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# Home care services for older people: findings from a national survey of social care commissioners

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**Abstract**
*This paper explores local authority commissioning and contracting arrangements for home care, staff training opportunities and the range of services provided for older people utilising data from a national postal survey with a 74 per cent response rate. Local authority provision focused on intermediate care services. Joint commissioning of this with health was common but less likely for specialist mental health services. Most home care was commissioned from and provided by independent sector providers with contractual requirements identified as a means of influencing and monitoring training opportunities. A range of services were provided for users, additional to personal care. Local authority training was sometimes available to independent providers, focused on statutory requirements rather than user needs. Implications for the development of high quality services are discussed in terms of user need, service flexibility and training for staff providing direct care. It is suggested that within the commissioning process key drivers of the development of more personalised high quality home care services are: regular dialogue with service providers; greater health and social care involvement in a joint commissioning process; alignment of contracting arrangements to reflect service outcomes; and specification of training requirements within the setting and monitoring of home care contracts.*

**Keywords:** personalisation, older people, domiciliary care, quality

## Introduction

Personalisation and related constructs have been identified as a cornerstone of the transformation of public services in England. For users in receipt of home care, this requires that services are of high quality and promote independence, wellbeing and dignity and that they have choice and control over how that support is delivered (Cm 8378, 2012). To promote the latter guidance has required that the allocation of resources to individual users become a more transparent process. Personal budgets were identified as the mechanism to achieve this (Department of Health, 2008). Responsibility for the construction of the associated care plan may be with the older person or a family member, who receive a cash payment and negotiate with providers directly about the assistance they require. Alternatively, a professional may do this on the user's behalf. Thus home care providers operating within the contractual framework provided by local service commissioners are challenged to respond to both care managers' commissioning services on behalf of users and carers and direct requests from users, or family and friends acting on their behalf.

Home care services have long been part of the fabric of the Welfare State with their development characterised by evolutionary change in response to national policy initiatives, local circumstances and existing service configurations. In 1971 responsibility for their planning and provision was transferred from the public health department to a social services department within local government. Increasingly these services were caring for a more disabled and frail clientele; providing help with activities of daily living

rather than domestic assistance; and assistance at weekends and evenings as well as during the day. In short, more intensive personal care provision for people as an alternative to admission to residential or nursing care. It was recommended that the home care service should change to one which was more professional, flexible and targeted. To achieve this required both the revision of the core tasks undertaken and the provision of training for home carers (Department of Health and Social Security/ Social Services Inspectorate, 1987). The community care reforms confirmed the commitment to enabling people to remain at home and receive the care they need to maximise their independence if possible and the development of home care services was integral to this (Cm 849, 1989).

Following the recommendation of the Griffiths report (1988) that local authorities should become 'enabling agencies' focusing on the commissioning of services rather than their provision, home care has become increasingly but not exclusively provided by the independent sector, with planning about its scale and content within the remit of the commissioning function undertaken by local authorities (Cm 849, 1989). The subsequent introduction of the concept of *Best Value* into local authority commissioning and contracting processes, also influenced the relative balance of home care provided by the independent and local authority sectors and the development of specialist services. *Best Value* was defined as 'a duty to deliver services to clear standards – covering both quality and cost – by the most effective, economic and efficient means available' (Cm 4169, 1998, p.113). These principles provided an incentive for local authority sector home care provision to focus on specialist services such as those for older people with mental health problems. Another incentive for the development of specialist home care services, together with a more general requirement for their development, was provided by the *Fair Access to Care Services* guidance. It confirmed the duty placed on councils to have services in place to meet eligible needs, with the caveat that specialist services for groups of users, such as people with mental health problems, should be developed where there was justification for such (Department of Health, 2002). Subsequently, local authorities have been required to demonstrate an investment in prevention, early intervention/ re-ablement, and provision of intensive care and support for those with high-level complex needs, including older people with mental health problems (Department of Health, 2008; 2009a; 2009b). The facility for commissioning to be undertaken jointly with other agencies was established subsequently influencing the development of specialist home care services (Cm 4169, 1998). Mechanisms to promote this and joint service provision were enacted in 2000 – pooled budgets, lead commissioning and integrated provision - endorsed by subsequent policy guidance and legislation (Cm 4818-I, 2000; Cm 6499, 2005; Cm 6737, 2006; Cm 8380, 2012). Key areas for the joint commissioning of specialist home care related to old age mental health services, particularly for services users with dementia, and within the intermediate care sector, for patients discharged from acute hospitals (Department of Health, 2001; 2003; 2009a; 2009b). The aim of this paper was defined in this context: to explore commissioning arrangements for home care services for older people. More specifically:

- How and what types of services are commissioned?
- To what extent are training opportunities specified within the contract setting process?
- What services are available from home care providers?

## Method

Findings from a postal survey of English local authorities undertaken in 2008 are described. Its purpose was to explore the nature of local authority commissioning and contracting arrangements for older people's services. Approval was received from the Association of Directors of Adult Social

Services Research Group and the university research ethics committee. Following the initial distribution of the questionnaire, non-respondents were contacted twice by telephone and replacement questionnaires were sent. The principal respondents were service commissioners although some were operational managers or had project management responsibilities.

The development of the questionnaire was informed by a relevant, purposive review of policy and literature. In the former there was an emphasis on developments following the White Paper: *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (Cm 4169, 1998). The inclusion criteria for the latter are specified in **Table 1**. In addition, meetings were arranged with senior managers in two local authorities to develop a greater understanding of the issues relating to the interrelationship between commissioning, contracting and care coordination arrangements. Questions were constructed that related to these three domains of activity, focusing particularly on home care services and care home provision for people aged 65 and over, including those with mental health problems. The format of the survey was structured, with some opportunities for respondents to provide additional comments. Both are incorporated into the findings and discussion. Some data is presented in the form of figures and tables and some solely as text.

## Findings

Almost three-quarters of English local authorities returned completed questionnaires.

### *Commissioning and contracting arrangements*

Nearly all authorities (92 per cent) commissioned older people's home care services and about half (49 per cent) commissioned specialist services for older people, including those for ethnic minority groups or with specific health conditions including dementia. A significant investment in joint commissioning with commissioners of primary care services was also reported in respect of intermediate care and old age mental health services. Over three-quarters of authorities jointly commissioned home care with their local primary care service to facilitate early supported discharge from hospital (78 per cent) and rehabilitation at home following illness (77 per cent) and four fifths to prevent hospital admission (80 per cent). On the other hand, just under a third of authorities (32 per cent) jointly commissioned specialist home care services for use within old age mental health services. Thus, whilst joint commissioning of home care services with the NHS was a feature of the intermediate care sector, it was less likely to be so within old age mental health services. Developments within the intermediate care sector reflected implementation guidance which accompanied the *Community Care (Delayed Discharges etc.) Act*, 2003. One of its principal aims was to encourage the development of new services to facilitate patient transfer to community settings which promote independence or prevent unnecessary hospital admission (Department of Health, 2003).

A large proportion of home care services were provided by the independent sector. Just under three-quarters of local authorities (71 per cent) allocated over 60 per cent of their expenditure on home care to independent providers, with nearly two-fifths (37 per cent) allocating over 80 per cent. **Table 2** provides details of local authority contracting arrangements for independent sector home care. Home care was most likely to be purchased using a fixed term contract, most typically two to three years in length. Roll on contracts and those of duration of up to a year were less common. Other types of more flexible arrangements were derived from the coding of 'other' response categories, and therefore possibly underrepresented, but included spot purchase and cost and volume contracts.

**Table 1**. Literature review: inclusion criteria

| | |
|---|---|
| **Participants/ service recipients** | Primarily older people (65+)[1] |
| **Service** | Community–based social care[2] or social services including intermediate care and old age mental health services |
| **Location** | United Kingdom |
| **Dates** | Data collected after 1991 |
| **Design/study type** | Any empirical study |
| **Focus of study** | Commissioning, contracting and care management arrangements for older people |

[1] Relaxation of this inclusion criterion to include all adult groups for Direct Payments and Individual Budgets due to the newness of these concepts and their centrality to the study.
[2] Social care was defined as services provided, commissioned, funded or facilitated by the lead social services agency in the locality.

**Table 2**. Contracting arrangements: independent sector domiciliary care

| | No. | % |
|---|---|---|
| **Length of contract (n=104)** | | |
| **Up to one year** | 5 | 5 |
| **Two to three years** | 54 | 52 |
| **Four years and over** | 45 | 43 |
| **Type (n=103)** | | |
| **Fixed term** | 74 | 72 |
| **Roll on** | 20 | 19 |
| **Flexible arrangement** | 9 | 9 |

Whilst under two-fifths of authorities (37 per cent) did not have a block contract for independent sector home care, just over two-fifths of respondents (41 per cent) reported block contracting for more than 60 per cent of the home care hours purchased from this sector. This suggests that where block contracts were in place, this tended to be for the majority of home care provision. Differences in contract types are important, as it is reasonable to consider that fixed longer term contracts for a specified level of service associated with block contracting might provide more stability for providers and their employees. This may encourage investment in the training of care workers, and permit the provider to commit to planning patterns of staff deployment over a longer time frame. The challenge, however, is to promote staff training within the contracting framework and responsiveness to user need at the point of service delivery, both of which are identified as important in the provision of more personalised care (Cm 8378, 2012).

Many local authorities indicated that they were anticipating changes to existing contracting arrangements, with the implementation of Self Directed Support cited as the main reason for this. The most frequently reported changes were moves towards outcome based contracting for home care and more flexible contracting arrangements to respond to the personalisation agenda. More specifically, the latter was expected to be achieved in time by a move from cost and volume or block contracting, towards more flexible forms of contracting: the use of approved or preferred provider lists; framework agreements; or the use of individual placement agreements or contracts. It was also noteworthy that a number of respondents anticipated greater involvement of primary care and housing

departments in contracting for home care; possibly contingent on these organisations' involvement in the commissioning process.

### *Training*

In this section, data is reported that relates to the training opportunities for staff providing direct care to users in a variety of settings: home care services and care homes in both the independent and local authority sectors. Nearly all local authorities reported that they provided training to these staff groups. It is important to note that whilst detailing the provision of training, we have no measure of the extent to which home care workers, and particularly those in the independent sector, are able to attend such courses. Neither do we have data on training offered by independent sector providers.

In general, data in **Figure 1** suggests a much stronger local authority focus on training that is organisational, often fulfilling statutory requirements for example safeguarding adults or health and safety, rather than needs focused, such as the care of an older person with Parkinson's disease, or diabetes. Each type of training separately was more likely to be provided to local authority staff compared to those working in the independent sector. However, overall, whilst just over half of authorities (53 per cent) provided more of their training courses to local authority staff, in two-fifths these were equally available to local authority and independent sector care workers.

One means by which local authorities can potentially influence the uptake of available training for staff employed by independent providers is by making this a contractual requirement. The contract could, for example, stipulate specific training requirements which might be provided by the employer or sourced from an alternative organisation such as the local authority, a college of further education or a specialist training company. Two findings are of note in this context. First, **Figure 2** provides details of specifications in contracts relating to the training of home care workers. Authorities were most likely to specify induction and training for new staff and staff development and appraisal. Least likely to be specified were specialist training in the care of older people with dementia and rarely was it also specified that employers should pay staff to attend training courses. The latter in particular may be an important factor influencing uptake of training amongst home care workers. Second, the most frequently reported area of review in the monitoring of home care contracts with the independent sector was staff development and training. Over four-fifths (82 per cent) of respondents specified this within their overall monitoring of human resources policies. The inclusion of specific requirements within contracts relating to staff training are important because they provide an impetus for providers to enhance the skills of their workforce and a set of formal criteria against which the performance of their organisation can be monitored.

### *Service focus and delivery*

In this section, there is a dual focus. First, data from a strategic commissioning and contracting perspective are reported and second, data relating to service delivery are explored both in terms of the range of provision and the manner in which it is commissioned on an individual basis. The former represents the framework for the provision of more personalised care and the latter a measure of its development.

Additional to their generic provision which focused on the provision of care to older people in general (98 per cent), most local authorities in England reported that their home care services were within the intermediate care sector (84 per cent) and old age mental health (91 per cent) services. Around a fifth of local authorities (21 per cent) reported other foci including: services for specific ethnic groups; extra care housing; support to carers; and palliative care. In terms of the balance between independent and local authority provision, **Figure 3** reveals that all of these services were more likely to

**Figure 1.** Training availability by service sector (minimum n=100, maximum n=101)

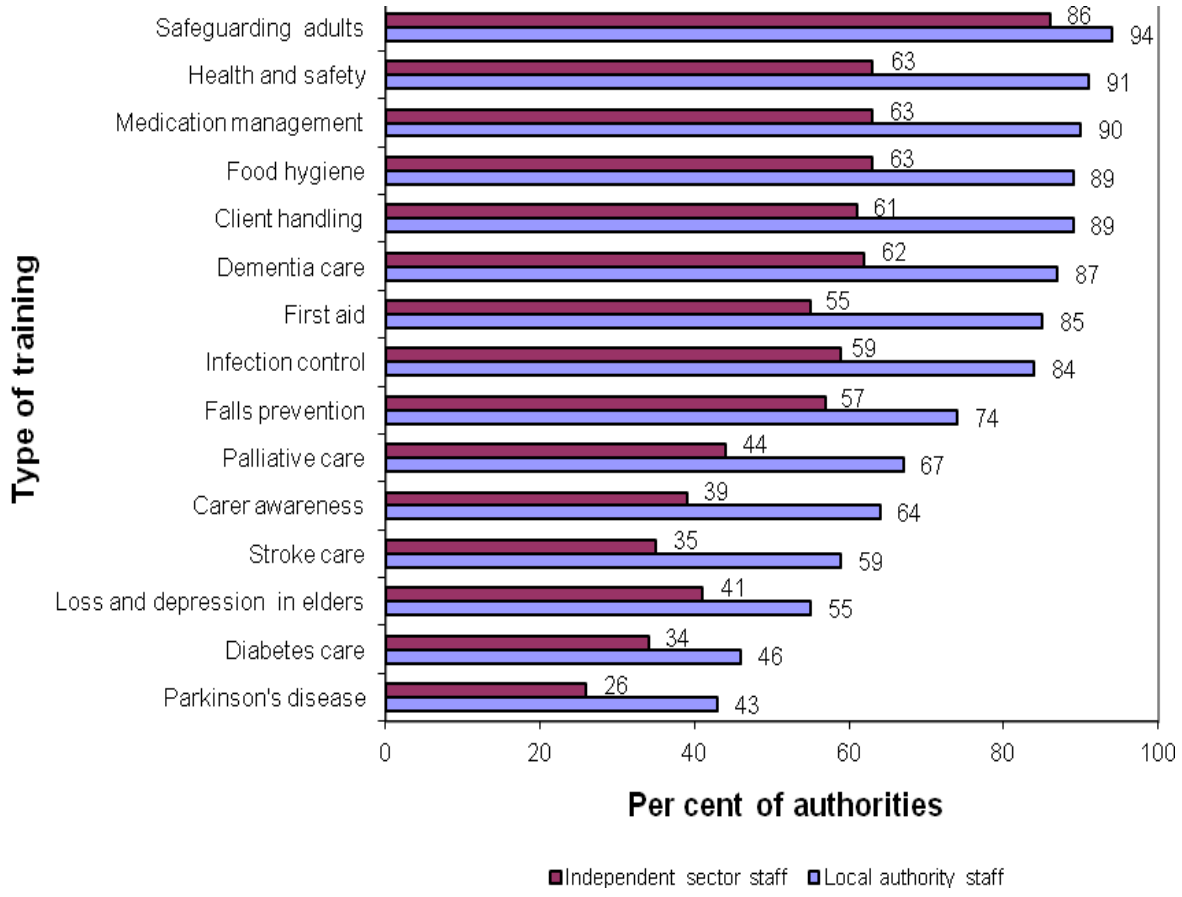



**Figure 2.** Contracting for domiciliary care: training specification (n=102)

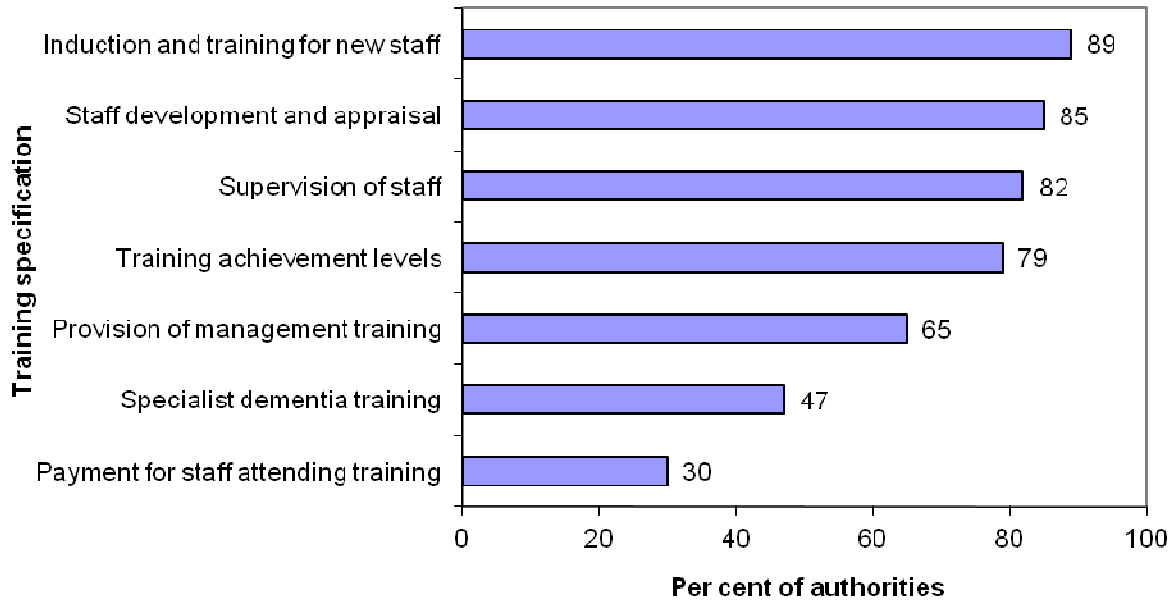
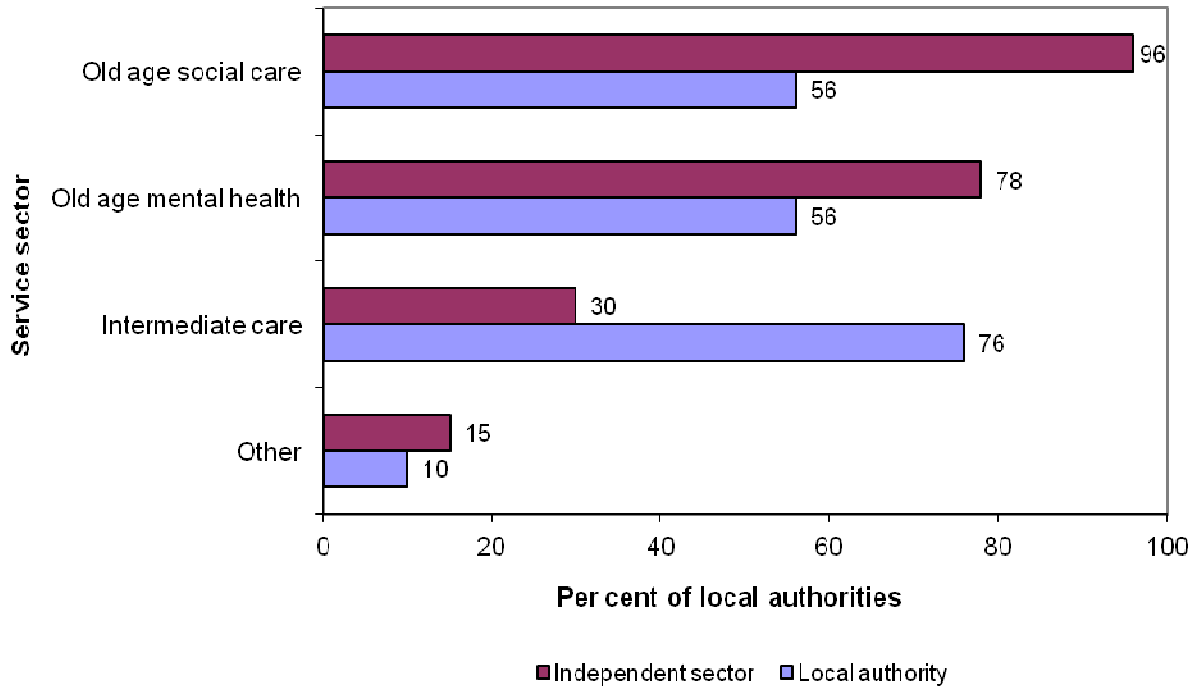


**Figure 3.** Foci of domiciliary care services (minimum n=101, maximum n=105)




be provided by independent care agencies, with the exception of those provided within the intermediate care sector. The latter has become the dominant area of activity for local authorities.

Nearly all authorities (95 per cent and 98 per cent respectively) reported that their local authority and independent sector providers were available daytime on weekdays suggesting that both sectors were equally likely to be providing care during this time period. By comparison, around four-fifths (79 per cent) reported that independent sector providers were available at night, and just over half of authorities (54 per cent) reported that the local authority home care service was available at this time. This implies that local authority providers were less likely to be providing night time care, which may be a reflection of this sector's specialist focus on rehabilitation within the intermediate care sector noted above.

The range of tasks undertaken by home care providers in addition to personal care is an indicator of the extent to which services are responding flexibly to individual needs. **Table 3** reveals that, as well as personal care, local authority or independent sector organisations were most frequently contracted to provide: assistance with meal preparation; shopping; and help with housework; and that these were much more likely to be provided to older people than to support informal carers in their role. The range of tasks that home care workers are expected to undertake is important, as some will require different skills to others. This may imply that workers need to be trained to do specialist tasks, or that home care providers require a workforce with a diversity of skills to meet their contractual requirements. For example, providing care to an older person, thereby offering the principal carer respite from the task, may require different qualities or skills, compared to helping an older person living alone with practical tasks for daily living.

In terms of responding flexibly to individual need, the manner in which services are commissioned for service users at the point of delivery is likely to influence the requirements for home care services specified in the contracting process. This is explored from two perspectives: the capacity of care

managers to commission services and the extent to which local authorities had arrangements in place to permit the flexible use of finance. First, only a quarter of local authorities had arrangements whereby care managers were able to commit finance to and/or allocate local authority provided services to implement a care package, without consultation with a first line manager. Second, just over a fifth of local authorities (22 per cent) reported that they routinely used bespoke arrangements to access care; examples of these were individual budgets and vouchers for carers. However, it is not clear from these data the extent to which these initiatives complement, or substitute for, home care provided through a service commissioned by the local authority and provided, for example, through a block contract. Nevertheless, together these findings provide an indication of the extent to which authorities have the capacity to tailor services to meet the specific needs of older people and their carers. They constitute a measure of the extent the provision of personalised care since they are indicators of the extent to which service users have choice and control over how that support is delivered (Cm 8378, 2012).

## Discussion

This paper has provided data relating to local authority arrangements in England for the commissioning and contracting of home care services; the availability of training for 'hands on' workers; and the range of services provided by independent agencies and local authorities. It was collected through a self completion questionnaire. A disadvantage of this approach is that responses may reflect the pre-coded choices presented to respondents rather than their actual knowledge of these arrangements (Bowling, 2002). Furthermore, the findings solely reflect the perspective of local authorities and the ways services are commissioned and contracted continually evolve in response to policy and practice guidance. With regard to the latter the rollout of personal budgets and the emphasis on the promotion of dignity and respect in the care process have been particularly important (Cm 8378, 2012). Finally, it is relevant to note that in the time which has elapsed since the survey was conducted the current period of financial austerity will have influenced the development of the home care service. Nevertheless, these data represent the views of almost three-quarters of the local authorities in England and provide an overview of home care services at a point in time. In the remainder of this paper the significance of these findings are appraised in a context in which the number of people cared for at home is expected to continue to increase with a consequent increase in the provision of home care services (CQC, 2013a; Cm 8378, 2012). It will explore the extent to which the survey findings provide insights into the main drivers for change in relation to the strategic commissioning of home care in pursuit of quality services tailored to individual need.

**Table 3**. Range of domiciliary care support (n=93)

| | Older person | | Carer | |
|---|---|---|---|---|
| | **No.** | **%** | **No.** | **%** |
| **Shopping** | 72 | 77 | 41 | 44 |
| **Housework** | 60 | 65 | 38 | 41 |
| **Help with meal preparation** | 86 | 93 | 36 | 39 |
| **Teleshopping** | 17 | 18 | 13 | 14 |
| **Sitting service/respite care** | 5 | 5 | 9 | 10 |
| **Laundry** | 4 | 4 | 3 | 3 |
| **Medication prompting** | 3 | 3 | 1 | 1 |
| **Transport** | 1 | 1 | 1 | 1 |

***Who are the principal recipients of home care?***

In the management literature it has long been recognised that the segmenting and differentiating of mass markets leads to more specialised services replacing a single dominating service response (Normann, 1991). Whilst previously local authorities lacked the necessary information and infrastructure for segmentation analysis of the home care recipients, there are signs of this emerging within the service commissioning framework associated with the focus on specific groups of those with substantial needs (Department of Health, 2002). In terms of case-mix, the evidence below suggests that the needs of older people for home care fall predominantly into three groups. It is estimated that there are more than 570,000 people in England living with dementia (Department of Health, 2009a) but there is little information on the use of social care services by people with this condition. Although people have not received a formal diagnosis it is reasonable to assume that a substantial proportion of service users in receipt of home care have a degree of cognitive impairment (Challis *et al*., 2007; 2011; Moriarty & Webb, 2000; Sutcliffe *et al*., 2008). These constitute the first broad group who frequently require long-term support to enable them to remain in their own homes. Over and above this there is a second group comprising older people with a diagnosis of dementia and their carers who are in touch with specialist old age mental health services. There is evidence to suggest that to retain their community tenure they require specialist home care support (Challis *et al*., 2009). However, it is only comparatively recently that the specialist needs of this group have been explicitly recognised in policy guidance (Department of Health, 2009a). Patients on discharge from hospital constitute the third group of older people with specialist home care needs. The provision of appropriate care for at home for this group and avoidance of premature admission to long-term care is a longstanding concern (Audit Commission, 1997; Department of Health, 2001). Research has demonstrated that the provision of home care has effected a small, but significant, reduction in hospital days (Hughes *et al*., 1997) and, for older people with undifferentiated clinical problems, support on discharge from hospital has been reported to reduce admission to long stay care (Hyde *et al*., 2000). Typically, such provision is now located within the intermediate care sector and there is some evidence of the efficacy of these services (Cm 6737, 2006).

Evidence from our survey indicated that home care provision was aligned with intermediate care and old age mental health services suggesting that substantial resources are invested in meeting the needs of frail older people with multiple health problems and this has been confirmed subsequently (CQC, 2013b). Furthermore, other research suggests that undiagnosed morbidity is likely to be a significant component of their presenting problems (Challis *et al*., 2004). To provide care in a timely and appropriate manner requires arrangements that permit a flexible response in terms of time and task, and a knowledge base which permits interpretation and understanding of presenting behaviours and problems. The creation of such a culture within home care services is arguably one of the biggest challenges to the implementation of the personalisation agenda (Cm 8378, 2012). Whilst our survey reported the extent to which training was prioritised within the contract setting and monitoring process, it did not provide evidence of the training opportunities afforded to home care workers.

***How might a more personalised service be provided?***

It was anticipated that the introduction of arrangements which permitted older people and carers to assume responsibility for their own care plans and direct negotiations with home care providers would impact on local strategic planning processes (Fernández *et al*., 2007; Glendinning *et al*., 2008). Commissioners were required to take account

of this and develop and deliver a strategy for home care which demonstrated both an investment in preventative services alongside those focusing on re-ablement following illness and the provision of long-term intensive care and support for older people with complex needs (Cm 8378, 2012; Department of Health, 2008). This study provided evidence of how service commissioners might promote the development of home care services to respond to these requirements. First, a number of respondents identified strong relationships with independent providers, including those from the third sector, and collaboration between providers of home care when invited to comment on the strengths of their current commissioning arrangements in free text at the end of the questionnaire. The importance of this has previously been noted in the literature (Ware *et al.*, 2001) and more recent guidance has emphasised the importance of commissioners and providers working in partnership to achieve the necessary changes in service provision that personalisation requires (Department of Health, 2009c; TLAP, 2012). Second, survey respondents identified joint commissioning or partnership working arrangements with local primary care commissioners and housing departments, as an area in which they had made progress, and which would assist in the transition to personalised care services, reflecting policy guidance (Cm 8380, 2012; Department of Health, 2008; 2009b; 2009c). However, the survey data indicated that at present joint commissioning was predominantly within intermediate care services and to a lesser extent, old age mental health. This suggests some progress with respect to an integrated approach to service commissioning for home care in advance of substantive guidance but also scope for further development (Cm 8380, 2012). Third, respondents demonstrated an awareness that decisions relating to length and type of contract were important in the development of more personalised home care services in advance of guidance relating to this (Department of Health, 2009c; TLAP, 2012). Comments of respondents in the free text at the end of the questionnaire suggested that block contracts with home care providers might be an impediment to greater flexibility in response to individual circumstances. Experience of introducing more flexible contracting arrangements will enable local authorities to be well placed to respond to the forthcoming NICE standards for the quality of home care (Cm 8378, 2012). However, when the survey was conducted block contracts were employed by a majority of authorities.

### *How can commissioners promote quality services?*

The quest for quality in social care services is enduring and has particular importance for home care services as they are required to demonstrate a flexible response to individual need as part of the personalisation agenda (CQC, 2013a; Cm 849, 1989; Cm 8378, 2012). Part of the vision for adult social care services in the 21st century is that they are of high quality, and delivered by a well-trained workforce, whether provided by the local authority, the NHS or another type of provider (Cm 6499, 2005; Cm 7432, 2008; Cm 8378, 2012; Department of Health, 2009d). However, survey findings indicated that whilst most provided home care services within old age mental health services and the intermediate care sector training opportunities for staff working in these settings were limited. Our findings are limited to services commissioned by local authorities but present a mixed picture in respect of specialist training for home care workers within the old age mental health and intermediate care sectors.

First, with regard to the provision of specialist dementia care training, whilst **Figure 1** indicated that was widely available, **Figure 2** indicated that its provision was less frequently specified as a requirement within the contracting process. The discretion accorded to providers with regard to the provision of specialist dementia training is of concern in the light of findings from a study of a similar sector of the workforce in care

homes. This revealed that although staff knowledge of dementia was reasonable, confidence in dealing with related situations was lower, although training could positively influence confidence in dealing with behaviour related with the condition (Hughes *et al*., 2008). Arguably, such training would be even more valuable to home care staff who often work in isolation with users in their own homes, particularly those employed in those home care services specially commissioned to provide support for older people with mental health problems. More generally it has been noted that when home care staff understood people's illnesses they were better able to provide appropriate support and that training may aid the recruitment and retention of care workers thereby promoting a higher standard of care for older people (CQC, 2013a; Chester *et al*., 2013).

Second, despite the fact that the majority of local authorities commission home care specifically to provide intermediate care, our data suggests that the training needs associated with this appear not to be reflected in the commissioning and contracting processes for home care, perhaps because they are not as readily identified as, for example, the need for dementia care training. The exception to this is the provision of training on the care of stroke victims, but this does not fully address the multiplicity of needs likely to emerge from home care staff providing care to vulnerable older people with undifferentiated clinical problems. Contract monitoring by commissioners is additional and complementary to the regulatory role of the *Care Quality Commission* but it has rarely been addressed in either policy guidance or literature. However, it provides a means of dialogue to overcome the often reported barriers to staff in independent home care agencies accessing training and the setting of realistic staff training targets (Balloch *et al*., 2004; Francis & Netten, 2004; Timonen & Doyle, 2007). The monitoring of this is important because it can be construed as an indicator of the development of a more personalised service. Our findings suggest that the degree of detail in contracts may provide the basis for their monitoring and for a more adequate ongoing dialogue between the commissioner and provider. This would permit local performance to be benchmarked against the national picture with regard to, for example, the provision of induction training, an important but often neglected issue (CQC, 2013a; Skills for Care, 2012).

## Conclusion

In this paper findings of a national survey of commissioning arrangements for home care are reported. These are placed in the context of previous evolution of the service and plans for future development as identified in national policy guidance. Arrangements for commissioning and service delivery will have evolved in the interim. Nevertheless, the implications of the findings remain relevant because they provide a benchmark of practice at the inception of the changes designed to promote more personalised services and, in the context of this transformation agenda, evidence of commissioners anticipating policy directives. This momentum is a good omen for the continued service development which has characterised the home care service over time. Furthermore, study findings suggest that four aspects of the policy agenda relating to the commissioning of home care services are particularly important and could usefully be a focus of attention for commissioners. First, the development of partnership working between health and social care agencies to promote a more integrated approach to service commissioning around a local authority or clinical commissioning group (Cm 8380, 2012). Second, the specification for and monitoring of the uptake of training by hands on care staff within the contracting framework (Cm 8378, 2012). Third, greater involvement of providers within the commissioning and contracting processes (Department of Health 2008; 2010). Fourth, commissioners should regularly appraise their contracting arrangements for home care. This should include the review of the type of contract

employed and take account of nationally determined social care outcome measures (Department of Health, 2012). For the regulators, the research findings highlight the importance of ensuring that appropriate training is available to ensure service user needs are met by competent staff. Prior to the introduction of the community care reforms, there was an acknowledgement that community care was not a cheap option and twenty years later, this remains the case (Griffiths, 1988). An enduring challenge for the public sector is to provide value for money and respond to ever increasing demands for assistance both in terms of content and quality of the home care services which it commissions.

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