e.g. this was found in Luton in the LGA work on efficiency in 2014⁷). Unfortunately, the new Apprenticeship Levy and requirement to give apprentices 20 per cent of time out of the workplace whilst training has resulted in a 60 per cent reduction in take-up. With inadequate workforce capacity and unsustainable fee rates, providers simply cannot afford to lose 20 per cent of an employee’s time from direct care, or to back fill to cover this time. Councils and Health Trusts (Boards) could consider how they support apprenticeships as part of their commissioning process.

Some councils (and some providers) have taken initiatives with local schools and colleges of further education to assist staff in promoting the delivery of care as a career. The importance of counteracting some of the negative perceptions portrayed by parts of the media that has been given to poor care is a significant part of helping young people see the opportunities and satisfaction that can be gained from helping others.

⁷ Case study from Luton in the LGA Productivity Programme - <https://www.local.gov.uk/our.../efficiency.../care-and-health-efficiency>

It is worth noting that there is not just a problem for the recruitment of front line care workers. The same is true in recruiting managerial and supervisory staff. Many parts of the health and care system are experiencing challenges in recruiting staff to vacant posts. A combination of negative press reporting financial challenges and allegations of poor care; stress on workers; as well as low pay and unfavourable terms and conditions has made the caring professions less attractive to people seeking employment. There will need to be a concerted effort to address these public perceptions to give the industry a more positive outlook.

As already highlighted, though money is of course an issue for staff in these low paid jobs the terms and conditions in which they work also have an impact on supply. Such issues as how travel time is managed; how jobs are allocated and the expectations on time with customers can all play a part in the job satisfaction for the care workers. Commissioners need to be aware that if the price is too low for the work then poor conditions of employment are likely to be experienced by front line care staff which leads to unhappiness and high turn-over. This is particularly true where councils have taken a view that care workers should be employed on guaranteed hours contracts (as opposed to zero hours contracts). The responsibility for this mostly lies with the commissioners not solely with the providers.

There has been a very recent trend for councils to consider bringing back in-house all or parts of the domiciliary care service to try and better manage the supply of front line care workers. There is a significant cost to councils in undertaking this approach and to date there is insufficient evidence that they have achieved any greater success with recruitment. Again there is likely to be at least a short term disruption to the local care market as a major change is implemented. It is worth looking with local providers for better solutions (even if they might involve a bit more cost) than trying to transform the market single handed given the history of the last three decades for domiciliary care.

Possible solutions:

- 1. Where there are local initiatives that are led by commissioners it is usually experienced as a positive act of partnership when councils and providers come together to meet these challenges. It is a positive way of building better relationships than the ones that are experienced through the tendering process (which can be experienced as competitive and hostile).*
- 2. It is best to allow providers to share their issues and to collectively come up with solutions. The monies available to support local training initiatives, including apprenticeships, can assist in oiling the wheels for dialogue.*
- 3. Having a local college which supports NVQs (QCFs) and other training in social care involved in the process is also often seen as a positive step and can assist in finding some additional resources.*

3 How might demand be better managed?

In this section we suggest that Councils need to be confident that their assessment and care management practices and their in-house reablement services are managing the possible demand in the most effective way. Therefore:

“Can Councils better manage the demands on the domiciliary care services, in partnership with their customers and local providers?”

If it seems that the costs of domiciliary care are likely to rise in many places to meet the requirement of the statutory Minimum Wage; the recruitment and retention of staff; the training and development of staff and the cost pressures on providers then there may still be an option for councils to consider if they can better manage the demand for domiciliary care (with their providers).

One of the key issues that councils may need to consider is whether they have maximised their supply of contracted domiciliary care. Experience seems to indicate that ultimately the supply of care in the community is limited. If supply is limited then it is really important that those managing that supply have every opportunity to deliver the best possible care where staff feel satisfied that they are delivering a good service but, that the resources are best targeted at those who will most benefit from the service.

The simple aim of domiciliary care is to help people to remain well and independent in their own homes – but other services can also assist with this task. Services such as assistive technology; volunteer visitors; occupational therapists; local community organisations and others can all play a part in ensuring that people are not using the scarce resource of domiciliary care when there are other better solutions. Some staff are good at finding these solutions with older people whilst others always want to prescribe a formal care solution in most situations. This requires careful management.



John Bolton's presentations regularly refer to the evidence that a "little bit of care may be bad for you"⁸. This is where a person can become dependent on care once they start to receive it and their dependency hastens their decline. Social care has to tread a careful line between assessing and getting people the right care to meet their needs but not giving care unnecessarily to people when all it will achieve is dependence and the need for more and more services. In his work John Bolton also refers to the work of ADL Smartcare⁹ where they can demonstrate that by getting the right help to older people one can reduce their levels of frailty and therefore their personal need for care¹⁰. So it's really important that older people (and others) are getting the right help which gets the balance between delivering care and enabling people to retain/regain their independence.

One of the most important services that is now delivered/commissioned by every council is the domiciliary care reablement service. The aim of this service is to seek to maximise older people's independence either because of a need to support physical or emotional recovery. Councils need to know if the investment they are making in this service is delivering the outcomes that should be expected, whether the service is run in-house by the council, run in partnership with the NHS or procured from the independent sector.

There are simple measures already used to measure the impact of reablement. The DH defined measure "the proportion of older people who were still at home 91 days after being discharged from hospital into reablement/rehabilitation services," is still seen as a good measure for a total system for health and social care.

⁸ https://ipc.brookes.ac.uk/publications/Predicting_and_managing_demand.html

⁹ <https://adlsmartcare.com/Home/LifeCurve>

¹⁰ https://ipc.brookes.ac.uk/publications/Predicting_and_managing_demand.html

There is a range of simple measures that may be used to assess the outcomes from a care and health system, which are detailed in the IPC paper: “Six steps to Managing Demand in Adult Social Care – a performance management approach¹¹”:

The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery.

This figure should preferably be close to zero.

The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed.

This figure should be close to 75%.

The proportion of people who receive long-term care after a period of short-term / reablement based care (this could be either a therapy led programme or domiciliary care based re-ablement).

This figure should preferably be close to 25%

The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks.

This should be 66% (after 6 weeks)

The proportion of older people who receive longer term domiciliary care that had not benefitted from a reablement /rehabilitation based service?

This should be close to Zero

The latter two measures are a good indication of the success of a reablement domiciliary care service. Though, there may be other factors at play here. First the evidence that domiciliary care-based reablement should be OT led¹² and how this works for customers and second, the behaviours and practices of staff in assessment and care management functions which are explored below.

There are three main additional areas where councils have shown that they can reduce demand on their local domiciliary care market and secure capacity for those with greatest needs.

¹¹ <https://ipc.brookes.ac.uk/publications.html>

¹² Reablement: a key role for occupational therapists - Published: October 2011 SCIE

Discharges from hospital

There is clear evidence that older people being discharged from hospital are over prescribed the care they need. (The LGA study by Newton (Europe)¹³ indicated 1 in 5 Older People have more care requested than they actually need). There needs to be an easy mechanism that allows those delivering care to older people who have been in hospital whose needs indicate that they do not require domiciliary care to stop the service with the minimum of ease (and not creating a complex bureaucracy of full assessments involving social work professionals). The number of care hours required can be reduced by managing this effectively. It is understood that Councils already have in place a two week rule to assist with this. This allows care workers to cease the service where the person has recovered within two weeks of the service starting. The council needs to be clear that this is being consistently applied.

Double handed visits by care workers

Another area, also often linked to hospital discharge (but not solely) is where a care agency is required to send two care workers to assist a person when they need to be lifted and handled as part of the delivery of their care. This can take much needed capacity from the market. Some councils have introduced an Occupational Therapy assessment at the point that a double handed visit is recommended where an assessment takes place of what equipment could be put into the person's home that a single care worker could safely use to assist the delivery of the person's care. Councils who have used this approach have found that they can significantly reduce the number of double-up visits that are actually needed.

Low level packages of care

As has already been identified above there may well be better ways of assisting a person than offering them a very low level of domiciliary care service. For older people receiving less than 5 hours per week of care there may be a better solution (unless the low package is put in to support a carer who does the majority of the direct support). Many councils strictly review these cases (some have selected a higher threshold of 10 hours care per week). They often find that there are better solutions and the high costs of shorter visits can be reduced.

Flexibility in care packages

It is also possible that someone's care needs are not being met because an inadequate amount of care or the "wrong" type of care has been prescribed for them. This is a common concern from some providers who indicate that either a lack of allocated time for the customer or a lack of flexibility in the package of care can lead to unnecessary problems down the line. It is in this area that the services need to be more personalised and be seen in the context of personal budgets. Greater choice and control may be provided through use of direct payments or individual service funds (ISFs) and less prescriptive commissioning of packages of care.

¹³ Efficiency opportunities through health and social care integration
<https://www.local.gov.uk/sites/default/files/documents/lga-efficiency-opportunit-b9c.pdf>

If the aim of care at home is to assist people to remain in their own homes, supported by informal carers, then an important part of any care package may need to include respite care for family members and informal carers. This can be an important part of a care package to support a family carer who is the main help for a loved one to remain at home or it may offer an individual an opportunity to “get back on their feet” after a difficult period. Including respite care as an option within the personal budget can be a contributor to a person remaining at home for longer. Some councils appear to be reluctant to include that option for people (despite the clarity in the Guidance to the Care Act 2014) and this means the customer is more at risk of requiring longer term care than if a suitable place can be found that will support a person through a particularly challenging or difficult period.

One of the important aspects of the policy on personal budgets was that the customer could control how the money is spent to best help them. *If councils are going to offer personal budgets (which they should) they should also ensure that the menu of options where the money can be spent is available for the customer. There should be a range of purposeful and focused short term help available to assist older people which include both domiciliary and bedded care provision.* Later this paper explores the importance of looking at the outcomes for the customer from the help offered.

Practices in assessment and care management

The Adult Social Care Efficiency Programme commissioned by the LGA¹⁴ found that it was social work practice that made one of the biggest differences in managing or driving up costs within the social care system. This was not related to either the practice of commissioners or the stated eligibility criteria of a council. Each social worker tended to operate their own thresholds. Some were more risk averse which led to higher overall costs of packages of care and others were able to manage risks better and find new creative solutions with customers and their carers which were at lower costs. So it is important to consider how a council might achieve a greater consistency in practice that doesn't unnecessarily drive up demand and costs where there are better solutions for people to meet their needs.

A key factor for helping people to remain in their own homes is the range of options that are made available to the older person:

- How is assistive technology used?
- How can volunteer visitors/ community neighbours make a contribution?
- What is the local offer from the community and voluntary sector?
- What are the aspirations for the older person and how might these be met?

These are all key contributory questions that an assessment may need to consider before agreeing the right range of inputs that may best assist someone. The new move to “strengths-based” assessments which focus on the positive aspects of a person's life expectations can play an important role in ensuring that the “menu of support” isn't as narrow as – are you eligible for domiciliary care or not?

¹⁴ Case study from Kingston Upon Thames in the LGA Productivity Programme - <https://www.local.gov.uk/our.../efficiency.../care-and-health-efficiency>
This continues to be a consistent finding from the work of Newton (Europe) with councils

One of the important issues that councils need to address is whether or not providers of domiciliary care (whether in house or from other sources) can agree with a customer to either stop or reduce a service. Many councils insist that a visit is undertaken by an independent assessor before such an action is approved. This can often be unnecessary, create delays and add bureaucracy (costs) to the process. The people who best know the customer and most likely to have the greater understanding and awareness of the customer's needs is often those providing the day to day care. They will probably have developed a relationship with the customer and are able to discuss with them how best their needs may be met in the future. This already applies for those funding their own care at home so why should it not apply to those who are funded through councils?

Possible solutions

If Councils have effective reablement; good demand management (as above) and creative staff working with communities and voluntary organisations there can be a reduced pressure on the overall need for formal care by up to 20%. This frees capacity to support those who do need formal domiciliary care. This is a really important aspect of managing the care market. The people who are best placed to agree this with their customers are those who provide domiciliary care.

- 1. Ensure that the aim of a reablement service is to seek to maximise older people's independence either because of a need to support physical or emotional recovery.*
- 2. Put in place effective measuring and monitoring arrangements to ensure that councils know if the investment they are making in this service is delivering the outcomes that should be expected*
- 3. Councils should consider the most cost effective way of commissioning their reablement –based domiciliary care services and ensure that it deliver the agreed outcomes.*

4 Personalisation and menus of choices

In this section we explore the principle that councils should commission for a range of options to best assist a person in a way that meets their individual needs. Therefore,

“Is domiciliary care a single service or a range of services from which a care package can be constructed with either a single or range of different providers?”

Over the past decade successive governments have focused their policy direction on “the personalisation of care”. This was meant to be a radical change for the way in which social care is arranged for those who needed care and support. It has three main principles at its heart:

- That the customer should be the person who most influences how their care should be delivered
- That each person would need a unique package of care that actually met their needs
- That care should be delivered in a way that empowered the users of the services rather than inadvertently made them dependent on the services they received.

It is our contention that so far there has been a failure to deliver this policy for services purchased by the state. This can in part be explained by the severe cuts to the government spend on social care for adults over the same period. This has led to Local Authorities focusing more on the cost of care than on the outcomes they can deliver for their customers.



This is not the only reason why the policy has not delivered the expected changes to the care system. The concept of a person having a budget from which they could use the right services to help them as their needs changed has hardly been developed. Councils have commissioned or provided for the same services as were available 50 years ago in the shape of day care centres, domiciliary care packages or residential care placements. There has been very little change in the market and very little influence from customers (or providers) on the market. This paper now considers what the market may look like if actually the policy of personalisation was being seriously advanced by local authorities in partnership with their customers and their providers.

Currently the menu of services, purchased by councils tends to be quite limited and certainly rarely offers any choice to the customer. If one solely considers the needs of an older person in order to make the point, one may find that there is a range of different needs that must be met. The list below is not exhaustive but tries to indicate that people will need very different types of care and support depending on their condition.

- To assist older people settle back at home for a two week period after a hospital episode (probably about half of those elders discharged from hospital)
- To assist people in a crisis or post crisis to recover through reablement - often a 6 - 12 week process (might include speedy discharge from hospital – see later comments). This may be to assist with emotional support or for personal care.
- To assist people whose recovery may take more than 6 weeks but is likely to happen within a year of the service being set
- To assist people with a longer term condition(s) to best manage how they live with that condition and where possible to help regain some independence
- To support the NHS in delivering care and support to a person e.g. medicine management or wound management
- To assist a person who has a dementia (and their carer) to maximise their opportunities to retain independence through helping them cope better with the condition
- To assist a person to receive palliative care
- To assist a person who is at high risk of an admission to a permanent place in residential care
- To assist a family carer in supporting a person in the categories above and to reduce carer breakdown

The Personal Budget was introduced to try and assist a person to make the best choices about the services which would suit their circumstances. However, that has not been what has happened for the majority of customers. There is often a lack of flexibility within the care plan (where one exists) and within the overall care available. It may be the case that where a carer is involved as the main person delivering day to day support that a small amount of domiciliary care can be helpful. In addition in these circumstances offering the carer some short term respite care with agreement from the person requiring support can help sustain longer term relationships.

An older person may want to consider a range of options from a service menu that might best suit their circumstances. A range of interventions should be available that will

best assist the person to meet their goals. These might focus on any of the services below:

- Recovery
- Relaxation
- Use of telecare
- Use of applications for I-pads
- Support for personal care
- Physical support
- Emotional support, e.g., promoting social connection
- Use of monitoring and prompting
- Medical assistance
- Support with financial or household arrangements
- Practical help
- Dietary help
- Support to carer

Our conclusion is that domiciliary care should never operate as a single service. It should at best offer a range of services to customers from which they can select the right help to meet their needs. A person who has a diagnosed dementia may require any or all of the following:

- Specialist personal care from a carer who is trained in supporting people with the condition
- Equipment that will assist in prompting and reminding
- Massage and relaxation support
- I-pad technology that will assist in memory exercises to reduce deterioration
- Assistance with meal preparation and encouragement to eat
- Dietary help
- Support to a carer
- Community activities in which they might engage e.g. dementia cafes
- Safe communities in which they can participate in ordinary activities
- Technology that can keep them safe – e.g. tracking devices
- Care robots and other technology to encourage engagement; assist with tasks like microwaving a meal or following reablement exercises



This list is not exhaustive but it might give an indication of the range of offers that should be available. *The question is – should this all come from the same provider or from a range of providers? Could one provider coordinate inputs from others focused on the needs of an individual?*

5 A focus on outcomes

In this section we explore the following:

“Can we be confident that services are being commissioned to meet people’s needs not just solely procured at the lowest price?”

“To what extent is the flexibility of the services that are required from domiciliary care recognised in the contract (as shown in the section above)?”

“How might councils manage the transformation with their current providers? What help and support might they need to deliver this?”

“How might we move to a stronger focus on outcomes without creating a large bureaucratic process?”

One way in which some councils have tried to change their relationship with providers has been through considering a change in the way in which the business between councils and providers is conducted including moving towards models that focus more on the outcomes for the customers than the current model of a provider being paid for time and task.

The roots of outcome-based commissioning come from the early development of a system called payment-by-results (sometimes referred to by the initials PBR). This is where providers of a service whose purpose is to offer a “preventive” set of actions are paid according to how many people they assist to recover or rehabilitate from the problems they had faced. This process was introduced for those services within the former Department of Communities and Local Government (DCLG) Supporting People (SP) Programme. The model appeared to work in encouraging providers to focus on their prime task of helping people “get back on their feet” after they had experienced a crisis or life changing event e.g. homelessness; substance abuse; domestic violence; prison etc.¹⁵

For adult social care there has also been much consideration about the evidence for preventive actions and how a person can be helped in a way that may reduce or eliminate their need for longer term care¹⁶. (The focus has intensified because of the financial challenges faced by councils cited above). There has been much discussion and debate about the methods that a council might take to help it manage longer-term demand for social care¹⁷. For each customer of social care there is a serious question to be asked – “Do we have the right help for this person and is it being delivered in a way that will maximise their opportunities for greater independence?”

¹⁵ Two discussion papers on domiciliary care commissioning and procurement
https://ipc.brookes.ac.uk/publications/Wales_domiciliary_care_commissioning_and_procurement.html

¹⁶ For example see LGA paper on “Prevention – A shared commitment -
[www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+\(1\).pdf/06530655-1a4e-495b-b512-c3cbef5654a6](http://www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+(1).pdf/06530655-1a4e-495b-b512-c3cbef5654a6)

It is this question that has led some councils to adopt an approach which focuses on outcome based commissioning for domiciliary care. The model is based on having the right intervention available to help a person given their particular circumstances at a given point in time.

Coventry

Coventry City Council procures domiciliary care reablement from their local suppliers. It holds all of their suppliers (four providers) to account for the proportion of people whom they help who need no further longer term care. This is an important part of the contract monitoring process. The results are publicly shared.

This section of the paper will start with the consideration of the challenges in commissioning domiciliary care. (This is a service which is rarely commissioned it is usually procured by the council at the lowest possible price on the base of minimal time and maximum task). Domiciliary Care for older people might serve seven different functions (with different sets of outcomes expected from each function). These functions are:

- **To assist older people settle back at home for a two week period after a hospital episode (probably about half of those elders discharged from hospital)**

Older people are living at home with little need for further services

95% of older people who have received elective surgery for a replacement joint will require no further formal care after two weeks.

- **To assist people in a crisis or post crisis to recover through reablement – often a 6-12 week process. This may be to assist with emotional support or for personal care**

Older people are living at home with a high percentage of those requiring no further services.

66% of Older People require no further care after an episode of reablement-based domiciliary care and a further 20% require less care after a six week period of reablement.

- **To assist people whose recovery may take more than six weeks but is likely to happen within a year of the service being set**

Older People are living at home and they will be receiving services which are likely to reduce over time.

Within one year of receiving a domiciliary care package long term 15% of older people might expect to see a decrease in their care package because they have made a full or partial recovery.

- **To assist people with a longer term condition(s) to best manage how they live with that condition and where possible to help regain some independence**

Older People are living at home and they will be receiving services which focus on how they live with their long term condition(s). Some older people may require less service over time. Each year around 15% of those older people receiving long term care and support should see a reduction in their care needs.

- **To support the NHS in delivering care and support to a person e.g. medicine management or wound management**

Older People are being helped in the short term to manage a medical condition or are having low level nursing tasks being carried out under the guidance of a District Nurse. Many of these people will not require longer term help or support.

- **To assist a person who has a dementia (and their carer) to maximise their opportunities to retain independence through helping them cope better with the condition**

Older People are helped to live at home and with the right care and support an admission to residential care is either deferred or delayed.

Only 20% of those being supported at home with dementia care are admitted to residential care in a one year period.

- **To assist a person to receive palliative care**

An older person is helped to live at home and they can choose where and how they might die with dignity.

- **To assist a person who is at high risk of an admission to a permanent place in residential care**

The older person is helped to live at home to delay their likely admission to residential care where that is their choice.

50% of older people who are assessed as being at risk of residential care but wish to remain at home are still at home one year later.

- **To assist a family carer in supporting a person in the categories above and to reduce carer breakdown**

The family carer feels supported in helping the older person remain in their own home.

The outcome for each of the sub-set of people within these cohorts is quite different. Therefore the type of help (or intervention) each person needs and requires is quite different.

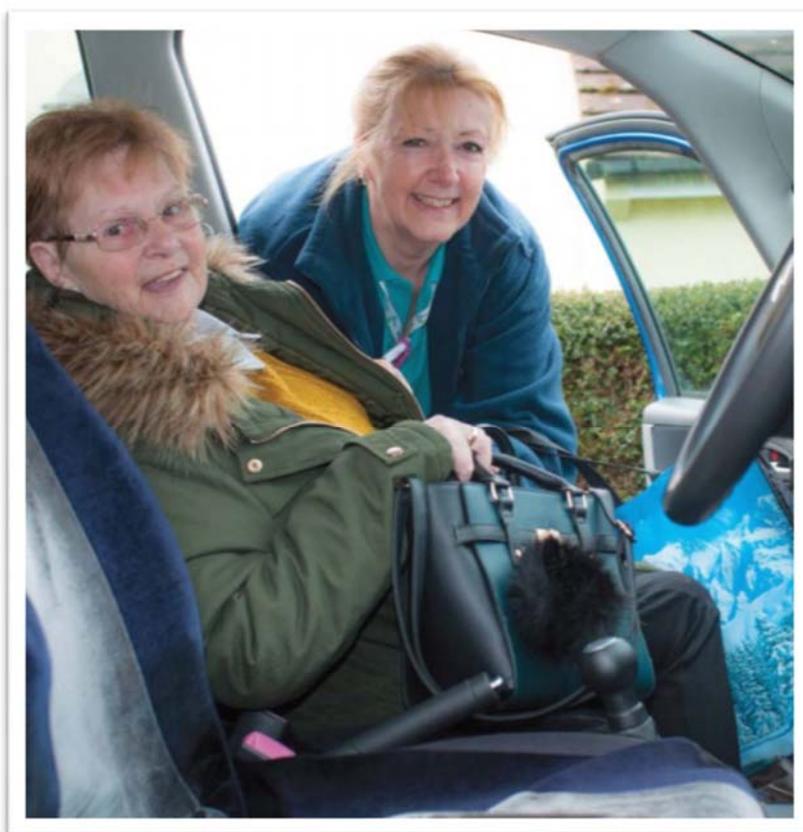
- For a person who is living with dementia the use of assistive and other technological solutions may play a vital part alongside the care provided. This will be a different approach from a person who is being helped towards regaining levels of independence.
- For those where the focus is on recovery one might expect a good percentage to need no further care after a defined period of time.
- For those who are being helped to live at home with a long-term condition or set of conditions it may be expected that both the level of care required might decrease but more likely the outcome is to assist someone in remaining at home, managing their condition effectively (reducing the risk and costs of residential care).
- For those who are dying the focus may solely be on having dignity and personal space at that time but it might be avoiding a placement in a nursing home. (Families are often prepared to offer more support short-term at home to a dying relative).

All of these factors have to be taken into consideration when considering outcomes from domiciliary care. The determination of what are the important outcomes that will be expected to be delivered from a particular service is the key focus for outcome based commissioning. Often these outcomes are set against the vision and direction that has been established by a council for its adult social care. (See the vision established for

Hackney Council's Adult Social Care cited in the LGA's Adult Care Efficiency Programme¹⁸).

A common comment from providers who undertake work on behalf of councils is that the assessments of people's needs are not clear and they are rarely described in the form of the outcomes to which the (older) person aspires. So it is always worth recognising that the services that are delivered by providers for domiciliary care may often reflect local social work assessment practice which can be both unclear and unfocussed. *If a council wants to move to outcome based commissioning it must also move towards asset based and outcome based assessments which involve the older person in determining their longer term goals.*

It is therefore important for commissioners (and providers) to consider what the overall outcomes individuals may need from a domiciliary care service. These will need to be defined. What some councils are now doing is setting the commissioning of domiciliary care within the confines of the outcomes required. This is in contrast to the current more common model where the numbers of hours of domiciliary care that are likely to be required are stipulated in the tender documents (known as "time and task"). Where this happens, the outcomes need to be clearly defined, along with a proper measure to judge success.



Perhaps the outcome that domiciliary care can most consistently attain is to support people to remain in their own homes (where that is appropriate). The simplest measure for any domiciliary care system is: What percentage of older people who had previously

¹⁸Case Study from Hackney and published in the Local Government Associations Adult Social Care Efficiency Programme - <https://www.local.gov.uk/our.../efficiency.../care-and-health-efficiency>

received domiciliary care entered a residential care home in the past year? If this figure is higher than 20% then it may be suggested that the local care system isn't working effectively. This requires investigation and greater understanding.

This does not mean that an admission to a residential care home is necessarily a "poor outcome" for an older person. For some older people it is absolutely the right place to ensure that they are safe and offered the right care. However, the focus of domiciliary care is to offer the right support to help an older person to remain at home. It should not be the failures of the service to meet a person's needs that are the reason for an admission to a care home. There will always be some older people for whom the admission is the right assessment of need – this should never be because of a failure to deliver the right service.

The main early pioneer of outcome-based commissioning was the Wiltshire "helped-to-live-at-home" approach to care. This had many strong features and is well recorded within the IPC papers¹⁹. However, three critiques remain from this approach. First that to move to the situation that Wiltshire wanted with fewer providers delivering the care there was considerable turmoil in the local care market; second, the market was not well-managed to enable retention of workforce capacity via sub-contracting, though this was a goal defined in the contract; and third in order to achieve an outcome based approach the council introduced a level of bureaucracy that could have been avoided.

Because of the growing difficulty that has been observed over the last few years as councils have tried to manage the market it is now suggested that a different approach is taken to best make changes in the local market. This approach has been developed by Swindon Council. They decided that there was no benefit in upsetting local providers and local staff so they set about a making a transition towards a more outcomes based approach with their current local providers. They re-commissioned many of the same providers from their local market but looked to engage more with those providers who wished to further assist in managing the challenges going forward. They have developed a lead provider model where main provider(s) would be selected to take a wider responsibility for meeting needs in one of the two main areas in the borough. With these main providers they set about agreeing a simple set of outcome measures that may demonstrate that the providers were delivering the ambition of the council. This does not need to be a complex or bureaucratic process. As has already been stated this could be as simple as: Are people being helped to remain in their own home? There may be additional or different measures for the subsets of the population identified above – such as for older people who require palliative care was there death managed in the way they would have chosen?

The key issues are twofold – *it is possible to move to a more outcome based approach without significantly changing (or disrupting) the local care markets and it is possible to move to an outcome based approach with simple measures where it is easy to collect the data without creating a costly bureaucracy.*

It is important to stress that this is best achieved in a collaborative way. There does not need to be any change to the current contracts if all parties agree to trial new approaches. It is also important that any measures agreed are not used against providers in a punitive way but are part of a changing culture for both the council and

¹⁹ See IPC Paper by author on Outcomes Based Commissioning
<http://ipc.brookes.ac.uk/publications/index.php?absid=691>

the local providers. Lessons can be learnt without anyone being non compliant with the contract.

6 Innovation in Care at Home

Here we explore the question of whether commissioners want to encourage providers to innovate in the way in which they deliver care.

“How much are councils prepared to do in order to encourage / support providers to innovate?”

In discussing the ideas in this paper Dr Townson noted that her experience showed that there is little thought from commissioners as to how they might contribute to creating the conditions in which providers are encouraged to research and innovate for new and best practice. If, for example, contracts are only 3 years long and, at the end of it, you the provider might be “booted out”, why would a provider invest thousands of pounds in innovations?

Dr Townson gave a concrete example of a cloud-based mobile app for home care delivery management called Mobizo (Access Group) that enables providers, customers and staff to best manage the delivery of care. The approach can be shown to improve both the quality of care (in relation to transparency, reliability and confidence for the customer) and increase efficiency for the provider. It would cost about £300k to implement Mobizo in a service delivering around 20,000 hours of care per week (not including any development costs). Investment in such a system is rarely considered as part of the contract price. Yet councils have invested hundreds of thousands in computer systems to monitor domiciliary care. A shared approach to this type of development would be a very positive step for both providers and commissioners.

A separate example is the emergence of social robots or Virtual Care Models that are emerging in the market. The new social robots can add a new dimension to the delivery of care. They can act as supporters of older people who are undergoing reablement, assisting with the exercises a person may need to take. They can act as prompts and reminders to older people who are forgetful. They can assist in cooking a microwave meal for an older person with dementia. Some can even assist with moving and handling people.



They currently cost around £25,000 each, though this will undoubtedly reduce over time as the technology develops. Investment in such futuristic products would require a much longer term investment than the current three year contracts offered by local authorities²⁰. Providers are asking Government if there could there be more grant money to encourage research and innovation. Alternatively, could Councils offer longer contracts, e.g., 10-12 years (obviously with clauses to allow for reviews of practice and delivery outcomes)? Providers need opportunity and stability in order for themselves to invest and to innovate.

²⁰ <https://twitter.com/drjanetownson/status/920621756150411264?s=21> or doing exercises for reablement - <https://twitter.com/drjanetownson/status/920902681555886081?s=21> or general "get fit while you sit" physical activity - <https://twitter.com/drjanetownson/status/968588900036988928?s=21>

7 Housing with Care

The important principle here is:

“Do commissioners have a housing policy for older people that recognise the need for flexible care?”

“How can extra-care housing be commissioned in a way that assists older people to maintain or regain their levels of independence?”

Finally, we want to acknowledge that good commissioning of domiciliary care has in part to be related to the local housing strategy for older people. Supporting people in their own homes has been the basis of this paper. However, for some older people there may need to be the additional option of moving into more suitable accommodation. For some this may be residential care but for many it may be the option of supported or extra-care housing. In these environments domiciliary care can be delivered in a cost effective way to a range of individuals living in appropriately designed accommodation. It is still essential that care and support that is delivered in these buildings is accountable for the outcomes for each individual older person. There are some extra-care housing facilities that have become highly institutionalised and can offer worse care (and more expensive) than residential care. Other places offer suitable accommodation with good quality care delivering improved outcomes for the people who live there.

There are a number of studies²¹ that demonstrate even when an older person has been defined as being “frail” it may be possible to reduce their levels of frailty. The underlying approach follows a process of delaying decline by reactivation through targeted exercises, the proportional use of assistive technology to compensate for decline, and the timely introduction of care/services only when these become evidentially necessary²². Each stage of decline is approached differently, and currently around 170 distinct difficulties can be addressed. The Aston University Research²³ project commissioned by the Extra Care Charitable Trust demonstrated that older people offered help with diet; exercise and activity (a “well-being” programme) could increase their strength and improve their health reducing their levels of frailty and their use of both NHS and social care services. This confirms the overall theme of this paper that if we can get the right assistance to people in the best way it is possible to improve people’s lives even where their recent past has shown symptoms of decline. Commissioning these services for individuals is critical to any care and health system.

²¹ Jagger, Kingston Australian Women’s Longitudinal study (not yet published)
Peeters,G et al. “WHO A life-course perspective on physical functioning in women” Sept 2013
Hoenig Role of AT in community dwelling elders in Florida

Marco Pahor MD; Jack M Guralnik et al. “Effect of structured physical activity on prevention of major mobility disability in older adults: The LIFE study RCT.” JAMA 2014

²² Software developed by the organisation ADL Smartcare.

²³ [ExtraCare Project - Aston University www.aston.ac.uk/lhs/research/centres-facilities/archa/extracare-project/](http://www.aston.ac.uk/lhs/research/centres-facilities/archa/extracare-project/) A research project between Aston Research Centre for Healthy Ageing (ARCHA) and the ExtraCare Charitable Trust.

8 Conclusion

There is much to consider if a council wants to commission care that meets people's needs rather than solely procure domiciliary care to assist older people to remain in their own home.

- There should be a clear understanding of the price of the care to be offered
- There should be a clear understanding of the choice of menu of services that may be required to help a person remain in their own home
- Customers should be assessed by both care managers and by providers in order to ensure that they are getting the right help
- Steps should be taken to ensure that domiciliary care is not over prescribed
- A partnership approach to recruitment and retention of staff is required in an area where providers and commissioners work in partnership
- There should be an understanding of the outcomes that are being sought and these can be measured in a collective and simple way.