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Quality in home care: client and provider views

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PSSRU Discussion Paper 2017
June 2003

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Summary

1. This paper reports on the findings of a small-scale study that investigated the meaning and delivery of quality in home care in four local authorities from the perspective of informal carers, users and providers and explored the views of users about proposed changes in the ethos of home care stipulated in the National Care Standards for Domiciliary Care (2003).

2. Thirty-two users and 13 providers were interviewed about their experiences and attitudes to quality in home care. Users were receiving services from eight of the providers interviewed. Although the samples were small, users and providers reflected a wide range of circumstances. Users were mostly receiving high levels of homecare, and had usually been receiving services for several years.

3. There was some evidence of discrepancies between the activities undertaken and reported care plan (based on the user's perspective). Four users had domestic tasks, meals prepared or shopping undertaken outside the commissioned hours. Home carers undertook this in their own time.

4. Of the seven key aspects of quality; reliability, staff attitudes and flexibility were of key concern to service users, identified most frequently when first asked about the aspects of service quality that was important to them.

5. With few exceptions users were very happy with the attitudes of their carers. The three attitudes most commonly cited as important were being 'understanding', 'friendly' and 'obliging'. Other common views were that carers should be cheerful and that they should treat people with respect.

6. Most of those asked said that they had a preferred carer type. Mature women were most often cited as being an ideal care worker and this was centred on the perception of women as 'natural carers'. However, a number of people, both British white and from minority ethnic groups emphasised the importance of a care worker from the same ethnic group. This was most frequently stated to be because of language issues.

7. Timing of visits and reliability were crucial aspects of quality for over half the users interviewed. It was the tasks to be undertaken together with the attitudes of the individual user that determined the importance of timing and reliability. Providers tended to rate their

performance in the areas of reliability and communication rather higher than would be expected given the views of the users of their services.

8. Experience of flexibility of the home care service tended to be very much at the level of the individual care worker and her attitude to the rules and doing tasks in her own time, resulting in inequitable service receipt by service users and, arguably, exploitation of home carers. Providers saw themselves as tied into the care plan so having little scope to offer a flexible service. This arrangement results in inequity where those who feel unable to ask for changes and those with uncooperative home carers receive less than those where the carer helps out over and above the official hours.

9. Users and their informal carers tended to prefer having the same home carers. The issue of continuity was of critical importance to many of those interviewed. This was linked to their particular circumstances including mental health, sensory impairment and to issues of trust and communication.

10. Communication was an important issue to many of the service users and it was intrinsically linked to both reliability and continuity. Although most users felt they were kept informed this was often through the home carers rather than the organization, which users often felt was inappropriate. This was particularly important for those very dependent on the service.

11. Skills and knowledge were linked to the characteristics of the home carer in most users' minds: their age and gender and above all their motivation. Providers were primarily concerned with the cost and practical implications of meeting the new Care Standards, particularly the training requirements.

12. With a couple of exceptions (based on bad experiences) users felt their home carers were trustworthy. They primarily defined this in terms of honesty rather than confidentiality. There was some evidence that some home carers were not keeping the confidences of service users.

13. There are clearly a lot of time pressures under the existing arrangements, which will be heightened by the care standards and their 'enabling' ethos. Any arrangement that allows capacity for carers to spend time encouraging people to do things for themselves will need to compete with pressure from users to get other tasks done, including those tasks not officially part of their care package.

14. Managers welcome the regulations for delivering a quality service that are set out in the National Care Standards for domiciliary care. However, there are serious concerns about whether the prices paid by local authorities will cover all the costs that they are likely to incur in order to meet the standards and especially, the demands for the training and development of their work force.

1. Background

An important issue for commissioners, providers and evaluators is the identification of the quality of services from the user perspective. Many variables may affect service user's perspectives on the quality and expectations of the home care they receive. In particular, a number of observers have identified that service users from minority ethnic groups have specific preferences about the way their home care is delivered related to their religious and cultural requirements (Raynes et al, 2001). It has also been identified that the immediate family, or primary carers of service users have needs and expectations of the way formal care should be delivered (Qureshi et al, 1998). In particular, where primary carers live with a dependent spouse, parent or sibling they are also 'service users' and they have needs relating to the way the service is delivered.

However, those who provide home care also have distinct views about the way the service should be delivered. They are also well positioned to understand what service users and carers want from their home care. Faced with pressures like financial constraints and work force issues providers' priorities may not match those of service users. Moreover, the home care organisation may face challenges beyond its own control that compromise its ability to deliver a good quality home care service.

This paper reports on the findings of a small-scale study that investigated the meaning and delivery of quality in home care in four local authorities from the perspective of users and providers.

We start by outlining the method used and then describe the characteristics of the consulted provider agencies and the characteristics and needs of the service users. Section 5 reports users' experience of the home care service and section 6 the important aspects of quality from the perspective of users and providers. Finally, the report addresses the implications of our findings on the future development of home care provision.

2. Method

In order to explore the range of experiences of home care and investigate the breadth of possible preferences, interviews were carried out with a random sample of service users, a sample of informal carers and a purposively sampled group of minority ethnic service users. The provider interviews were carried out predominantly in one local authority but a specialist minority ethnic provider in a further authority was also interviewed.

Thirteen provider agencies were randomly sampled and their managers agreed to be consulted. After two pilot interviews, slight changes were made to the interview schedule for the remaining 11. One of the 13 agencies had been specifically established to deliver home care to minority ethnic elders. The same interview schedule was used for this as for the other 12 agencies.

All provider interviews were in depth and face to face and with the exception of one, they were tape-recorded. The exception was one manager who did not want her views recorded despite assurances of complete confidentiality.

A previous round of service user consultation, via the Higher Standards questionnaires completed in one authority in March 2002 meant that the council was able to identify a list of older people who, in the previous consultation, had agreed to be contacted again in future to give their views on quality issues. Ten out of the fifty service users were initially approached for the pilot stage and six were interviewed.

Following the pilot stage and consequent revisions to the interview schedule, a further 23 service users were approached and 14 were interviewed. In total 33 were approached and 20 interviews undertaken with service users and in some cases, their carers.

Service users from a minority ethnic home care provider and others from a respite provider were also sampled. Only two of the people approached were unable to participate in the study and for both it was due to the service users' poor health. This enhanced our sample to include 10 minority ethnic respondents and seven informal carer interviews.

Overall, 32 service users were interviewed during the study. Four different 'Councils with Social Services Responsibilities' (CSSRs) commissioned their home care but one commissioned care to the majority, twenty respondents. The service users, between them, represented 14 different home care providers.

As with the provider interviews, all service user interviews were in depth, face to face and all were tape-recorded. Once offered assurances that neither their carers, home care managers nor care managers would find out their views, all service users were happy to have the interviews recorded.

The qualitative material derived from the provider interviews was organised in a framework for analysis. The same information was extracted from every interview so that the material could be properly compared and usefully analysed.

The material gathered throughout the service user consultation was analysed in a database using SPSS. This allowed simple statistical analysis to be carried out to provide frequencies and cross tabulations of the data. The implications of these are outlined in the rest of the report.

3. Characteristics of providers

Seven of the 13 home care providers were private, for profit organisations and six were voluntary and/ or charity organisations. One provider was a carer's organisation and one delivered home care to ethnic minority service users.

The size of the provider organisations varied in terms of numbers of full and part time care staff, number of care hours provided in an average week and the geographical extent of their businesses.

Six domiciliary providers employed less than 50 care staff, four employed between 50 and 100 carers and three employed over 100 carers, the biggest of which employed over 300 care staff. In terms of average weekly care hours, six organisations reportedly provided 1,000 hours or more, five provided 500 to 1,000 hours and two provided less than 500 care hours per week. The geographical extent of the providers varied but over half covered the whole of one authority plus part of at least one other neighbouring authority. Two covered the whole of one authority and no other authority and three covered just part of a local authority.

While agencies' capacity varied significantly, the tasks that they carried out and the aspects of home care they delivered were more consistent. All except one agency provided domestic help, meal preparation, laundry and personal care. The exception was the carer's organisation that concentrated on personal care and medication calls. The ethnic minority organisation provided, in addition, assistance with visits to the Mosque and translation of official correspondence. All except two agencies provided bathing calls and those that did not were part of a larger organisation in which there was a specific bathing service that would be separately commissioned. Three providers specified that bathing would only by provided following the satisfactory completion of a risk assessment exercise on an individual case basis. Sitting and night sitting calls were also commonly available. Two thirds of the agencies reported being able to deliver those aspects of care but about half of those currently had no social services contracts to provide them. Only three out of the 13 organisations reported providing shopping either with or for their clients. Two of those were private providers.

The tasks highlighted above are those that were most commonly provided by the study providers. However, there are a range of other tasks including respite, befriending, help to hospital appointments, advocacy, hairdressing, chiropody, ‘put to beds’, wake up calls, check up calls and emergency telephone systems which were variously provided, especially where large organisations encompassed separate agencies that deliver those activities.

4. Characteristics of service users

Thirty-two service users were interviewed during the consultation process. The group consisted of fifteen men and seventeen women. Thirteen were over 75 years old at the time of interview, with ten 85 years or older. Twenty-two people interviewed described their ethnic origin as British white, one as Irish white, and one as ‘other’ white. Two people described themselves as Black, Caribbean. Six described themselves as Asian including Indian, Pakistani and Bangladeshi.

Just over half of those interviewed lived in a single person household, and seven were married and lived with their spouse at home. A further seven service users, some married, some single, lived together with members of their immediate family.

With the exception of only one person, most of those living alone enjoyed some form of social contact from a friend, neighbour or family member. For half, that contact was on a daily basis and only one person living alone enjoyed social contact less than once weekly. All but one service user living with their spouse had regular social contact from family members, neighbours or friends.

Twenty-five of the respondents used formal support services other than home care. These included regular treatment from a district nurse; attendance at a day centre and, in only two cases the receipt of a ‘meals on wheels’ service. One person receiving meals on wheels lived alone and the other lived with his son who worked full-time.

The frequency of visits and treatment by the district nurse varied greatly but the most common situation was to see them between once a week and once a month. Only one person saw their district nurse more than once a week. That service user, was over 85 years of age, lived alone and had chronic health problems. Almost half the group as a whole either never saw a district nurse or saw one only when necessary.

Take up of day care was low. Only nine of the entire group attended a day centre, one of those was only on a monthly basis. Most of those who attended were from single person households; only two people living with their spouse and two living with their immediate family reported visiting a day centre at all and in those situations the motivation was for respite for the spouse or other informal carer. Negative attitudes about the concept or image of day care were pervasive and illustrated by one service user who, although she recognised her old age and frailty was adamant she wouldn't like to attend a day centre " wouldn't like to go and sit down among all those old people…I don't know why I call them old, I'm old…I just don't feel old."

Areas of concern about service provision other than home care focused on gardening and aids and adaptations. Two service users lamented the fact that they could no longer keep their gardens looking "nice" and had no one who would do it for them. One service user, who was visually impaired, was simply waiting for someone to paint two white stripes along the edge of his garden step. Another had applied to social services 5 months previously to have a shower installed, as without it she was unable to wash properly. Frustrated at the lack of communication and activity on the part of social services she exclaimed, "I think it's (the shower) still in China!"

5. Receipt of home care

Eight of the provider organisations being used were among the 13 providers interviewed during the consultation process.

Nineteen of all those interviewed had begun receiving home care following hospital discharge. Another seven began when their health had deteriorated, four after a fall or illness and one where there had been a reduction or withdrawal of informal care. The remaining person could not clearly remember the circumstances which led to them receiving home care.

Although the time that people had been receiving home care varied, almost half had been receiving it for between one and four years. Five service users had been receiving home care for five years or more and five people had had home care support for 10 years or more. Only three people who were relatively new service users had been receiving it for between six months and a year and one had been receiving home care for less than six months.

For the most part service users were receiving high levels of home care input. Twenty-three of 32 service users received the service every day of the week. Two people received visits six days per week and seven between five days and one day per week. The least amount of care hours provided per week was one hour and the most was 28 and a half hours[1]. On average, the 32 service users interviewed received 9.2 hours of home care per week**.** This compares with a national average of 7.6 hours per week. (Department of Health, 2001).

Table 1 shows the types of help that people received from their home care organisation and other sources. In some instances people received help from more than one source. The most frequently commissioned task was personal care. Three quarters of those interviewed received help with personal care and none of the remaining seven reported that 'personal care' was an unmet need.

Table 1: Types and sources of help

	Home care		*Informal care**
	Formal arrangement	*Informal arrangement*	
Personal care	25	0	10
Domestic tasks	11	2	17
Meals preparation[1]	12	1	-[2]
Shopping	4	1	25

Notes:

1. Excludes one person who was receiving meals on wheels
2. This information was not collected

** By household or by family/ friend or neighbour*

Around a third of those interviewed reported receiving domestic help as agreed in their care plan. A further two people reported having domestic help that had been informally arranged with their home carer. The remaining nineteen service users reported having no need for domestic help; 13 because they had help from their spouse or other household member, four because they had other informal help and two because they could manage alone.

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[1] Where service users' care delivered by two care workers for every visit. Each care workers' hours are treated separately and added together to calculate total hours received.

Meal preparation was delivered to 13 of the 32 service users. Twelve said that it had been agreed in their original care plan and one person had an informal arrangement with their carer.

Tasks that were less commonly delivered were shopping and errands and medication calls including dressings and medication prompts. Five of those interviewed had help from home carers with shopping and other errands. Four identified this as part of the formal care plan and one through an informal arrangement. Another two people felt they needed formal support with shopping and they were currently entirely dependent on informal help. However, twenty five service users said they had no additional need for help with shopping; eight because their spouse or other household member was capable of doing the household shopping and errands, 13 because a friend or other family member did their shopping either with or for them and four could reportedly manage alone. There was a similar situation with medication calls as only five of those interviewed said they needed help and they all received it. The rest of those interviewed received help with dressings from their district nurse or spouse.

The interviews also gathered information about the changing nature of people’s care plans over the period they have been in receipt of home care. Just over half of the service users had experienced no change in the level of care they received, as there had been no change in their own health or mobility or in the health or mobility of their spouse. Nine of those interviewed reported that their care package had been increased since it’s inception and in most cases, they put this down to their own deteriorating health and/ or mobility. More than half of those people had been receiving home care for five years or longer. Finally, five of those interviewed reported having less care than when they first started receiving home care. In three cases this was because they had got stronger or improved and no longer needed as much help. The other two service users put the reduction down to cuts by their local council in social care funding. Both service users were from the same local authority.

6. Quality of service

Before exploring the specific quality characteristics, the interviews gave service users the chance to raise aspects of their home care that they particularly valued or points that they saw as being problematic. Those interviewed after the pilot stage were also asked to assess the overall quality of their home care. Out of those 26, 20 felt they received a good quality service, two people felt they did not and four others judged their service as “fair”.

The issues that people volunteered initially as positive aspects of their home care were principally around the attitudes of their carers and their willingness to help and do jobs beyond those stipulated on the care plan. Nineteen of the 32 interviewed positively identified attitudes of their carers. They valued friendliness, understanding and respect. Three people cited staff attitudes as a problem of their home care service and one felt, "they should treat me with more respect and shouldn't be over familiar. I wish they'd draw a line with the familiarity. I wish they would show more respect and professionalism".

Ten out of all those interviewed cited flexibility as one of the good aspects of their service. Service users and their families both valued carers willingness to do extra jobs often, without even being asked, "they want to do everything they can for me, they're very good". However, seven people identified lack of flexibility as a problem citing the view that their carers seemed to do the bare minimum, that they were confused about exactly what their carers were allowed to do and that having being turned down in the past, they knew there was little point asking for extra help again.

The reliability of their home care service was something service users also volunteered as being an issue. Opinion was divided. Although eight people reported having a reliable service with carers who generally arrived on time, another ten raised it as a problematic issue (see section 6.1 below). However, the remaining fourteen did not mention reliability at all when asked about the good or poor aspects of their service.

Attitudes, reliability and flexibility were aspects of care people most commonly raised. However, they also identified communication by their provider, the sense of security provided by their carers' visits, the way care tasks are carried out, the choice of carer and the trustworthiness of their carers.

Following the open-ended discussion service users were invited to consider key aspects of quality that had been identified from the literature or initial pilot interviews. They were continuity (Edebalk et al., 1995), reliability (Qureshi et al., 1998), flexibility (Henwood et al., 1998), communication (Raynes et al., 2001), staff attitudes (Sinclair and Gibbs, 2000; Qureshi and Henwood, 2000) and skills and knowledge (Raynes et al., 2001). Interviewees also answered questions around the issue of trust.

6.1 Reliability and timing of visits

Users were asked specifically about their views on reliability and the precise timing of visits. Reliability was clearly an important quality characteristic to over half the respondents with 22 out of the 32 citing specific reasons why timing was crucial. People emphasized their need to retain control over their daily lives and saw waiting for home carers who never came or arrived late compromising this. They were also concerned about the routine necessary to manage diabetes, the need for regular and routine meals, and the importance of control over the daily lives of either themselves or their informal carer "You can control your own life if you know what's going to happen with your day …There's nothing worse than sitting round all day waiting for someone who should have been there…" Thirteen out of those 22 people wanted their carer to arrive at a precise time. However, just under half always received their visit at the time it was expected.

However, time keeping is not important to everyone. One third of those interviewed placed little priority on the actual time they arrived and placed more importance on simply knowing their home carer would arrive at some point in the day, "It doesn't matter, as long as I know they're coming, that's the main thing".

Reliability of the service

Respondents were asked to rate the reliability of the service they received. As table 2 shows, 97 per cent of people said their home carer usually or always arrived when they expected them to.

Table 2: Reliability of the service

	Number	*Percent*
They always come when I expect them to	13	40
They usually come when I expect them to	18	57
They sometimes come when I expect them to	1	3
They never come when I expect them to	0	0
Total	32	100

This result was somewhat surprising as in the initial discussion about quality ten respondents had identified problems with reliability. For example, one service user reported having nine missed calls over the time he's been receiving care. Another service user reported that she'd been left without carers on a number of occasions. She even explained that on those occasions her home care company have told her to find her own carer and she was clearly unhappy with her situation, "By the time you realise nobody's coming, it's too late to phone up…I don't know whether that's the general practice or whether it's just the one company but I feel it's wrong…"

Most of the service users explained that their carers were unable to arrive at the same time due to a range of human circumstances. So for example, "I find that they're a bit anxious to get it done – and that's not altogether their fault, it's because they have so many to get done in one day" and "if the carers are late there's always a human answer for it, like an emergency with the person before or they're stuck in traffic…" Another service user recognised that although her carers were sometimes late, this is due to emergencies with other service users or other human factors, which mean that they can't always arrive on time. The service user felt that it was all about give and take, "when the girls have finished their work I let them leave, 'cause I know they're not allowed travelling time". The issue of travelling time was something many of the service users were aware of and many felt the situation as they saw it was unfair and illogical. More than one person suggested it would make more sense for their carers to work in geographical patches as a way to reduce travelling time between calls and reduce the problems of traffic hold ups between visits.

It is possible that going through this reasoning process meant that when they came to identifying the reliability of their service, respondents were actually judging whether their carers were *reasonably* on time – whether it was excusable that they were often late. So perhaps, "they usually come when I expect them to" was more "they're rarely on time, but you can't blame them, it's not their fault".

It is of interest to link respondents' views of the importance of reliability with their experience. Of the 10 who felt timing was unimportant, three always received visits when they expected them and seven usually did. Of the 22 who, for a range of reasons, felt timing was important, ten people always received visits when they expected them; eleven usually did and one person only sometimes did.

The preferences in terms of the timing of visits differed slightly among the minority ethnic service users and their carers. Where 10 white British respondents felt the timing of the visit was not important, all minority ethnic service users felt it was. In all but one case, the reason given for the importance of timing was 'control over daily life.' In terms of their actual experience of the reliability of their own home care service, all minority ethnic service users reported that their care workers always or usually arrived when expected. Therefore there was no real discernable between the experience of white and ethnic minority service users in terms of the reliability of their services.

The provider perspective

The views of the managers of the provider organisations who were interviewed largely matched those of the service users' views on reliability. Some of the explanations service users gave for their carer's late arrivals or missed calls were the same as the reasons given by providers for not being able to consistently maintain reliability, "there's not a lot we can do if a client is ill or has a fall and the carer needs to stay with them longer…" or "traffic – there's not a lot we can do about that".

However, there was also the suggestion, by providers, that pressures exerted by social services commissioning arrangements made it very difficult for them to deliver a reliable service. In answer to the question 'what makes it difficult to provide a reliable service?' one provider reported,

> "It's partly because of the current task focussed SDO's[3] and the current financial constraints that affect local authorities. We're being paid to do half hour after half hour, one after another. We're rushing between clients at the moment and have less chance of maintaining reliability…"

Although the service users did not make any link back to the local authority commissioning arrangements they did feel that an unreasonable burden of work fell on their home carer. They felt that their carers had too many visits to make in very little time, over an unreasonable geographical patch and that the outcome was rushed visits and late or even missed calls.

Nevertheless, there was some significant difference in opinion between service users and providers. The difference lay in their views about the providers' level of success in delivering a reliable service with consistently punctual visits and no missed calls. Providers had a much more positive perception of their performance and were confident that they had the organisational mechanisms in place to ensure that reliability is maintained. Those mechanisms included monitoring, supervisions and service user spot checks. They also included the organisation's philosophy and policies and almost all managers reported that the aim to provide a reliable service was central to their work,

> "It's the way the organisation has evolved. At the beginning we agreed standards and values and we've made sure that that's been the case the whole way along. New carers are taught our ethos right from the start".

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[3] Service Delivery Order

And another manager claimed “we work very hard to achieve that aspect…it’s the management structure in place that makes it possible….and good communication”.

However, service users of the second quoted provider identified poor reliability. One service user counted nine missed calls during the time he’d been receiving care. Another, who had since asked to change her provider company, reported that they “forgot me quite a lot”. That service user had late and even missed calls and had never been warned when her carer was going to be late. Nevertheless, she was much happier with the reliability of the provider she subsequently changed to. The manager of that company felt strongly that:

> “The two managers working on that (reliability) aspect of the service are very hot on the moral aspect of the service. As far as they’re concerned they work for a charity whose prime concern is the welfare of the older person. It’s that combined with good practice – no missed calls, no calling cards…”

So, although service user and provider views often conflicted on the issue of achieving reliability, some supported the optimistic assessments by home care managers.

6.2 Flexibility

Service users were also invited to discuss the importance of flexibility in their home care service.

It was clearly important to service users that they could ask for help with tasks beyond those on their care plan. This was most commonly the case among service users living alone. Not everyone felt they could ask for changes but if they could, the sorts of things they asked for was for washing to be hung on the line, for errands such as shopping or pension collection and for help filling out forms. “I have x (carer) in the morning, she’ll do anything I ask, she’s another diamond…” Other than help with extra tasks some service users felt able to ask for changes in the times their carers visit. Only three people felt they could or needed to do this and in each case it was so that their care could fit round day care or hospital appointments.

The most common experience was service users who felt they could but did not need to ask for changes. The explanations given were either that their needs were routinely met by their care plan or by their home carers volunteering any extra help. The majority of those interviewed were found to be in that situation and were very happy with it. Reporting her carers willingness to do anything at all, one service user commented, “she does everything I can’t do and I can’t do nothing…except lean on me elbows!”

However, not all service users felt they could ask for changes. Although they were few in number (six), their experiences are important. For example, one service user, living alone, would have liked her carers to do more jobs for her, especially wiping the inside of her windows and changing her net curtains. Although she asks her home carers to do those and other jobs they have told her they are not allowed to do them. She was clearly distressed about the situation and confused about what things her home carers are allowed to do. The spouse of another service user reported that she had not asked for changes since the supervisor had explicitly told her the carers would only deliver personal care. Although she would have liked to ask the carers to do odd jobs, she had the feeling that the carers' time was very limited and consequently she did not want to put them under any pressure.

Another service user receiving home care from the ethnic minority provider was clearly anxious because, as non-English speaking she badly needed help with translationof official correspondence and to interpret appointments with her English speaking GP. She had asked her care workers for help but she was informed that "it's not on my job sheet" and when she asked her provider he told her it was not their role. However, when he was interviewed, the manager of that agency reported "GP appointments" and "(translation of) letters" as two of the services they routinely provide.

Another service user who never asked for changes because she did not want to "put upon the carers" echoed those feelings. Not only was she unsure about what her carers were allowed to do, she reported that she had never seen a care plan and did not know what her carers were supposed to do. As a result she felt she could not ask for any changes which related to tasks or timing of visits.

Flexibility of service

Having explored the possibilities of making changes to their care, service users were asked to rate their service in terms of its overall flexibility.

Table 3 shows that when half those interviewed asked for extra help or different times, the changes were always made. Ten out of the thirty two people interviewed had never asked for changes due to a range of reasons; one had no need to ask, one did not know whether they could ask, five felt unable to ask and three felt they could but as yet had no need to. Although the table shows that only two service users felt "the changes I asked for are never made", this does not reflect the other individuals who had once been refused and had never asked again or those who felt they shouldn't "put upon" their carers.

Table 3: Flexibility of the service

	Number	*Percent*
The changes I ask for are <u>always</u> made	16	50
The changes I ask for are <u>sometimes</u> made	4	12
The changes I ask for are <u>never</u> made	2	6
I have <u>never asked</u> for any changes	10	31
Total	32	100

For the minority ethnic service users, numbers were evenly split between whether they felt they could ask for changes and whether they felt they could not. Only one person felt they could ask for changes from some care workers and not others.

There was a marked difference between the experience of minority ethnic service users and that of white British service users in terms of the flexibility of their home care. Only one minority ethnic respondent reported that the changes they ask for are always made. The rest said that the changes they ask for are either sometimes made, never made or they'd never asked for any changes. The reasons given for having never asked for changes were the same as those offered by white British respondents. The only experience particular to the religious requirements of the minority ethnic service users was one reported by a man anxious that flexibilities to the times of his visits could be incorporated. The week following his interview saw the start of a religious month of prayer and fasting and the service user needed to attend his mosque and pray at specific times. He was awaiting a response from his provider about whether they could accommodate his requirements in terms of flexibility of times of visits.

The provider perspective

The managers of the home care organisations were also invited to explore issues around the flexibility of the service they provide. Interestingly, the notion of flexibility did not mean the same thing to every manager. To some it meant their capacity to respond to service users' fluctuating needs, "to have the ability to provide care when the client needs it – that we look at the care needs of our clients rather than at the work needs of our employees." However, others felt 'flexibility' was something their service users ought to demonstrate. A quarter of those interviewed expressed the view captured by one manager; “We do wish clients would be more flexible, especially with 8am calls because everyone wants an 8am call. We can’t always provide an 8am call” and another, “that the service users have some appreciation of how difficult it is to provide their visits at exactly the time they want them…”

However, the managers did generally agree about what makes it difficult to provide a flexible service. Their views on this issue also concurred with the explanations service users had been given and they were mainly time pressures and prescriptive, inflexible care plans. Many managers were frustrated by uncompromising commissioning arrangements including unrealistic time allocations and in some cases, inappropriate needs assessments; “we always find that when we go out to assess a new client, their care needs, in terms of time, are very different to what the SDO says”. Almost all those interviewed complained about the inflexible nature of the SDO’s, which mean that if any changes need to be made, they are obliged to let social services know and, in some cases a new assessment will be carried out, “It’s very difficult to achieve flexibility because current contracts are task oriented” and “we’re not allowed to be flexible unfortunately a lot of the time cause we’re dictated to as to the times we have to do things”. Manager’s frustration about their inability to deliver that aspect of quality was evident, “it would be nice to be flexible if you were trusted to be flexible.”

Similarly, the manager of the Bengali provider felt that because of social services he was no longer able to respond in a flexible way to the cultural needs of his service users. When the organisation was first established, social services routinely involved the provider in assessments for new referrals so that they could properly identify religious or cultural preferences and incorporate them into new care plans. However, social services no longer involved the provider agency and the result, according to the manager is that there was little scope to respond appropriately to the service users actual needs.

However, the restrictions felt by managers were not always observed by home carers, and in some cases, managers were very well aware of this, “the carer and the client usually end up sorting it out between themselves – though that’s not really what social services want.” The views of the service users supported that suspicion as a higher proportion received help with extra tasks than the frustration of the managers would suggest. In several instances home carers were undertaking additional tasks at their own discretion. Although this represented a positive outcome for some this meant that carers were doing work they were not being paid for and service users were not receiving an equitable service.

6.3 Continuity

Respondents were invited to discuss the importance of having a regular carer, or where that was not possible, a team of regular carers. It was not an issue of great importance to all those interviewed. Half of those interviewed had specific views. Of those, opinion was weighted more toward those who preferred to have regular carers.

Some people were keen to have the same carers because they had become attached to them and felt they were like members of their own family. One service user had enjoyed the same carer for 11 years and become very close to her but she recognised that when the carer was ill or it was the weekend, it was not possible to keep the same one. Others also recognised that the volume of their care package meant that, at weekends, they would have to have other carers, "…then at the weekends I get the funny ones because the other ones have worked all week." Nevertheless, one or two users were unhappy when they didn't know their carer or did not know who to expect, "When they are on holiday you never know who you're going to get and that's the trouble"

A small number of services users and informal carers also felt that continuity was important so that immediate family and household members could establish a relationship with regular carers. One service user living with his wife and young children felt it was crucial that they get to know his carers because his children are afraid to answer the door to strangers.

Some service users and their informal carers had reasons other than personal preference for why they needed the same care workers. One service user, living alone placed paramount importance on having regular carers because he was only partially sighted and had to get to know someone's voice because he cannot see their face. He found it unnerving to have to let complete strangers into his home. In another case, the wife of a service user explained the importance of having regular carers for her husbands' sake, "it's because of his mind…he has very poor short term memory so if there's a string of different carers he gets confused, it's not fair (on him)…"

However, some service users were happy to have a range of different carers and some were confident that even if they had different ones, they had always seen them before and they were never strangers. Those who were happy with different carers were only concerned that the people that came could do the job. One service user with a six-day package reported being able to see five different carers in a week, but he didn't mind, "just as long as they can cook!"

Continuity of the service

Service users were asked how they would rate their service in terms of continuity. Table 4 shows that almost all those interviewed "nearly always" saw the same care workers. Although four reported "always" seeing the same care workers, all those interviewed understood that it would be logistically impossible, to always see the same single carer. They appreciated that given the complexity of their care package; they couldn't expect one carer to visit twice a day seven days a week. They also understood that when their carers were ill or on holiday they would have to have relief carers. The four who reported "always" seeing the same care worker made their judgement on the basis of their usual routine but always qualified their statement with "except when she's on holiday"

Table 4: Continuity of the service

	Number	*Percent*
Yes, I always see the same care workers	4	12
No, but I nearly always see the same care workers	27	84
No, I hardly ever see the same care workers	1	3
No, I never see the same care workers	0	0
Total	32	100.0

The experience of the minority ethnic respondents differed little from that of white British service users. All of those interviewed reported that they always or nearly always see the same care worker.

The provider perspective

When asked about issues around continuity, the home care managers recognised that, to some service users, it was crucial, "It's very important to service users, if you need intimate personal care you're not going to want a different person every day". They supported the service user perspective that, continuity of care generally meant continuity of carers. However, those who were interviewed underestimated service users' capacity to appreciate that "One carer, seven days a week, four calls a day" was not possible, "we can't promise what the service users want – no carer works seven days!" Home care managers instead sought to provide continuity in a *team* of carers. This supported most service user's experiences that they had two, three or four regular carers, and that, overall, they were happy with the situation.

Invited to discuss the things that made it difficult to maintain continuity, the providers' views again concurred with the service users' explanations. They cited sick leave as being particularly problematic, because along with other personal emergencies, it could not be planned for. Furthermore, in the case of unauthorized absences it was difficult to provide cover by carers already known to the service user. The managers also referred to staff recruitment and retention problems to explain that with a small pool of carers it was very difficult to allocate carers to certain service users and maintain that arrangement.

Home care managers identified the strategies and practices they adopted in order to achieve as much continuity as possible. Many of them arranged their carers in teams that were attached to certain service users and this was in the hope that when a relief carer was needed it would be someone the service user knew. Other organisations reported methods of arranging rotas so that gaps could be identified well in advance and service users could be warned that someone other than their regular carer would visit. Some organisations also made introductory visits so that service users met their carers before they started receiving the service.

Although service users were unaware of the planning provisions made to ensure the continuity of their service, most of their views supported those of the providers that overall, they enjoyed a regular carer or team of carers and that they only very rarely received care from "strangers", "once or twice I've had strangers in but normally it's someone I know."

6.4 Communication

Communication was an important issue to many of the service users and it was intrinsically linked to both reliability and continuity. If carers were going to be late for a call, service users wanted to be informed, and similarly, if they were going to have a carer other than their regular one, many wanted advanced warning, "if they don't tell you when they're going to be late you'd end up hanging around and waiting for them." That was a view echoed by many service users who felt it was important that they should be kept informed if their carer was going be held up. Those who had "get up" calls felt particularly strongly that they should be warned, "I don't want to be in my pyjamas all day!"

Communication by home care services

When asked to rate their home care company, there was a mix of opinion about their performance on the issue of communication. Table 5 shows that half the service users reported that their home care company always kept them informed if their carer was going to be late, but eight people were not always kept informed and eight service users felt they never really knew what was going on.

However, some service users found it very difficult to answer the question. All of those interviewed understood the question to be about whether the supervisors and managers – "the office" – keep them informed and, they found it difficult to answer because in eleven out of the 32 cases, they were kept informed by their carer, and never the organisation itself (table 5 below). In all of those cases, the carer undertook to keep the service user informed about any changes to their care plan, whether their service would be late or whether they would have a different carer.

Table 5: Communication

	Kept informed by carer	*Kept informed by HC organisation*	*Not kept informed*	*Total*
They always phone ahead to warn me when the carers going to be late	8	8	0	16
They don't always phone me when the carers going to be late	2	4	2	8
I never really know what's going on	1	0	7	8
Total	11	12	9	32

Although seven of those that the carer kept informed were content with this situation, four people felt it wasn't an appropriate way for the company to operate. They felt strongly that their home care organisation had a responsibility to keep them better informed and were unimpressed with the level of communication, "the organisation needs organising! If I ring up to ask who my carer is when my normal ones away they never know where they are."

Some were only kept informed in certain circumstances. Although their carers kept them informed if they were going to be late, people were less commonly kept informed if they should expect a different carer. This was particularly significant in the case of the partially sighted service user who was one of the three to "never really know what's going on." The other six who felt they were never kept informed were both housebound and living alone.

In terms of their experience of communication, the minority ethnic service users reported each level of quality in equal numbers. Furthermore, no more or fewer of them had bad experiences of communication than the white British respondents.

However, during the open-ended questions, ethnic minority service users and carers cited the importance of the communication issue in terms of language. It was clearly important that care workers were able to properly communicate with the service user and their informal carers and families. This issue is discussed further below. *(See section 6.8)*

The provider perspective

Invited to discuss the issue of communication, home care managers recognized its importance. To some, it was a central element of their service, “Communication is the be all and end all of what we do because that’s where we start off and that’s where we finish.”

All of the home care managers who were interviewed recognized how crucial it was that they keep their service users informed about any changes to their care packages. However, over half of them felt that communication was important at more than one level. In addition to keeping the service user informed, the providers were determined that there should be good communication between care managers and providers and between home care managers and home carers and that in both cases communication should be two way. They felt that care managers have a responsibility to properly communicate the service users needs and that they themselves have a responsibility to keep social services informed of any changes to the client’s health. They also felt that care workers ought to keep them informed about the service users’ fluctuating health and needs and that, as managers, they had to properly communicate with carers to inform them whenever there needs to be a change to normal routine, “it’s got to be key to it all.”

One or two managers also identified communication between care workers and service users as important. A small number were resigned to the fact that communication about changes in arrangements at that level was actually the most common channel. However, some felt this was problematic;

> “The carers tend to communicate directly with the service users so sometimes we get missed out of the loop – but because of the confusion sometimes the client gets missed out of the loop and they’re the last to know or they only know after the event.”

Although a small number of managers recognized that communication with the client was mainly through the care worker, this did not account for the 11 out of 32 service users who reported that it was their carer alone who kept them informed. Furthermore, the managers' accounts of their practices to maintain sound communication did not support four cases where service users were not kept informed at all and the three who felt they "never really know what's going on." For example, the provider of one service user who felt that she was never kept informed, claimed to phone clients a week in advance about changes to their service, and claimed that carers phone the office whenever they've been held up so that the client can be informed. However, the manager of that provider organization did concede that it was sometimes impossible to maintain that level of communication, "sometimes it's just so hectic, so busy, and we're not able to keep the client informed as much we'd like to."

Overall, home care managers recognized the overriding importance of sound communication. They felt it was key to the smooth running of their organization and to the proper delivery of care. Most managers reported mechanisms in place that included out of hours contact, 24-hour pager systems, and organized forward planning but unfortunately these were not reflected in service users' experiences. Twenty out of the 32 users interviewed were either kept informed by their carer, and not "the office", or they were not kept informed at all.

6.5 Trustworthiness

During the pilot stage interviews when service users were invited to talk generally about the good and poor aspects of their home care several raised the issue of the trustworthiness of their carers. Therefore, during the remaining interviews service users were invited to talk specifically about the issue of trustworthiness. They talked about its definition, it's importance and the level of trust they had in their own carers.

The term 'trustworthy' did not mean the same thing to every service user. Over half of those asked felt it was about honesty. They wanted to feel that they could let carers into their homes with the confidence that they wouldn't take anything or interfere with their personal possessions. On the other hand, three people felt that trustworthiness was about being able to tell their carers anything and know the information wouldn't be repeated. Out of the 29 people who gave their definition of 'trustworthy', five felt it was a combination of honesty and confidentiality. The spouse of one service user had a very different view of 'trustworthiness' as she felt that it was more to do with trusting the carers to be able to look after her husband properly, "I need to be able to trust the carers to be strong enough to help him."

Trustworthiness of home carers

Having explored their definitions of the term, service users were asked to rate the level of trustworthiness among their home carers. Of the 26 asked to rate their carers in terms of trustworthiness seven voiced reservations and felt they could trust most, but not all of their carers. None of those interviewed felt they could not trust any of their carers.

Although the results reflect well on the provider organizations, they do disguise the fact that some service users had experienced problems in the past that had since been resolved. There were only a small number of reported incidents but the most serious ones were recounted by the seven people who understandably felt that they could trust most but not all their carers.

One service user who was partially sighted had to let a carer into his home who he had never met before. He was unnerved by the situation but felt he had no choice but to let her in to provide his care. During her visit the carer manoeuvred herself behind the service user's chair, out of his field of vision and took his pension from his sideboard. The service user only later realized what had happened and although she never visited again, no action could be brought against the carer because of a lack of evidence. In the second instance a broken confidence caused an argument and bad feeling among the service user's neighbours. Although the service user confronted her carer with the evidence and explained the trouble it had caused she still did not feel that she could ever trust her carer again.

Another service user felt that it was more the case that when they talk about other service users his carers have to trust him, "to tell you the truth dear, they tell me things more than I tell them…enough said!" Although in this case the service user did not identify the carer as untrustworthy it was clear that his carers were passing on information about other service users.

The meanings that minority ethnic respondents attached to the term 'trustworthy' followed the same pattern as all the other respondents. Most felt that trustworthiness was about their care worker being honest. Only one considered the issue to have something to do with confidentiality. However, the minority ethnic respondents did have different experiences of the trustworthiness of their care workers. Whereas almost all white British respondents reported that all their carers are trustworthy, minority ethnic service users experiences were more evenly spread between being able to trust "all" and being able to trust just "most" of their carers.

6.6 Staff attitudes

It was identified above that staff attitudes was the factor most commonly cited by users as crucial to a high quality service. Everybody felt that their carers should have the right attitudes and had views about what those attitudes should be. Attitudes cited included respect, friendliness, cheerfulness and understanding. In order to explore what attitudes were seen key to a quality service, users were asked to identify the three most important ones. The three attitudes most commonly cited as important were being 'obliging', 'friendly', and 'understanding'. However, other common views were that carers should be, 'happy go lucky', 'jovial' and that they should treat people with respect.

Being obliging was identified 13 times and 'friendliness' was cited 17 times as being an important carer attitude. People wanted to feel at ease and at home with their carers and those who felt like their carers were "one of the family" were generally very happy with their service delivery.

'Understanding' was mentioned by just over half of those interviewed as being one of the most important aspects of staff attitudes. Service users value carers who understand them and their situation. It is important that they know what service users are capable of and are patient about the things they have difficulty with.

Closely related to "friendliness", was the disposition of the carer, whether they're happy, and in a lot of cases, whether they're "jovial". "Happy go lucky" and "jovial" were together, cited 17 times and their importance was clear and captured by one service users' spouse who said:

> "You don't want someone coming in like a dying duck in a thunderstorm…we want someone that's cheerful otherwise you can end up feeling down yourself!"

Although mentioned less frequently, respect was very important to those who identified this aspect of staff attitude. One service user, who had lost the use of a leg following a stroke, was determined that his carers should treat him with respect,

> "Really and truly, I am disabled but some people talk to you as though you are a child – and that matters to me, to have a bit of dignity…I might be disabled but I'm not mentally disabled or anything like that."

Both the service user and his wife felt that it was important that carers did not talk over him, for example, "does he want this? Is he alright? How is he? He's looking well."

Home care staff attitudes

Once they had explained the importance of attitudes and general disposition, service users then rated their service in terms of the overall attitudes of their carers. Just under three quarters of those interviewed were happy with the way all their carers treated them (see table 6). Of the nine who had reservations, most had experienced a problem with one of their carers in the past. Those problems ranged from betrayals of trust to carers incompetence at certain tasks, especially cooking. Although not strictly staff attitudes these were the type of factors that respondents took into consideration when asked this question.

Home carers of the services being received were rated highly on the areas of importance that service users had originally referred to. Reflecting on her carer's disposition, one service user felt, "she makes my day when she comes!" Another service user gave an overwhelming endorsement of the attitudes of his carers who are obliging, friendly and "happy go lucky";

> "I have x (carer's name) in the morning, she'll do anything I ask, she's another diamond is x…I have y (carer's name) at lunch time, she's wonderful, in fact I think I'm in love with her!…and then there's z (carer's name) at 5pm and she's a dream as well…"

Table 6: Staff attitudes

	Number	*Percent*
I am happy with the way <u>all</u> my carers treat me	23	71
I am happy with the way <u>most</u> of my carers treat me	8	25
I am only happy with the way <u>some</u> of my carers treat me	1	3
I am <u>not</u> happy with the way <u>any</u> of my carers treat me	0	0
Total	32	100.0

A number of service users felt that their carers were "like one of the family". They clearly had the understanding, friendliness and respect to make the service users happy and comfortable. One service user reported, "I'm always quite at home with them…they're just like one of my daughters." And another reflected,

> "They treat me as a friend, not just as someone they're caring for…at Christmas and on my birthday they always make sure I have things, and on mother's day there's always a bunch of flowers…they're family to me."

Service users cited very few examples of poor staff attitudes. However, one man explained that one of his carers was the very opposite of obliging and certainly wasn't friendly or jovial, "if she can do the job in five minutes she will…you don't have time to talk to her much before she's gone."

The experience of the minority ethnic service users mirrored those of white British respondents in that the majority were happy with they way all their carers treat them. However, the one respondent (a primary carer) who reported only being "happy with the way some of the carers treat me" was answering by proxy for her mother – a minority ethnic service user. The respondent reported that her mother was routinely looked after by care workers, who weren't gentle, who didn't move her properly, who were careless and who seemed entirely inexperienced. Nevertheless, the daughter did not infer that her mother's mal treatment owed anything to racism or ignorance of her cultural requirements.

Provider views

Home care managers concurred with users' definitions of staff attitudes and importantly, the things which managers sought to deliver were the attitudes that service users most valued. For example, providers were determined that their carers should deliver the service with respect, care and sympathy. They recognised the need for their carers to be sensitive and understanding and felt that carers should be mindful of always doing and saying the right thing, "anything they do or say should not harm a client in any way, and anything they *don't* do or say should not harm a client in any way."

Many managers felt that the carer's attitude was central to the delivery of care, and some felt it was the most important quality aspect, "even if the carer does their job properly, does what they're supposed to do, if they do it with a bad attitude they have just ruined everything." The same manager placed paramount importance on the issue of delivering care with dignity and respect, a view, which concurs with that of some service users. The manager reported,

> "I tell them, 'Always treat elderly people with respect…why? Because being old is a blessing…No matter whether you are rich or poor, being old is a great achievement."

One aspect of carers' attitudes that managers raised was the value of carers who are motivated by care and not solely by economics. Managers were concerned that where the latter was the case, it would be obvious in the carer's attitude and apparent to the service user. One manager reflected, "you get carers who are really, really caring and those that are just doing it for the job – that's where the difference in attitude is." And another felt that, "Whether they actually do the job because it's a vocation or whether they do the job to pay the bills – that attitude can come across." Although service users didn't allude to those issues when they were considering the notion of staff attitudes, the caring motivation became significant when they later considered what made their carers, 'good' or 'poor' carers (see section 6.7).

Home care managers also reflected on what made it possible to find and maintain those qualities in their carers. The main practices that managers employed were induction training that emphasized respect and dignity in care, ongoing supervision, and monitoring of standards. One manager outlined her company's practices which was the same as many others,

> "We send questionnaires to clients and they give us feedback on what carers are doing, what they're not doing, what they're saying, what they're not saying…if there's an issue we bring the girls in straight away and deal with it."

6.7 Knowledge and skills

The skills and knowledge that their carers demonstrated were clearly important to all service users. However it was also an important issue for the informal carers who participated in the interview process and their reasoning was different to those the service users raised themselves. They were less concerned with demonstrable skills like moving and handling, personal care tasks or domestic help and more with home carers' initiative and professional awareness. The wife of one of the service users felt, "it's about keeping an eye on him and knowing by looking at him and talking to him whether or not he looks well." The wife of another service user agreed, "it's important that the carers keep an eye on his physical condition and can spot if there's something amiss – if he doesn't look well…"

For the home carers to have this sort of awareness they clearly need to have a good existing knowledge of the service user. Some service users identified the importance of their carers having knowledge about them and about the way they liked to have either personal or domestic tasks done. Some felt that knowledge, rather than skill was the critical aspect and appreciated the carers who knew them well, "they know me inside out I think!"

However, many service users did not judge their carers' knowledge and skills in the way they would be commonly defined by training methods and standards. Almost all service users made a clear distinction between that concept and their own which prioritised the 'caring motivation'. To many it was simple; if their carers *care* they are good carers, if they don't then they are poor carers. The normal notion of skills and knowledge was much less significant. For example, answering the question 'what makes them good carers?', one service user responded, "because they're in the right work, they really care for people…they're not just doing a job, they really care." This opinion supported many home care managers' views about staff attitudes. However, to service users; it was the quality on which they judged the overall performance of their carers.

One service user went further than others in his reflection on skills and knowledge and the caring motivation. He even asserted that carers did not need skills, and that all that qualified them was having a "human approach". Although he captured most people's views about the centrality of 'care', his represented a more fundamental view;

> "Quite frankly, there's not a skill attached to it really, it's women who can cook and wash up and help you dress and undress, really, that's all they have to do – there's not a lot of skill attached to it. You could say it's more or less an ability to do that. Skill is different."

And he continued, "nurses have skill, they have to sit an exam…a carer doesn't have a skill, they just have a human approach, be kind and happy…"

Although his was a rather extreme view, it did also allude to another perspective held by service users that the caring motivation was something people, particularly women had acquired through life experience. For example, another service user felt, "the older ones have the skills, they're mothers and they know how to cook, the younger ones need teaching."

Skills and knowledge of home carers

Table 7 shows that every service user felt that most or all their carers were skilled. This does reflect well on the provider organisations, but it is important to remember that most people were actually judging the ‘caring motivation’ or the human approach of their carers. Only twelve service users attributed their carers’ good performance to their training, and four to their professional experience. Another 16 attributed their carer’s skills and knowledge to either their personal experience or their motivation for their work or something else entirely.

Table 7: Skills and knowledge

	Number	*Percent*
My carers are good at what they do	17	53
Mostly my carers are good at what they do	15	47
Mostly my carers are not good at what they do	0	0
My carers are not good at what they do	0	0
Total	32	100.0

It is important to note that the number (15) choosing “mostly my carers are good at what they do” actually fails to draw attention to some examples of very poor practice. Respondents were reluctant to base their judgement of all their carers on the poor performance of one or two care workers or on a small number of bad experiences and in those situations they always opted for “mostly…good”. For example, one of those who assessed her carer’s skills as being mostly good had also described one of her carer workers’ lack of awareness and skill by suggesting, “even if I was dead on the sofa the carer wouldn’t look at me because it’s not her job to!”

An informal carer who had claimed her mother’s carers were “mostly good” had also reported, “some of them (care workers) talk on their mobiles while they’re looking after my mother so that they’re only helping her, dressing her or washing her with one hand.” The same informal carer explained that because of the careless way they move and handle her mother she is often hurt and bruised after the care workers have left.

The explanation behind the trend that served to disguise such bad practice arguably lies both in the construction of the “skills and knowledge” measure itself and in service user’s reluctance to record a completely negative assessment of their care workers. As with reporting poor staff attitudes many service users expressed their reluctance to complain about the care they receive out of a fear that either the service will be stopped or that their care workers will punish them.

There were no differences between the experiences of minority ethnic and white British service users in terms of the quality of skills and knowledge demonstrated by their care workers. However, there were differences between the explanations given for the level of skills the care workers showed. Most minority ethnic service users explained carer's skills in terms of the training they receive. None considered skills in terms of the carer's motivations for a career in social care.

The provider perspective

Home care managers' views about skills and knowledge were different to those expressed by service users. Although some felt that caring skills were to some extent "instinctive", all those interviewed felt that skills and knowledge were those things which are instilled, maintained and assessed through induction and training, "Its competence, it's being properly trained in delivering the care which you say you're there to deliver." Another manager agreed that to have appropriate skills and knowledge carers should "have proper induction and training." He also felt it was important "That they are kept up to date with new techniques – for example developments in moving and handling."

Many home care managers also recognised the importance of having specific knowledge about service users and their needs, "it's also about the carers knowledge of the individual service user." A small number of managers reported that team leaders make visits to service users before they start receiving the service and they then pass on all relevant personal information or preferences to those delivering the care. This concurs with the priorities of some informal carers and some service users who valued the knowledge their carers had built up about them.

Although only four service users felt that their carer's ability was due to their training, all the home care managers identified that their organisations followed their own and national guidelines about training and skill standards. Agencies provided a core of induction, moving and handling, and first aid. As well as induction and subsequent courses, home care managers were confident that their carers' regular reviews served to identify any gaps in training that could be quickly addressed.

However, care managers were also invited to discuss any barriers they faced to maintaining a properly skilled workforce. At the time of interview they were all concerned with the demands of the impending Care Standards on training. The two main barriers they had to contend with were reluctant care staff and financial constraints.

The most commonly cited issue was financial constraints. Many had already decided on in-house training as the cheapest option. However, most still faced problems. One home care manager was clearly worried about their inability to finance training, especially in the face of Care Standards, “There are definitely costs implications for training. NVQ’s are very expensive, this is a big problem and at the moment we have no carers working toward them.” Not every manager faced the same degree of concern. However, most agreed that the cause of the problem was the restrictive prices the council pay for their contracts and they agreed about the consequential effects of the situation,

> “{The council’s) prices allow for only minimal training at the moment. This is a restriction in trying to provide quality of care. To achieve and maintain quality we ought to be able to pay the carers more money. But, we have to train them so the restrictions hit the wages.”

The financial restrictions on training also heightened the practical problem that managers faced in arranging courses around carers’ shifts and in most cases, finding the money to pay carers to attend training sessions.

The other barrier to providing adequate training was care workers’ reluctance to take up courses and follow training programmes cited by two managers. There were care workers who had been in the profession for a long time who did not see the sense in taking exams in things they had been doing well for years, “Some of the older ones really can’t be bothered with training. It’s a headache chasing them, reminding them and making them come in for training.” However, some younger carers were also reluctant because they had chosen the profession thinking they had endured their last exam at school,

> “Sometimes its the carers motivations that make it difficult. Some of them are just looking for a bit of pocket money and whether they actually take in all the training and knowledge we give them is debatable. Some of them didn’t come into this work to learn and train.”

6.8 Choice of care worker

Having explored all the quality aspects raised by the interviews, service users were invited to discuss any other issues, which they felt affected the quality of their service. The one overriding concern, which they raised, was the choice of their care worker.

Of the 30 service users asked specifically whether they had a preferred carer type only six people had no preference at all and were only concerned that their carers should be good at their job. Ten people stipulated that they wanted their care delivered by a mature woman and a further eight stipulated a preference for a woman of any age. The preference for a female care worker centred on the perception of women as "natural carers" and this is reflected in the comment of one service user who felt, "women have got a better, more humane, more caring way…"

The ten who wanted only mature women generally equated maturity with experience and skills. The notion of dignity was also intrinsic to most people's preference for mature female carers, "I think in carers when you're old, you don't want young girls around you…middle aged women have had a family and they know the business of looking after people…"

A number of informal carers and service users expressed a preference for carer workers of their own ethnic origin. These included both minority ethnic and white, British older people. One service user explained why some older people might feel and express those preferences,

> "Older people have a short memory that is bad and a long memory that is better. It means that they memorise things from their childhood more than what is going on later. When they are of a different race they memorise the race of where they came from and when they are treated by someone of a different race it's not pleasant. It's nothing to do with discrimination of race, it's just normal human thinking and feeling."

Despite the fact that her views might be unpalatable to some, another service user raised the related issue of whether they are actually given any choice in the matter of their carer,

> "I'm not a racist…(but) I do feel that before they send anybody coloured into a house they should ask if you mind…a lot of people my age are very colour prejudice and I just think that it's a bad thing to send in coloured people without asking if it's alright…I know that you hope that in this society that there's not going to be this colour prejudice but it's there…"

Most of those who did register a preference were concerned with having a care worker of their own ethnic origin stated that this was purely because of language issues. One service user, living at home with his family, was anxious that his care workers have to be Bangladeshi so that his wife, a non-English speaker, could understand them and communicate with them. Similarly, an English-speaking service user expressed her preference to always have a care worker who speaks the same language, "There's a language question. I had one (care worker) and I couldn't understand a word she said, that was terrible."

One informal carer reflected on the importance of giving people a choice about their care workers,

> "I think we need to appreciate that even though the person is ill…what they feel should be taken into account as well…you don't impose on them that 'you have got this carer'"

7. Future developments

This small-scale study was carried out at a time when the impending Care Standards Act, whose regulations come into force on April 1st 2003, was foremost in the mind of the managers of the home care organisations. They were also asked to reflect on other aspects of the care standards such as the overriding theme of the "promotion of independence through the delivery of high quality personal care in the community" (Department of Health 2003). Apart from their concern about the demand on resources by training and the delivery of quality home care, they were also sceptical about the willingness of service users to participate in the new drive toward an "enabling" home care service. We also took the opportunity to explore service user's perceptions about the role of home care particularly in relation to the promotion of independence. The service users were asked to reflect on the purpose of their home care service and on whether they felt their care workers served to encourage or undermine their independence.

7.1 The move toward 'enabling'

Although most service users felt their home carers already tried to promote their independence, three quarters believed that the role of domiciliary care was "to do things *for*" them. Only three people reported that their home carers did things *with* them. Even though they represented a small proportion of those interviewed, they were happy with the independence their carers encouraged, "I don't want pampering because that don't do me any good. If I give in I've had it…I've got to get up and get on with it." However, with three quarters of all respondents feeling that the role of their home care is to do "for" and not "with" them this would suggest that a sea change in opinion is required before service users are persuaded about the virtue of the 'enabling' ethos promulgated in the national minimum standards.

A small number of service users valued the independence home care gave them from their otherwise constant dependence on their spouse. In particular, two service users identified the respite benefits intrinsic to their care. One reflected,

> "Although I'm getting stronger, we still need them for x's sake (service users' wife) because, I mean, it's a tiring business for her by herself…she couldn't do it all the time – you've got to remember, I'm 73 and she's 74, she does get shattered…"
>
> His wife agreed,
>
> "…it's quite hard work, I'm not young myself, so we've found they've (the carers) been a big help."

A small number of those interviewed also recognised the independence home care gave them at the most basic level. Where home care had been introduced following hospital discharge, they realised that the alternative to care at home was care *in* a home. For both service users and care workers, that was an unattractive alternative. One service user had been offered residential care at the time of his latest hospital discharge. However, he was adamant that he wanted to remain in his own home so, at a case conference, he was told that dependent on his receiving home care and meals on wheels, he could stay at home. His relief was clear, "Having home care is the only way I could keep my independence!"

Although some service users and their carers recognise the benefit of home care workers who strive to stimulate independence, those people were in the minority. One home care manager reflected on the significant change in mindset needed to introduce and implement the 'enabling ethos':

> "…(there are) some good ideas about enabling and so on but it's going to take a lot of time – people are used to having things done for them and now they have to do them themselves…it's not what they're used to"

7.2 The need for training

Standard 20 of the national minimum standards stipulates as its outcome, "The personal care of service users is provided by qualified and competent staff…" It proceeds to outline the specific quotas and time scales for existing and new care staff but basically, home care organisers are faced with having to ensure that by 2008, 50 per cent of the personal care they provide, is delivered by NVQ (or equivalent) qualified staff (Department of Health, 2003).

Even after the 50 per cent target has been reached, providers must ensure that new care workers continue to take up the NVQ course.

Although the care managers who were interviewed emphasised the importance of training and development in their effort to deliver a quality service, they expressed their concern about the feasibility of achieving the standards in the face of inadequate local authority fees. The minimum standards stipulate "the agency has financial resources allocated, plans and operational procedures to achieve and monitor the requirements for workforce training and qualification." This, 'financial resources', is exactly the point about which many managers were anxious and during their interviews they were invited to discuss their concerns which were particularly about local authority fee levels.

An overwhelming majority, 11 of the 13 interviewed, reported that the fees their local authority paid were inadequate, falling well short of covering costs. Home care managers agreed that the two areas which were affected were training and wage levels and that one is usually compromised for the sake of the other. In the face of the impending Care Standards, managers' concerns were clear,

> "Local authority fees do not cover all costs per head, they fall short by a long way. The short fall rests on training. At the last tender, our company did not have team leaders or senior carers (who are paid more) or NVQ's to finance. There are many requirements from the Care Standards Act and they all have serious cost implications."

In the context of the continuing recruitment and retention crisis in social care, managers expressed their concerns about the impact of low fee levels on carers wage levels. One manager pointed out that in the new contract, he would have to charge social services more per head so that he can increase his carers' pay in an attempt to retain them.

However, some managers were sceptical about whether these issues would be recognised by social services and reflected in the fees they are prepared to pay. They were quite convinced about the implications for home care if their calls for more realistic resources were not heard;

> "…Hopefully they'll take into account things like training, after all, we can't provide quality care if we have to cut corners."

8. Discussion

Although the samples were small, users and providers reflected a wide range of circumstances. Users were mostly receiving high levels of homecare, and had usually been receiving services for a number of years. As such they represented considerable experience in using home care services. Overall it is reasonable to conclude that their views and experiences largely reflect those of users of home care services in the four local authorities.

Of the seven key aspects of quality; reliability, staff attitudes, and continuity were of key concern to service users, identified most frequently when first asked about the aspects of service quality that was important to them. Flexibility was also fundamentally important to service users and it was cited almost as much as ‘continuity’.

The home care workers personify the service for users. Probably for this reason it was clear in the discussions that staff attitudes were sometimes taken to encompass other aspects of quality of the service such as flexibility, trustworthiness and competence. However, personal aspects of the carers such as friendliness and cheerfulness were clearly very important for people very dependent on their (usually) daily visits. With few exceptions users were very happy with the attitudes of their carers. However, as providers made clear, these are difficult qualities to ensure as a provider, and even more so as part of the commissioning process. Recruitment policies, training and pay clearly have a role to play in the attitudes of staff and these are likely to be affected by the prices paid and types of contract negotiated. Of course, some factors are beyond the control of home care managers. More than one respondent identified that in the very tight labour market, recruitment of staff of the right caliber in the first place was an increasing problem.

Timing of visits and reliability were crucial aspects of quality for about half the users interviewed. These aspects of the service were important for generating outcomes such as control over daily life and aspects of health such as diabetes. However, for half the sample timing of visits was much less important. The issues raised in discussion suggested that it was the tasks to be undertaken together with the attitudes of the individual user that determine the importance of timing and reliability. Providers identified the logistical problems associated with a lot of people needing to be got up in the morning at a similar time. It is clearly important as part of the assessment process and setting up the package of care that users’ preferences are identified and taken into consideration in the way services are delivered.

There was some disparity between the degree to which providers and users felt the services provided were reliable, although users were generally understanding about the problems that arose so appeared to under-report their experiences in the more structured question. The disparity in user and provider perceptions was also evident for communication, which is critically linked to the reliability of the service. Providers clearly felt that they were much better at communicating about changes in timing and carers than users reported experiencing. Much of the communication appeared to be dependent on the home carers themselves, not something that users always felt was appropriate. Providers also emphasised communication between those commissioning and provider organisations. In all areas of communication there appeared to be room for improvement.

Ensuring flexibility in service provision is a difficult area while current policies and practice are aimed both at targeting services primarily on personal care needs. Experience of flexibility of the home care service tended to be very much at the level of the individual carer and her attitude to the rules and doing tasks in her own time, resulting in inequitable service receipt by service users and, arguably, exploitation of home carers. Providers saw themselves as tied into the care plan so having little scope to offer a flexible service. Whatever system is put in place to allow more flexibility on the part of the provider, there will always be tasks (such as certain domestic tasks and shopping) that it is not intended for the contract to cover. If problems of inequity and the potential for exploitation are not to persist commissioners need to be clear how these needs are to be met where informal sources of assistance do not exist. Clarity is needed at all levels both about who provides and who meets the cost.

Service users tended to prefer having the same home carers, and the issue of continuity was of critical importance to many service users and their informal carers. This was linked to their particular circumstances and to issues of trust and communication and was most commonly cited for service users with dementia for whom stability and familiarity is fundamental. In terms of commissioning care this issue appears best addressed at ensuring that preferences and specific concerns of the user are established when the care plan is being agreed.

Users and providers interpreted skills and knowledge of home carers differently. Users tended to rather underplay the skills involved and tended to see these as associated with motivation and the characteristics of mature women. Cultural factors and knowledge of individual circumstances were important and there was an acknowledgement of the importance of the monitoring role of the home carer. The provider perspective was dominated by concerns about cost implications of the training requirements of the new Care Standards. They saw a clear trade-off between training and wages, as for the most part they do not feel that current prices paid cover their costs. If this were to work through in practice, potentially those prepared to train will lose their workers to those prepared to pay higher wages. Moreover, undue downward pressure on costs will clearly impact recruitment and retention, which in turn, affects other quality issues such as reliability and continuity. These types of problems are already being experienced in the care home industry, resulting in home closures (Netten et al., 2002).

As would be expected only a minority of users had experienced a reduction in home care services. Similarly a minority felt the service as it currently stands did things with them rather than for them. It is well established that older people define independence in many different ways, depending primarily on their circumstances (Hayden et al., 1999). For the most part the role of the service in promoting their independence is primarily about enabling them to remain in their own homes and home care services do this by doing things *for* them.

Indeed, standard 9.3 of the national minimum standards stipulates that "care and support workers carry out tasks *with* the service user and not *for* them, minimising the intervention and supporting service users to take risks…" However, these results suggest that there may be some resistance to services that aim to be enabling. Nevertheless it is more likely that the policy will also be problematic to implement in practice because it usually takes longer to do things with people than for them. There is clearly a lot of time pressure under the existing arrangements. In any cost limited package that allows capacity for carers to spend time encouraging people to do things for themselves there will be pressure from users to get other tasks done, including those tasks not officially part of the package.

References

Department of Health (2001) *Building Capacity and Partnership in Care: An Agreement Between the Statutory and the Independent Social Care, Health Care and Housing Sectors*, Department of Health, London.

Department of Health (2003) *Domiciliary Care: National Minimum Standards Regulations*, Department of Health, London

Edebalk, P.G., Samuelsson, G. and Ingvad, B. (1995) How elderly people rank-order the quality characteristics of home services, *Ageing and Society*, **15,** 83-102.

Hayden, C., Boaz, A. and Taylor, A. (1999) *Attitudes and Aspirations of Older People: A Qualitative Study*, Research Report No. 102, Department of Social Security, Leeds.

Henwood, M., Lewis, H. and Waddington, E. (1998) *Listening to Users of Domiciliary Care Services: Developing and Monitoring Quality Standards*, Nuffield Institute for Health, Leeds.

Netten, A., Darton, R. and Williams, J. (2002) *The Rate, Causes and Consequences of Home Closures*, PSSRU Discussion Paper No. 1741/2, Personal Social Services Research Unit, University of Kent, Canterbury.

Williams, J., Netten, A., Hardy, B., Matosevic, T. and Ware, P. (2002) *Care Home Closures: The Provider Perspective*, PSSRU Discussion Paper No. 1753/2, Personal Social Services Research Unit, University of Kent, Canterbury.

Qureshi, H., Patmore, C., Nicholas, E. and Bamford, C. (1998) *Overview: Outcomes of Social Care for Older People and Carers: Outcomes in Community Care Practice Series No 5*, Social Policy Research Unit, University of York, York.

Qureshi, H. and Henwood, M. (2000) *Older People's Definitions of Quality Services*, Joseph Rowntree Foundation, York

Raynes, N., Temple, B., Glenister, C. and Coulthard, L. (2001) *Quality at Home for Older People: Involving Service Users in Defining Home Care Specifications*, The Policy Press and Joseph Rowntree Foundation, York.

Sinclair, I., Gibbs, I. and Hicks, L. (2000) *The Management and Effectiveness of the Home Care Service*, Social Work Research and Development Unit, University of York, York.