Quality of jobs and
Innovation generated
Employment outcomes

QuInnE.eu

NIELA KLEINSMITH[1]
BAS KOENE[2]
ANNE GREEN[3]
SALLY WRIGHT[4]

VIP Home Care Services: Innovating for Employee and Client Well-Being in a Low-Wage, High-Value Industry

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[1] *Erasmus University, Rotterdam School of Management, Netherlands*
[2] *Erasmus University, Rotterdam School of Management, Netherlands*
[3] *City-REDI, Birmingham Business School, University of Birmingham, UK*
[4] *Warwick Institute for Employment Research, University of Warwick, UK*

QuInnE - ***Qu****ality of jobs and* ***Inn****ovation generated* ***E****mployment outcomes* - was an interdisciplinary project investigating how job quality and innovation mutually impact each other, and the effects this has on job creation and the quality of these jobs.

Drawing on the Oslo Manual, both technological and non-technological innovation were investigated. Through quantitative analyses and qualitative organization-level case studies, the factors, as well as the mechanisms and processes by which job quality and innovation impact each other were identified.

The QuInnE project brought together a multidisciplinary team of experts from nine partner institutions across seven European countries.

QuInnE Project Member Institutions:

- *Lund University, Sweden*
- *The University of Warwick, UK*
- *Universitaet Duisberg-Essen, Germany*
- *Centre Pour La Recherche Economique Et Ses Applications (CEPREMAP), France*
- *Magyar Tudomanyos Akademia Tarsadalomtudomanyi Kutatokozpont, Hungary*
- *Universiteit van Amsterdam, The Netherlands*
- *Erasmus Universiteit Rotterdam, The Netherlands*
- *Universidad de Salamanca, Spain*
- *Malmö University, Sweden*

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More information about the project and project generated publications and material can be found at www.quinne.eu. QuInnE contact person: Chris Mathieu, Christopher.Mathieu@soc.lu.se or quinne@soc.lu.se.

The QuInnE teaching cases and teaching notes are based on the confidential field research conducted in the context of the QuInnE project. They are written to provide material for training and class discussion rather than to illustrate either effective or ineffective handling of a management situation. Personal names and identifying information from the research cases have been altered for the purpose of confidentiality. The case studies and teaching notes have been developed in cooperation with RSM Case Development Centre of Rotterdam School of Management, Erasmus University (www.rsm.nl/cdc).

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The VIP Home Care Services company case is largely based on confidential UK field research cases conducted by Sally Wright and Anne Green in the context of the QuInnE project, WP6. For the purpose of confidentiality, all company and personal names and identifying information from the research cases have been altered.

VIP Home Care Services: Innovating for Employee and Client Well-Being in a Low-Wage, High-Value Industry

Introduction

On a rainy November morning in 2017, Gwen Jones, founder and owner of VIP Home Care Services, a local UK home care company, began reviewing her company's monthly financial reports, as well as employee recruitment and retention plans for the coming months. Recent legislation and the increasing budget squeeze for social care were constantly challenging Jones's creativity to meet client and employee needs with fewer resources. In 2015, VIP Care had been awarded the local authority's block contract to deliver care in several local towns, which should have placed the company in a strong position in the market. But the sudden market withdrawal of several large, national care providers had left VIP Care struggling to adapt overnight to their new role; further, the local authority's continued use of 'spot' contracts had eroded a level playing field, as block providers were paid less than spot providers. Additionally, local care companies were faced with chronic labour shortages and were competing among themselves for employees.

Jones had started her company in 2006 because she cared deeply for the elderly and disabled clients she served. Her previous home care employers had placed bureaucracy and profits over quality care and employee well-being, with work focused on tasks instead of outcomes, and the satisfaction of the shareholder more important than that of the client that the company had been entrusted to serve. But as budgets and the employee pool shrank, constraints to remain competitive within the home care industry were becoming overwhelming. Jones needed to find a way to maintain high levels of client-focused, quality care while simultaneously supporting, motivating and retaining her employees in an increasingly financially-strapped and competitive industry.

The Home Care Service Industry Deconstructed

<u>The Actors</u>

In the home care service industry, there were four principal actors: care funders, care commissioners, care providers, and care recipients. (See Appendix A for a brief history of home care Europe, Appendix B for an overview of key factors in

the European home care industry, and Appendix C for Key Figures from the UK home care industry.)

- Funding could be provided from public sources (i.e. from taxation either through the government's health or social insurance systems) or from private sources (i.e. private insurance companies or individual savings). There were a few exceptions across other European countries, such as in Hungary, where nearly half of national home care needs were being met through Church-run and charitable organizations.
- Care commissioners were local agents who negotiated and received the public funding, determined eligibility, and purchased the care for individuals within a region.
- Care providers could either be qualified self-employed care workers or companies with a qualified employee pool of care workers. However, home care was increasingly being provided informally by family, friends and volunteers.
- Recipients of publicly-funded home care were elderly and/or disabled persons who met state eligibility requirements.

Sources of Funding and UK Local Authority Care Commissioners

In the UK, as in other European countries, the social care system was separate from the health care system. The UK's health care system, or National Health Service (NHS), was free for all at point of use; its budget was paid out of the general taxation, apportioned to each of the UK's four countries (England,[5] Scotland, Wales, and Northern Ireland) and ring-fenced[6]. The social care budget was also apportioned to the four countries, but was not ring-fenced. The budgets were directly allocated to local authorities with appointed care commissioners.

Publicly-funded home care in the UK was both needs- and means-tested to determine an individual's eligibility. Once eligibility and the corresponding budget were determined, one could either request to have the local authority arrange the required care, or to receive the funds oneself, and to either self-organise the care or to have someone else, such as a family member or care professional, manage the budget and organise the services required.

[5] This case study is located in England.

[6] meaning that it is a delimited budget guaranteed to only apply to health services

The Home Care Service Industry, Home Care Providers and Employees

UK home care providers fell into one of three groups[7]: personal assistants, who contracted individually with clients; local agencies, such as VIP Care, which assigned care workers within a delineated perimeter; and national, or even global, agencies. Agencies cost more[8] than independent personal assistants; generally, the larger the agency, the higher the cost. However, agencies could better guarantee care, if a care worker fell ill or went on holiday, and could usually provide a wider range of services, including more specialised or medicalised care. National agencies were more prone than local agencies to actively recruit employees from outside of the UK. Regional agencies, in particular, seemed to provide the best combination of available services and broader employee skills coupled with competitive rates and personalised care, as the care workers frequently lived in the same area as their clients. In certain European countries, such as Hungary, this was underscored by the fact that many regional care providers were congregation-based, with the consequence that care workers felt more responsible for the persons they served, who belonged not only to their community, but also to their congregation of worship.

The years following the global financial crisis in 2008 had seen a restructuring of the home care industry, with many large agencies shrinking substantially, divesting businesses, or even declaring bankruptcy. In the UK, some large home care service providers were exiting the market of publicly-funded home care, and were no longer bidding on block contracts, as the rates being paid were too low. At the same time, and in response to the industry restructuring and growing demand for home care, there had been substantial growth across Europe in the number of individual personal assistants and smaller agencies (see, for example, the restructuring of the Dutch Home Care Industry in Appendix D).

Home care workers provided a range of services. A home care worker traveled to clients' homes, sometimes several homes in one day, and so spent time in public transportation or driving. When caring for someone, a worker would often have to physically help a person into and out of a bed, a chair, a shower or bath; could possibly have to dress wounds, apply lotions, dispense medications, wash and change or dress the client, put on contention stockings, etc.; clean up dishes, toilets, adult diapers and the household; do laundry, including changing dirty sheets and towels, and other domestic tasks; prepare meals. All the while, the

[7] Collinson, P. (21 Jan 2017) *Paying for care at home: how to negotiate the minefield.* Available at: https://www.theguardian.com/money/2017/jan/21/paying-for-care-at-home-cost-help-paying-for-it.
[8] Ibid.

worker would often have to maintain a conversation, listen and help with problems, as well as address other pressing needs for the client (e.g., home maintenance, shopping, reaching for items on top shelves, etc.). There was close, personal, physical contact between a care worker and a client. A home care worker could also have to deal with a client's worsening condition and eventual death. Home care work was therefore physically and emotionally demanding, requiring inner strength and resilience, some abilities in domestic skills, such as cooking and cleaning, fearlessness when faced with sometimes gruesome tasks, some medical knowledge, and high amounts of simultaneous empathy and distance.

Home Care Recipients

Between 2006 and 2016, the UK population aged 65 and over increased by 22%, from 15.9% of the population to 18%, and was predicted to reach roughly 25% of the total population by 2050 (see Appendix E). This was in line with the general population trends across Europe (see Appendix F). Between 2006 and 2016, there had been a similar increase in the number of disabled persons.

> *While the focus of attention in the social care debate tends to rest with older people, it is important we do not forget the importance of other groups in receipt of services.*
>
> -- Lauren Lucas and Jonathan Carr-West, LGiU[9]

The total population in the UK reporting a disability had increased from 18% to 22% (see Appendix F). Among disabled persons, the percent of children with a disability had increased 60%, from 5% to 8%; the number of working age adults reporting a disability had increased 36%, from 14% to 19% of this segment of the population, while the percent of pension age adults reporting a disability had decreased from 47% to 45%[10]. Not all elderly and/or disabled persons required home care, nor did the overwhelming majority of those who required home care meet eligibility requirements for publicly-funded assistance. However, the demand for home care services requiring more complex skills, to manage the range of needs of an increasingly older and disabled population, was growing dramatically, and predicted to keep growing well into the future.

[9] Lucas, L. and Carr-West, J. (2012) *Outcomes Matter: Effective Commissioning of Domiciliary Care*. Local Government Information Unit. Available at: https://www.lgiu.org.uk/wp-content/uploads/2012/10/Outcomes-Matter-Full-report.pdf.

[10] Gov.UK. (2017) *Family Resources Survey: financial year 2016/2017*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692771/family-resources-survey-2016-17.pdf. Further statistical analyses available at: https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201617

The Issues

Sources of Funding and Care Commissioners

Despite the growth in demand, public social care spending in the UK, and across Europe in general, was decreasing. In England, for example:

> *...real-terms public spending on local-authority-organised social care has fallen by 1.0% since 2009–10... social care spending by local authorities from their own revenues has fallen by 8.4% in real terms over this period, with substantially bigger falls for adult social care. ... forecasts suggest that a steadily increasing share of national income will need to be spent on providing these services...the reported increase reflects better recognition of likely cost pressures rather than any substantive change. As a result, policymakers must consider whether, and if so how, to fund these future increases...*
>
> -- UK Institute for Fiscal Studies, 2017[11]

Social care spending was decreasing, and would be decreasing further in the near future: more than 70% of local authorities were anticipating making additional cuts to social care budgets. Spending cuts were being achieved in several ways:

- Eligibility thresholds had been increased. As of July 2015, people in England with savings of more than £23,250[12] were not eligible to receive any publicly-funded social care. As a result, 20% fewer people were receiving publicly-funded home care. The UK government had earlier promised to lift the savings cap from £23,250 to £118,000 from April 2017. But the new cap had been delayed until at least April 2020, as councils said they could not afford it under the current austerity regime[13].
- Tight budget constraints were being passed on to home care providers[14]. In 2016, the UK Home Care Association (UKHCA) estimated that nine out of 10 councils in the UK were failing to pay realistic prices to support older and disabled people in their own homes. [15] For example, the UKHCA calculated that the minimum price councils should pay was £16.70 per

[11] Luchinskaya, D. et al. UK health and social care spending. IFS Green Book 2017. Published by UK Institute for Fiscal Studies, 7 February 2017. Available at: https://www.ifs.org.uk/publications/8879.
[12] This threshold amount varied slightly among the four UK countries
[13] Collinson, P. (21 Jan 2017) *Paying for care at home: how to negotiate the minefield.* Available at: https://www.theguardian.com/money/2017/jan/21/paying-for-care-at-home-cost-help-paying-for-it.
[14] LangBuisson (2015) calculate that local authorities reduced their fee rates by a national average of over 9% between 2010/11 and 2015/16.
[15] UKHCA (2016) *Summary: An Overview of the Domiciliary Care Market in the United Kingdom*, May 2016, p.8. Found at: https://www.ukhca.co.uk/pdfs/marketoverview_v352016_final.pdf ‘.

hour, but the average being paid was actually £14.58[16] (see Appendix G and Appendix H). This average figure reflected some local authorities' payments of below £12 per hour for contracted care, while only 10% paid above the UK HCA minimum. For employees in the home care industry, after accounting for company administration and other overhead costs, as well as employee transportation costs to reach their clients' homes, this translated into an hourly wage that sometimes fell below the National Minimum Wage of £7.20.[17]

- Nearly 75% of councils had begun commissioning home care visits lasting 15 minutes or less[18], resulting in a reduction of nearly 7% in the number of hours of home care provided[19].
- Local authorities were rapidly shifting toward Individual Service Funds (ISFs) and self-directed support as the default model of delivery of publicly-funded home care, thereby transferring the burden of finding care providers within ever-tightening budget constraints to the elderly or disabled persons receiving the funding.

Home Care Service Providers

With more than 75% of home care services purchased by the state[20], home care service providers needed to mitigate their budget shortfalls or face insolvency. Some providers used privately-funded care -- higher paid but less predictable -- to cross-subsidise publicly-funded, lower-paid, but predictable care. This was the case with VIP Care, which had started with private clients and still maintained roughly 20% of its client base on private contracts. Many providers, however, had few or no private clients.

With the low publicly-contracted rates, more and more providers were choosing to exit the publicly-funded home care market altogether. In 2016, 95 councils had had home care contracts cancelled by private companies who could no longer

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[16] Triggle, N. ‚Councils don’t pay fair price for care‘, BBC News, 25 October 2016. Found at: http://www.bbc.co.uk/news/health-37756433

[17] National Minimum Wage as of March, 2017. UK minimum wage was raised to £7.50 in April 2017.

[18] UNISON (2016) *Suffering alone at home: A UNISON report on the lack of time in our homecare system*, January 2016, p.1. Found at: https://www.unison.org.uk/content/uploads/2016/01/23574_Save_care_now_homecare_report-5.pdf.

[19] UKHCA (2016) *Summary: An Overview of the Domiciliary Care Market in the United Kingdom*, May 2016, p.8. Found at: https://www.ukhca.co.uk/pdfs/marketoverview_v352016_final.pdf ‘.

[20] Source: UK Home Care Association. (October 2016). *The Home Care Deficit 2016 (Version 1),* p. 3. Available at: http://www.ukhca.co.uk/pdfs/ukhca_homecare_deficit_2016_final.pdf.

afford to deliver their services[21]. In March 2017 it was estimated that around one-quarter of the UK's 2,500 home care companies were at risk of insolvency.

In addition to the severe financial constraints that were limiting any increase in employee wages, the CQC (Care Quality Commission) had introduced new regulations in April 2015 covering the conduct and level of training of care service providers. These were deemed essential to protect clients, but placed an additional burden on providers. In particular, a more formal Care Certificate replaced the National Minimum Training Standards.

Further, as the state was reducing both the health and the social care budgets, home care work was becoming more medicalised and specialised, with home care workers performing duties or procedures previously done by medical professionals or associates.

For the care worker, job constraints of low wages, shortened visits, heavy schedules, working alone with challenging individuals, and increasing pressures for higher skill levels, led to high levels of stress, feelings of inadequacy, and burn out. As a result, the turnover rate for care workers in 2016 was over 40%[22], reflecting the daily hardships faced by this profession, and further underscoring the difficulties faced by care companies in attracting, motivating and retaining their workforce. This high turnover rate also reflected the fact that many service recipients could not rely on consistent care.

Home Care Service Recipients

With a growing number of people unable to meet eligibility requirements, most home care was being provided informally on an unpaid basis by family, friends and neighbours. For those persons who were eligible for home care, the increasing pressure on home care providers to recruit and retain employees at very low wages for the physically- and emotionally-demanding job of elderly or disabled home care often led to low-quality or sometimes even unavailable care.

Low quality care included shortened or missed visits; discontinuity in care with multiple care workers assigned to the same individual; poorly trained staff unable to perform all of their duties; staff with poor English skills making communication

[21] Press Association.'Care contracts cancelled at 95 UK councils in funding squeeze', *The Guardian*, 20 March 2017. Available at: https://www.theguardian.com/society/2017/mar/20/care-contracts-cancelled-at-95-uk-councils-in-funding-squeeze

[22] UNISON (2016) *Suffering alone at home: A UNISON report on the lack of time in our homecare system*, January 2016, p.36. Available at: https://www.unison.org.uk/content/uploads/2016/01/23574_Save_care_now_homecare_report-5.pdf.

difficult or impossible; poorly timed visits as there was insufficient staff to cover the peak demand times of waking, meals and bedtimes -- meaning that persons would be out of bed too early or too late, given meals at odd times, or made to spend much of their day simply waiting for help. Unavailable or low quality care led to hospital admissions, re-admissions, and late discharges, as no social care was available at the time that discharge could occur. One consequence that often went unnoticed to the general public, was the precipitated death of those unable to receive adequate care. In 2013, the case of Gloria Foster, left to starve after her home care agency closed and the local authority failed to respond to this closure, made national headlines and brought public attention to the vital nature of the home care sector[23].

Industry Trends

> *'Back to the future' is an expression that could accurately reflect the potential to explore, exploit and implement an old idea [home care] with today's knowledge and new means.*
>
> -- WHO report, *The Solid Facts: Home Care in Europe*[24]

When local authorities had begun assuming responsibility for social care, a time-and-task approach to provisioning and payment had been adopted. Care workers had a list of assigned tasks to be checked off at each visit within a given amount of time. A client's changing needs or personal preferences were given secondary or no consideration. This approach underscored the inhumane way that the elderly and disabled could be treated, and proponents of an 'outcome-based' approach appeared.

> *We want to put an end to undignified care by the minute. We want care that is judged by outcomes and that matter to people receiving the care.*
>
> *-- Norman Lamb, MP, Minister of State at the Dept. of Health*[25]

An 'outcome-based' approach looked at a client's complete well-being within his environment, with the goal of designing a system of support, comprising services

[23] BBC news. (10 September 2014). *Gloria Foster inquest: 'Neglect contributed to death'*. Available at: http://www.bbc.com/news/uk-england-29131999.

[24] *Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe*. For an introduction to the history and background of home care in Europe, see Appendix A.

[25] Lucas, L. and Carr-West, J. (2012) *Outcomes Matter: Effective Commissioning of Domiciliary Care*. Local Government Information Unit. Available at: https://www.lgiu.org.uk/wp-content/uploads/2012/10/Outcomes-Matter-Full-report.pdf.

and delivery agents, to stabilise, or if possible, reduce, dependence on services, in line with a service users' own expressed preferences.[26] A major aim was to integrate the three pillars of independent living: health, housing and social care, and to ensure on the one hand, that the client was supported according to his needs in all three of these domains, and on the other hand, that the needed services were rendered in the most complete and efficient way, with no gaps or overlap in funding or care. However, putting in place such a cooperative, holistic, outcome-based approach was, at the very least, challenging.

Although most local authorities agreed that commissioning care based on outcomes was a 'very important' priority, over 90% were still paying providers based on the time they spent with a service user rather than on outcomes[27].

Technology as well was playing an increasing role in the home care sector, reducing the administrative burden on workers. At a basic level, care visits could be electronically monitored, thereby bypassing the need for care workers to call in and check out of each client visit. Taking this idea further, some companies were opting for completely remote oversight of client visits, where care workers checked in visually with clients via computer or smartphone cameras, for uncomplicated tasks, such as verifying that the client had taken his medicine or his meals. VIP Care, however, had decided not to go this path, as Jones felt that the personal touch of social care required a physical, not remote, presence. Other smartphone applications included using mileage apps to monitor travelling distances and times for workers.

The biggest recent innovation involved the digitalisation of care plans, enabling easier monitoring of clients, faster administrative compliance, easier transfer of care providers when necessary, and a big step in the direction of a more holistic, outcome-based approach to client care. VIP Care was in the process of implementing a digitalised care plan system.

The VIP Care Company Story

Gwen Jones began working in social care while still in college. Jones had an affinity with elderly people and was strongly influenced by a close family member who already worked in social services. After gaining work experience in care

[26] Ibid.
[27] Ibid.

companies and switching employers several times, she grew disenchanted with the quality of care provided to clients and the way that staff were treated.

> *I became a care coordinator for a large company but I didn't feel they treated me particularly well. And I felt that they'd forgotten about the people that we cared for. When it became a public limited company, management became much more interested in the shareholders than in what they were doing for the people they were caring for.*

As a result, Jones decided to start her own care company, with a strong ethos around delivery of high quality care.

> *We [want] to keep the service user at the focus of everything we do... we have always thought of it as: Would that care be good enough for my family? And if it isn't, then it shouldn't be good enough for here really.*

Initially drawing on her own and her family members' skills, Jones built up a base of private home care clients and applied with the local authority to become a registered provider. The company grew steadily, reaching 100 employees by 2016. Jones actively recruited employees from the region and went out of her way to retain them. Employee well-being became the second principal ethos of the company. According to one leader at VIP Care:

> *My loyalty lies with Gwen and it always will... [She gave me] my first real job. VIP Care had just opened in my town at the time. But... I didn't drive. So Gwen would pick me up every morning and take me to my care call. I was there 9 to 5, and then she would pick me up and take me home. And she done that until I passed my driving test which was two years later. She has been ever so good to me.*

Several years later, her company began providing 'spot' (i.e., temporary or supplemental) services for another local authority in a neighbouring town. Finally, in 2014, with the aim of obtaining greater stability for her business and enabling investment in her staff, Jones bid for a block contract to provide publicly-funded services to the public client base of four local towns. At the same time, conscious of the time and distance barriers, Jones opted not to take on contracts for rural areas; this proved a wise decision, as the local authority had much difficulty contracting for low-rate services in far-out rural areas.

VIP Care won the bid for several local towns, but the outcome wasn't exactly as expected.

We were under the impression that all contracts would transfer to us. So we thought that almost overnight, we would inherit carers and clients from other companies and it would be very big, very quickly.

Implementing the new contracts turned out to be complex and played out in different ways in the four towns. As the business in one town was still growing, the company found it difficult to employ the required number of staff to provide the contracted services. In another town, all of the other providers immediately exited the market, and all of the local authority clients and the staff who used to work for the other providers immediately transferred over to VIP Care. The company had to deal with problems associated with inheriting clients and staff from other care companies overnight, as there was no transition period. In some cases, clients and staff transferred over to VIP Care. In other cases, clients shifted to Individual Service Funds (ISFs), thus excluding themselves from the block contract. Additionally, some of the staff that were supposed to transfer, for whatever reasons, did not.

The providers didn't pull out with a month's notice; they pulled out the next week. Service users that were with other providers had to come to us with the new contract. We had to work morning and evening to get all of the clients' care plans in place to begin their care. But the small companies are still hanging on and trying to keep their businesses afloat by making the most of the spot purchases of local authorities and recruiting clients who are taking up the ISF offer.

The local authority had extended block contracts with a dozen home care providers, but as the providers did not take up as much work as was anticipated, the local authority remained reliant on 'spot' providers, which were paid higher hourly rates than contracted providers. Jones found herself competing for employees:

The spot providers are paid a £1 an hour more than the block. Which means that they can potentially pay people more. [But other care companies] are putting people on false promises. If you work here [at VIP Care], and you're paid between the minimum wage and £8 an hour, you will be paid for the whole shift, from 7 until 3 or 3 to 10. If you go and work somewhere else, you might get paid £9 an hour, but between 7 and 3, you might only be given 3 hours of work. But sometimes [employees] don't see that.

The local authority care commissioner attempted to explain and diffuse the situation:

> *Our whole ambition is to get away from 'spot'. Providers had to put in their bids within a price range but some of them have come back and said the prices they put in are just not manageable... and have [had] to hand back the areas because...it is just not profitable. So now contract providers could be saying, 'well, what's in it for us?' So we are working very closely with them to make sure they are stabilised.*

One of Jones's aims in taking on public home care work was to reshape regional home care services from a 'time-and-task' approach to an 'outcome-focused' approach for her clients, in line with the general trend across all commissioning authorities. As the local care commissioner described:

> *The main driver now for commissioning is to have a service which is based on people's outcomes rather than just blocks of times and task visits; a service fit for the future which gives geographic coverage and also works to a 7-day provision. Another big driver is integration with health.*

But having been awarded the block contract, and now dealing with the difficult transitions from previous providers, the constant search for employees, and the decreased time allotments and wages for public social care, Jones had begun questioning her decision to work so extensively with publicly-funded beneficiaries.

Addressing the Issues: Employee Recruitment

According to Jane Allen, VIP Care's recruitment coordinator, recruitment in the home care sector was constantly an issue: *'There are so many care companies out there and...there are not enough carers.'* However, recruitment issues did not just centre around low wages. There were also misconceptions about the work itself: '*Some people coming into the job think it will be easy, just pottering around looking after old ladies. It's a hard job and I don't think people realise that.'*

Jones had learned over time to be discerning in the people she hired, placing emphasis on soft skills, rather than on hard qualifications:

> *Certainly one lesson I've learnt over the years...is to recruit the right people, to look at their values more than their qualifications. It's happened*

> *occasionally over the years, when we're really busy, and it's holiday time and we're short-staffed... we've given people a job where perhaps we shouldn't have. And those people don't work out and it's a waste of time, effort and money to recruit the wrong people. You've got to get the right people, and that's difficult.*

This was echoed by her staff. According to Jane Allen: *'We're not looking for experience. We can train our workers. We just want, basically, people that are caring, that have the right attitude for the job.'* Allen's colleague agreed: *'I think care comes naturally to a person. I don't think you can do it just as a job. I think care work comes from within.'*

The issue for Jones was thus doubly difficult: not just finding enough staff, but finding enough staff with the right mindset for the job.

Addressing the Issues: Employee Wages and Job Quality

Because of the low rate that the local authority paid under the block contract, VIP Care was limited in its ability to pay much above the legal minimum rates of pay.

> *I would like to see carers get paid more. I don't think carers are recognised for what they do. We're limited to what we can pay people an hour... because there are cut-backs happening across the country. These are out of our hands... and it's not going to change any time soon... So if employees are moving to a different job for more money, we can't always compete.*

The only way for employees to earn more money was to work more hours. One long-time employee laughed as she counted her hours:

> *I work Monday day times [7 to 3] here [doing support work in the office], and Monday night supporting a young boy with learning difficulties, and I'm again with him Tuesday morning. Wednesday, I'm here; Thursdays, I'm in here, and then provide support or home care Thursday evening. Friday morning I'm in here. On a Saturday I do a home care round 6.45 to 2.30, and a care round 4 til 10. On Sunday, I do 6.45 to 2 and 4 til 10 supporting my boy with learning difficulties. I don't really know how many hours that is. I don't want to know.*

However, from her own experience, Jones knew that there was more to employee well-being than simply being handed a paycheck. Workers often worked those long hours alone, in difficult circumstances. They would take home their

emotional stress or grief after difficulties or a client's death, and have contact with other employees only on a sporadic, informal basis. According to one expert social care researcher:

> *People talk to their husbands or children, having to deal with grief, if somebody dies, and taking that home. Job quality is all over the place... There are some employers who try consciously to have events in support of their workers, so they have weekly gatherings in the staff room or free cake -- things like that. But this is not the norm and there is no kind of framework for providers that recognise these dynamics and how to support the workers.*

Jones was deeply aware of her employees' concerns, and took them to heart: '*The girls do struggle sometimes. There are things that they want to talk about. They don't want to particularly go to the coordinator or the manager. There needs to be a level person'.* Jones was searching for a way to address this need.

Further, workers often completed the necessary paperwork -- to track their visits and their clients' needs -- on the go or even after hours. In 2016, VIP Care had decided to digitalize its clients' care plans in order to facilitate the administrative burden on its workers, to satisfy the local authorities' expectations for contracted care providers to have electronic monitoring systems in place, and to improve communication between the company, the clients and their families. The digital transformation of VIP Care involved not just electronic monitoring to schedule visits, check in and out of clients' homes, and track work by use of a smart phone app. Clients' entire care plans would be digitized in a 'live' format, with alerts when visits or work had not been completed. After addressing all security concerns, VIP Care had begun implementing this new system, allowing the company, client and allowed family members access to details of the care delivered to the client and the staff involved in delivering the care. According to Jones, this was also a big step toward more outcome-focused care.

Addressing the Issues: Employee Retention

Once an employee with the right mindset had been found and hired, there were issues of training and retention.

For years, since starting to recruit employees from outside her family circle, Jones had been developing employee training and support programs. VIP Care worked closely with Skills for Care, the UK care industry's skills training organisation, to

implement vocational training. Jones's company had received a number of industry awards in recognition of its innovative approach:

> *What we've always kept along the way is that personal touch with people... supporting and treating them as human beings, and valuing them and respecting their wishes. And...saying to people that they can do it and that it is possible with support.*

VIP Care was involved in a Skills for Care initiative concerning '*skills around the person*'. This initiative started from the belief that not only are person-centred approaches vital in ensuring that care and support meet individual needs and preferences, but also that care workers each have their own skills, knowledge, and attributes which they bring with them to work. The programme aimed to explore how such skills might be enhanced to maximise a client's independence and improve quality of life. [28] Jones's felt a strong sense of responsibility to her employees:

> *We can't blame [our employees] if they don't do a good job. It starts and stops with us. We've got to support them, give them adequate supervision, listen to them. They've got to know that when they ring there will always be someone on the end of the line to help them. We want to instill confidence in staff. We are very keen on being one voice.*

Faced with one of the highest turnover rates of any service industry, Jones was trying to shift the paradigm of care workers drifting into and out of home care, and was actively developing ways for care workers to build careers in the sector. '*We want people to see care as a career. We want to be able to up skill and for people that want to, to be able to progress into other areas.*'

All new employees received 4 to 5 days of induction training, including 2 to 3 days of physical handling and medication training to receive the required Care Certificate. They would then spend three shifts shadowing an experienced care worker and going through a checklist of specific work experiences so that they would be able to care for a variety of clients. After 13 weeks of probationary, on-the-job experience, workers could decide to move up the career ladder by obtaining QCF (Quality and Credit Framework) level 2, and later, level 3.

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[28] Skills for Care (2014) *Skills around the person: Implementing asset-based approaches in adult social care and end of life care*, Leeds: Skills for Care, October 2014. F found at: http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/community-skills/skills-around-the-person-web.pdf

According to Allen: *'We are always encouraging staff to do more training. But it's not for everybody... studying does scare some people.'*

If an employee completed their QCF level 2, they received a 25 pence an hour pay increase. This would be further increased by 25 pence an hour if they completed their level 3. The pay raises were minor, but still served to recognise the higher level of qualification and responsibility.

The opportunity to undertake specialist training was also offered to staff on topics of particular relevance to their jobs, such as dementia, Parkinson's disease, diabetes and stomas. All training was company-funded. In the past, most of this type of training was undertaken online or was outsourced. Jones had recently invested in a purpose-built training room and had brought almost all of the training in-house. Staff who had undertaken specialist training now acted as 'train-the-trainers' to cascade specialist learning to their colleagues.

Jones encouraged existing staff to develop and, wherever possible, promoted from within. One recent example was an experienced employee who had brought Jones's attention the scarcity of care providers operating in her home town. With Jones's support, the employee had trained to become a registered manager, had obtained her registration from the CQC ad was now the town manager with the largest client and employee base for VIP Care. Jones was looking for ways to further expand this care-as-a-career model for her employees.

Jones had always worked with an open door policy, helping her employees as much as she possibly could. She kept the company hierarchy flat, with everyone who could help and support employees easily reachable. As Jones described:

> *Team work is very important to people... and it's important for people even if they are alone working a lot. So it's really important for us to have all of the doors open and to allow people to come in and talk to us whenever they want, about whatever they want. And also being very level. That there isn't a hierarchy of me up here.*

But the administrative demands of her position had grown tremendously, especially since taking on the local authority block contracts. She felt as if she just didn't have enough time in the day to spend with her employees on their personal or work concerns and wondered how she could best solve this dilemma. According to Jones:

This is a hard job. What I want to be able to tell employees is: we are never going to be able to pay you the money you deserve to be paid but what we can do is look after you, nurture you. Support you in a way you deserve to be supported.

Addressing the Issues: Treating Clients with Dignity

In addition to championing her employees' well-being, Jones was also trying to champion that of her clients. She wanted her employees to always, in every circumstance, view and treat their clients with warmth, respect and dignity.

We are trying to get people out of saying 'I am going to do Mrs. Smith'. Another one we hear a lot is 'Oh, he suffers with dementia'. The term is now Mr. Smith 'lives with' dementia. He doesn't suffer, he lives with it.

Jones was trying to change not just the language of the business, but the way in which business was actually done, so that the end result would be one of a warmer, more personal atmosphere. In addition to the language used to speak about clients, Jones was also encouraging her employees to use appropriate actions, such as *'closing curtains when we're providing personal care, and shutting doors'.* Jones was trying to find a way of making this a company-wide effort.

Conclusion

Jones's double focus on her employees and her clients was a winning combination, as confirmed by VIP Care's strong growth in a highly competitive industry. According to Jones: '*We want to empower our staff and the clients we support. We want people to feel valued and to enjoy working with us.'*

VIP Care had already received a number of industry awards in recognition of its innovative approach to skills and care as a career. Jones's philosophy was clear:

Every job that I've ever left in the past has been because I didn't feel valued. I don't want people here to feel like that. I want people to know that they are important. We want our staff to see that the job they do is amazing. I think that in any job, you need to have someone there to say thank you when you've done it.

However, Jones knew that her company, in terms of providing support to her employees and to her clients, could still be improved, to shift some of the care industry paradigms; and she intended to do just that.

Appendix A

From the Foreword to WHO 2008 publication on Home Care in Europe[29]

There is an intrinsic appeal to the term home care that has caught the imagination of politicians, professionals and the public. "Back to the future" is an expression that could accurately reflect the potential to explore, exploit and implement an old idea with today's knowledge and new means. Home care offers the possibility to receive a wide range of services in one's familiar surroundings. Home care emerges now as an increasingly promising option for providing health and social care for many conditions that are especially associated with older age, disability and chronic diseases. Many factors drive the need and demand for home care: demographic trends, changes in the epidemiological landscape of disease, the increased focus on user-centred services, the availability of new support technologies and the pressing need to reconfigure health systems to improve responsiveness, continuity, efficiency and equity. Home care is understood and practised differently around the European Region.

History of home care

There is no single, uniform history of the evolution of home care services policy and provision across Europe. The development of home nursing and home help are bound up with the emergence of complex systems of welfare, social security and health care that have followed different trajectories and given rise to different patterns of funding and provision within each country. Adding to this diversity, prevailing social and cultural institutions at the national level colour the welfare reforms and policy mix. The result is a rich mix of approaches and strategies for funding, organizing and delivering home care services, tax-based provision, municipal, regional and national levels of responsibility, differences in health and social service boundaries and greater or lesser policy support for informal care.

Home care provision across all European countries has relied historically on informal care (primarily family) and voluntary or church provision. The central

[29] *Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe.*

place of the family and extended kinship networks in delivering support to older and disabled people is a consistent theme across all European welfare regimes. Only during the late 19th century did growing state involvement in health and social welfare begin to augment, but not displace, this form of provision (2).

During the 20th century, large-scale institutions and hospitals became the dominant forms of provision for supporting a range of groups including older people, children, disabled people and people with mental disorders. Nevertheless, professional and consumer criticism of the place of these institutions grew from the 1950s across western Europe and the Nordic countries.

There have been moves since the 1960s to reduce the number of long-stay beds for older people and children in hospitals, to improve nursing homes and residential homes for older people, children and people with disability and to close long-stay mental institutions. Policies known variously as deinstitutionalization, community care, continuous care, integrated care and home-based care were promoted as an alternative to or replacement for institutionalized and acute provision. A major push was to acknowledge the key role and enhance the provision of informal and family care across these groups. In such countries as the Scandinavian countries and England, there was not a direct policy shift from institution-based to family care but a shift from institutional care to community-based formal services and only subsequently to a greater emphasis on family-based care.

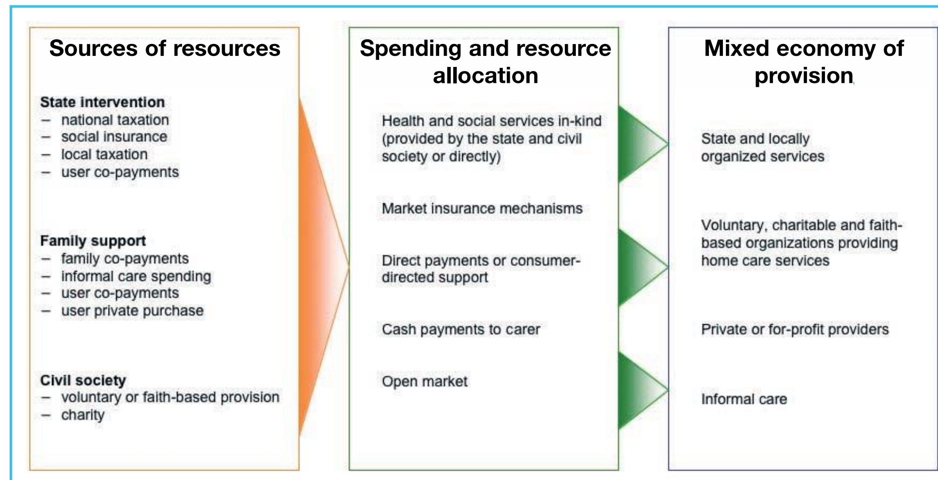
Institutionalization and deinstitutionalization processes took place at very different times and paces across Europe. Both were much more recent phenomena in countries in southern and eastern Europe. In countries in eastern Europe, for example, institutional care persisted as a dominant form of provision until the early 1990's.

Adding to traditional forms of home care, hospital and hospice-at-home schemes, home nursing and home help are more recent and complex forms of intervention that reflect developments in medical and information technology. All European countries currently emphasize the importance of providing a spectrum of care for vulnerable groups, but the precise meaning of this and the policy challenges vary within each country according to the contingencies of history and context. In many southern European countries, for example, formal home care has still not been developed fully, whereas some Nordic countries have comparatively underdeveloped voluntary sectors. These differences are explained in part by the differing histories, inherited levels of provision, traditional roles of state and civil

society and evolving expectations about where responsibility for home care should lie.

Appendix B

Funding, Allocation and Provision of Home Care in Europe



Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe, p.18.

Influences on the Supply of and Demand for Home Care

Source: WHO 2008, publication E91884. The Solid Facts: Home Care in Europe, p.3.

Appendix C

Headline figures: Homecare in England for the financial year 2014/15

- 673,000 people were using home care in England;
- 249 million hours of home care was delivered;
- total direct expenditure on home care was £3.3 billion split between:
    - local authorities (£2.6 billion) and
    - self-funders (£623 million);
- 144,000 people received a direct payment;
- 527,000 people were employed in the sector;
- 8,458 registered locations providing home care (an increase of 3% compared to 2013/14). [1]

Source: Wright, S. and Green, A. QuInnE, 2017a. WP-6 Case Study - F I a. UK-Social Care: Good Intentions Undermined by External Constraints.

Appendix D

The Netherlands Home Care Industry: Number of Companies by Size (# of employees) 2008 - 2016

		Number of employees per company									
	Total # of companies	1	2	3 to 5	5 to 10	10 to 20	20 to 50	50 to 100	100 or more	0 to 50	0 to 250
2008	1680	1180	90	65	65	65	65	45	105	1530	1610
2009	4080	3565	115	65	75	65	60	40	95	3950	4020
2010	6135	5620	110	90	75	65	60	25	90	6015	6065
2011	7700	7100	145	100	95	65	70	25	95	7575	7630
2012	8535	7915	145	100	95	90	60	35	95	8405	8475
2013	10120	9445	180	100	110	80	70	40	95	9985	10055
2014	11130	10410	210	115	110	85	70	45	80	11005	11080
2015	12100	11320	230	115	130	100	80	50	75	11975	12050
2016	12555	11745	215	140	125	115	90	50	80	12425	12505

Note: 2016 data only available to 2nd quarter
Source: NL CBS, 2016

Appendix E

Age Distribution of the UK Population, 1976 - 2046 (projected)

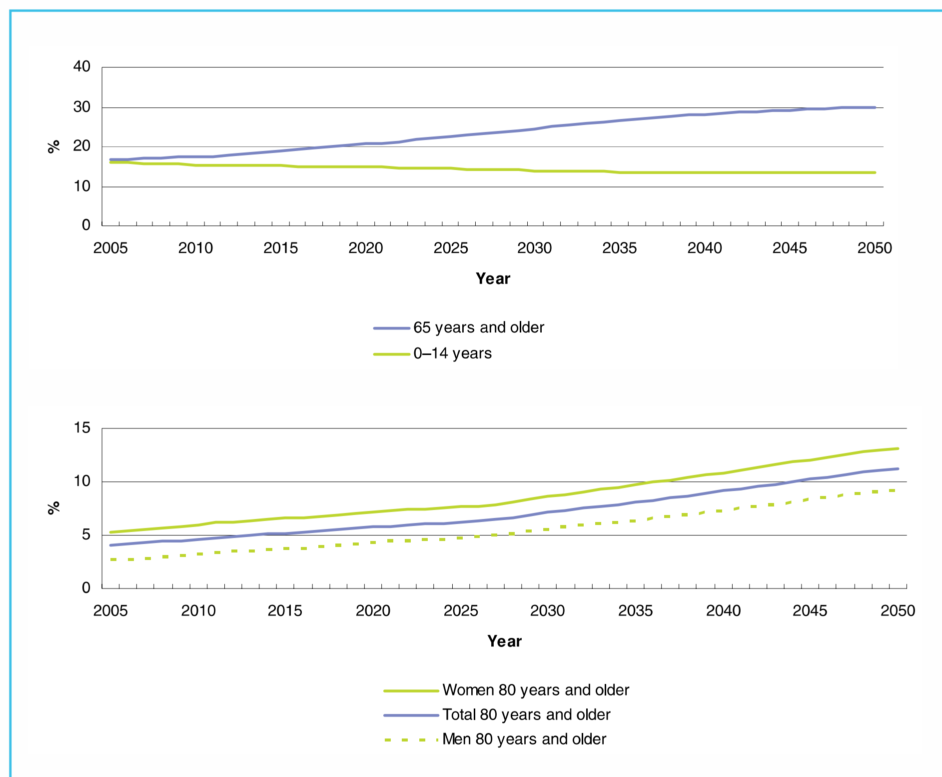
	0 to 15 years (%)	16 to 64 years (%)	Aged 65 and over (%)	UK population
1976	24.5	61.2	14.2	56,216,121
1986	20.5	64.1	15.4	56,683,835
1996	20.7	63.5	15.9	58,164,374
2006	19.2	64.9	15.9	60,827,067
2016	18.9	63.1	18.0	65,648,054
2026	18.8	60.7	20.5	69,843,515
2036	18.0	58.2	23.9	73,360,907
2046	17.7	57.7	24.7	76,342,235

Source: Office for National Statistics

See Table 1 at:
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/july2017

Appendix F

Fig. 2.2. Projections for the proportion of the population in various age groups in the European Union (27 countries), 2005–2050



Source: *Eurostat (2). © European Communities, 1995–2008.*

As found in *WHO 2008, publication E91884. The Solid Facts: Home Care in Europe. Available at: www.euro.who.int/en/publications/abstracts/home-care-in-europe.-the-solid-facts*

Appendix G: The calculation of UK HCA's minimum price for homecare

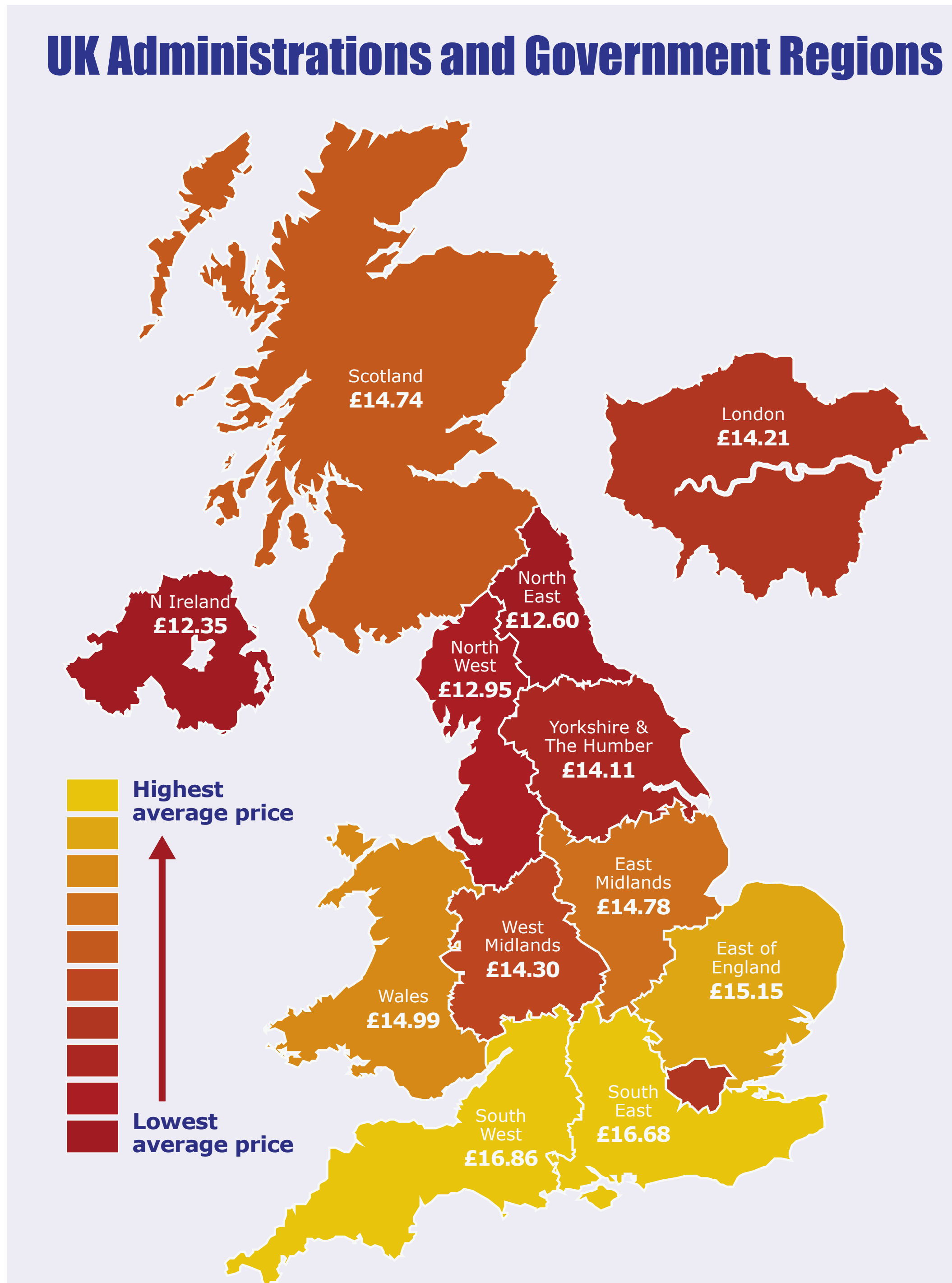
Breakdown of UKHCA's Minimum Price for Homecare

Cost	Assumption	Hourly cost
Basic pay for "contact time" (see below)	National Minimum/Living Wage combined	£7.13
Enhancement for unsocial hours	None	£0.00
Travel time	11.4 minutes to 1 hour of contact time	£1.35
Wage costs:		**£8.48**
National Insurance	9.5% of gross pay	£0.81
Holiday pay	12.07% of gross pay	£1.02
Training & supervisory time	1.73% of gross pay	£0.15
Pension contributions	1% of gross pay	£0.08
Distance travelled	4 miles per hour at £0.35/mile	£1.40
On-costs:		**£3.46**
Costs of sale:	**Wage costs + on-costs**	**£11.94**
Running the business (see page 15)	27% of total price	£4.26
Profit or surplus	3% of total price	£0.50
Overheads:		**£4.76**
Total hourly price:	**Costs of sale + overheads**	**£16.70**

Source: UK Home Care Association. (October 2016). The Home Care Deficit 2016 (Version 1), p. 14. Available at: http://www.ukhca.co.uk/pdfs/ukhca_homecare_deficit_2016_final.pdf. Accessed 19 May 2018.

Appendix H

2016 actual weighted average hourly price paid for homecare in each UK government region and devolved administration. 2016 UK average hourly rate for publicly-funded home care was £14.58, as compared to the UK HCA proposed minimum rate of £16.70.



Source: UK Home Care Association. (October 2016). The Home Care Deficit 2016 (Version 1), p.19. Available at: http://www.ukhca.co.uk/pdfs/ukhca_homecare_deficit_2016_final.pdf. Accessed 19 May 2018.