

Leicester City Council Scrutiny Review

Domiciliary Care

A Review Report of the Adult Social Care Scrutiny Commission

May 2014

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Adult Social Care Scrutiny Commission

Commission Members:

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Councillor Dawn Alfonso
Councillor Luis Fonseca
Councillor Rashmi Joshi

Councillor Lucy Chaplin (Vice-chair)
Councillor Rob Wann
Councillor Ross Willmott

Chair's Foreword

This review has been long in the making. The decision to carry it out was a response both to members' personal experience and to disturbing reports in the media about standards of domiciliary care which did not respect the physical, emotional and social needs of elderly and vulnerable people. We wished to investigate the quality of care given, and to see if there was a connection between this and the conditions of services for carers.

At the time, the council was in the middle of a procurement exercise to find private providers, and it was felt that conducting a review in these circumstances and with this particular focus would prejudice the outcome of the procurement exercise. The commission agreed to delay the review and to change its focus to look at the outcome of the tendering process and how future tendering exercises might be improved if necessary.

Once the review was underway, obstacles to collection of evidence were presented: the majority of providers were unwilling to meet with me to answer questions; and officers advised of the risk of betraying confidentiality if actual visits by carers were observed. In spite of this, clients, members of their families, and some private providers responded to requests to give information; and it was possible to take evidence from clients, carers and managers; to talk with recipients of domiciliary care; and to observe care given during a home visit.

The general picture did not inspire confidence, with negative experiences outnumbering positives. In these times of austerity, it is fiscally impossible at present for the council to run its own service so as to ensure high standards of care; but the recommendations of the report lay out a possible path to follow. In improving the lot of people who need domiciliary care, we are each and every one of us attempting to safeguard our own ability to stay healthy at home, at a time when demographics are indicating real and serious challenges in funding humane and effective care for the elderly.



Councillor Dr Lynn Moore
Chair, Adult Social Care Scrutiny Commission

1 Executive Summary

1.1 Background to the Review and Key Findings

- 1.1.1. With national reporting showing that there had been a failing on the quality of care for older people and also poor terms and conditions for staff, the commission used the review to explore what the local picture was.
- 1.1.2. Whilst the review found that the procurement exercise was thoroughly conducted, concerns were expressed that there was not enough focus on procuring solely from not-for-profit organisations. It is hoped that this would be considered in future tendering processes.
- 1.1.3. It was heard that all providers were moving towards phasing out 15 minute visits with 30 minutes being the smallest allocated time. This was endorsed by the commission as it was felt that 15 minutes did not allow adequate enough time to provide enough quality care.
- 1.1.4. Evidence heard by the commission painted an alarming picture for care staff with poor training, poor wages, lack of support, no travel costs and inadequate user information being cited as some of the problems they face. This inevitably throws light on why there is a high staff turnover in the domiciliary care sector. In turn, this leads to difficulties when allocating staff to clients so that care users can face frightening uncertainty as to which worker will be visiting them. Whilst all staff may provide quality care, the evidence heard indicated that users need the continuity which is the foundation of a positive, reassuring and trusting relationship with their carers. A policy which has to pursue issues of cost as a priority can actually jeopardise the wellbeing of service users and may not be giving best value for money.
- 1.1.5. The Unison Ethical Care Charter was cited as a good benchmarking tool for offering good quality care and conditions for staff. The commission felt that the council should sign up to this and also encourage providers to do the same whilst acknowledging that this couldn't be enforced.
- 1.1.6. Reassurance was given that there was a robust quality assurance framework (QAF) in place to ensure good quality of care from all providers with leverage for action to be taken from the council where this was not the case.

1.2 Recommendations

The Assistant Mayor for Adult Social Care and the Executive are asked to consider the following recommendations:

- 1.2.1. The phasing out of 15 minute visits is endorsed. The commission asks that an update comes back to the commission to ensure that all providers have ended them.

- 1.2.2. Future procurement exercises should have a greater focus on not-for-profit organisations where the primary aim is on the quality of care over financial profitability.
- 1.2.3. The council signs up to the Unison Ethical Care Charter, encouraging other providers to do the same. Whilst this can't be enforced, the council can try and persuade providers of the benefits of this to deter the high turnover of staff and the effect of that on users.
- 1.2.4. The commission to receive contact management progress reports including customer satisfaction surveys, complaints and audits of providers on a regular basis.

2 Report

2.1 Background

- 2.1.1 Nationally there is a great amount of focus on the care sector and in particular on domiciliary care. The commission is also aware that domiciliary care staff working for the private sector seem to be paid considerably less than council staff.
- 2.1.2 With these issues in mind the commission felt it was necessary to complete a review to look into the quality of domiciliary care provision in the independent sector; and to consider whether there is a link between conditions of service and levels of pay, staff morale and the quality of care given.
- 2.1.3 Initially the commission had also hoped to look at what could be included in new contracts with care providers as part of the tendering process but the tendering process had already begun. As such the commission changed the scope of this to look at how successful the tendering process was and the outcome of it and how future tendering exercises might be improved if necessary.

2.2 Tendering Process for Contracts with Domiciliary Care Providers

- 2.2.1 The commission heard that the new contracts for domiciliary care provision began in October 2013. 14 contracts were issued including to six new contractors for Generic Domiciliary Support Services. Four specialist contracts were also awarded. In order to maintain controlled management of providers, a reserve list of providers had been compiled. Therefore, if one of the main providers was unable to provide the package of work awarded, one of the providers on the reserve list could be used
- 2.2.2 The process of tendering was explained to the commission and it was mentioned that the percentage scores from each mandatory section of the tender document were totalled for each bidder. Quality was then weighted at 80%. A test also was completed by each bidder. Service specifications

were compiled based on the requirements of the Regulator and of the Council.

- 2.2.3 The commission had concerns about the number of people employed by care providers. It was recognised that care workers tended to be a transient work force, but the Commission was informed that the contracts being operated were not block contracts. Each new care package was offered through a mini tendering exercise, so each package would state the minimum number of staff required for that particular element. The Care Quality Commission did not set minimum numbers of staff required.
- 2.2.4 At the pre-qualification stage of letting the contracts a full financial assessment was undertaken. This provided reassurance that providers would only take on the number of care packages they could provide. Although it was very unlikely to disrupt care if a large number of staff left a particular provider, there was provision in the contract about the action that would be taken if a large number left or were ill simultaneously.
- 2.2.5 There also was provision in the contract for the Council to suspend a provider from the framework or terminate a package of care, but in practice this would be very unlikely to happen, as contract monitoring would enable action to be taken before it reached this stage.
- 2.2.6 The commission felt that there should have been more emphasis on tendering to not-for-profit organisations where the primary focus is solely on providing quality care and not on making profits.
- 2.2.7 Overall, the commission felt the procurement exercise was conducted thoroughly with a good framework of providers in place.

2.3 Quality Assurance

- 2.3.1 The commission sought assurances that all of the tenders invited were from providers recognised as being of adequate performance, as recognised by the Care Quality Commission (CQC). The CQC assessments were considered as part of the selection process, and it was confirmed that domiciliary care is a regulated service and CQC monitor and inspect services and alert the City Council if they have concerns. A Quality Assurance Framework (QAF) was built in to the domiciliary care framework.
- 2.3.2 The commission asked whether any form of “mystery shopping” was done. Officers informed that telephone consultation began on 27 January 2014 with users of Home Care. It was noted that all 688 service users invited to participate in the survey on Home Care Services had responded. Most of the responses returned were of positive feedback about the service.

- 2.3.3 Whilst acknowledging the survey returned mostly positive responses, concerns were expressed that there appeared to be a very low variation in the data, particularly in the number of “Always” responses. Officers advised the Commission that the questions asked were taken from the quality assurance framework for the service. This was the first time that these questions had been used, so they would be adapted as assessments were made of whether the right questions were being asked. In the meantime, the results would be cross-checked with other feedback, to ensure that it corresponded. The next stage in the process is to scrutinise the results of the survey with providers, to establish where improvements were needed.
- 2.3.4 Requirements of the QAF as the mechanism to monitor contracts with providers ensured regular undertaking of customer satisfaction surveys and regular audits to ensure adequate levels of training, care and safeguarding. Copies of the training matrix, staff supervisions files and evidence of certification are all checked via the QAF process.
- 2.3.5 It was confirmed that all providers would be undertaking the QAF audit by the end of the calendar year. The requirement to ensure that information on the levels of care being given, as received from the carers themselves, was reiterated as an important part of that process.
- 2.3.6 The ABC assessment rating was explained where level A shows they are exceeding expectation, at level B they are performing over and above and at C they are meeting the contractual obligations. The ladder of intervention policy would be implemented if a provider fell below level C including relevant timescales for revisits and evidence. Should a provider still fall below the minimum level C, suspension and termination from the framework could result.

2.4 Care Workers Terms and Conditions

- 2.4.1 Members questioned whether there was a relationship between terms and conditions and quality of provision, and whether people stayed in a job longer if they were paid more. It was recognised nationally that obtaining contracts at the lowest price had the effect of driving down wages and could also have a serious impact on quality of service provided.
- 2.4.2 It was heard that if a service user was difficult, or refused to accept care, or the care provider felt unable to continue to provide care for someone, the Council would work with the user, and their family if appropriate, to manage such situations. The Council’s statutory duty to provide care and support would remain, but carers could not be required to work with an individual in these situations. If this developed to the extent that an agency could not continue to provide a person’s care, alternatives could be examined, such as establishing a tailor-made service from the user’s personal budget, or linking the user to a personal assistant.

- 2.4.3 Home carers could support users' very specific needs and could identify issues that prevented adequate care being given, (for example, if there was inadequate hot water in a home). When the things that were important to individual users were understood, it was usually possible to work to accommodate them. Service contracts stipulated that employee training and development work had to be carried out by suppliers to enable carers to work with these situations.
- 2.4.4 At some authorities, trades unions had negotiated an agreement that zero hour contracts would not be allowed and this included external providers. The commission agreed that this approach should also remain in the city.
- 2.4.5 It was also considered that care providers should be given information about any potential difficult clients from the Council, to prevent problems resulting from staff being sent to difficult situations. It was accepted that an increase in the information available to them could prevent problems for carers, leading to better staff retention. A copy of the care plan is sent to providers, so they have the relevant information including risk assessments, to understand the needs of a client before providing care.
- 2.4.6 The minimum time to be allocated to each visit was now 30 minutes, but many service users would have much longer visits. The change from a minimum 15 minute visit was endorsed by the Commission.
- 2.4.7 Approximately 6% of users had 15 minute visits allocated to them. However, these could be part of a package that included other visits on the same day of different durations. Work was underway to phase out 15 minute visits over the next 12 months, as users' reviews were completed.
- 2.4.8 Currently, the only in-house care service was the Reablement Service and that team does not use 15 minute calls.

2.5 Case Studies

- 2.5.1 The commission were keen to ensure that as well as evidence from key literature and officers, the voices of those in the industry and family members and users were also heard. As such a media appeal was made for people to come forward. Two responses resulted and can be found in Appendix B. As well as this, the Chair asked that providers with council contracts be contacted and asked whether they would be willing to arrange for her to observe some visits. Officers expressed concerns about issues of confidentiality but agreed to contact providers to request these visits.

Of these 21 providers, 9 did not respond. Of the remainder, 4 said they had no Leicester City clients at the time, 2 said it was inconvenient but were happy to meet at a later date, 2 did not wish to arrange an observed visit, but were happy to meet for a discussion instead; and 4 were happy to arrange visits. In the event, the Chair met with two middle managers from a provider. A visit to another provider was postponed then cancelled. She also visited an extra care facility to talk to providers; and was invited by a colleague to observe a visit to his wife. Two constituents of the Chair gave feedback to her about their experiences. Notes of these contacts are provided in Appendix C.

2.5.2 As well as this the husband of a client receiving domiciliary care attended a meeting of the commission to give his own evidence. He advised the Commission of the care required for his wife and the decision made by the family to take up a direct payment, so they could choose the domiciliary care provider themselves to deliver the care package.

2.5.2.1 It was reported that a converted room had allowed for proper implementation of the care plan, although difficulties with some care providers had been experienced, particularly with the turnover of carers visiting his wife. The relationship between staff was also considered important when working together and having handovers, as his wife was very sensitive to anything but the gentlest handling. The Commission noted the requirement for care providers to ensure, as much as possible, that consistency was maintained in the carers being sent to individuals. This was also noticed by the Chair at the visits she undertook also emphasising this requirement that if changes were necessary, prior notice should be given.

2.5.2.2 He stated that the greatest difficulty he faced was in accessing the service and it was only because he knew people in the service that he knew the correct avenues to follow to ensure that his wife received the correct level of care.

2.5.3 An ex-carer (retired in 2011) also presented written evidence of her experiences in domiciliary care (Appendix D). She highlighted particular issues including poor training and support, little travel time which is unpaid, not enough information provided about clients, an unreliable logging system which did not record hours fully and a bullying culture by companies on their staff.

2.5.3.1 Asked why she had found it necessary to leave the service, she stated that largely it was due to the daily pressures. She considered that during her work she had felt that there had been too much room for major error, and also she personally was not being given enough hours to remain in the profession.

2.5.3.2 The carer was asked if she knew of processes to 'whistle-blow'. She reported that she felt that the opportunity had not been

evident and it was difficult for her to identify whom she should contact in the first instance. The commission was informed that cards with details on how to report any problems in the service were circulated to all carers in February 2014 as a means of enabling carers to raise concerns with the Council or the Care Quality Commission.

- 2.5.3.3 It was noted with concern that a large amount of the problems experienced by the carer had been due to a lack of appropriate training, and that a shadowing arrangement had been considered sufficient. The requirement to ensure adequate monitoring of care providers was expressed, particularly given the apparent assurances needed in respect of training.
- 2.5.4 The commission was informed that there was a robust QAF in place with regular checks of providers as described earlier in the report. It was hoped that this would be a deterrent from any of the issues experienced by this ex-carer occurring under the current contractual agreements.

2.6 Conclusions

- 2.6.1 The procurement exercise was conducted thoroughly and to an acceptable standard, with the use of questions designed to collect qualitative and quantitative data.
- 2.6.2 The highly positive data about experience of care collected from a survey was not borne out by most client accounts. This raised questions about the methodology used. Although one could argue that clients who have had a negative experience have a motive to report it, and may be in the minority, their evidence confirms the reports quoted in Unison's survey of home workers (Appendix A).

Of particular concern was the pessimism of the two middle managers who reported that many visits of 15 minutes only were still taking place; that staff turnover was a major cause for concern; and that they felt that the conditions of service offered (no pay for time travelling between appointments, a digital method of calculating hours worked, no time for allowed for basic admin) was not conducive to high morale and made their task of managing the organisation difficult if not impossible. Their concern for their clients was clear; and an inability to provide adequate care was blamed on the policy of the organisation which reduced overheads by paying low wages.

- 2.6.3 Those workers who did not have to travel between clients (i.e. were based in an extra care facility) expressed the most job satisfaction, despite low wages. The two care workers whose visit was observed by the Chair, expressed similar satisfaction as they lived locally and were able to walk to the client's house; but repeated the criticisms expressed elsewhere when they had to drive to clients.
- 2.6.4 Clients who were able to manage their own affairs, or who had supportive family members were able to "shop around" and find a good provider; but the commission were concerned that more vulnerable and lonely clients might be at risk.
- 2.6.5 Accounts from several clients reported unacceptable practice and inefficiency bordering on dishonesty from providers.
- 2.6.6 It can be argued that low costs of domiciliary care lead to imperfect service, which does not always guarantee sensitive, respectful, humane and adequate care.

3 Financial, Legal and Other Implications

3.1 Financial implications

To be completed

Rod Pearson, Head of Finance ASC, Public Health & Housing

3.2 Legal implications

To be completed

Pretty Patel, Principal Solicitor, Social Care and Safeguarding

3.3 Equalities implications

To be completed

Irene Kszyk, Corporate Equalities Lead

4 Useful Links

Unison Ethical Care Charter

<http://www.unison.org.uk/upload/sharepoint/Research%20Material/Final%20Ethical%20Care%20Charter%20PDF.pdf>

UKHCA – An overview of the UK domiciliary care sector

<https://www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf>

Care Quality Commission (CQC) – Not just a number

http://www.cqc.org.uk/sites/default/files/media/documents/9331-cqc-home_care_report-web_0.pdf

5 Summary of Appendices

Appendix A – Headline Information from Key Reports

Appendix B – Response from Media Appeal

Appendix C – Char's Visits to Domiciliary Care Facilities

Appendix D – Experience of an ex-care worker

6 Officers to Contact

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Scrutiny Support Officer
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Headline Information from Key Reports

1. UNISON's Ethical Care Charter

The Charter was initiated by Unison after they had conducted a survey of homecare workers. The feeling was that many reports had been produced to be critical of the services provided without the views of homecare workers so the survey was intended to address the imbalance. There were 431 responses. Some of the key findings are as follows:

Key Finding	Outcome
79.1% of respondents reported that their work schedule is arranged in such a way that they either have to rush their work or leave a client early to get to their next visit on time.	The clients don't get the service they are entitled to
56% of respondents received between the national minimum wage of £6.08 an hour (at the time of survey) and £8 an hour.	Low pay leads to a high level of staff turnover as workers cannot afford to stay in the sector. Clients have to suffer a succession of new care staff.
36.7% of respondents reported that they were often allocated different clients.	This doesn't allow continuity and affects the ability of clients to form relationships with their care workers, which is especially crucial for dementia sufferers.
Although most respondents had a clearly defined way of reporting concerns about their clients' wellbeing, 52.3% reported that these concerns were only sometimes acted on.	This highlights a potential major safeguarding problem.
57.8% of respondents were not paid for their travelling time between visits.	Potentially breaches the minimum wage law and eats away at already low pay.
Over half of the respondents reported that their terms & conditions (pay, adversely changed hours and given more duties) had worsened over the last year.	Race to the bottom mentality (competing to offer the cheapest and least conditions) in the provision of homecare services.
Only 43.7% of respondents see fellow homecare workers on a daily basis at work.	This isolation is not good for morale and impacts on the ability to learn and develop in the role.
41.1% are not given specialist training to deal with their clients specific medical needs, such as dementia and stroke related conditions.	This could lead to medical errors which are detrimental to the client.

Ethical care charter for the commissioning of homecare services

Stage 1

- The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
- The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients
- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
- Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
- Those homecare workers who are eligible must be paid statutory sick pay

Stage 2

- Clients will be allocated the same homecare worker(s) wherever possible
- Zero hour contracts will not be used in place of permanent contracts
- Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing
- All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)
- Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation

Stage 3

- All homecare workers will be paid at least the Living Wage (As of September 2012 it is currently £7.20 an hour for the whole of the UK apart from London. For London it is £8.30 an hour. The Living Wage will be calculated again in November 2012 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract
- All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

2. UKHCA – An overview of the UK domiciliary care sector

UK Home Care Association summarise headline statistics on the homecare sector in this report. The data is split by each country in the UK.

Headlines from the report are as follows:

Headline	Outcome
Contract prices offered by local authorities often fail to keep pace with inflation and other statutory burdens on employers, prioritising cost over quality.	Cheap contracts at the detriment of the service provided.
41% of people receiving homecare in 2011-12 received intensive support (more than 10 contact hours and 6 or more visits during the week) compared to just 22% in 2002.	Increase in the intensity of care for clients.
Increasing numbers of people need or choose to fund their own care.	Eligibility criteria means less people will be entitled to state funded care.

3. Care Quality Commission (CQC) – Not just a number

The CQC carried out a themed inspection programme of the quality of care provided to older people in their own homes. It looked at whether people receiving care at home are treated with dignity and respect, are supported by skilled staff, have choice about their care and benefit from processes that are meant to keep them safe. The report summarises the inspection which sampled 250 home care services of different sizes providing care to more than 26,000 people. Overall the report found that 74% of services met all the standards inspected. CQC's overall concerns related to:

- Respecting and involving people who use services
- Lack of continuity of care workers
- Limited information to people about the choices available to them
- Failures to keep people informed about changes to their visits
- Poor training opportunities and support for staff

This is divided as follows:

The care and welfare of people who use services	Missed or late calls and inconsistent weekend services
	Lack of staff knowledge and skill, particularly with regard to dementia
	Inadequate assessment of needs including reviews and updates
	Lack of detailed care plans including choices and preferences and complex care needs
	A lack of coordination of visits requiring two care workers
	The lack of involvement of family or other carers
Safeguarding people who use services from abuse	Failures to report safeguarding concerns in line with local policy
	Out of date procedures and staff not understanding safeguarding or whistle-blowing procedures
Supporting staff	Staff feeling unsupported by their management teams and not always being able to deliver care in the right way because they are too rushed, with no travel time and unscheduled visits added to their day.
	A lack of planned supervision and performance monitoring for staff.
	Training needs not being identified or if they are identified, not met.
	Staff not being confident in using equipment.
	Induction not always being completed, or not following recognised standards and not monitored.

Response from Media Appeal

Case 1

I have a neighbour who has no family; she is over 80 years old and has been housebound for some years now. Any friends she had have died or are unable to visit. The system that operates in the City at present does not seem to be set up to deal with the situation of someone without friends and relatives to care for them. I understand she pays for carers to attend 2 or 3 times a day but they often end up on my doorstep asking me to help with something which they are not permitted to do themselves. We have tried to help by organising a gardener to do work for our neighbour but although the price was reasonable and had been agreed beforehand she was very slow to pay them. I have been reluctant to help organising any further work for her and feel it would be good if there was someone independent who could act on her behalf to keep her home in order, as she is unable to do this herself.

I have been asked to pick her up if she has fallen as the carers are not allowed to do this on their own. I have been asked to change light bulbs as the carers are not allowed to use the ladder. I have been asked to find a gardener, a plumber, an electrician, supply a multi-socket extension cable to the man who had been asked to move the care line box into another room. Recently she was taken to hospital and I was asked to take some clothes for her as apparently the 3 person ambulance crew who took her into hospital are not permitted to pack a bag for her. I only found out she had been taken into hospital when the hospital staff phoned two days later, one of her main carers also knocked on our door to ask where she was as she hadn't been informed either. I did ask the hospital staff if the carers would have been informed and they told me that this would have happened, clearly it did not happen.

The care staff would like her to go into residential care but the lady concerned has not wanted to move from her home so they are unable to do anything but to continue to care for her there as best they can.

Case 2

I am a working carer for a number of people. Only one of them resides in the City. My mother resides in the City and her experiences of domiciliary care have been mixed. I think it is important to state that my other relatives (who live outside of the City boundary) have had poor experiences of domiciliary care, particularly in relation to commissioned 15 minutes visits. All these type of visits allow is a quick hello, do you want a drink and sandwich?, a medication prompt. Is your personal alarm at hand ? and a note in the care log saying all is well on leaving – that's not quality care.

Currently, my mother employs a personal assistant to provide her with support with her shopping and cleaning and personal care. The individual concerned is reliable and professional and I have no worries that my mother is receiving excellent care whilst I am at work. My mother has developed a rapport with her personal assistant where as previously she was unnerved by the constant changes of new carers.

Previously, she used a company identified via her City Council care management officer. It came to light that the carers employed were stating that they had spent more time with my mother than they actually had and there appeared to be no system check to alert that this financial abuse was taking place. The carers were taking her to shop but doing their own shopping on her time and were constantly on their mobile phones. On one occasion, the carer said she was late as she had been applying for some immigration documentation. The carers' notes were incomplete and on reviewing the notes it appeared to me that the notes were copied from those above on a constant basis.

My mother did not raise these issues with me for some time as she felt sorry for the carers who appeared to be vulnerable individuals themselves. We were left feeling that my mother was not being safeguarded and that the carers were being exploited by the company who employed them.

When I contacted the care management team to complain they stated that there had been complaints about the company previously – so why were they still on the list? Where is the initial and continued quality check for commissioned services?

I hope you accept these comments so constructive criticism. Our loved ones deserve the best care possible.

Chair's Visits to Domiciliary Care Facilities

1 Visit to Danbury Gardens, an extra care facility

I met informally with two carers, a man and a woman, and we spoke for about 45 minutes. The man was a graduate and had chosen to do the work, despite low pay, because he had a strong religious ethic to help others. Other members of his family had done care work which he had witnessed. He had been working at Danbury Gardens for two years. The other carer did not divulge this level of information about herself.

I asked them both to describe a typical day time routine. They would visit 4 or 5 residents in their own flats and help them according to their care plans. If necessary, two carers would work together. Care varied from intensive physical care to taking a resident out shopping. Typical activities were sitting and talking with residents ("the best part of the job"), helping them with meals, cleaning the flats and doing laundry once a week. All residents had a lifeline worn on their wrist or around their neck; or used a pulley in their flat. Carers had a mobile handset so they could connect to a flat if the alarm sounded and talk to the resident. Some residents did not have care plans, and lived an independent life e.g. owning and using cars.

Typical hours of work were 7am to 5pm Monday to Thursday and every other weekend; or 7 to 6 with night duty on a Sunday. They are paid £6.30 an hour (i.e. minimum wage) and 6.70 an hour at weekends. They both felt that the pay was too low, but they nevertheless enjoyed the work. The man felt it was a vocation. They are employed by Care UK, whom, they felt, were good employers, offering caring management and prospects of promotion. They compared these conditions of employment with a former work placement, when they only received pay while engaged in a house call.

2 Interview with two middle managers from a private provider

I spent an hour talking to two women managers with one of the largest private providers of domiciliary care in the UK.

They made the following points to me:

- Massive changes are being introduced in terms of length of calls, and this is good as 15m calls are unsafe and undignified. But despite information to the contrary, 15m calls have not yet been phased out and are still being commissioned.
- Clients have extremely complex needs which are often difficult to meet in the time allocated. This causes stress to the carers who are often expected to be nurses – and this has a knock-on effect on recruitment, moral and retention of staff. For example, they often have to cope with stomas, catheters, mental health needs, alcoholism, verbal abuse and sexual comments.
- Carers are expected to be virtual social workers and mental health workers. If members of the family are not involved, they also have to make GP

appointments. This seems to be taken as given by social services departments.

- The company met with a representative of Leicester City Council to discuss the framework and difficulties faced by providers. For example, the form which has to be completed for a client is inappropriate and it is impossible to make a safe match between client and carers. They have offered seven possible packages but all were declined, with no reasons given. They felt that departments weren't talking to each other.
- No feedback is given so how can they recruit and meet demands?
- In the last 18 months, the biggest issue is a hike on fuel. They can't afford to employ drivers and can't afford to pay workers when they are in their cars. They pay mileage at .25 a mile (less than the inland revenue recommended rate). If a carer is travelling from one house to another during rush-hour, they may only be travelling a few miles, but consuming petrol while in queues.
- The council is not forthcoming with information. For example, they agreed to care for a man but were not told that the house was so riddled with bedbugs that it had to be fumigated.
- There is a better ethos in the 3rd sector, which pays staff more, so better quality of staff, who stay longer, have high morale. But because not-for-profit organisations are dearer as a result, they don't get contracts.
- LCC is the worst payer out of LLR.
- Carers should be promoting independence in their clients but this means longer visits.
- Pay is calculated per 15 minutes. They log in when they arrive by phone. If they work for 24 m (i.e. less than 30 minutes), they only get paid for 15 minutes. Phones vibrate when the time is up. If a member of the family arrives and wants to do something for the client, then the carer has to leave...and so earns less. This doesn't encourage honesty.
- The amount of pressure and responsibility carried by carers is making the industry suffer. Care should be "dignified, timely and respectful". Carers can be expected to bath someone, dry them, get them into bed, clean up the bathroom within 30 minutes, then drive to the next client. There is no factoring in of time taken to get into the house, look at paperwork, meet the family, park the care, feed the meter if there is a parking fee, and record the visit.
- The Dale Project, based in Melton Mowbray, ran for three years, then ran out of funding. It was run in conjunction with a district nurse, who set up a proper care plan within 24 hours, which was precise, put the emphasis on dignity, provided appropriate equipment, gave nursing input, and generally made time for all involved to work together.

3 Visit to a home to meet and observe care workers

I was invited to go to the home of a colleague with a severely disabled wife, who has been receiving high level care for twenty years. They both agreed that I could observe a visit from her two carers.

The two women arrived within a few minute of each other. It was clear that they had a good, warm and informal relationship with the couple, being on first name terms. They carried out physical care: washing and changing their client, then helping her

eat her sandwich lunch. They were gentle, efficient, thorough, and co-ordinated their actions so the client had minimal discomfort, maximum dignity.

When asked they felt they had enough time on each visit to provide good care. Visits varied between 30 and 75 minutes, four times a day. On the first visit, in the morning, they get their client out of bed, help with toilet, give her a full body wash, dress her and get her breakfast. At lunchtime, they change her pad and make lunch. At teatime, they make her tea and sit and talk with her. At bedtime they get her ready for bed. For all their clients, they are paid by the hour, ring in when they arrive, ring when leaving. Sometimes they have problems logging on. They are paid minimum wage. Managers can vary in helpfulness.

I talked to the husband, who was very satisfied with the care given his wife by these particular two carers. The city pays £2048.41 to the provider for this care. He has arranged this care himself and has made physical adaptations to the home to accommodate his wife's needs. He stressed how distressing it was to his wife if strange carers arrived without notice, particularly after dark, as she is very sensitive to pain. Hence his satisfaction with the two current carers, who have been able to form a good relationship with the family.

4 Conversation with elderly person

During a conversation about several matters, one of my constituents, aged 101, was keen to tell me (unsolicited) about his recent experience of domiciliary care. He has lived independently for many years and has only recently accepted care as he has begun to suffer dizziness. He is currently receiving free care for six weeks, then will choose his own carers and pay from his personal allowance. He likes to get up at 8am but despite his request, the earliest anyone has arrived has been 9.20, as a result of which he has missed his weekly bridge sessions, and hasn't been able to come to my drop in surgery once a fortnight, which he enjoys. He has never received the same carer twice. One morning, a woman arrived and told him that she was going to wash his hair and shave him. He asked her to fetch a chair from a bedroom so he could sit at the washbasin in the bathroom. He was upset that she dragged the chair along the carpet rather than lifting it. She said she had to use the shower but it didn't reach the basin so she suggested that she should use a jug. She went downstairs but came up with a saucepan. Despite his suggestion, she didn't use a fresh razor blade, so his face was raw and sore. She didn't replace any of the caps on the shampoo, shaving gel or aftershave gel.

5 email from a constituent about his mother's care

"The firm that was supposedly providing my mum's care was called *name omitted* (*this is one of the private providers who has a council contract*). One very specific example--she was supposed to have a call one Saturday evening. No one turned up and X's system (such as it is) failed to pick up that she hadn't been visited.

We were notified the following morning by the X worker who did the 10 am call. I immediately contacted X who could offer no explanation. I cancelled that evening's visit because we wanted to make sure she got a proper evening meal and some time

with us. I pointed out that I did not expect to be charged for that visit even though I had cancelled within the 24 hours since we were put in the position of needing to do so by X's incompetence.

Needless to say, when I asked for copies of the time sheet from X, we had been billed for that time (or the council had)--and for some other visits that were cancelled with the full 24 hours notice.

DRAFT

Experience of an ex-care worker

Her Job Experience:

June 2010 – November 2011 – domiciliary care work

November 2011 to present – support worker in supported housing scheme. Some residents require domiciliary care workers.

July 2012 – December 2013 – bank staff in nursing home. Completed written course on dementia.

Personal – my mother was wheelchair-bound for 17 years. Had domiciliary care for about 2 months.

Poor training and support

The job was advertised “Experience not essential as we will train you”.

All staff had to complete the written Common Induction Standards within 3 months of starting work. This includes some good information but does not prepare you for the practical job. Some of it is impractical – person-centred care, for example, is unachievable in domiciliary care as there is so little time at each call.

Practical training – I met up with another care worker at the first house on their rota on my first day. I spent about one week shadowing/working alongside this carer and thereafter we were on our own.

I was told at my interview that we would never be sent to someone we didn't know on our own on our first visit to them. The reason for this was that we would not be able to recognise any change if we'd had no previous contact with them. In reality, that never happened – we always had to go to people we'd not been to before on our own, which was upsetting both for the service user and the carer.

Workers were arranged in teams under the overall responsibility of a Field Supervisor. My team consisted of about 15 people all working in roughly the same area. We saw her from time to time but a lot of her work involved visiting service users to check up on care plans etc.

In addition there were On-call Supervisors who were responsible for the daily running of the rotas of over 100 carers and we were to let them know of any problems that arose or if we were running late etc. They did their best but the support they received was very poor and they struggled with the volume of work. I was told at my interview that if I turned up at a house and needed to call an ambulance for someone, the On-call Supervisor would always arrange for my next call to be covered. That never happened because there were never enough staff to allow for that. Sometimes I would ring the On-call Supervisor to ask them to let my next person know I was going to be late, but the message was never passed on. So we were really working without back up.

Each week we received our rota in the post for the following week for our agreed hours, but in addition we were constantly bombarded with texts asking if we could cover extras. We were really “on call” all the time. I bought a second phone exclusively for work use, which I switched off when I’d finished my rounds for that day and only checked intermittently – otherwise the stress of constant texts or phone calls was too much. From the Supervisors’ point of view they were just desperate to cover calls with insufficient available staff.

Rotas – no travelling time

This was my actual rota for a day in 2011. Although I wasn’t working in Leicester City, the principles are the same in all areas and across all care agencies, as I understand it.

0700 - 0745	Mrs H	Double-up requiring two carers
0745 – 0830	Mr N	
0830 – 0900	Mr M	
0900 – 0915	Mrs A	
0915 – 0928	Mr A	
0930 – 1000	Mrs B	
1000 – 1115	Mrs M	Double-up

All calls were in Kibworth but no time was given to travel from one place to the next or to gain access to the property. We were therefore obliged to short-change people on the amount of time spent with them, or run later and later. We were supposed to arrive within 15 minutes either side of the call time. For double calls, two carers working individual rotas are supposed to be able to arrive at the same time!

Rotas were an impossibility – you cannot travel from one place to the next in no time at all. Sometimes calls would be in other places – Fleckney, or even Foxton, Shearsby, East Langton, Saddington, Stonton Wyville. Even then, you were often given no travelling time at all or a very small gap. Traffic was not a particular problem in that area, but for workers in the City it certainly would be.

For service users with dementia, we were told we must stay the full time, but equally were expected to keep to time on our rota.

Call times

Timings of the calls themselves were never sufficient to do the job properly. A call could be as little as 15 minutes. Bear in mind that the carer is probably already running late, has to access the property, log into the phone system, and will have to shave some time off the end of the call to try and make it to the next one in reasonable time. They will also have an impossible amount to do whilst with the service user.

As an example – ¾ hour call. A man with complex issues – overweight, diabetic, breathing difficulties, controlled epilepsy. This involved:

- Accessing the property via key safe.
- Log into the phone system.
- Empty his night bag from his catheter (if it was your first visit there, you may not know how to do that!) and rinse it through.
- He slept in his chair and it took him time to mobilise because of his weight and breathing difficulties.
- Shower & dry thoroughly.
- Creams to apply.
- Get clean clothes and assist to dress.
- Clean up the bathroom, mop floor etc.
- Put washing on.
- Fold and put away any dry washing.
- Wash up any pots that were waiting.
- Get breakfast.
- Get drinks prepared for daytime.
- Empty kitchen bin.
- Pass medicines from dosette box, sign for all meds.
- Record the visit, what's been done and how you've found him in the daily log sheets.
- In addition, there may be extra cleaning up to do if he was soiled/wet.

I could never get it done in the time available and almost every call we were that pressed for time.

Before the care agency could even apply to Social Services for a longer call time, we had to be regularly running over the time by a significant amount. That made an already impossible rota even more impossible.

There was never time for anything to go wrong – if somebody was in a mess and had to be cleaned up for example, or needed an ambulance.

There was never any time to look after people's emotional needs by chatting for a few minutes. That is a vital part of caring for somebody and for their overall health and wellbeing. There has been research done into the impact of loneliness on people's mental health and it is now thought that loneliness significantly increases someone's risk of developing dementia. And yet there is no time to spend even just a moment talking to someone, raising their self-esteem by making them feel cared for and generally giving them a bit of TLC. The Induction Standards talk about person-centred care but frankly, that is pie-in-the-sky in reality. Not having any time at all just to pass the time of day with people is a huge failing in domiciliary care.

We never knew on a day-to-day basis what we might find when we arrived at someone's house but we also weren't given sufficient information when visiting new service users. We didn't get to see a care plan before arrival, so we had to try and skim through it on arrival to gather what we were supposed to do. There wasn't the time to read it in the allotted appointment time.

The care provided by a care agency actually only covers a very small part of that person's needs. Unless everything is in place for a carer when they arrive, they have no hope of achieving their tasks in the time. For example, you have time only to grab the next incontinence pad out of the packet – so who arranges for the pads to be there at all, or who waits in for the delivery? Unless there is good back up from the family, domiciliary care can't work and it can't work for people who have nobody. There are so many background jobs that need doing and just giving somebody a bath takes off very little of the strain.

Lack of continuity of carers

People liked to have the same carer. They wanted to get to know someone and be comfortable with them and be able to establish a peaceful routine. Frequently they would get different carers all the time which added to their stress because they had to keep telling people what they wanted done and how to do it.

The service users are being affected by poor rotas, people not turning up etc. They are supposed to be being cared for but instead they have all this worry put on to them. Likewise for the family; they do not need more stress to be caused by having carers in.

For the carers themselves, it's best to have a small number of service users you know – otherwise you don't know where anything is or what's required of you if you have to go to different people all the time. If the service user is unable to tell you themselves, then it makes it very difficult for the carer.

Medical issues

We were never given proper information about people's medical conditions. The office held the view that it was up to the service user to tell us if they wished. We were going in to people with complex care needs without knowing what we were dealing with. For example, people with MS, stroke victims with paralysis, Parkinson's, dementia etc. To provide proper care we should have been fully trained in the needs of each individual.

Also from the staff point of view, there was the "shock" factor. We did not expect to see such grim and complex needs in the job. Some people would be put off straight away and leave. If you stayed, you certainly had to toughen up to prepare yourself for the sights you would encounter.

Not being told put service users and carers in awful positions, for example, one of our carers strongly tried to encourage a service user to brush her teeth because nobody had told the carer she had oral cancer. Distressing and embarrassing for both parties.

We were rarely told about any issues such as MRSA or C. Diff. The personal protective equipment we had – gloves and aprons – wouldn't have been sufficient to stop us passing something on to the next person on our rota in any case.

Dementia

In my opinion, people with dementia are not suitable for domiciliary care unless they are only in the very early stages. The needs of someone who can't really orientate themselves in the world at all, who can't really remember who their family are, doesn't remember to eat and drink etc are too great to offer effective care in short slots during the day. It must be terrifying not to be able to make any sense of the world you're living in, and it's very important indeed that they have the stability of routine and environment and familiar faces. A string of different carers who don't know their personal routine will increase their anxiety, not help it.

Medication

This is an area where staff can find themselves very vulnerable. We were not supposed to "administer" medication and were only supposed to give them medication contained in a dosette box and encourage them to take it. The problem is some medications e.g. antibiotics, lactulose come in liquid form – we were not supposed to measure it out because we would effectively be doing the job of a pharmacist as we would be measuring the dose. The problem is that many elderly people can't see or don't have the dexterity to do these things themselves. Many people are very confused about their medication and can't remember to take it because of short term memory problems, or they don't remember if they've taken two doses or none at all.

We may also be handling medicines such as controlled drugs without any regulation whatsoever. My understanding is that within a hospital environment or GP surgery, there are strict regulations about the storage and handling of controlled drugs, and yet we were handling them entirely without regulation.

Medication is an area where I felt very vulnerable. The care agency might have rules about us not measuring out drugs etc, but the carers on the ground were often faced with the situation that they either gave the drug anyway or the person simply did not get the medication they had been prescribed because they were incapable of taking it themselves. If they didn't get their medication then there would be consequences for their health. If, however, a carer made a mistake with the medication and a tragedy or accident occurred, there would have been no backing from the care agency because they would say that we had not acted within the company's policies and procedures. That is a terrible position for carers to be put in.

Some people had quite a complicated array of medicines to take. Unfortunately, the lack of time at the calls made it more likely that a mistake might happen. Add to that the fact that it may be someone you've never seen before or go to irregularly and the whole medication issue is an accident waiting to happen.

Logging into and out of phones

We were required to log into the office's call system from the person's phone on each visit and to log out at the end. This was to keep track of where we were, to monitor how long we spent at each call and to register the call so we got paid. This took up time during the call and was unreliable. It was also used as a stick to beat us with if people forgot to log in or out. There was a facility to "retro log" calls but the whole system was unfair and inaccurate. What it really meant was we were not being paid until we were in the property – no account was taken of the time spent entering the property. One day I spent about 15 minutes trying to access the flat of a lady in a warden-controlled building – there was no warden to be found, I couldn't make the lady hear and I had to climb through bushes in the rain to bang on her window to try and wake her up. Another lady was afraid of living alone and would barricade herself in, so we might have to tackle things that had been pushed against the door.

We were also not being paid for any time travelling between properties. So you could start work at 7am and finish a morning shift at, say, midday, - that is, 5 hours' work – but you might only have been paid for, say, 3½ hours because the other 1½ was spent travelling between service users.

Travelling costs

When I first started, we were not paid any travelling costs. By the time I left, a petrol allowance of about 21p a mile had been introduced – way below the government recommended amount. I usually kept to short hours and a small locality but some people did a huge mileage every day. People could not afford to do the job because they were not being properly recompensed for petrol and wear and tear on their car.

Wages

Wages were low – only a small amount above the minimum wage at the time. That is totally unfair, because domiciliary care workers bear huge responsibility. They are dealing with peoples' lives. They could walk into any situation at every call they attend. Someone may be on the floor when they arrive; they have to try and make educated judgments about a person's state of health; when to call in the emergency services; recognise whether someone is deteriorating; recognise things such as symptoms of stroke or confusion that may not have been there the last time they were visited. Sometimes families or spouses could be difficult. All these things are being expected of untrained people working for a pittance.

Zero hours contracts

I know the government is now looking at this. There was no guarantee of work, though in reality we were never likely to be without work. There was a big staff turnover and they were always desperate for people to cover calls. You were more likely to get far too much work than not enough, unless you put your foot down very strongly.

Culture of poor treatment/lack of respect for staff

There is a culture in the domiciliary care sector of employers poorly treating the staff. Apart from being poorly paid and not being reimbursed for petrol, the staff are not respected and they are often badly treated. You certainly have to stand up for yourself. Shortly before I left, I was shouted at for calling in sick one morning and told I'd got to go out anyway. Staff have to put up with rudeness and being pushed around. Many staff did not stay long because the working conditions were so horrible.

Vulnerability of staff

Staff are very vulnerable going into other people's houses in many ways. Some service users are just not nice. Some can be aggressive because of dementia. It is also the only job where I have been subjected to sexual harassment. We also had to suffer the flack for running late.

Carers are also vulnerable to accusations of theft from people who have short term memories and can't remember what they've done with their money. One of my fellow carers was dismissed for that reason – the police took the allegation with a pinch of salt. The dismissal wasn't handled properly by the care agency either and she was told that she would have a strong case at an employment tribunal but chose not to do that because of the costs involved. However, that has ruined her employment prospects. She also knew that she was not well-liked by the management and this is another example of the type of treatment you could expect from a care agency.

Where does the blame lie?

Mostly, NOT with the carers.

I'm sure there are poor carers out there but my experience was that there were very good, hard-working, caring people trying to do the best job they could and with a real heart for their service users. In my opinion, a big part of the blame lies with the management of the companies providing care services. The job can't be done properly without travelling time, and the poor employment culture is just not right.

Some of the blame also must be laid at the door of Social Services, who won't provide the funding for more than the bare minimum of time. Many people I went to could have done with an extra ¼ hour at least.

Ultimately, the government needs to look at the whole system because it is not working either for the service users or the care workers. The idea of care within the home is a good one but it is not working in practice.