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WHY WE NEED SOCIAL INNOVATION IN HOME CARE FOR OLDER PEOPLE

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Introduction

This report is about how good intentions are not enough. Good intentions and wishing things are different does not make them so, even if you have all the top down authority of the central state behind you; especially if you have the highly centralised and active British state behind you (because then you begin to believe in the illusion that everything can be redesigned from offices in Whitehall).

In adult care (as in other kinds of care) we have a central state apparatus and an expert community with good intentions: because they have the worthy aims of personalisation of care and outcomes based commissioning. Personalisation is the overarching idea guiding Government policy in social care. At its simplest, personalisation is about starting with one person at the centre of any process concerned with responding to social care (and increasingly, health care) needs. The quasi-official Social Care Institute for Excellence has suggested that this will require 'significant transformation' of adult social care services, structures and processes, with implications for the role of social workers.[1]

Successive governments have seen personalisation as a way of improving care quality because it can be a means to achieve outcomes based commissioning. Practically, this involves: identifying and fostering a greater variety of services for users to choose from; aligning the services users receive more closely to the outcomes they want to achieve; building on users' existing capabilities; and enabling users to have more control over their care. Users may change the way they receive services. For example they may use direct payments to pay for personal assistants, receive services that meet their cultural and religious needs, or meet their needs through community-based social and sports activities rather than conventional social care services.

Despite these worthy policy intentions adult social care is a sector now facing multiple crises. There is a financial crisis about service cuts, a care quality crisis, a workforce recruitment and retention crisis and a provider crisis about squeezed margins. There is a large gap between the rhetoric about choice, control and independence and the lived experience of home care for the majority of individuals in the UK who tend to receive short 15-30 minute visits focused on basic bodily tasks like eating, taking medication or getting dressed with the assistance of carers who

[1] Social Care Institute for Excellence, (2010), 'At a glance 29: Personalisation briefing - Implications for social workers in adults' services', October, pg1.

change regularly and are themselves under pressure. Home care appeals as a way of keeping people in their own homes and living independently but is on the whole not doing this well.

In this report we analyse the root causes of this disappointment and explain how and why we have made uneven and inconsistent progress towards the worthy aims of personalisation and outcome based commissioning. We then propose an alternative radical social innovation approach to thinking about ways in which home care can effectively and consistently deliver choice, control and independence across the board.

The argument in this report is set out in three main sections:

1. We describe the hyper active state and the centrally driven reforms in the sector and explain the disappointment which arises from thinking about home care through a narrow market citizenship lens. Personal budgets, direct payments and local authority sponsorship of competitive markets have disappointed in the case of the elderly because they are built on a limited understanding of choice, control and independence and because they accept the underlying business model and commissioning practices as given.

2. We analyse how the activity specifics of home care intersect with the sectoral business model to create an intractable mess so that putting more state money in is a necessary but insufficient condition of reform. At an individual level, the sector consists of travelling carers performing physical maintenance tasks on unsettled rotas. At firm level, the branch retail business model sees firms choosing to pursue diverse objectives of resilience or cash generation; specifics which are often obscured by provider demands for a fair price from local authorities.

3. We sketch a new agenda for radical social innovation that connects with a much broader notion of full citizenship which is about our duty towards carers and those who are cared for as much as their rights to a decent living. In our view, this should be led by local authority commissioners, empowered by mobilisation of a political coalition for change; engaging old people and other citizens in political debate and choices about the general form of provision for the elderly and recognising the huge social value of maintaining precarious independence in our later years.

This report is the second part of a larger action research agenda on adult social care which draws on the CRESC research centre's concept of the "foundational economy" as that part of the economy which delivers welfare critical goods and service, including health, care and much else to all the population.[2] The concept of the foundational economy is important because it challenges mainstream thinking about what economic and social progress and 'success' mean; and because it allows us to develop practical policies for citizen welfare. Social care is of

[2] Bentham, Justin *et al*, (2013), 'Manifesto for the Foundational Economy', CRESC Working Paper 131, November.

interest to us as researchers because it provides an essential service to large numbers of citizens and, done well, it encourages social participation and improved quality of life for cared-for people and their families. In addition the sector is a large employer which again if it acts responsibly has the potential to provide secure and properly paid jobs, while improving the capabilities of the workforce.

Essential background

Current policy in the UK is covered in England by The Care Act (2014), in Wales by The Social Services and Wellbeing (Wales) Act 2014, and in Scotland by the Social Care (Self-directed Support) (Scotland) Act 2013. In England the "wellbeing principle" puts a duty on local authorities to place people's wellbeing at the centre of their social care activities and there is a greater emphasis on social care outcomes and helping people to connect with their local community. The White Paper "Caring for our future: reforming care and support" (2012) forms a key part of this policy framework with an emphasis on "control" through aiming to improve aspects of personalisation, integration of services, promoting models of coordinated care for older people and better end of life care.

In Wales the aim is to improve the well-being outcomes for people who need care and support and carers who need support but there is also an emphasis on co-operation and partnership by public authorities. In Scotland the emphasis is on principles to ensure that a person must have as much involvement as the person wishes in relation to the assessment of need and the provision of support or services. Free personal care is available for everyone aged 65 and over in Scotland who have been assessed by the local authority as needing it. In Northern Ireland the legal framework is The Health and Social Care (Reform) Act (NI) 2009.

In England the first parts of The Care Act came into effect in April 2015, but the remaining changes have been delayed by the government until April 2020. The delayed changes relate to a spending cap on care needs, new rules about top-up fees in care homes and provisions for the right to appeal. Key principles in place since 2015 include the right to free needs assessment combined with new national eligibility criteria that are binding on councils. Individuals in receipt of care support now have a right to request a personal budget if they are not offered one. Devolution within England is also an important feature of health and social care policy going forward with Greater Manchester Combined Authority and public bodies in Cornwall securing devolution deals that involve a framework for achieving the delegation and ultimate devolution of health and social care responsibilities.

Home care has been preferred to residential and nursing care because many suppose that if older people can live in their own homes they will retain their independence and quality of life for longer. It is on this basis that state supported initiatives such as Think Local Act Personal, and the Local Government Towards Excellence in Adult Social Care (TEASC) programme, promote the use of personalised budgets. Equally important, but not highlighted in official

justifications, is the fact that the relative low cost of home care makes it desirable and even necessary as a means of managing increased demand for social care while keeping budgets under control.

Despite the long term focus on promoting home care, between 2009 and 2015 the number of people receiving local authority funded domiciliary care in the UK decreased by 20%. Over the same period the hours delivered decreased by 6.8%. The shift towards fewer people receiving more hours of care and support at home is widely believed to be a result of local authorities tightening their eligibility criteria and rationing care to those who are deemed to need it most in the face of severe financial austerity. Table 1 gives a broad overview of the scale of home care in terms of people, hours, expenditure, workforce, local authority and self-funders, registered branches and direct payments.

Table 1: Home care at a glance (all figures relate to the 2014/15 financial year)[3]

	England	Scotland	Wales	Northern Ireland	UK total
Total people using home care in 2014/15	673,00	112,000	47,300	41,200	873,500
Hours of home care delivered in 2014/15	249 mil.	39.6 mil.	15.4 mil.	14 mil.	318 mil.
Total expenditure on home care	£3.3 bn.	£0.796 bn.	£0.309 bn.	£0.215 bn.	£4.62 bn.
- Expenditure by local authority/HSCTs	£2.6 bn.	£0.732 bn.	£0.293 bn.	£0.204 bn.	£3.83 bn.
- Expenditure by self-funders	£623 mil.	£63.7 mil.	£15.4 mil.	£10.7 mil.	£713 mil.
People receiving a direct payment	144,000	6,453	4,463	3,026	157,942
Expenditure on direct payments	£1.36 bn.	£0.086 bn.	£0.050 bn.	£0.019 bn.	£1.52 bn.
People employed (headcount)	527,000	64,300	26,100	12,000	629,400
Registered locations	8,458	943	468	307	10,176

[3] Holmes, Jonathon, (2016), 'An Overview of the Domiciliary Care Market in the United Kingdom', United Kingdom Homecare Association Limited, May, pg7.

The central state and market citizenship

The Cabinet Office vision of social reform

What we have in adult care (as in many other areas) is a hyper active state with endless top down initiatives in a narrow format with strong preconceptions and an unlearning state with a very limited ability to reflect on how its preconceptions do not fit with activity specifics.

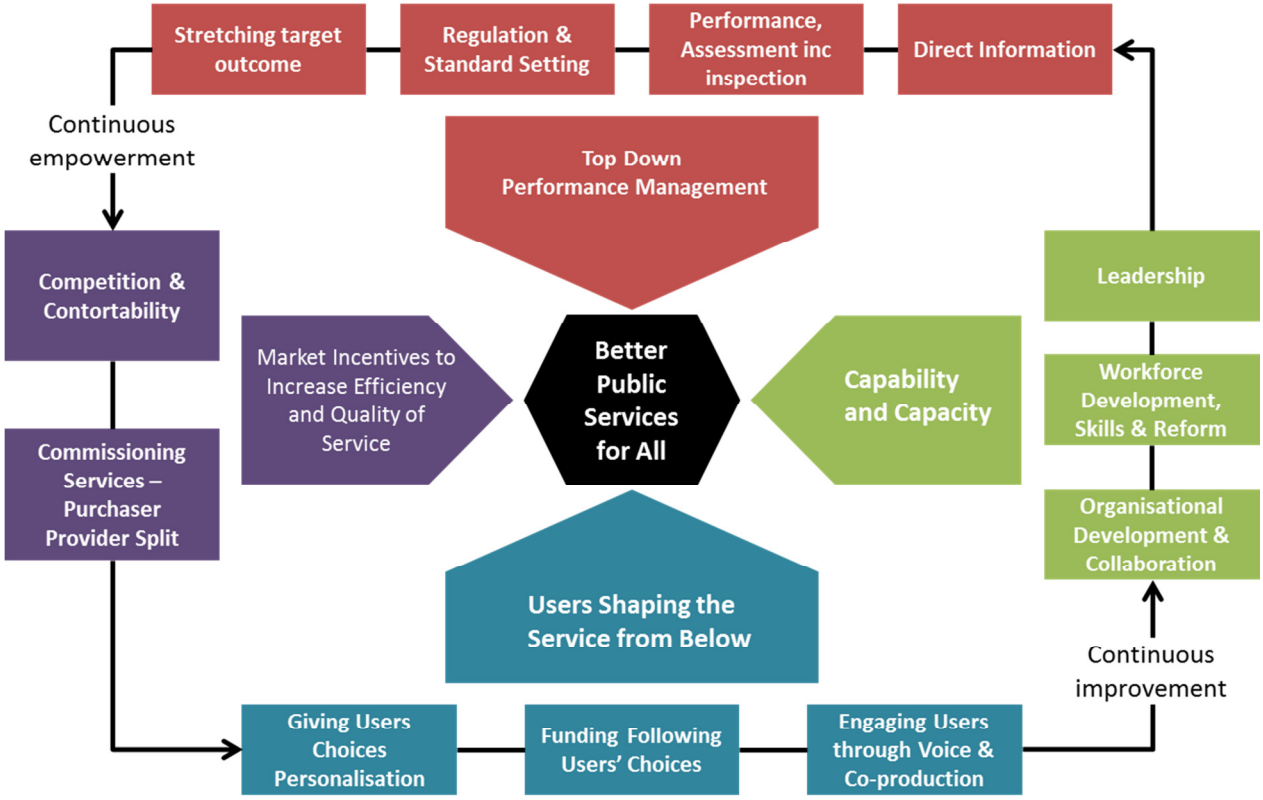
In home care we have a well-intentioned but largely ineffectual attempt to create a kind of market citizenship in home care through applying variants on the generic policies applied in many other areas by the central state. The policy for home care is then one of constructing markets through the use of personal budgets and direct payments on the demand side and making local authorities responsible for developing a diverse and competitive market of providers on the supply side. Market citizenship is an essential part of what might be called the generic Cabinet Office vision of social reform: in home care, as in other areas, citizens are expected to drive reform as they exercise market choice to purchase care in a market created, shaped and regulated by top down performance management.

This vision encounters difficulties in this (and other) policy areas because the elderly, local authorities and providers do not perform their required/expected roles. The response of the state is not to question assumptions and rethink the frame but to try and make things work by using the apparatus of audit and regulation to load official bodies with formal obligations, targets and inspection. This is the *modus operandi* of the unlearning state whose market revolution can be deemed to have failed only because it is incomplete - and so the solution put forward by the state is more markets.

In the next section we outline how the strategy of market citizenship has manifested itself in social care; and has expanded under Coalition and Conservative governments, despite trenchant criticism of New Labour's earlier promotion of citizen consumers in welfare reform which came out of the work of Julian Le Grand and others on choice and competition in health care.[4]

[4] Clarke, John *et al*, (2007), *Creating Citizen-Consumers: Changing Publics and Changing Public Services.*

Table 2: The UK Government's Approach to Public Service Reform (2006)[5]



The strategy of market citizenship in home care

In the strategy of market citizenship in home care, the concept of personalisation provides the overarching policy goal for social care and then **personal budgets and direct payments after assessment** are the central means by which personalisation will achieved. The Care Act gives local authorities a duty to carry out a needs assessment in order to determine whether an adult has needs for care and support. They must initially decide whether the person is eligible for care and support. The person will have eligible needs if they meet all of the following: they have care and support needs as a result of a physical or a mental condition, because of those needs, they cannot achieve two or more of the outcomes specified as a result, there is a significant impact on their wellbeing. The outcomes are specified in the regulations, and include everyday achievements such as dressing, maintaining personal relationships, and working or going to school.

The local authority must produce a plan that sets out the detail of what was agreed. As part of the planning process, the local authority will tell the person about their personal budget. This is the amount of money that the local authority has worked out it will cost to arrange the

[5] Cabinet Office, (2006), 'The UK Government's Approach to Public Service Reform', Public Service Reform Team, The Prime Minister's Strategy Unit, June, pg6.

necessary care and support for that person. This includes any amount that the local authority is going to pay itself towards those costs (which might range from all, to none of the total). The personal budget helps the adult to decide how much control they want to have over arranging their own care and support, by seeing how much money is available to buy the care they need.

Using the information from the personal budget, the person can ask the local authority for a direct payment. A direct payment is a payment of money from the local authority to either the person needing care and support, or to someone else acting on their behalf, to pay for the cost of arranging all or part of their own support. The local authority could make a direct payment instead of arranging or providing any services itself, if the adult asks them to do so. This is supposed to ensure that the adult can take full control over their own care.

Local authorities are, under the 2014 care act 254v, responsible for promoting the efficient and effective operation of care markets with a view to ensuring that there are a variety of high quality providers to choose from and that people needing care have sufficient information to make informed decisions.

In previous years LAs have typically purchased social care using large block contracts. This allowed LAs to maximise economies of scale and drive costs down through bulk buying of home care. However, large block purchases did not allow enough flexibility to respond to changing care needs nor the control over decision-making about one's own care demanded from within the Disability Rights Movement/groups. Large block provision was commonly replaced by the use of framework agreements with providers selected via tendering processes, as these allow greater flexibility in the system and can increase service user's control over their care package. A recent example of the policy shift towards outcomes based commissioning can be found in the DoH funded joint ADASS/University of Birmingham report Commissioning for Better Outcomes: A Route Map (2015).

The Care Quality Commission (CQC) register 'Services in your home' including home care agencies, mobile doctors and phone/online advice (clinical services). Services are inspected, as with residential care, under the following headings; safe, effective, caring, responsive, well-led. Currently 14,389 organisations are registered with CQC. From the website and downloaded excel data sheet, there are a surprising proportion for which inspection reports are not yet published and there are a number where the most recent report is from 2013.

The whole process is then to be rendered transparent and accountable by **audit using the ASCOF framework.** The Adult Social Care Outcomes Framework (ASCOF), now in its fourth year provides information on the outcomes for people using social care services and their carers. This information not only gives a national picture of the overall effectiveness of the sector but also shows how well individual councils are meeting the needs of their populations. In its own words the purpose of measuring outcomes is as follows:

ASCOF is the Department of Health's main tool for setting direction and strengthening transparency in adult social care… Locally, the ASCOF provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements. Local authorities can also use ASCOF to inform outcome-based commissioning models...Locally, the ASCOF also strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, the ASCOF enables local people to hold their council to account for the quality of the services that they provide, commission or arrange.[6]

Disappointing outcomes, actors not playing their part

This framework is designed to promote choice, control and independence for recipients of social care in the UK. However, it is widely recognised that the system is so far failing to deliver on these promises. A recent National Audit Office report on personalisation found that[7]:

Much of the positive evidence for personalising commissioning is old or relates only to subgroups of users. Centrally collected data on local authorities' progress might be overstating how personalised the commissioning of care really is for some users. There is therefore a strong case for better use of existing surveys and evidence gathering. Learning from the implementation of personalised commissioning in social care will benefit the Department as it extends personal budgets in healthcare.

Some authorities are finding personalising commissioning a challenge as they seek to save money, particularly in areas where providers are under financial strain. Authorities are limiting the extent to which some users' services are personalised because of financial pressures. The Department expects personalised commissioning to improve outcomes for users, not necessarily to help local authorities save money. Nevertheless, most local authorities say they expect to save money through personalised commissioning. The Department has not investigated how services can be personalised when money is tight, nor questioned whether authorities' plans to save money would adversely affect user outcomes.

Some authorities have transformed their care and support processes to ration their resources fairly, share information about a broad range of local services, and monitor and manage spending on personal budgets efficiently, particularly direct payments. Authorities that do not ensure users are adequately supported to commission services within a personal budget can pass risks on to the users. More authorities could improve user

[6] Department of Health, (2014), 'The Adult Social Care Outcomes Framework 2015/16', November, pp8-9.
[7] National Audit Office, (2016), 'Personalised commissioning in adult social care', HC 883, Session 2015-16, March, pg11.

outcomes, and potentially save some money, by learning from or adopting the practices of those authorities that have implemented successful approaches to personalised commissioning.

It is important to recognise that personalisation is being promoted in unfavourable circumstances, with swingeing austerity cuts in local authority budgets, which would greatly complicate the perennial problems of securing implementation by the many different local authorities responsible for care. But there are a series of underlying problems about unconsidered assumptions. There never was any kind of cost benefit analysis of whether the benefit of increased agency for market actors had offsetting costs for individuals and organizations: this is unfortunate when recent case study research by Rodrigues and Glendinning[8] argues that any small increases in agency come at the cost of increasing risks and costs at individual and organisational levels. More fundamentally, the personalisation agenda rests on strong and unexamined assumptions about the possibility of changing behaviour and doing so in ways which do not have perverse and unintended consequences. As Needham has argued[9], the personalisation agenda makes three unjustified assumptions about market efficiency in a world of market failure. First, that budget-holders will be empowered market actors; second, that budget holders will pool resources to give them purchasing power; and third, that communal services like day centres (which cannot be disaggregated into individual or group budgets) are not valued by service users. Leaving aside unintended consequences, the practical problem is that social actors are not playing the parts they should if market citizenship is to be enacted.

Although the Care Act 2014 gives people a legal entitlement to a care and support package and personal budget, fewer older people are opting to take their budget as a direct payment compared to other user groups.[10] It is widely acknowledged that personal budgets and direct payments better suit younger disabled people than they do older people.[11] [12] Independence through choice is of importance to all user groups of social care services and control over resources is a means to that end. But all this is likely to be less important for older people than for younger disabled people. Because older people have already experienced an active role in family, work and community life and are not being offered the realisation of an aspiration but

[8] Rodrigues, Ricardo and Glendinning, Caroline, (2015), 'Choice, Competition and Care – Developments in English Social Care and the Impacts on Providers and Older Users of Home Care Services', *Social Policy & Administration*, Vol. 49, No. 5, pp649-664.
[9] Needham , Catherine, (2013), 'Personalized commissioning, public spaces: the limits of the market in English social care services', *BMC Health Services Research*, Vol. 13, Suppl 1.
[10] Davey, Vanessa *et al*, (2007), 'Direct payments: a national survey of direct payments policy and practice', Personal Social Services Research Unit, London School of Economics, May.
[11] Baxter, Kate and Rabiee, Parvaneh, (2013), 'Council-managed personal budgets for older people: improving choice through market development and brokerage?', *Journal of Care Service Management*, Vol. 7, No. 4, pp136-145.
[12] Health and Social Care Information Centre, (2012), 'Community Care Statistics 2010-11: Social Services Activity Report, England', March.

the burden of more choice. The expansion of 'choice' can have unintended effects; for example it may aggravate practical problems about "bed blocking". An Age UK report attributed increased delays in hospital discharge between 2011/12 and 2014/15 to 'patient and family choice' as growing numbers of people needed to organise and fund their own care.[13]

In line with this, evidence gathered by Age UK suggests that older people want to access choice and flexibility in care but do not want to manage the arrangements themselves and older people experience fewer benefits from personal budgets compared to other user groups[14]. The outcomes of personal budgets for older people often then do not provide good value for the costs incurred[15] with older people commonly reporting anxieties about the responsibility of organising their own support and manging their budgets.[16] Such anxiety is understandable, given a range of factors that make it more difficult for older people to predict their care needs. Older people are more likely to be assessed at times of crisis – such as hospital discharge – when their needs have not stabilised and they themselves are uncertain of how much help they will need. They are also more likely to have unstable and deteriorating conditions which need ongoing support and frequent review of their needs and plan for home care.

Slasberg *et al*[17] argue that direct payments are most effective for those who have high levels of assertiveness and strong social skills (and that conversely more frail, socially isolated or marginalised people are more likely to struggle). They cite a study of direct payments in Essex published by the Office of Public Management:

> *For the majority of the people interviewed (both service users and relatives) the most important skills needed to make cash payments work were confidence, assertiveness, and an ability to articulate needs*.[18]

They argue that personal budgets through up-front allocations of resource – are serving only to disguise the perpetuation of a system that works in ways that are dysfunctional and depersonalising for all but a small minority.

There is a risk of older people being squeezed into a 'one-size-fits-all' model for personalisation designed with and for younger people with physical or learning disabilities and larger budgets.

[13] Mortimer, Jill and Green, Marcus, (2015), 'Briefing: The Health and Care of Older People in England 2015', Age UK, October.
[14] Orellana, Katherine, (2010), 'Personalisation in practice: lessons from experience', Age UK, October.
[15] Woodham, John and Benton, Chris, (2013), 'The costs and benefits of personal budgets for older people: Evidence from a single local authority', *The British Journal of Social Work*, Vol. 43, No. 8, pp1472-1491.
[16] Moran, Nicola *et al*, (2013), 'Older people's experiences of cash-for-care-schemes: evidence from English Individual Budget pilot projects', *Ageing & Society*, Vol. 33, No. 5, pp826-851.
[17] Slasberg, Colin *et al*, (2014/15), 'Further lessons from the continuing failure of the national strategy to deliver personal budgets and personalisation', *Research, Policy and Planning*, Vol. 31, No. 1, pp43-53.
[18] Holloway, Sarah *et al*, (2011), 'Longitudinal Study of Cash Payments for Adult Social Care in Essex' quoted in Slasberg, Colin *et al*, (2014/15), pg47.

Age UK argue older people are likely to be allocated smaller personal budgets than younger disabled people with comparable levels of need with restrictive effect as smaller budgets limit the scope for innovation.[19] Although the outcomes proposed for adults with care and support needs under the Care Act 2014 include developing and maintaining relationships and access to the local community, there is little evidence of any other than the basic personal care needs being addressed for older people receiving home care. An evaluation of 13 Individual Budget Pilots found older people spent their budget predominantly on personal care, with very little left for social or leisure activities.[20] This is not necessarily a matter of choice. Surveys of older people using social care services report that commissioned home care provision is focused on personal care delivered in one's own home. The type of provision older people want, however, integrates the delivery of personal care and support with a 'day centre' model and more opportunity for shared social activity.

The personalisation agenda may be contributing to an increasingly mixed economy of care[21] but it is not necessarily empowering older groups nor giving them the intended control and independence. The New Economics Foundation (Nef) has fundamental doubts about the possibility of empowerment through budgets which encourage individuals to 'buy solutions' rather than have an active stake in "producing" their own solutions'.[22] Reviews of personal budgeting in health care have highlighted the possibility of individuals making choices that are harmful to their long term health[23]; if personal budgets create opportunities, they also raise the question of balancing individual choices with professional concerns for risk, equity and the sustainability of existing community services

The national roll out of budgets in health care was arguably built on misrecognition of cause and effect in pilot studies which apparently showed the success of budgets and direct payments. The Government believed that benefits were a result of *consumer choice* and that extending choice to all through an up-front allocation would lead to better outcomes for all. Slasberg *et al* argue that early successes instead came from the conditions of application which involved an accurate and holistic assessment of individual needs allied to sufficient resource to meet them.[24] Unlike the *resource led* council based assessments of need for care, the assessments in the health pilots were authentically *person-centred*. Slasberg *et al* argue that all assessments of need should be holistic and person-centred, for as much need as current

[19] Orellana, Katherine, (2010).
[20] Moran, Nicola *et al*, (2013).
[21] Hardill, Irene, and Dwyer, Peter, (2011), 'Delivering public services in the mixed economy of welfare: perspectives from the voluntary and community sector in rural England' *Journal of Social Policy,* Vol. 40, No. 1, pp157-72.
[22] Stephens, Lucie *et al*, (2008), 'Co-production: A manifesto for growing the core economy', New Economics Foundation.
[23] Alakeson, Vidhya *et al*, (2016), 'Debating personal health budgets', *BJPsych Bulletin*, vol. 40 no. 1, pp34-37.
[24] Slasberg, Colin et al, (2014), 'Personalization of health care in England: have the wrong lessons been drawn from the personal health budget pilots?', *J Health Serv Res Policy*, Vol. 19, No. 3, pp183-188.

resources permit to be met, with open acknowledgement of the funding gap in terms of needs not met and a commitment to close the gap over time as the democratic will permits.[25] As none of these conditions are met in care budgeting, the benefits are likely to be limited.

If older people are not playing the part necessary for market citizenship, nor are the local authorities. The shift away from block contracts should have offered potential opportunities for providers of many kinds, large and small both private for-profits and non-profit enterprises. The common approach taken by local authorities is however to limit the number of providers on a framework agreement so that there is some competition in the market but not so much competition that it brings over capacity with providers open to a real risk of not being able to win sufficient work to remain financially viable. Problems of this kind are familiar from other areas of outsourcing, as classically in rail franchising, where the promised benefits do not and cannot materialise because the state has to write contracts whose terms are determined by the over-riding requirement to keep the game going by ensuring a credible number of bidders.[26] When the central state has a dogmatic commitment to outsourcing (and is not prepared to admit defeat) it maintains the appearance of competition without any of the benefits.

Increasing the number of providers in a framework agreement does not automatically increase choices for service users and gaps in capacity can result. Evaluation research of local authority managed personal budgets for older people found some providers will sign up to the framework but not take any cases at all; other providers were found to hand cases back to the LAs if there are difficulties such as staff recruitment problems or other issues such as the geographical remoteness or because the case required 'double ups' (two care workers being present). Under the previous regime of large block purchases, providers were guaranteed work and obliged to take on additional packages of care if they were delivering below contracted capacity; but framework agreements impose no such obligation. Under framework agreements, providers are unable to guarantee work for employees and as a result some employers have moved employees onto zero hour contracts. At the same time, providers can struggle to take on cases during the school holidays because employees, worried about the costs of childcare, are opting not to work during these periods. From the service user perspective, the result is restricted choice and control[27] when, for example, the service provider cannot offer *continuity of care* by the same staff member.

When the sector underperforms or fails to change quickly enough the Government increases pressure or changes tactics but does not rethink the framework. Alternative approaches are

[25] Slasberg, Colin *et al*, (2014/15), pg50.
[26] Bowman, Andrew *et al*, (2013), 'The Great Train Robbery: rail privatisation and after', CRESC public interest report and Andrew *et al*, (2015), *What a Waste. Outsourcing and How it Goes Wrong.*
[27] McNicoll, Andy, (2016), 'Council's 'disregard' for Care Act triggers user-group complaint to CQC', *Community Care*, 10th February.

suggested, for instance, service gateways[28] to allow both the development of markets and greater choice for older people as the local authority would become "the estate agent of care". In the service gateway model all providers are included and they are free to set their own prices and the types of services they provide – both of which would be agreed in advance. A service gateway works like an e-market website which brings together buyers and sellers: all Care Quality Commission registered or local authority approved providers in one local region/area are included and the web site provides an interactive facility for service users to commission their own support. We need evidence of how gateway sites are used by service users and those who help to manage personal budgets. [29]

The generic centralised approach to developing a form of market citizenship fails to provide choice, control and independence for the majority of service users. As the argument above shows, this much is clear from the relevant social policy literature. But, if the aim is more effective government policy, then that needs to address the specifics of provider business models and local authority commissioning practices which stand in the way of effective and consistent improvement in outcomes for service users. In the next section we set out how and why this is so.

Activity specifics: tasks, rounds and retail branches

In most of the social policy literature, the empirical issue is what results are obtained when the state pulls different policy levers and therefore how the policy levers should be set. But, if we are to understand the results of policy and what needs to change in an outsourced activity like care, it is important to understand not only how results are mediated by the care model which is defined by commissioner practice but also more fundamentally how they are limited by the trade's standard business model. The silo nature of social science knowledge and the widespread aversion to financial analysis together account for the way in which the business model (of for profit and not for profit providers) is nowhere discussed in the policy debate on adult care. Instead, in an attempt to lever higher hourly rates out of local authority commissioners, the care trade has produced and promoted a self-serving accounting calculation of the "fair price of care".

While higher hourly rates are necessary to better home care, they are not a sufficient condition unless policy engages the specifics of the activity and understand the limits set by the care model and the underlying business model. Thus, this section analyses the care model of paying peripatetic workers for bio maintenance tasks of feeding and care in timed slots and also explains the underlying standard business model of branch retail. The first implication of this analysis is that it is difficult or impossible to calculate one "fair price" for care when firms have

[28] Rowlett, Nick, (2009), 'Letting go of the power: why social care authorities need to start from scratch to deliver choice and control', *Journal of Care Services Management*, Vol. 3, No. 4, pp334-56.
[29] Baxter, Kate and Rabiee, Parvaneh, (2013).

discretion about branch staffing levels and about loading individual branches with care hours. The second implication is that the branch retail organisation of peripatetic care workers has inbuilt inefficiencies and is very unlikely to produce consistent quality care. Instead, we have a policy mess which rests on a kind of symbiosis between unimaginative commissioning and the business model which together frustrate "choice" because real choice would require a variety of care offerings with some directly related to social outcomes.

The care model: tasks in time slots

Care is formatted because local authorities commission and providers offer the performance of tasks in time slots by peripatetic workers paid to perform set maintenance tasks (getting up in the morning, meal preparation, bathing) typically in 15- 30 minute time slots on a round. A model of bio maintenance underlies this definition of the care assistant's tasks: the needs of the old person are represented in a reductive quasi physical way which abstracts from all the values and social interactions which make independent living worthwhile: getting dressed and ready for the day is after all only a means to the end of having visitors or going out shopping or to the pub of an evening which all add quality and meaning to life. Paying for maintenance tasks is nevertheless nearly universal because it is a kind of safe political default for a local authority commissioner and the standard offer of the provider; public money is here being spent on forms of personal care which the tabloids cannot criticise and the care trade can easily cost.

The bio maintenance tasks are performed by peripatetic workers under acute time pressure. Data obtained by the Freedom of Information Act, revealed that 74% of local authorities in England are still commissioning 15 minute homecare visits; and a Unison survey of more than 1,000 home care workers reported that 58% were given 15 minutes or less to deliver personal care.[30] The problems are compounded by employers who use zero-hours contracts and limit paid hours to face- to face contact time; when travel time and other work related activities are unpaid, this in turn leads to staff shortages and turnover which is bad for care quality.[31] If employment contracts could be changed, there are also inherent and intractable problems about how paying for tasks in time slots does not guarantee care quality or efficient labour utilisation because the activity characteristics of home care are very different from those of fast food or car assembly where the tasks in time slots approach produces process efficiency and underwrites quality.

In home care, the task is based around complex social relations; so proceduralisation is largely irrelevant. Compare and contrast fast food where operators under management supervision

[30] Unison, (2016), 'Suffering alone at home: a Unison report on the lack of time in our homecare system', January.
[31] Rubery, Jill *et al*, (2015), '"It's All About Time": Time as Contested Terrain in the Management and Experience of Domiciliary Care Work in England', *Human Resource Management*, Vol. 54, No. 5, pp753–772.

work to an operations manual which standardises process and removes labour discretion so guaranteeing consistent quality: so fast food has rules and procedures about dating of ingredients, using ingredients in sequence, specifying frying temperature and time, discarding prepared food after set intervals etc. But you cannot write an operations manual for getting an old person up in the morning because it is a social relation as much as an exercise in doing up buttons; and there is no supervisor to check the worker is doing it right because the peripatetic worker is unsupervised. Most fundamentally, the tasks have little to do with outcomes, which is what we want to influence if the concern is with care quality; especially when depression and dehydration can, for example, produce symptoms very similar to dementia.

Against this background, the miracle is that 73% of home care inspections by the CQC from 2014-2016 resulted in a "good verdict". This partly reflects the focus of inspections on basic branch systems (like record keeping on medication) which are usually in place; and more significantly it is a tribute to the common sense and humanity of the mainly middle aged and poorly paid female workforce who are accustomed to keeping things going at work as in many of their life roles. In these circumstances, the direct worker's on the job experience in dealing with similar problems and snags is a key resource. But that is limited by high rates of workforce turnover when, for care workers in England, the annual workforce turnover rate was 32.4% in 2015 and 41.4% in 2016.[32] At the simplest, such turnover rates imply that many older people each year have to bond with new strangers performing intimate tasks.

The other problem is labour utilisation and the waste and expense of travelling time for the peripatetic work. Compare and contrast car assembly, where paying for tasks in time slots is about extracting high rates of direct labour utilisation along with smooth materials flow. In Toyota's production engineering, techniques like cellular manufacturing are used to eliminate the individual worker's wasted movement with Kanban cards used to synchronise processes for steady value adding. But the domestic care worker is peripatetic and the UKHCA trade association assumes in its home care costings that for every 60 working minutes, there are 11.4 travelling minutes which are not only unproductive but costly because they add 4 miles of car travel.[33] Using the new national living wage from spring 2016 an hour of contact time costs £7.13p but payment for travel time and cost then in the UKHCA costings add £2.75 per hour.[34] So, in this model, the 20% of the worker's day spent travelling accounts for 28% of the direct labour costs which account for 70% of all costs. The result is a kind of constant temptation for employers; because the simplest way of cutting labour costs and improving margins is not to pay the direct worker adequately for travel time and cost.

If we ask why all this waste is built into the system, the answer lies with the business model of retail branches.

[32] Holmes, Jonathon, (2016), pg36.
[33] Angel, Colin, (2015), 'A Minimum Price for Homecare', UKHCA Briefing, November, pg26.
[34] Angel, Colin, (2015), pp26-27.

The business model: retail branches

Home care is organised as a retail branch business where providers serve local demand from store front branches where a manager has a territory (worked in rounds by peripatetic workers who do the home visits). As in any kind of branch retail, the business model is then to manage branches by adjusting physical and financial levers which raise revenues or reduce costs within semi fixed outer limits set by the character of the activity. The interesting point is that this then opens up a large space for the pursuit of discretionary objectives which range from high profits to a resilient service. The business model is standardised but firm objectives are not.

The variation in objectives can only be understood if we analyse the adjusting levers that can be pulled (and those that cannot) because of the nature of the home care activity. The two basic levers are hourly volume and staff crewing. Putting more volume in terms of care worker hours through the care branch helps because, as in any kind of retail, sales up to a point cover branch fixed costs and beyond that break-even point, extra sales are highly cash generative. Staff crewing levels are then important because costs are influenced by how many managers and supervisors are employed in each branch and how central overhead is allocated. Branch volume and crewing interact because more hourly volume will require more supervisors in a step like adjustment which is practically limited by difficulty in recruitment and retention of direct workers. In our interviews with managers (see below) one provider said “if I could take on 100 extra staff, there would be work” and another told us “if we could double staff base we would double our turnover”.

Home care is a relatively simple retail business because premium pricing and economies of scale are largely irrelevant. Premium pricing through adding de-luxe service only makes sense if the customer is prepared to pay a premium price for it. Local authorities are not interested in that and they account for most of the market. Equally, there are no significant economies of scale in the home care business and firms that run large chains of branches do not have lower costs: by way of contrast, in food retailing supermarkets can realise large economies of scale from bulk purchasing and regional distribution so their branches can sell at prices cheaper than individual corner shops can buy. Nobody in home care has, to our knowledge, made a success of a centralised organisation with, for example, duty rosters and rounds put together at head office not at the branches.

If branch management around hours and crewing is critical, we tried to get a deeper understanding by interviewing senior managers in three different providers: an investor questioned the chief executive of a leading financialised chain, and two academics questioned an East Anglian small family owned operator and a large Welsh not for profit. This was not any kind of representative sample but the diversity of the responses underlined the way in which

firms have choices about how to load and staff the branch; and these choices within the industry business model have dramatic consequences for branch profitability and resilience:

- The financialised chain was explicitly running for high profit per branch by ramping up the volume and limiting branch staffing expense so as to realise a target profit of £100,000 per branch; this is nearly 8 times the profit which a 500 hour branch would realise on UKHCA costings and helps to explain why home care can attract private equity (in 2014 five out of six of the biggest home care providers had private equity backing).[35] A Laing Buisson 2009 survey found that the median responding independent sector branch provided 510 hours per week of hourly-paid homecare.[36] But the financialised chain average was 1000 hours a week per branch handled by a branch manager on a salary of £30-35,000 and a couple of coordinators at half that pay who each handle 500-1000 hours The CEO's "expectation" and target was that all branches should grow to reach 2,000 hours and make a contribution of £100-150,000; overall group returns would always be worse because growth also requires new branches which lose money because they don't have enough hours. This CEO believed that one large chain competitor with more than 100 branches had already reached a target of 2,000 hours per branch.

- Our Welsh not for profit and the East Anglian family owned operator were service oriented firms prepared to sacrifice profit and incur higher costs by spending more on higher staffed branches which they believed could deliver a more resilient service. Welsh not for profit had an area manager on £29-32k and then 5 Assistant service managers (5 per 1,000 hours) as senior care assistants whose duties are covering absences, assessment, mentoring etc.; this incurs an extra cost which we estimate at £60k extra per branch compared with the financialised provider. So the Welsh not for profit has 1100 employees, £20 million turnover and a group wide surplus of £75k, partly or even mainly because the surplus is being taken out as branch staff salaries. Interestingly, small for profit operators can be just as committed to resilience through extra staffing cost, The Anglian family owned small provider has in each branch a manager, an assistant manager, 3 care coordinators drawing up rosters and 4 experienced care assistants acting as rapid response carers and trouble shooters. Even if we assumed more than 1,000 hours per branch, that's a serious load in overhead salary costs and the family Anglian said it needed a minimum hourly rate of £20.

These interviews highlighted important trade-offs when volume and high profits may come at the expense of resilience which raises the minimum price:

[35] Care Quality Commission (2014), 'The Stability of the Care Market and Market Oversight in England', Institute of Public Care, pg29.
[36] Bosanquet, Nick and Haldenby, Andrew, (2015), 'Value and strategy for homecare', UKHCA, November, pg14.

- The financialised chains represent the hope of financial targets asserted against the experience of organisational fragility. Financial targets are set high but, with tight branch staffing levels and pressure on branch management. If hours are ramped things are always going wrong: branches fall over with burnt out managers and it is difficult to cover the 5-10% of care staff who routinely "let you down" in this kind of operation. Private equity typically wants growth as well as margins which means new branches that lose money and intensify the pressure on the rest.

- The conservatively run firms (both for profit and others) incur extra costs and sacrifice profit so as to deliver a more resilient service which is better able to cope with things going wrong through back up provision, like rapid response staff which float to cover problems with staff who do not turn up. Significantly, the financialised provider CEO conceded "the well run mom and pop businesses are still the best in the sector" But the resilient business incurs extra costs if it is paying manager and supervisor salaries; while in the single branch mom and pops, the principals will often cover problems by working all hours.

Service oriented firms are just as likely to be quitting the industry as financialised chains but for rather different reasons. Service oriented firms cannot deliver the kind of service they want at the price local authorities pay; while financialised chains will quit because they want the impossible in the form of high profits from ramped volume and pruned costs. There are a host of issues here about the resilience of the service which local authorities are paying for and about the scope for ramping volume with the aim of profit extraction. As an interim step, it would be sensible for providers to report branch staffing levels and weekly volume to commissioners in local authorities.

The distraction of fair price calculations

"Fair price" calculations have recently migrated from residential to domiciliary care. Since 2013 UKHCA, the domiciliary care trade association has published a free on line costing of domiciliary care which "aims to calculate a fair and sustainable price in an open and transparent format".[37] UKHCA costings are annually updated, most recently in autumn 2015; Laing Buisson previously produced separate costings within paid for reports but its series of annual domiciliary care reports ends in 2013.[38] We would argue that all these calculations are more a distraction than a helpful guide, because fair price calculations model the costs of one ideal type of firm in a sector where there is a diversity of providers with very different cost structures and return requirements.

[37] Angel, Colin, (2015), pg12.
[38] Laing and Buisson, (2013), 'Domiciliary Care UK Market Report 2013', Twelfth Edition.

The background to UKHCA involvement is of course an austerity squeeze on margins in local authority funded home visits which account for more than 70% of the home care market in the UK.

The costings are part of a "give us more money" argument and their political job is as a lever in local bargaining against local authorities and as evidence in national debates about widespread underpayment by local authorities for the domiciliary care hours they commission. When UKHCA published its first fair rate of pay in early 2014, estimated at £15.19, a FOI request found only four out of 101 responding councils paid at this level.[39]

> *UKHCA's more recent analysis (in 2015) found that just 28 councils of the 203 authorities in the United Kingdom, where an average price could be established, paid their independent and voluntary sector homecare providers fees at or above UKHCA's minimum price for homecare of £15.74/hour at that time.*[40]

The fair price is set by making a fairly standard management accounting calculation of costs incurred plus margin required. The UKHCA costings are obtained by inputting direct labour costs and travelling time, then adding "the costs of running the business" and making allowance for reasonable profit. We do not doubt the trade's claim that local authorities are underpaying given the direct labour and travelling costs incurred by most branches but we would dispute the trade's implication that the fair price provides a guide to how much more the local authority commissioner should pay. The issue here is that the UKHCA assumes a median branch and there is a large variation in the indirect costs and profit requirements of different branches and various kinds of operators.

Survey evidence on the care trade discloses large and unexplained variations in the cost of running the business and the profit margin realised. The UKHCA resolves this problem of unexplained dispersion quite arbitrarily by choosing the median. Using the median, 30% is the assumed gross margin of the model business including costs of running the business and 3% profit; after a higher minimum wage in 2016 the assumed gross margin falls to 25.5% on a higher total cost, to maintain net surplus at 3%. But the median is calculated in relation to an unexplained 2: 1 range of variation in margins. An April 2016 survey of 10 providers, including national providers, found a range of gross margin from 21% to 42%; and profitability is even more opaque because we are told domiciliary care providers "realistically make a net profit or surplus of 2%-3% and usually not more than 5% of the total price".

[39] Angel, Colin, (2015), pg9.
[40] Ibid.

What's interesting about the domiciliary care business is the huge range of variation in margins and returns. The range can be large because domiciliary care requires very little capital and there are very few barriers to entry. So that, even more so than in residential, the acceptable profit return is very different for various kinds of operators in a sector which includes financialised chains, mom and pops with single branches and everything in between. Consider, for example, a single, relatively small retail branch selling 500 hours per week and with 3% profit margin, making 50 pence per hour sold as in the standard UKHCA 2016 costings.[41] For a financialised chain, after paying the costs of business (including manager's salary of around £30k) the lump of profit from this branch is just £12,500 which is measly at best and (if squeezed just a little) will evaporate at worst. But a mom and pop owner/ manager firm would take the £30k manager salary plus the £12.5k profit jointly as income and no doubt charge various household expenses including motoring to the business. So that for a nurse and partner in a low income area like the valleys of south Wales, the same financials could be an attractive opportunity.

There cannot be one fair price for domiciliary care because a price which does not cover the costs and margin requirements of some providers may be attractive for others. This helps to explain the paradoxes of current patterns of entry into and exit from the sector. Margins are being squeezed with 93% of UKHCA members reporting that costs are increasing faster than local authority prices paid so that more than 74% of providers are thinking of reducing the local authority funded care they provide.[42] But, at the same time, the number of firms in the business increased by 3.6 % with more than 300 new entrants in the year to March 2016. This also explains the different responses of various providers within one local authority area to increases currently being offered so as to cover the mandated increases in the minimum wage; in one Northern city an 8% offer was tolerable for some providers but completely unacceptable to other providers who wanted a 20% enhancement.

The UKHCA is using accounting knowledge to model an imaginary, ideal type business. It would be altogether more interesting to use accounting knowledge as way of understanding the range of variation and the drivers of cost and return; and to set all that in a broader understanding of the limits on domiciliary care quality inherent in paying for tasks and the branch business model. From a local authority point of view, costings of care and calculations of a fair hourly price only make sense if the commissioner has extra contextual information on hours per branch and level of staffing, especially "back up" per branch which would make sense of firm choices within the standard business model. The fair price needs to be replaced by *open book accounting* but we should also remember that the social policy answer is never

[41] Angel, Colin, (2015), pg26.
[42] Holmes, Jonathon, (2016), pg9.

simply in the financial numbers because financial understanding needs to be combined with more imaginative and innovative responses.

Towards radical social innovation

What we want from state funded home care is **a learning response** which would require commissioners and others to engage activity specifics and understand the implications by drawing on local insider knowledge and realising that the largely female middle-aged workforce are keeping things going. The question is how do we harness this knowledge and resource; how we can rethink the career of the cared for and how we support precarious independence instead of the early and irreversible transition to residential home.

In driving this agenda we would explicitly draw on Roberto Unger's concept of social innovation as disruptive experiment which is part of a collective project that challenges established political and economic interests; and would add our own distinctive emphasis on financial practicality and sustainability considered from a broad social point of view. Our proposal is for local and regional experiment initiated by local authority commissioners but involving civil society, providers, workers and older people. Experiments should be sponsored by players who are engaged with specifics so they can come up with the ideas; as academics we would have a secondary role as action researchers in organising networking and advice and appraisal (not consultants or evaluation wonks).

What is social innovation (how is it different from centralised hyper activity)?

Improving care is a complex problem: at present, a limited range of home care options are available to a heterogeneous range of individuals with diverse care needs; all of this is exacerbated by severe financial pressures on local authority budgets transmitted through firms to the care workforce. In thinking about the response, we need to move beyond standard calls for reform, if that means central state initiatives combined with unreal hopes that quasi markets will deliver change; indeed , any one simple paradigmatic change would not be an appropriate response to a situation where there are overlapping challenges and differing needs. New 'policy' runs the risk of creating different forms of - or standards for - care that address some problems and create others, while also absorbing considerable management time and energy in compliance and change. Instead, we argue that we need a response based on the idea of social innovation, which starts from two key understandings: first that there may be no single best way to provide care; and, second, that effective change needs to be participative, imaginative and often involving new processes or partnerships.

Social innovation is now a popular term within policy and academic communities to describe attempts to change the nature and delivery of key products or services to better meet social

needs. Although there are competing definitions and classifications of social innovation,[43] there are some common themes which include: rejecting a traditional dichotomy between the state and private organisations as competing providers, and in doing so recognising that innovation may come from new organisations or collaborations; the emphasis on processes as much as outcomes, and recognising inter-dependence between these; the role of bottom-up initiatives (and social entrepreneurs) in shaping provision; and recognising the possibility of failure if experiments in provision are to be encouraged.[44]

There have been criticisms that social innovation has been readily adopted by some politicians as a cover for austerity, so that small amounts of social enterprise and innovation are expected to soften the edges of (or mop up some of the problems caused by) the reduction or withdrawal of state funding.[45] To avoid social innovation being captured by an austerity agenda, or used merely as a bolt-on to hyper-active policy making, we propose a more radical framing for social innovation in domiciliary care. In doing so we draw on and extend the ideas of Roberto Unger,[46] who outlines a radical agenda that emphasises social solidarity and community-based action as starting points for a project that must disrupt existing forms of organisation and politics, while also setting out collective agendas that can command wide support. But we also need an emphasis on the practicalities of social innovation including an understanding of how the processes of experiment and learning can take place, as well as of how models of care need to be financially sustainable.

Our prospectus for social innovation in adult care therefore starts from four framing principles.

1. **Social innovation should be part of a broad argument about what matters.** Unger emphasises the importance of grounding innovation in a 'collective project for society',[47] rather than it being a pocket of resistance amidst unchanged institutions and practices.
   In relation to adult care, we need to start from an argument that the care of vulnerable people matters and that we can do it better. On its own, of course, that can appear as a trite statement, but it is also an essential starting point that both expresses discontent with current choices and outcomes, while also setting out an ambition to try something different. This framing argument is based on the notion that care is a foundational activity[48] in two connected ways: first, it provides an essential service to large numbers of citizens and, done well, it encourages social participation and improved quality of life for

[43] See for example, a series of reports by TEPSIE, including TEPSIE, (2014), 'Social Innovation Theory and Research: A Guide for Researchers', December.
[44] On health and care specifically, see Davies, Anna and Boelman, Victoria, (2016), 'Social Innovation in Health and Social Care', Policy Paper, The Young Foundation/ Social Innovation Europe, January.
[45] Grisolia, Francesco and Feragina, Emanuele, (2015), 'Social innovation on the rise: yet another buzzword in a time of austerity?', *Salute e Società*, No. 1, pp169-179.
[46] Unger, Roberto, (2015), 'Conclusion. The task of the social innovation movement', in Nicholls, Alex *et al* (Eds), *New Frontiers in Social Innovation Research,* Palgrave Macmillan.
[47] Unger, Roberto, (2015), pg236.
[48] Bentham, Justin *et al*, (2013).

the cared-for and their families; second, it is a large employment sector[49] and, organised well, has the potential to provide secure and properly paid jobs, while improving the capabilities of the workforce. The collective project for society, therefore, is to align these two elements in order to provide better care. This is likely to require defeating the 'dictatorship of no alternatives',[50] so that it becomes possible to think about different kinds of care, while building democratic connections to community and other organisations to ensure political sustainability.

2. **In challenging dominant narratives and models, social innovation will need to disrupt and to some extent displace existing economic and political interests**. Most radical social innovations have combined a new political or social vision that can command widespread support with disruption of some existing interests; for example, the establishment of the NHS was based on the principle of access to health services; this required both the creation of new institutions and the dislodging of existing providers who operated under a model of limited access to health care based on charging.

   In relation to adult care, social innovation might involve disruption of commissioning practices. Local authorities are key players and have a leading role in shaping the way that care is received and, by implication, in how it is organised. Disruption of commissioning models might include a move away from commissioning based on numbers of visits or minutes of care, towards a range of models which could include participation in activities in or outside the home. Or it might require a re-organisation of care provision away from large branches to local groups or networks that allows different relations between carers and cared-for and between those receiving care and others in their community. Disruption does not necessarily mean hostility or displacement: care commissioners and providers can be actively involved in a process of rethinking; however, their interests and existing patterns of commissioning and provisioning should not simply block change.

3. **Radical social innovation requires experiments and new projects that allow learning, development and upscaling**. Big bang change is unlikely to work. Instead we need to start with small scale experiments that reflect local conditions and which can help to demonstrate different kinds of provision; such individual and small scale initiatives can and should become a movement to prevent experiments becoming isolated exceptions in an otherwise unchanged landscape of care. The result should be a diverse, developing ecosystem which avoids promoting one particular model and accepts that some experiments will fail.

[49] Skills for Care estimate that there are 1.45 million workers in the social care sector. See Skills for Care, (2015), 'The state of the adult social care sector and workforce in England', Workforce Intelligence Analysis Team, March.
[50] Unger, Roberto, (2015), pg237.

In relation to adult care, we need to think about how to licence and facilitate experiments through partnerships between existing actors and organisations, as well as bringing in new ones. Commissioners are key gatekeepers who have statutory responsibilities; their support is crucial, as is their willingness to contribute to new partnerships and networks. Experiments can draw on forms of care provision operating in others places and times; radical social innovation can bring together old ideas with new visions and networks.

4. **Social innovation needs to be pragmatic as well as visionary and political if it is to develop and spread. Most critically in this context, it needs to incorporate the development of financially sustainable models**. Such models need to take account of the resources required to operate services, the financing, ownership and use of assets and the expectations about risk and reward. One of the purposes of experiments is to develop better understanding of costs and the relationship between costs and outcomes for different kinds of models.
   In relation to adult care, we need to accumulate evidence about costs and outcomes, using broad criteria so that options can be framed in relation to experiments and models. It is not a case of 'discovering' the cost of provision but exploring how different ways of providing care have different cost profiles (based on the numbers and composition of the care workforce); and how these relate to the experience of being cared-for and of being a carer

Finding the point of intervention: the role for LA initiative

When we analysed residential of care for older people in an earlier report[51], we highlighted the key problem of 11-12% returns on capital sought by financialised chain providers; and argued that debt based financial engineering was being inappropriately applied to an activity which should be low risk and low return. In contrast, our analysis of home care suggests the key problem here is the standard retail offer determined by unimaginative commissioning from branch based providers; our suggestion is that the precondition for breaking out of this impasse is Local Authority initiative.

None of the providers we interviewed were complacent. All were making an effort to improve service quality with different targets that reflected their discretionary objectives about financial returns and service quality. For example, the financialised chain worked through Key Performance Indicators, such as, missed visits and soft indicators like missed supervisions; and each branch had a "target for growth" - a financial target expressed in hours per branch terms. Alternatively, the East Anglian small provider had less pressurised targets (targets but "no pressure") and targets could be set in the form of "ten more staff in six months' time".

[51] Burns, Diane *et al*, (2016), 'Where does the money go? Financialised chains and the crisis in residential care', CRESC Public Interest Report, March.

The Welsh not-for-profit stood out because of its interest in real innovation in home care. For example, it was positive about commissioning for 'outcomes' rather than 'tasks in time slots' and it had experimented in going beyond fixed rotas. The potential for innovation in the Welsh not-for-profit was linked to a more social and less medicalised attitude to helping older people at home and, for example, recognition that it might be worthwhile to organise a mini bus to take a group of older people for a night out at the pub. Medical and personal care remained important but the necessity for social contact was also prioritised. Other providers wanted the right rate for home visits and staff who could cope with medical care such as peg feeding of an increasingly infirm clientele.

If asked to explain the absence of large scale experiment, we would point to unimaginative commissioning by local authorities who wanted to outsource the problem of providing home care so they avoided engagement with the specifics of service provision and did not have to think about business model and form of service. The Welsh not-for-profit described how local authorities put contracts out to tender in blocks of 1,000 hours at a time. The Financialised provider noted that one West Country local authority was looking to retain one or two large providers on the understanding that they would take responsibility for the service and hire subcontractors as necessary. Both noted that local authorities want to outsource and "forget". We conclude that local authority commissioning is what needs to change in home care.

But what to do? Thinking holistically about care and some principles of innovation

All the above leads us to endorse the idea that *outcomes* could and should shape the commissioning of home care. Our caveat and qualification is that outcomes should displace the current reliance on brief, body-focused and task-based care as they can allow and encourage varieties of care options for different people. The question is not whether to adopt outcomes-based commissioning but how to adopt an outcomes-based system that focuses on the specifics of each person's need.[52] This is not a narrowly technical problem. Instead it requires some thought about how paying for outcomes might be designed and paid for given the issues exposed by programs like 'Back to Work'. It ought to be possible to do better than budgets and direct payments for more of the same by offering support and professional guidance for help with making choices.

There are a variety of ways to rethink the dominant branch business model, around the general long term objective of making care a decently paid vocation which would allow a more highly trained and motivated workforce to self-manage; and more immediately focusing

[52] For example, see the Adult Social Care Outcomes Toolkit (ASCOT) designed to capture information on individual social care related quality of life (http://www.pssru.ac.uk/ascot/). This tool is aimed at local authorities to help them measure outcomes. It is not clear whether they have yet been adopted. See Towers *et al*, (2015), 'Adapting the adult social care outcomes toolkit (ASCOT) for use in care home quality monitoring: conceptual development and testing', *BMC Health Services Research*, (15:305).

innovation on reducing travelling time in ways which eliminate waste and involve a radical recomposition of the labour process. The potential here is considerable because, in the UKHCA fair price calculations, office management costs account for 25% of total costs and travelling costs adds £2.67 per hour in the UKHCA calculation. Our Welsh not-for-profit provider talked of "creating a good run" but, so far as we know, nobody has previously experimented with ultra-localism and walking rounds in urban areas (as Sheffield Council now proposes to do). If this kind of simple experiment within home care succeeds, it should be possible to experiment with an integration of different services including home care around some kind of hub.

Innovation needs to move beyond (but not away from) a focus on financial arrangements. Radical Social Innovation (RSI) is explicitly political, social and cultural. We might in due course question the boundaries and interactions between formal/informal care or consider ways of changing the rights and responsibilities of citizens to give and receive care in their communities. At the same time, the kind of RSI we propose recognises the financials and business model constraints because there is no point in pursuing unsustainable and unaffordable excellence and we have to work our way around existing business models.

Here are three simple RSI principles.

1. For the foreseeable future, commissioners will have to manage the existing system of tasks in time slots by existing providers. Here, we propose o**pen book accounting with contextual information about staffing and hours per branch.** This would make a very useful first step in commissioning reform within the existing system.

This is an established technique. Supermarkets often use open book accounting with suppliers. This technique allows the supermarkets to gain an advantage in taking margins off suppliers. What we are suggesting is that some variant be used by local authorities in domiciliary care. The aim is for commissioners to understand what the hourly rate buys by way of service resilience and travelling time; this could be explicitly tied to LA pricing to allow a profit on sales of 2.5 to 3% (as a minimum and maximum). This would most likely be followed by the exit of private equity which seeks higher returns to justify the cost of buying and building home care chains.

2. The second basic principle is not to fixate on domiciliary care but to consider **the whole set of living and care arrangements available to the older person to choose from**. We have suggested in previous reports that older people become resigned to residential care in the absence of a fuller or more imaginative range of community-based care services.

When thinking about the costs of these community arrangements we should bear in mind the cost of the alternatives: hospital and residential care. If older people are supported at home more effectively, this may cost more than the current domiciliary care arrangements but far

less than full board residential alternatives. These opportunity costs and benefits need to be incorporated into commissioner decision making.

We have also argued that the range of services available to older people is narrowing to simple, short home visits (selected from a limited menu) focused on the bio maintenance of hygiene, medication and nutrition; with removal from home to a residential home or from hospital to a step-down bed as the only institutional options. Splitting home-based and residential care may make business sense as it allows providers to specialise in one or other type of care (recognising that the cost structures are quite different for these two kinds of operator) but we argue that organising services in this way builds in perverse incentives as well as rigidities, for example, to over-emphasise care needs to obtain higher payments and to be slow to recognise recovery or reducing care needs. As a diagnosis of dementia can release health funded money to pay for care, there is an incentive for individuals and local authorities to move to this diagnosis rather than recognise treatable conditions such as depression that can present in similar ways in older people. The wider the gap between home-based support services and residential care the more readily older people may find residential care to be the one, irreversible way of getting the care and support they need. Arrangements for domiciliary care can slow or accelerate the move to residential care by offering more or less support at home.

Alongside the narrowing of services available there may be a narrowing of specialist understanding about medicine for the elderly. In old age many health conditions are provisional and recovery is possible; although the recovery period may be extended because of additional frailties linked to old age. Also, common conditions such as urinary tract infection and depression may present in a similar way to certain types of dementia. Specialist assessment is required to make these differential diagnoses. Whilst we note the possibility that alternative diagnoses are being overlooked, this is not the focus of this report, we merely observe the fact that current arrangements do not incentivise a recovery narrative or the patience and time required to underpin accurate diagnosis and care.

The narrowing of services to home or residential care alternatives has had a significant effect on the adult care workforce. These jobs can often be characterised as low paid and low skill involving hard, heavy and stressful work with little time for social interaction with the person being cared for or to assess how the older person's care needs might be changing. Home care is also dominated by part time jobs, which may make it harder to recruit and retain a diverse and high quality workforce. We think it is important to recognise the links between job and care quality and to explore ways in which both of these could be simultaneously improved.

We argue that RSI provides one means of extending the range of alternatives available, both to supplement, postpone or avoid hospital or residential care, as well as to enhance the choice and quality of home care available.[53]

3. The third basic principle is to examine the potential for social innovation to provide alternatives or additions to care based on bodily needs and bio maintenance so that we **consider other types of care need such as social interaction and other factors that sustain people at home** The aim should not be to construct consumer identities through individual budgets (assuming that a quasi-market solves problems) but to allow different possibilities and help with making choices.

To generate alternatives or additions to care, several immediate questions arise: What are the possibilities for a range of intermediate options from which the older person may choose according to their preference? The options here could include supported housing, warden-controlled accommodation, opportunities for respite care (to allow relatives and carers a holiday) and day care centres. What are the pros and cons in specific cases and how might these relate to particular kinds of care needs? How do we identify different kinds of transitions and breaks with the idea of the one career from independent living to residential home? The answers to these questions, and the further questions they raise, open up a potentially varied and bespoke range of services that may cater more effectively to individual needs. For example, services provided through a day centre may fulfil both a social need for older people and a peer-support need of care staff whilst costing less in terms of travel and staff time.

The problem of how to arrange care services to remove perverse incentives to over-emphasise need is more difficult to overcome. For example, step down care involves an increased income that homes may be reluctant to give up; in addition some homes have established guaranteed occupancy rates for these beds under contract arrangements. These perverse incentives act against the interests of older people especially their hopes of regaining a degree of independence. A focus on outcomes could build in reward for improvements and recovery as well as recognising increased costs of care during decline.

Building an evidence base for experiment

These possibilities raise a series of research questions to consider in building an evidence base for social experiment:

[53] The Age UK Integrated Care Programme, first implemented in Cornwall, now in 8 sites including Sheffield, and being evaluated by the Nuffield Trust, claims to coordinate health and social care services closely around people's needs, bringing together voluntary, health and care organisations to help older people who are living with long term conditions and are at risk of recurring hospital admissions. This programme has support from charitable sources and the Cabinet Office for Social Action. For further information see: www.ageuk.org.uk/professional-resources-home/services-and-practice/integrated-care/integrated-care-model/

a. What socially innovative provision becomes possible if we remove the idea of organising by age and instead organise by care need? Do more localised solutions become possible if a wider group of people of all ages with similar care needs can be considered as one group?

b. What happens if we move from fixed menus of provision to outcomes-based measures? How do we value outcomes like precarious independence? How do users of care services value different things like risk of accident against independence? How do they value minutes of care against continuity of care and relations with one carer. How do they value home-based care vs out of the home facilities? How do we find ways of measuring what's important?

c. What happens to older people who are misdiagnosed or recover? What happens if we think about multiple career trajectories (rather than an inevitable one-way route to residential care)?

d. How can social innovation improve working conditions for domiciliary workers who are often part-time or for residential care workers? For example, providing an outreach service from a care home or day centre may enrich the work and allow for career development. Also, we need a research focus on the relation between variability in job and care quality.

In summary, we need to broaden the cost debate in domiciliary care to account for other costs of care such as residential care and hospital admissions (when domiciliary care is not used to prevent the move) in a society where we already have 400,000 residential beds for older people charged out at £500 per week. The residential care sector appears to be ready to offer step down beds in residential care facilities if offered suitable financial returns but we have little evidence as yet of a broadening out of care options from residential and hospital care to community-based alternatives. If we take a wider view of costs to include costs of alternatives, how does this open up new kinds of choices? And in relation to (a.) above, we need to understand how local authority limits for domiciliary care are arrived at. Given that local authorities pay for home or residential care in many cases why not fill the gap with day care and other community based alternatives?

We need a better understanding of recovery pathways to understand how these intermediate alternatives may mitigate the current set of arrangements where the threshold for provision of domiciliary care is set high and the maximum provision is set low (in some cases no more than a few short visits a day are funded) meaning that removal to residential care occurs before the potential for home care has been either triggered or exhausted. This means relinquishing one's home for sale or for new tenants with the possibility of return then permanently removed.

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