Market shaping and the supply of home care for older adults in England: a qualitative study.

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Abstract

Local authorities (LAs) in England have a duty to ensure that there is a wide variety of good quality home care services available for older adults who need them. However, workforce shortages, which are especially acute in rural areas, make this challenging. LAs are expected to participate in 'market shaping', collaborating closely with relevant partners to encourage and facilitate the whole home care market in their area.

The aim of this thesis was to explore how LAs were approaching their market shaping duties and to examine differences between them and between rural and urban settings.

Analysing 117 interviews, I identified three themes: care as a problem (as opposed to an enabler); care as quantity (with 'problems' and therefore, 'solutions' conceptualised in terms of quantity); and market shaping as maintaining dysfunction (with care rushed and unfulfilling and staff pressurised and leaving, creating more pressure for those remaining).

There were exceptions to this where care provision departed from the industry standard model of care agencies contracting with LAs to deliver 'time and task' care. In some predominantly rural settings, LA staff had supported implementation of alternative models. The rural context initially helped reduced resistance from care agencies, many of whom could not deliver services in these settings.

Applying Bourdieu's concepts of field, capital and habitus I suggest that the structures of the home care field encourage care agencies and LA commissioners to engage in reproduction of field rules and regularities. However, some LAs implemented changes which departed from these rules. LA staff actions were key to disrupting expectations and practices associated with a gendered class-based habitus, which might have otherwise constrained carers' access to sources of capital. This enabled paid carers to accumulate economic, social, cultural and symbolic capital in a way which facilitated personalised and fulfilling care delivery.

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Chapter 1 Introduction

1.1 Background to the thesis

My thesis concerns home care for older adults and has its origins in a policy problem identified by local authority staff participating in the Applied Research Collaboration (ARC) for the North East and North Cumbria (National Institute for Health and Care Research Applied Research Collaboration NENC, n.d.). Local authorities in England have a duty to ensure that there is a wide variety of good quality social care services available for people who need them (Care Act 2014; Department of Health, 2023). As part of this duty, local authorities are expected to participate in "market shaping" and this involves the local authority collaborating closely with other relevant partners. These include care providers, "people with care and support needs, carers and families, to encourage and facilitate the whole market in its area for care, support and related services" (Department of Health, 2023: 4.6).

The problem identified by the local authority staff was an inability to secure care to help older adults remain in their own homes (hereafter "home care") in a timely manner for those who were assessed as needing it. Initially this problem was viewed as related to rural contexts where traditional agency providers were unwilling and/or unable to provide care and support services. In a short space of time (a matter of months into my PhD) the local authorities were struggling to secure care in urban areas too. In addition, this problem was not confined to the North East of England and North Cumbria, but was a national phenomenon reaching what some have described as "crisis" (Booth and Wolfe-Robinson, 2021) proportions.

1.2 My motivation for the study

When the advertisement for this PhD appeared, I had relatively recently moved to live at my partner's home in a small village in Wales. We were both retired and had returned from travelling overseas due to the COVID-19 pandemic a few months earlier. Living in the village brought home to me the nature of rural life and the huge constraints which this imposed on villagers. The surrounding countryside was beautiful, and villagers often volunteered to help out fellow villagers when needed. (They also bickered with each other, and relationships were characterised by a range of divisions and antagonisms which at times intruded into village life more generally). My partner had worked for several years

as a volunteer driver ferrying older villagers to hospital and other appointments. The nearest hospital was a 15-mile drive from the village. The GP practice and pharmacy were located in a small town seven miles away, with the closest supermarket even further. Public transport was non-existent and in snowy weather my partner had on occasion been forced to walk to the nearest main road, hitching a ride to the pharmacy and back. The lack of local employment opportunities contributed to young adults moving to urban areas and the village school had closed several years earlier.

My partner's immunosuppressed status meant that he was unable to continue as a volunteer driver. In the context of the village's ageing population, I had not previously given a great deal of thought to the fragility of a system based on voluntarism and goodwill. I wondered how on earth some of the older adults who relied on volunteers would manage in the absence of such voluntarism. But the pandemic meant that those appointments were postponed in any case. Nationally, the pandemic appeared to create unprecedent enthusiasm for volunteering (Mao *et al.*, 2021). Perhaps the sort of mutual support and help which characterised village relationships prior to the pandemic would now spread to urban areas, I thought. Or maybe these arrangements were already present, and I had failed to notice them when I was living in an urban area prior to the pandemic.

I did think, however, about how villagers in receipt of formal care were managing. This was prompted by a PhD advertisement which described sourcing home care for older adults in rural areas as problematic. After months of country walks and washing the shopping deliveries, I had begun to tire of the boredom which lockdown constraints had helped induce. I wanted to do something to engage my brain and focus my energy on a topic which was socially useful and interesting. The prospect of researching older adults, home care and rural communities was very appealing, therefore. The PhD advertisement was very broad, and my immediate task having been accepted on to the PhD programme, was to focus on a manageable area of study.

1.3 Focusing the study

The advertisement mentioned providers, care commissioners and citizens, as well as rural and coastal communities. The prospect of travelling around such communities listening to older adults was very attractive, especially during the summer months. But I had to make

choices about where best to put my energies. I began to immerse myself in relevant literature as part of this process and decided that I would focus on rural communities and local authority activities. This was mainly because so little appeared to be known about this topic. One area where the literature was robust and consistent concerned the impact of national policy on local authority activity. Years of austerity, imposed by national funding regimes had helped to significantly erode the resources available to local authorities (Arrieta, 2022; Bach, 2016; Gray and Barford, 2018; National Audit Office, 2021a). This, combined with the uncertainty which characterised national funding allocations, contributed to difficulties in making long term local authority financial commitments for the home care sector (National Audit Office, 2021b). My prior conception, initially reinforced by the literature was that local authorities were facing an impossible task. It was hard to disagree with Needham *et al.*'s conclusion that "[m]arket shaping requires stability and investment over the long-term" (2020: 7) and both of these were largely absent. But Needham *et al.* (2020) also described a range of approaches at local authority level, some of which they saw as preferable to others.

A large of part of my motivation was a desire to do something useful. I did not want to contribute to the scholarly literature, which according to Tronto (2017) depicts neoliberalism as an undesirable way to organise human society, but regards it as an unstoppable force, nevertheless. Given the clear and consistent message concerning the shortcomings of national policy, I decided to focus on the local level approaches to market shaping. My reasoning was that if some approaches are better than others, then this raises questions about why there should be such variation. I expand on this in the remainder of the thesis, which is structured as outlined below.

1.4 Structure of the thesis

In chapter 2 I review relevant literature and present my research questions. The literature on care is vast and I had to make decisions about what to include in my review. I was conscious in drawing boundaries of the local authority commissioners' desire to learn something that might be of practical use. For example, the member of my supervisory panel who was a local authority commissioner was unimpressed when I raised the topic of care and gender. I had to reassure him that my PhD was unlikely to suggest that nothing could be done unless patriarchy was overturned. My pragmatic approach means that I

have included literature on gender and care, but excluded much of the literature dealing with for example, the ethics and philosophy of care (e.g., Tronto, 1998). The scholarly literature is replete with critiques of neoliberalism (Lane, 2023; Ward 2015). But I have alluded to this only briefly, rather than spending time discussing this topic at length. Similarly, I have largely excluded literature on welfare states and party politics, focusing instead on research which appeared most helpful in explaining the local context. I do, however, acknowledge the relevance of national policy and indicate the constraints this imposes on local decision making.

Chapter 3 describes the study methodology as well as the theoretical framework which provides a conceptual lens for data analysis. It also outlines the ways in which my original study design changed over time and the reasons for these changes. For example, I had intended to undertake comparative case study research in a small number of sites (where a site is a local authority footprint) in England and Wales. Instead, I used online and telephone interviews in a large number of sites and abandoned my aim of using observation as part of my data collection toolkit.

In Chapters 4 to 7 I draw on my empirical data to describe views, attitudes and behaviours of research participants. I also present my interpretation of these based on my data analysis of a large number (n=117) of interviews. Chapter 4 concerns local authority staff and related participants. In Chapter 5, the focus is on administrative and managerial staff employed by, or sometimes owning, provider agencies. Chapter 6 is concerned with paid carers working as agency employees, including some who have left the sector altogether. Chapter 7 focuses on forms of care delivery which differ from the "industry standard" (Burns *et al.*, 2023) model. Most of that chapter is about individuals who were working in a self-employed capacity. It also includes (limited) data pertaining to self-managing teams and small organisations, whose operations and mode of service delivery differ from those of larger agency providers.

I discuss my claims in chapter 8, and I also use a theoretical framework to add to my thematic analysis which informed chapters 4 to 7.

Chapter 9 comprises brief concluding remarks. Mindful of Tronto's (2017) comments, I focus on what can be done, rather than engaging in mere critique. Yet I have deliberately

avoided including a list of simple (or simplistic) recommendations (e.g., more money, more training, better career structures for paid carers) for action. Instead, in the final chapter, I consider how my findings relate to theory and practice, as well as highlighting areas for further research.

Chapter 2 Literature review

1.1 Introduction

In this chapter I review relevant literature and present my research questions, which arise from gaps that I have identified in that literature.

1.2 An ageing population

In the UK, as in many other developed economies, improvements in life expectancy and a decrease in fertility have contributed to changes in the population age profile (Office for National Statistics, 2018; United Nations, 2017). Overall, the population is ageing, but age profiles vary across the UK. In part, this is due to decisions people make about where to live. However, it is important to note that the ability to make these choices is not widely available across the income spectrum (Public Health England, 2019; Scharf *et al.*, 2017). The study of residential choices of older adults has a long history (e.g., Wiseman, 1980) and there is a considerable volume of research on the topic (Sharma, 2018). This suggests that residential preferences vary according to an individual's stage of life (Evandrou, Falkingham and Green, 2010). For older adults, being close to countryside and green spaces is much more important than for younger adults (Thomas, Serwicka and Swinney, 2015). The former are also more likely to be retired and to have no dependent children. Factors such as proximity to the workplace, schools and childcare are much less important than for younger adults, therefore (Thomas, Serwicka and Swinney, 2015). The result of migration behaviours is often that older adults are geographically separated from their extended family (Green and Canny, 2003). In rural areas, the disproportionate outward migration of young adults and inward migration of older adults (Local Government Association and Public Health England, 2017) may mean that they are also geographically separated from much of the workforce which provides care and support to adults in their own homes (Hart and Lavis, 2017; Hall *et al.*, 2017; Whitty, 2023).

The majority of older adults want to stay in their own home as they age (Roy et al., 2018), but physical and cognitive impairments may mean that they need support to do this. Ageing in place is a policy goal in the UK and beyond (Wammes et al., 2024) which aims to enable older adults to remain living in their community, rather than moving into residential care (Oswald et al., 2011). Often ageing in place is viewed as synonymous with enabling adults to remain in their home. However, 'place' also includes the wider

neighbourhood in which one's home is situated. Remaining in one's home is viewed as preferential to 'unhomely' (Stones and Gullifer, 2016) care home living. The fact that it is less costly than relocating may also explain why it is attractive to adults and policy makers alike (Marek *et al.,* 2012). Whilst "ageing in place" (Sixsmith and Sixsmith, 2008) is viewed as desirable by citizens and policy makers (Boaz, Hayden and Bernard, 2009; Department for Communities and Local Government 2008), the ageing of the population is likely to result in increased need for home care services to enable this to happen (Hu, Hancock and Wittenberg, 2020).

1.3 Care and care work

Care has been defined in various ways and this reflects, in part, the fact that care contexts differ (Bowden 1997). For example, care involved in parenting is likely to involve strong emotional bonds between parents and children (Ruddick, 1989). This is not necessarily the case for paid care work. It is important to distinguish between caring for and caring about (Noddings, 1984: Held, 2006), since care goes beyond mere concern for others. Some definitions of care describe it as being a practice. In contrast to a set of individual actions, practice develops over time, along with its appropriate attitudes (Held, 2006). Linked to this, the practice of care has been defined as responding to "need". ''Caring for is the meeting of the needs of one person by another person, where face-to-face interaction between carer and cared-for is a crucial element of the overall activity and where the need is of such a nature that it cannot possibly be met by the person in need herself.'' (Bubeck, 1995:129). However, assessment of need is not necessarily straightforward in relation to care generally and for home care specifically (Equality and Human Rights Commission, 2011; Tronto, 1993).

It has been suggested that care can be understood as a virtue (Slote, 2007), but this word has been seen as obscuring the fact that care is labour (Held, 2006) and implying that care comes naturally to women (Steyl, 2019). (I discuss this further below when considering care work, gender, ethnicity and class). Care has also been defined as a 'cluster of values' (Held, 2006: 4). The concept of values indicates that it is possible to make judgements about what constitutes good care. This implies that care involves some level of skill and competence and that it is in some way effective (Fotaki, Islam and Anotoni, 2019). However, assessing effectiveness raises questions about how this is to be judged and from

whose perspective (Keeling, 2014). In a context where care is treated as a commodity, measuring effectiveness might imply standardised approaches, which fail to reflect the fact that care recipients are not standardised beings (Lynch, 2021).

Many commentators agree that care is a relational concept (Lynch 2021, 2023; Herring, 2019), with good care involving two-way interaction (Lindemann, 2003) and engagement of caregiver and care recipient. It may be true that "a recipient's capacity to receive affects a caregiver's capacity to provide" (Ruddick, 1998: 3). But the nature of caring relationships has been interpreted in different ways by different authors (Fotaki, Islam and Antoni, 2020). For example, care in a context of choice and (assumed) autonomy has been depicted as an opportunity to empower those in need of care (Ottman, Allen and Feldman, 2013). However, critics suggest that such a view presupposes an ideal of independence which is fictitious (Lindemann, 2003). Additionally, "the denigration of care and dependency tends toward an attitude that makes the work and value of the carers invisible, thus creating one oppression in the effort to alleviate another." (Kittay, 2011:51).

The fact that care is work does not mean that it is *only* work. Care often involves some degree of emotional engagement (Folbre, 2012). This can enhance worker satisfaction (Stone, 2000), but it also places care workers in a vulnerable position. "[B]y virtue of caring for someone who is dependent, the dependency worker herself becomes vulnerable" (Kittay, 1999: 49). Workers are vulnerable to exploitation and are not equally situated in society's hierarchy with those who are not obliged to perform paid care work (Kittay 1999; Lynch 2021). Practices of care are enacted within relations of power, which can hinder the delivery of good care and have adverse effects on both caregivers and recipients (Folbre, 2012). The treatment of care as a commodity (Claassen, 2011), whether in the state or independent sector is linked to institutional arrangements in which employers, and managers often have little or no direct contact with service users (Folbre, 2014). They are likely to be insulated from the adverse impacts of their actions on clients and workers, therefore. For example, they may consciously or otherwise, ignore the implications for workers of increasing workload. And they may take such actions, secure in the knowledge that 'emotional blackmail' (Allard and Whitfield, 2023: 8) can be used to secure worker compliance (Folbre, 2014).

Whether or not carers are paid, the potential for abuse of care recipients exists (Balkaran et al., 2024; Hussein et al., 2009). Abuse may include financial, physical, psychological, and sexual abuse, as well as neglect (WHO, 2024). Much of the literature on abuse in the context of home care is concerned with the vulnerable status of adults receiving care (Yon et al., 2017). Older adults with dementia appear to be at the highest risk for mistreatment (Rogers, Storey and Galloway, 2023). Often abuse is perpetrated by family members (Dominguez *et al.,* 2022), but there is evidence of abuse by care workers too (Balkaran et al., 2024). This is not always the fault of individual workers but may arise from systemic failures and/or organisational inadequacies (Sykes and Groom, 2011). In order to safeguard care recipients, care providers are normally required to register with and be overseen by a formal regulatory body. In England, for example, the Care Quality Commission [CQC] undertakes this role. Regulation and as part of that process quality ratings, are intended to provide some indication that organisations are (or are not) providing good quality care. Whilst such ratings may help to facilitate the process of care commodification (Claassen, 2011), they are necessarily crude and potentially flawed indicators of quality (Lynch, 2021). Furthermore, the focus on safeguarding concerns the treatment of clients, rather than workers (Care Quality Commission, 2014).

There is strong evidence that abuse of care workers is prevalent and may be viewed as just a normal part of the job (Cairncross and Crick, 2014). Balkaran and colleagues suggest that "communication breakdowns and stressful job demands contribute to a normalized culture of abuse in home care settings" (Balkaran et al., 2024:890). When care is provided on a paid for basis, the worker may feel obliged to tolerate working conditions which reduce their job satisfaction and may even place them in danger (Folbre, 2014; Prout et al. 2022). Mistreatment by service users includes verbal abuse and less commonly, physical abuse and sexual harassment (Hanson et al., 2015). Migrant workers are especially vulnerable (as I discuss in the context of home care in the section on care work, gender, ethnicity and class) (Green and Ayalon, 2016). As mentioned above, mistreatment by employers is also an important issue in the home care field.

Whilst there is a tendency to depict care recipients as vulnerable, in a care context characterised by structures of power and inequality, care workers are also vulnerable adults. For some commentators, vulnerability should be seen as part of the universal,

human condition (Finemann, 2008). Writers in this tradition critique the notion that society is comprised of independent autonomous citizens. Neoliberal individualism as a basis for organising society is viewed as devaluing care, relegating it to a residual, as opposed to central, category (Gopnik, 2023; Herring, 2019; Lynch, 2021; Slaughter, 2023). Herring (2019) suggests an alternative approach in which "all activities are assessed on what they contribute to the care of others. Economic productivity would be valued in so far as it produces what is needed to support care." (Herring, 2019:19). Recognition of interdependence and as part of this, human vulnerability, implies that the state has an obligation when it comes to care (Gopnik, 2023), but this creates tensions. Citizens may not necessarily want "large impersonal state institutions [to] replace the more personal relationships of care, though they may certainly supplement them" Gopnik (2023: 64).

1.4 Home care, older adults and ageism

Home care includes the provision of personal care (help with for example washing, dressing and eating) to people with long-term care needs (NHS, n.d. a). This is the core service commissioned by most local authorities, but home care also includes reablement services for people leaving hospital or receiving crisis interventions to prevent hospital admission (AGE UK, 2021). The term can also include assistance with household activities (e.g., shopping, cleaning, ironing). However, the requirement for these latter activities alone would not usually entitle people to local authority help (Bottery *et al.*, 2018).

The increased need for home care may be one reason why population is ageing is often depicted as problematic, rather than something to be celebrated (Anon, 2024; Whitty, 2023). This is despite the fact that the number of older adults recorded as receiving long-term care has been falling in recent years (Schlepper and Dodsworth, 2023). In addition, in percentage terms there has been a reduction from just over six per cent to just over five per cent for those aged over 65 receiving long term care comparing 2015/16 with 2021/22. This contrasts with the largely unchanged 0.8 per cent for working aged adults during the same period (Schlepper and Dodsworth, 2023). This fall in provision does not reflect a reduction in demand, however, and has been attributed to local authority budget cuts and strict means testing which limit access to funded services (Schlepper and Dodsworth, 2023). In addition, in a context where social work vacancies are high (Samuel, 2023) waiting times for a social care assessment are lengthy. In August 2022 an estimated

33% of adults were waiting over 6 months, having increased from a not insubstantial 20% in November 2021 (Schlepper and Dodsworth, 2023).

The view of ageing as a problem also reflects structural ageism, with negative beliefs and behaviours becoming ritualised and taken for granted in many aspects of society (Centre for Ageing Better, 2023). Older adults are not necessarily immune to these attitudes. Beliefs about one's inevitable cognitive and physical decline can become self-fulfilling prophecies (Golub and Langer, 2007). In addition, negative stereotypes can have an important impact on the nature and quality of care and support provided, since professionals who interact with older adults and make decisions about their needs are not immune from ageism (Kagan, 2017). A view of older adults as passive and/or in need of protection may obscure the capacity for active agency of individuals. It also risks othering older adults and treating them as a homogenous group (van Dyk, 2016). A view of older adults as "needy" may be reinforced by the fact that some service providers and local authority social work and related staff often come into contact with individuals at times when they are at their most vulnerable (Bornat and Bytheway, 2010).

Ageist assumptions embedded in risk-averse social work with older adults (Tanner and Harris, 2008: 191-192) can lead to restrictions on older adults, which are not applied to younger adults. For example, judgments about risks may be coloured by ageism rather than objective criteria (Carey, 2022). Furthermore, there is often a mismatch between professionals' and older adults' view of risk, with the former giving priority to physical risk and many older adults prioritising their autonomy and independence (Ballinger and Payne, 2002). This view of ageing as a problem is compounded by an approach to needs assessment which focuses on deficits rather than strengths (Milne, 2023), despite the emphasis in legislation on strengths-based approaches (Care Act, 2014).

There have been several initiatives which are underpinned by a conceptualisation of older adults as active citizens, as opposed to objects of need. These include asset (or strengths) based approaches to support and assessment (Glasby, Miller and Lynch, 2013). Such approaches challenge risk averse social work cultures (Lawson *et al.*, 2014) by helping the service user and their networks to manage risk effectively (Cooper, Cocker and Briggs,

2018). Asset based approaches have been shown to reduce safeguarding incidents and reassessments (Gollins *et al.*, 2016) but they take time to implement in a context where entrenched deficit-based principles are in place and IT systems and policies act to reinforce their perpetuation (Cooper, Cocker and Briggs, 2018). Linked to this, it has been suggested that asset-based approaches fail to acknowledge power differences between service users and professionals and ignore the broader structural inequalities which influence the micro level context of care interactions (Ambition for Ageing, 2018). They have also been seen as a response to local authority budget cuts, with those requesting care being signposted to social networks and/or denied some or all of the care requested (Schlepper and Dodsworth, 2023).

Other policies aimed at constructing ageing in more positive terms include the promotion of active ageing, which involves "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organization, 2002:12). This has been criticised for individualising responsibility for ageing well, in addition to neglecting the inequalities which prevent older adults from participating equally in such approaches (van Dyk, 2014). Similarly, critics suggest that policies to promote choice and personalisation in home care contribute to individual service users having to take on additional responsibilities and risks, which would previously have been the responsibility of the state (Carey, 2016). Yet there are many choices which individuals may want to make, for example, when to go to bed or get up in the morning, which the state is ill equipped to make.

Regardless of one's views about active ageing, it seems clear that the provision of care and support requires access to a competent workforce. At the time of writing, rates of unemployment in the UK are low (Office for National Statistics, 2024) and many working age adults have left the workforce (Strauss, 2022). It might be hypothesised therefore, that in order to secure a sufficient number and calibre of home care workers, employers must ensure that remuneration and conditions of employment are attractive and competitive with alternative employing sectors (Allen and Shembavnekar, 2023). However, the literature suggests that this is not necessarily the case, as I discuss in the following sections.

1.5 Home care work

Home care work is relatively unusual in that it takes place in the private world of service users' homes away from public scrutiny. This contributes to a perceived link with informal care, which is "notoriously under recognised" (Wibberley, 2013: 156; see also Twigg, 2000). The location of care, in clients' homes, can result in tensions between workers, service users and family members (Twigg, 1999). In addition, workers need to obtain the service user's permission to perform tasks and use their space and facilities. In a paid care relationship, the care receiver is in a vulnerable position (Ward, Ray and Tanner, 2020), but care givers are also vulnerable (Chatzidakis *et al.*, 2020). Whilst care is characterised by relationships of interdependence, these relationships are situated within a context of hierarchy and inequality. Employment by an organisation providing care can lead to a loss of autonomy for the care worker (Burns *et al.*, 2023). Furthermore, the introduction of electronic monitoring of workers can exacerbate this situation (Moore and Hayes, 2017). Care work can often involve "body work" and this is a core part of social care, particularly for older people in the form of personal care (Twigg, 2000). In addition to the work carers undertake, the concept of "body work" recognises that carers are embodied, emotional and relational beings (Twigg, *et al.*, 2011). Emotion can render home care meaningful and fulfilling, but the work can also take its emotional toll on those who perform it (Allard and Whitfield, 2023). In home care, the work has been described as "physically tainted" (Wibberley, 2013: 157) due to its association with bodies and bodily fluids in addition to waste (human and household), death and disease (Stacey 2005). Its association with a stigmatised group (older adults) who are also subjected to discrimination, as well as the potentially "servile relationship" Ashforth and Kreiner (1999: 415) between home care workers and service users result in such care also being "socially tainted" (Wibberley, 2013: 157). Care workers are also subject to "emotional blackmail" (Allard and Whitfield, 2023: 8), especially in contexts of resource scarcity.

Within the social care sector, home care staff turnover is higher compared with other areas (Hussein, Ismail and Manthorpe, 2014; Vadean and Saloniki, 2023). This may be due in part, to some of the less attractive aspects of caring for adults ranging from, for example, caring for "leaky bodies and unsettled minds" (Bolton and Wibberley, 2014: 685) and travelling in inclement weather (Kallas *et al.*, 2023). However, other factors which are

more related to the ways in which care is perceived and commissioned and therefore, delivered, are also heavily implicated in the recruitment and retention problems facing the home care sector.

1.6 Home care and workforce issues

Adult social care across the UK is characterised by relatively low status and rates of pay (Dromey and Hochlaf, 2018). Staff shortages have been a longstanding feature of the sector and increasing vacancy rates are in evidence (Skills for Care, 2020), with providers reporting difficulties retaining staff (Allen and Shembavnekar, 2023). This leads to additional pressure on existing staff, with burnout and low pay as factors contributing to this state of affairs (Allan and Darton, 2021). There is good evidence that improving pay and employment conditions involving full-time or guaranteed hours contracts reduces turnover within the sector (Vadean and Saloniki, 2023). A recent review of the literature suggested that offering "quality jobs", defined as including decent pay and conditions, job security and a good working environment, is essential to improving recruitment and retention (Turnpenny and Hussein, 2021). The number of jobs in home care has risen at a faster rate compared with the residential care sector (22% versus 4% over the last decade, Skills for Care, 2021) and workforce shortages, which characterise the care sector generally (Skills for Care, 2021), can be particularly acute in the home care context (Bottery *et al.*, 2018). According to Turnpenny and Hussein (2021), local authorities need to play a full role in supporting providers to create and offer quality jobs. However, local authority commissioning arrangements have been seen as indirectly contributing to a devaluation of the care role, as commissioners seek to drive costs down within diminishing resources (Davies *et al.*, 2022; Davies *et al.*, 2020; Glendinning, 2012).

Traditionally, home care commissioning has been planned around "time and task" based service delivery (Atkinson, Crozier and Lewis, 2016; Cunningham *et al.*, 2020). This "prioritises procedure and amount of time spent on care over meeting the needs of individual people" (National Institute for Health and Care Excellence, NICE 2016). These arrangements make care easier to measure and monitor, but what is measured may not be meaningful to staff and older adults (Welsh Government, 2016). "Time and task" has also been described as exerting downward pressure on provider income, thereby contributing to market instability (Bottery *et al.*, 2018). Additionally, delivery of such care

can leave staff feeling demotivated and micromanaged (Care and Social Services Inspectorate Wales, 2016; Lucas and Carr-West, 2012; Rubery *et al.*, 2015). In contrast, more flexible working arrangements are likely to motivate employees (Burns *et al.*, 2023) and are associated with higher quality care (Atkinson, Crozier and Lucas, 2018). Various commentators have cautioned against reducing care work to a set of tasks, emphasising that the caring relationship is crucial to the experience of care (Ungerson, 1983, 1987; Lewis and Meredith, 1989). Following this approach, since good care is dependent on the quality of the care relationship (Care and Social Services Inspectorate Wales, 2016), then the position of the care workforce is key to its provision. As Rubery and Urwin (2011: 122) have argued: "quality cannot be disentangled from this human interaction [between user and carer] and improvement strategies have to engage with the attitudes, skills and commitments of the people providing the care".

Many home care staff are employed on zero hours contracts (Bottery *et al.*, 2018). This may enhance flexibility, but it also places additional stress on employees in what is already a stressful occupation (Ravalier *et al.*, 2018). Unsocial hours, excessive workload and a failure to reimburse travelling time creates a disincentive for staff to work in these roles (Johnson, Rubery and Egan, 2021). In addition, the sector is characterised by limited opportunities for career progression and training, which can demotivate staff (Johnston *et al.*, 2017).

Recent research suggests that the COVID-19 pandemic has exacerbated existing problems for the adult social care workforce (Hussein *et al.*,2020; Saloniki *et al.*, 2022). A context of both increasing workload and responsibility has resulted in heightened stress and burnout for frontline staff (Aughterson *et al.*, 2012).

1.7 Care work, gender, ethnicity and class

In the UK, the vast majority of frontline care workers are females (Skills for Care, 2023). Care work's association with the domestic sphere, contributes to a view of care work as coming naturally to women (Chatzidakis *et al.*, 2020). Its link with informal, unpaid care is also seen as contributing to its low status (Stacey, 2011) and a perception that it is unskilled work (Bolton and Wibberley, 2014). It has been described as contributing to gendered, ethnic and economic inequalities (Romero and Perez, 2016). Furthermore, in the context of austerity (Gray and Barford, 2018), it has been argued that ostensibly

gender-equality oriented policies are aimed at promoting neoliberalism, resulting in women experiencing greater insecurity in paid employment in addition to their existing unpaid workload (Pearson and Elson, 2015; Rubery, 2015).

The trend for nation states, to varying degrees, to withdraw from the commitment to meet welfare needs collectively (Taylor-Gooby, 1991; Taylor-Gooby and Stoker, 2011) is underpinned by a reliance on families to provide care and support for their relatives (Frericks and Gurín, 2023). Women's unpaid labour is a key aspect of this support (Allen and Taylor,2012), with the good citizen combining "the behaviour expected of the modern neoliberal subject with traditional gender roles (the loving wife and mother). The "striver" not only withstands the consequences of the recession by being resilient and thrifty, but, at the same time, she helps to reinvigorate the economy and society by governing herself and her children in the 'right' ways" (Dabrowksi, 2021:92). It has been argued that for home care workers, this emphasis on "moral and social responsibilities as 'good citizens'" means "an increasing proportion of their working time is provided without pay…. [and] their individual expectations of a right to be paid on the basis of their actual labour are disappeared from view" (Hayes and Moore, 2017: 340). It has also been suggested that a high level of job satisfaction in the sector "reinforces women's low sense of entitlement to higher wages, an issue that is compounded by a perceived lack of effectiveness in collective action through trade unions" (Johnson, Rubery and Egan, 2021:370).

For members of staff from ethnic minority communities, the situation may be worse still. They are more likely to be on zero hours contracts compared with their White British counterparts (Equality and Human Rights Commission, 2022), especially in the independent home care sector. These staff are less likely to raise concerns, which is perhaps not surprising given their insecure employment terms and conditions (Equality and Human Rights Commission, 2022). Home care workers generally are often unaware of their rights (Equality and Human Rights Commission,2022). Staff from ethnic minority groups are significantly more likely to be on the receiving end of abuse compared with their White British counterparts (Saloniki *et al.*, 2022). Where such staff are migrant workers, additional factors such as language barriers and unclear pay slips help to muddy knowledge of legal entitlements (Equality and Human Rights Commission, 2022).

Migrants and particularly non-EU workers play an important role in the care workforce (Skills for Care, 2023; Turnpenny and Hussein, 2022). According to recent estimates, 14% of the domiciliary care workforce identified as non-British, non-EU (Skills for Care, 2023). This compares with around 9 to 10% in 2016/17 (Foster, 2024) and reflects policies to increase international recruitment in 2022/23 (see below for more information). However, although London and the South East of England have very high rates of migrant workers, these rates are much lower in other areas (Franklin and Brancati, 2015). In the North East of England, for example, only four percent of the adult social care workforce was from outside of the UK for the years 2020/2021 and 2021/2022, although this rose to 7% for 2022/2023 (Skills for Care, 2024a). In contrast in the London region, 41% were from outside the UK (Skills for Care, 2024b). This has implications for the ability to attract migrant workers in rural settings. In contrast to their counterparts in urban areas in the "rural idyll" (Garland and Chakraborti, 2006), migrant workers may face exclusion by locals (Cloke and Little, 1997; Tolia-Kelly, 2007) and experience particular difficulties in finding employment, travelling, networking and engaging in familiar social practices (de Lima, 2006; Spiliopoulos *et al.*, 2020).

The gendered and exclusionary aspects of citizenship have implications for migrant care workers too. They are often prevented from enjoying full recognition as citizens and are likely to be stuck in sectors where employment standards are more likely to be breached (Charlesworth and Malone, 2022). Furthermore, their working entitlements have been progressively eroded through successive changes to the UK immigration system (Ranci *et al.*, 2021). Historically, migrant social care workers have tended to be individuals who were already living in the country. However, more recently, in the context of acute workforce shortages, the addition of the occupation to the Shortage Occupation List increased opportunities for migrant worker exploitation (Migration Advisory Committee, 2023). Under this scheme, migrants' dependency on employers for sponsorship and their temporary visa status adds to their vulnerability. These are not hypothetical risks and many cases of abuse, harassment and exploitation have been reported (Citizens Advice, 2024).

Various writers have characterised care work as having a social class dimension to it, with working class women being overrepresented in jobs which preclude working from home

(Warren, Lyonette and the Women's Budget Group, 2021). Skeggs' (1997) Bourdiuesian informed research amongst working class women in the north of England explains the appeal of participation in caring courses to working class women in terms of their limited economic capital. For Skeggs (1997), such courses offer an opportunity to accrue cultural capital (formal qualifications), but participation might be viewed less as a positive step towards future development and more as a means of putting a lower limit on participants' economic and cultural capital. Drawing on Bourdieu (1984; 1990a) and Skeggs (1997), Hebson and colleagues (2015) describe how factors such as social capital (e.g., family and friends networks) and limited cultural capital influence women to enter care work. They suggest that a combination of economic, family and labour market circumstances explained women's choices and, in many cases, orientations to perform care work were developed over time, rather than existing prior to entry into the field. The authors emphasise the importance of both viewing job satisfaction in care work in ways that go beyond gender disadvantage and situating analyses in the context of economic and social processes, which shape opportunities and norms of low paid workers. Hebson, Rubery and Grimshaw (2015) also explain why women remain in care work, despite its limited (economic and cultural) rewards. They demonstrate that subjective evaluations of job satisfaction made by low-paid working women should be understood in the context of the socioeconomic constraints these women face, rather than accepted at face value.

1.8 The home care market – models of provision

Over 97 per cent of paid home care is provided by the independent sector, which mainly comprises private for-profit firms employing paid carers (Pursch and Isden, 2018). These are not the only providers in the home care market. Table 1 below describes the salient features of home care providers.

Table 1 Models of provision

Type	Employment relationships	National [CQC] regulatory oversight
Care provider organisation (known colloquially as care agency)	Employs workers	Y
Personal Assistant	Employed by client	N
Microprovider*	Self employed	N
Self-employed*	Self employed	N

* In this thesis I distinguish between individuals who participated in a local authority supported initiative aimed at increasing the number of self-employed providers and those self-employed providers who did not. I refer to the former as microproviders and the latter as "self-employed" to avoid confusion.

Organisations employing staff to undertake personal care are required to be registered with the national regulator the CQC (Care Quality Commission, 2024a). Some of these organisations provide home care on a "live-in" basis (Vandrevala and O'Dwyer, 2020). Additionally, individuals may employ a Personal Assistant (PA) to provide the care they need (Wilcock *et al.*, 2021). Turnover amongst PAs is much lower than that for those employed in the independent care sector (Bottery and Mallorie, 2024). But this arrangement requires care recipients to take on employment responsibilities, which may prove a disincentive to opting for PA provision (Leverton *et al.*, 2023). PAs and paid carers who operate on a self-employed basis are not subject to CQC regulation (Care Quality Commission, 2024a).

The direct employment of PAs has been described as exposing them to risk due to the weakly formalised employment conditions they experience, the dependency relationship on their employer and the difficulty of balancing their own rights and requirements with those of the people who employ them (Christensen and Manthorpe, 2016; Manthorpe *et al.*, 2020). Many PAs have no written contract and PA employers have much more support than PAs, although this is not uniformly available across the country (Woolham *et al.*, 2019). During the COVID-19 pandemic PAs were not routinely included in local authority communications and were often overlooked with regards to the availability of free Personal Protective Equipment (PPE) from local authorities (Woolham *et al*., 2020). The absence of the sort of infrastructure which would exist in care provider organisations (e.g., Human Resources support, manager, colleagues etc) is viewed as contributing to the isolation of PAs (Woolham *et al.*, 2019). Having said that, as outlined above, many agency-employed care workers report abuse from colleagues and service users (Saloniki *et al.*, 2022) and for PAs, employer abuse appears to be rare (Woolham *et al.*, 2019). However, there is some evidence that some employers of migrant PAs have failed to pay their tax and insurance contributions and/or incorrectly classified them as self-employed in order to avoid their responsibilities as an employer (Cangiano *et al.*, 2009). It has been suggested that local authorities should take action to address their indirect responsibilities to PAs

and ensure ongoing employment support to both parties is available within the local authority or commissioned elsewhere (Woolham *et al.*, 2019). Many PAs have an agency care background and dissatisfaction with that sector provides a huge impetus for becoming PAs (Woolham *et al.*, 2019). Whilst PAs are unlikely to be travelling between many service users on a daily basis, the issue of travel is an important one, since the probability of PAs taking sickness absence increases, the further away they are from their client base (Roland *et al.*, 2022). There is also some evidence that this probability is higher for PAs who have a permanent contract (Roland *et al.*, 2022).

In a context where legislation in England promotes an increased emphasis on personalised services, wellbeing and practitioner and user and agency (Care Act, 2014), variations on the care provider organisational forms, which focus on addressing the workforce challenge, have emerged to meet this aspiration (Needham and Glasby, 2015). Care cooperatives, based on user and community ownership have been touted as being promising models of provision (Co-operatives UK, 2017; Harrison and Pavia, 2020). However, some of the aspirations appear to be based on the fact that these settings are very challenging for statutory and private providers (Co-operatives UK, 2017), rather than solid evidence that such co-operatives can provide sustainable solutions. Nevertheless, there is evidence that care provision which differs in important respects from the "industry-standard model" (e.g., minimum 60 minutes visit time, self-employment, salaried self-managing teams) can contribute to worker motivation and greater personalisation (Burns *et al.*, 2023).

One response to the challenge of providing care to older adults with an assessed social care need has been the emergence of a novel type of provision, which is microenterprise (Bedford and Phagoora, 2020; Brindle, 2017; Needham and Glasby, 2015). This term refers to small (hence micro) businesses (hence enterprise) employing low numbers of staff. An evaluation of microenterprise providers in England (Needham and Glasby, 2015) found that they offered a more personalised service than larger organisations. This arose from three aspects of the microenterprise approach: the autonomy of frontline staff to vary the service being offered, greater continuity of staff and the high level of accessibility of managers to staff and people using the service. Microenterprises were deemed by users to have delivered more valued outcomes compared with larger providers. They also

offered better value for money than larger providers. Organisations employing small numbers of staff are distinct from microproviders which are self-employed individuals. Some local authorities have expressed concern about the unregulated status of microproviders (Welsh Government, 2024), yet PAs are also exempt from CQC registration but there is no evidence that this status creates anxieties amongst local authorities.

Furthermore, regulatory processes which apply to large providers may be unduly burdensome for microenterprise forms, where these are larger than sole traders. The CQC, the body which regulates the home care sector in England highlighted "substantial churn in the provision of domiciliary care, with around 500 agencies registering with [CQC] each quarter and around 400 deregistering" (Care Quality Commission, 2017: 24) in England, in its 2016/17 report. Regulation needs to be proportional and accessible for these very small organisations, therefore (Care Quality Commission, 2017; Needham and Glasby, 2015). According to Needham and Glasby (2015), if local authorities, wish to see microenterprise flourish, then they need to develop approaches to commissioning to enable microenterprises to join preferred provider lists. (These are lists of all home care providers that have a contract with the local authority). Needham and Glasby's (2015) research highlighted the need for microenterprises to have access to "dedicated start-up support, with care sector expertise, as well as ongoing support and peer networks" (2015: 4). With regard to the latter, a number of local authorities in England have actively promoted the development of these organisational forms, providing access to training and support networks. In some cases, this has happened with the support of third sector organisations with expertise in this area (Bedford and Phagoora, 2020; Duffy and Catley, 2018).

To operate as a sustainable business, providers need to be able to cover their costs. The use of direct payments (Poole, 2006) to drive greater personalisation (Lewis and West, 2014; Rodrigues and Glendinning, 2014) in social care is a feature of the policy landscape in England (Davey, 2021). If an individual is eligible for some or all of the costs of care to be covered by the local authority, then this financial support can be taken in the form of direct payments. These are payments from the local authority which enable people to buy in care to meet the needs identified as part of their needs assessment process. Direct payments may be used to: buy care from a care provider organisation or to employ a

personal assistant to provide care; pay self-employed providers of care and/or pay for activities or equipment where these are in accordance with the assessed needs. They may not be used for services which are outside of the local authority's remit such as specialist health care. Direct payments cannot normally be used to employ a close family member (Care and Support (Direct Payments) Regulations 2014).

In addition, people may self-fund (Baxter, Heavey and Birks, 2020; Henwood *et al.*, 2020), if they are assessed as having the means to pay for some or all of the care they need. Self-funders may contract directly with providers if they so choose, bypassing the local authority altogether. In common with co-operatives (Robertson-Steel and Jones, 2019) sustainable microenterprise provision has been inhibited by a dependence on self-funders and/or low levels of direct payments (Duffy and Catley, 2018; Needham and Glasby, 2015). Direct payments are intended to allow people using care services more choice and control over their own support. They have been around for some time but were intended as a key mechanism to help reform social care in the Care Act 2014 (Davey, 2021). Almost 10,000 fewer people used direct payments in 2022/23 than in 2015/16. Only 15% of older adults drawing on social care used direct payments. This compares with 28.1% in 2015/16 (Bottery and Mallorie, 2024). In part, the relatively low numbers may be due to the additional responsibility involved in managing a direct payment (Davey, 2021). This could include becoming an employer (Rodrigues, 2019) which might appear daunting. But this relatively low uptake and the decline in percentages also raises questions about whether all eligible individuals are given the opportunity to access direct payments, in a context where social workers make judgements about individual capacity to manage a direct payment (Southall, Lonbay and Brandon, 2021).

1.9 Local authorities and care markets

The field of home care has experienced many changes in recent decades (Lewis and West, 2014). Prior to reforms introduced in the 1990s, local authority funded home care was largely provided by in-house staff (Ward, Ray and Tanner, 2020; Ware *et al*., 2001). The reforms reduced the role of the state in direct service provision, leading to a growth in the independent care sector (Curtice and Fraser, 2000). Local authorities became commissioners of care from a growing independent provider sector. The development of a quasi-market for social care, with local authorities commissioning care on behalf of

service users, was intended to increase choice, flexibility, responsiveness, quality and cost effectiveness (Audit Commission, 1992). Local authority staff also play an important role in assessing and monitoring care needs, with local authority social workers and care managers undertaking these duties.

1.9.1 Local authorities as service commissioners

Local authorities have been responsible for commissioning home care for decades (Davies *et al.*, 2021). A recent systematic review (Bach-Mortensen and Barlow, 2021) of the experiences of social care providers and commissioners in quasi-markets covering a range of services (based on studies from 10 countries, published between 2000 and 2020) highlighted provider concerns about the nature of social care contracts, which they described as unstable and inadequately resourced. The commissioning system in which providers operated was depicted as dominated by austerity, deteriorating working conditions and competition based on short-term (proxy) outcomes and costs.

This systematic review (Bach-Mortensen and Barlow, 2021) included care for older adults, but was not primarily concerned with this sector. However, a recent scoping review focused specifically on commissioning home care for older people (Jasper *et al.*, 2019) concluded that "[u]nderstanding the complexities of market management in commissioning home care for older people is still at an early stage of development" (Jasper *et al.*, 2019: 176). The authors identified 21 studies from England and Wales, published between 1993 and 2018 and outlined a number of themes from the literature (Jasper et al., 2019: 179). The first of these was "guiding principles", which comprised a focus on outcomes and the nature of service delivery. The latter included person centred care, an integrated health and social care approach and improvements in recruitment and retention of staff. The second theme "pursuit of personalised care" was concerned with approaches to ensure provision of responsive, high quality services. Three aspects of this were: commissioners facilitating a local market to ensure adequate supply of care; service user choice; and relationships between commissioners and providers. The latter refers to quality relationships between these two groups, but also the need for them to work collaboratively at strategic and operational levels to design new models of care.

Factors influencing commissioning was the third theme and these included service user needs and their views about the uptake of personal budgets. In addition, local area

characteristics were important influences (e.g., local employment market, rurality), as was contract type, with spot contracts associated with a higher price per case compared with other types such as block or cost and volume. Local authorities have been responsible for commissioning home care for decades (Davies et al., 2021). As part of this process, they enter into contracts with care provider organisations. Block contracts involve the local authority committing to a specific sum of money in exchange for a service. This gives a high degree of financial security to the provider but runs the risk that the volume of service may be lower, compared with alternatives such as spot purchasing or cost and volume contracts. The latter links payment to a specified volume of activity to be delivered, whilst at the same time providing a higher degree of financial stability for the provider, compared with spot purchasing (i.e. buying care on a case-by-case basis).

The fourth and final theme was "the process of strategic commissioning" defined in terms of "stakeholder involvement; the contracting process; and the influence of the latter on service delivery" (Jasper *et al.*, 2019: 188). In terms of relevant stakeholders included in the process, earlier studies emphasised relationships between commissioners and providers, with service users and health staff added in more recent studies. Contracting process factors such as the extent to which contracts were outcome based and the length and nature of the contract (e.g., with longer term block contracts offering greater stability) were likely to impact on the nature of services provided and their cost.

There was little in the literature to identify factors influencing what the authors termed "market management" (which they state is synonymous with market shaping). The authors differentiated between factors viewed as outside of the commissioning process (such as, they write, recruitment and retention of home care staff) and endogenous factors such as the contractual arrangements, with the latter much more likely to be under the control of the local authority.

The literature review suggests that commissioners and providers need to work together to ensure that care provision goes beyond support for activities of daily living to encompass participation in social activities. The authors found that reference was made in the literature to outcome-based commissioning, but this was not explored in any detail. This may reflect the problems in operationalising the concept, as well as a lack of shared understanding of what this means. There was an absence of evidence concerning joint

(health and local authority) commissioning for older adults requiring long term (as opposed to short term post hospital discharge) care. The authors suggest that whilst a more integrated approach is desirable, it is likely to prove challenging for health and social care commissioners. Jasper and colleagues (2019: 190) also suggest a change in terminology from "home care" to "care at home" to convey a shift from the narrow remit of home care. This would also recognise the role that stakeholders such as housing providers and voluntary sector organisations can play in the commissioning process.

The review concludes that future research is needed to examine the home care commissioning process, particularly with a focus on key partners and their contributions. In addition, more research is required exploring the relative influence and interaction of endogenous variables (commissioning and contracting approaches) and exogenous factors (such as rurality and socioeconomic composition) on outcomes for older people receiving home care support in different localities.

These findings are understandable in a context where local authority commissioners face multiple and at times, competing objectives including cost reduction, quality improvement, user empowerment, promotion of local experimentation and compliance with national standards (Rubery, Grimshaw and Hebson, 2013). Even before the COVID-19 pandemic local authorities were facing significant financial pressures, (National Audit Office, 2021a) and their financial position remains a cause for concern (National Audit Office, 2023). The National Audit Office cites short-term funding and the lack of a long-term vision as hampering planning, innovation and investment in adult social care in England (National Audit Office, 2021b). It is perhaps not surprising that in 2023, the National Audit Office described the social care sector as "challenged by chronic workforce shortages, long waiting lists for care and fragile provider and local authority finances." (National Audit Office, 2023:12). The impact of national funding regime settlements has been described as leaving local authorities with little room for residual discretion (Johnson, Rubery and Grimshaw, 2021). Having said that, although all local authorities are financially constrained there are some local authorities which have been identified as demonstrating good practice by

> "…replacing top-down and paternalistic approaches with one which values the partnership between …. older adults, and the wider web of relationships that they

> exist within, which includes unpaid carers if this is their choice…. seeing [older adults] as individuals who could be enabled to live the best life they can—not as problems to be solved" (House of Lords, 2022: 17).

1.9.2 Local authorities and market shaping

The duties of local authorities in England concerning social care have changed in recent years as a result of legislation regarding the system for governing the provision of adult social care. The Care Act 2014 (Care Act, 2014) introduced reforms to local authorities' responsibilities aimed at improving assessment, care, support and safeguarding. The legislation introduced a new duty requiring local authorities to engage in "market shaping", defined as

> "the local authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to encourage and facilitate the whole market in its area for care, support and related services. This includes services arranged and paid for by the state through the authority itself, those services paid by the state through direct payments, and those services arranged and paid for by individuals from whatever sources (sometimes called 'self-funders'), and services paid for by a combination of these sources. Market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of the types of services and the types of provider organisation), and ensure the market as a whole remains vibrant and sustainable." (Department of Health, 2017: Section 1).

As part of this duty, local authorities need to understand their local market of care providers and stimulate diversity in terms of available care and support services. There is an emphasis on ensuring that service users and their carers have choice over how their needs are met, in addition to enabling them to achieve the outcomes that are important to them. The local authority must also ensure vibrancy and stability of the care market. There are some obvious tensions here. For example, the "time and task" approach to commissioning is at odds with the personalisation agenda (Sutcliffe *et al.*, 2021). Furthermore, as described above, it has also been seen as contributing to destabilisation in the market for care (Resolution Foundation, 2008).

According to the National Audit Office, local authorities understand their duties to shape the market, but they lack the levers to do this effectively (National Audit Office, 2021b: 10). In the context of growing workforce shortages, the National Audit Office is also critical of central government for its failure to implement key commitments made to enhance training and career development and address recruitment and retention challenges. In addition, the National Audit Office highlights that although the Department of Health and

Social Care recognises that local authorities pay providers below a sustainable rate, they do not challenge them on this matter (National Audit Office, 2021b). This seems unsurprising (to me at least) as local authority payments are made in a context of years of budget cuts imposed by central government (Gray and Barford, 2018).

As outlined above, the care context is characterised by an ageing population, which is disproportionately located in rural communities (Office for National Statistics, 2018) and workforce shortages may be particularly acute in rural areas (ADASS, 2019; Hart and Lavis, 2017; Reid *et al.*, 2020). Furthermore, home care services in county and rural councils are more expensive than for other types of council (County Council Network and the Rural Services Network, 2021). (County councils tend to cover large rural areas, see Studdert, 2021). This raises questions about the extent to which market shaping activities can help address the challenges in providing care to assist older people to remain in their own homes (Green *et al.*, 2018) in rural areas.

1.9.3 Market shaping in English local authorities – empirical research

Jasper and colleagues' (2019) review discussed above was part of a wider study focusing on commissioning of home care which sheds light on changes in the commissioning arrangements for home care in England over time (Jasper *et al.*, 2019). Based on two national surveys of commissioners undertaken ten years apart (2007 and 2017), the authors report increased collaboration between stakeholders and improved employment conditions and training for home care workers required as features of the commissioning process (Davies *et al.*, 2020). However, the proportion of local authority commissioners stipulating a requirement for management training had fallen (from 63 to 57 percent) over the period. Contract durations tended to be longer with two thirds likely to be for four or more years, compared with two fifths a decade earlier. A shift away from block contracts (from 65 per to 38 per cent) was also evident. The authors interpret this as indicative of a move towards more personalised contracting. At the same time, standardised contract rates (irrespective of time and day) were much more in evidence. Davies and colleagues (2020) note that there were variations between local authorities in approaches. Additionally, there was no attempt made to check responses against other data sources and respondents engaging in over reporting of good practice would go undetected, therefore.

Analysis of free text responses of anticipated service developments indicated that issues such as commissioning for outcomes, service improvement and flexible contracts were viewed as important in 2017, as they were a decade earlier. However, in the 2017 sample, recruitment and retention of care workers, was number four in a list of ten anticipated service developments. It did not feature in the 2007 list.

The study team subsequently interviewed a sample (n=10) of survey respondents (Davies *et al.*, 2021). Interviewees described attempting to build collaborative relationships with home care providers. At the same time relational approaches, involving the development of trust were inhibited in a context of transactional factors such as fixed budgets and prescriptive contracts. Previous adverse experiences concerning outcomes based and/or high trust contracts also acted to inhibit more relational approaches to commissioning. In addition, commissioners expressed concern about the workforce shortages citing employment conditions, low status and "time and task" contracts as factors contributing to this state of affairs.

As the authors acknowledge, findings are based on reports by local authority staff and do not necessarily reflect provider perspectives. The study team also interviewed 20 care provider staff (Davies *et al.*, 2020). Whilst some described well-established collaborative, trusting relationships, more frequently, interviewees expressed frustration in a context of limited collaboration and distant relationships. Some of this was linked to perceived inefficiencies of large bureaucracies (e.g., late payments, delays in initiating care packages, slow pace of working). Although in a number of cases providers perceived local authorities paid only lip service to collaboration, leaving them feeling undervalued. Providers also expressed frustration about the low pay and status of staff who were dealing with complex needs, without this necessarily being acknowledged in the commissioning process. Contracting arrangements which involved bidding for work were perceived as lengthy and cumbersome. Additionally, a focus on price, as opposed to quality, combined with tightly specified contracts detracted from the ability to deliver good quality care. Furthermore, incentives to compete for staff and for business in the market inhibited collaboration with other providers.

Changes in contract arrangements due for example, to local authority commissioning reorganisation were cited as lacking direction and disrupting service delivery. Other complaints included a lack of long-term planning, although some acknowledged that this was due in part at least to the constraints created by the limited financial resources of local authorities. The authors conclude that developing a relational (as opposed to a transactional) approach "appears to be pivotal to effective commissioning in the future" (Davies *et al.*, 2020:11). Although not explicitly stated in the paper, its contents imply that this will not be an easy process.

The only research study specifically focused on market shaping in England explored market shaping generally, as opposed to home care specifically (Needham *et al.*, 2020). It also examined the extent to which local authorities were enhancing personalisation, choice and control. Prior to conducting empirical research, the study authors conducted a literature review aimed at developing an understanding of the programme theories which underpin market shaping and personalisation (Needham *et al.*, n.d.). A number of theories were identified, not all of which were mutually compatible. One group of theories viewed local authorities as playing a pivotal role in market shaping, but needing information to do this, as well as the involvement of multiple stakeholders. Theories compatible with this include "Information", with local authorities playing a role in ensuring that citizens were able to make informed choices and "Supply". The latter refers to the absence of barriers to market entry for providers and the ability to charge sufficient fees to cover costs.

Alternative or rival framings challenge the assumptions inherent in "market shaping". From these alternative perspectives, local authorities are unable to gather sufficient information about supply or demand. Furthermore, they cannot provide the market with adequate incentives to stimulate sufficient, stable and high-quality support. These approaches also suggest that service users want the state to provide adequate, stable and high-quality support, as opposed to them taking responsibility for making choices and negotiating a range of diverse funding options (Needham *et al.*, n.d.). Based on their subsequent empirical research Needham and colleagues (Needham *et al.*, 2020)

developed a typology of local authority market shaping approaches, using the extent of local authority control (rules) and the nature of relationships with local stakeholders to categorise different approaches as follows: 1. open market (low control, distant relationships) 2. partnership (low control, close relationships) 3. procurement (high control, distant relationships) 4. managed market (high control, close relationships).

The researchers interviewed a range of what they term "stakeholders" including at national and local (e.g., health and voluntary sector) level. They report that stakeholder interviewees favoured approaches in which local authorities, providers and people using services worked together to shape services. These approaches correspond to types 1 (open market) and 2 (partnership) above. In the open market model, "local authorities encourage maximum diversity of providers and support individuals and families to find the best fit for their care and support" (Needham *et al.*, 2020: 3). The partnership approach is characterised by local authorities working closely with a smaller number of providers. The process involves community input and relevant data to co-design "support that is innovative and supports personalised outcomes" (Needham *et al.*, 2020: 3). The procurement and managed market models are both high on the dimension of local authority control and viewed, therefore as likely to inhibit diversity and innovation necessary for personalisation. Procurement is characterised by spot purchasing whereas a managed market involves "framework contracts" with a small number of preferred providers. Approaches which place less emphasis on local authority control require trusting relationships, particularly amongst commissioners and providers (Needham *et al.*, 2020:3). Yet the study authors found low levels of trust not only between commissioners and providers, but also amongst providers. This characterised all sites and inhibited the potential for partnership approaches to market shaping.

Needham and colleagues (2020) found that commissioners were using different approaches to market shaping for different service user populations. The procurement and managed market (both high control) approaches were most prevalent in services for older adults. Low control (open market or partnership) approaches were most prevalent in services for working age adults. In all sites some elements of the open market approach were in evidence. Often this was operating via direct payments to working age adults. Nevertheless, there were some examples of older self-funders engaging microenterprises

to provide their care and support. Direct payments uptake varied (from ten to 40 per cent) but everywhere limited support was available to individuals or providers to encourage supply or match it with demand.

Furthermore, rather than operating one approach consistently, sites were viewed as drifting between the four models over time. Often this process did not involve purposively choosing one over another or recognising the interdependence of different approaches. Tensions were evident in some sites, for example, with unregulated microproviders viewed by larger organisations as enjoying more favourable business conditions. Echoing the findings of Davies *et al.* (2021), the authors reported that high local authority staff turnover, workforce shortages and uncertainty about long-term funding were in evidence and these militated against a coherent approach to market shaping.

Needham *et al.* report that "austerity was a dominant theme in all phases of the fieldwork" (2020: 11). They highlight the importance of developing a sustainable funding settlement at national government level, to enable effective planning and partnerships at local level. They also suggest that national government should address workforce shortages and ensure that regulatory arrangements are proportionate and responsive to desired (open market and partnership) approaches. The authors conclude that local authority commissioners need nationally funded assistance to help them build technical and relational skills in order to engage in more effective market shaping. They also suggest that local authorities should pursue open market and partnership approaches. The latter requires the development of trusting relationships, long term investment and co-design. The former entails activities to stimulate a diverse set of providers, including PAs, and helping to work with service users including self-funders.

Reflecting a trend to use cultural theory as a tool in policy analysis Needham *et al.* (2023) conceptualise the four approaches to market shaping as reflecting different cultural forms (Douglas, 1970, 2007; Hood, 1998). They suggest that changes from one approach to another may reflect a loss of commitment to a cultural form. They caution that hybrid approaches are likely to be unstable (Needham *et al.*, 2023), but they provide illustrations of different approaches being operated alongside each other within the same local authority. This raises questions about the scale at which the theory is being applied. For example, are cultural biases viewed as reflecting individual behaviours and patterns of

interaction between individuals? If so, the application of market shaping types to collectives such as local authorities, risks downplaying subtleties and nuances, as well as differences between different local authority departments (Mamadouh, 1999). Furthermore, far from viewing hybrid approaches as inherently unstable, other cultural theory adherents suggest that these can help move stalemated policy processes toward constructive action (Hoppe 2007). Needham *et al.* (2023) speculate that the disruptive impacts of the COVID-19 pandemic may predispose commissioners to approaches which rely on strong rules. This may reflect an application of the theory at a collective level (i.e., the local state), which fails to recognise the role of individuals (as opposed to collectives) in building trusting relationships (Lewicki and Bunker, 1996).

Both sets of studies report similar findings in terms of the local commissioning context and the factors inhibiting more effective market shaping. At the same time, in contrast to the four-model approach used by Needham *et al.* (2020; 2023), Davies *et al.* (2022) invoke theories which suggest a continuum with cost minimisation at one end and partnership at the other, although partnership here conveys a relationship between commissioners and providers rather than the more expansive definition used by Needham and colleagues (2020). With regard to home care and rurality, the focus of my research, Jasper *et al.* (2019) suggest that local area characteristics are important influences (e.g., local employment market, rurality) on home care commissioning. However, their subsequent empirical research does not distinguish between rural and urban settings. Needham *et al.* (2020) do not focus on home care or rurality but taken together, these two sets of studies do provide useful information about the process of commissioning home care in local authorities.

1.10 Issues raised by the literature

The foregoing gives some indication of the difficulties faced by local authorities in discharging their market shaping duties generally and more specifically in relation to commissioning home care for older adults. It also suggests a degree of variation in terms of the ways in which local authorities approach their market shaping duties. Local authorities are not the only purchasers in the market, but self-funders (Henwood *et al.*, 2020) and those buying care using direct payments tend to receive little attention in the literature on market shaping (Needham *et al.*, 2020). This raises questions about the

extent to which local authority market shaping activities incorporate input from and support for these types of service users. Additionally, the literature highlights a diverse group of relevant stakeholders (including citizens, community groups and housing providers) who could potentially be involved in the process of market shaping. At the same time, a focus on commissioners and providers, which characterises much of the recent literature (Jasper *et al.*, 2019), raises questions about the breadth of participation and the ways in which this varies between local authorities.

The literature is helpful in distinguishing between factors which are within the control of local authorities and those which are not. However, this raises questions about the extent to which local authorities can and do work in partnership with other stakeholders to influence "exogenous" factors such as, for example, workforce supply. I did find one example of commissioners and employer representatives participating in a trade union campaign, with commissioners signing a voluntary charter guaranteeing workers an hourly living wage, payment for travel time and regular working hours (Johnson, Rubery and Egan, 2021). But this had very little impact on employment standards across the sector. Discussions of endogenous and exogenous factors, in the context of a national policy framework raises questions about the extent to which local authorities work together to tackle these issues. Over 20 years ago research exploring the ways in which local authority officials acquired and used information to help make decisions suggested that informal peer networks and particularly neighbouring local authority contacts were the most trusted sources of information for local authority decision makers (Wolman and Page, 2002). Local authority officials relied on their own sense of "what sounds right" (Wolman and Page, 2002: 493) and gave particular weight to what they personally could see or hear in practice. More generally, however, the researchers reported a reluctance to learn from the experience of other local authorities. It may be that the increased emphasis on evidence-based policy and the availability of online sources of information has changed this state of affairs. Furthermore, the market shaping literature discussed above was based on research conducted prior to the COVID-19 pandemic. Needham *et al.*'s (2023) speculation that the pandemic will result in a more rules-based approach requires further investigation. Additionally, the COVID-19 pandemic has resulted in developments which are likely to impact on the supply of home care for older people

(ranging from plans for compulsory vaccination in England to societal behaviour changes creating jobs in for example, online shopping warehouses). Additionally, the research sheds little light on how local authority commissioners in rural areas respond to the challenges of ensuring that care is delivered to those who are assessed as needing it. More generally, the research raises questions about the nature and impact on homecare services of local authority market shaping activities in rural areas.

1.11 Study aims and research questions

My research aims to provide insights into market shaping activities in local authorities. I seek to provide answers to the following research questions:

How and why, are local authorities attempting to undertake their market shaping duties in relation to home care for older adults in rural areas?

How does this differ from urban areas?

I do this using qualitative methods and a theoretical framework which I elaborate upon in the next chapter.

Chapter 3 Study Methodology

3.1 Introduction

Having discussed the literature and research questions relevant to my thesis, in this chapter I now outline the methods I used to attempt to answer those questions, as well as my ontological and epistemological approach which underpins the thesis. I describe my study design and explain how this changed during the early stages of my PhD, as well as providing my rationale for the approach I adopted. I have included a short section on research ethics and their relevance to my study. In addition, I explain my approach to data collection and analysis. My use of the term "collection" is not meant to suggest that data exist "out there" waiting to be collected. I use it as a convenient shorthand rather than in some way attempting to deny my role in generating data. At the same time, as I explain below, I want to claim that my account is a fair representation and not "merely" a construction. With this in mind, I retain the use of "collection", with the aforementioned caveat. In this chapter, I also describe the concepts from the work of Pierre Bourdieu (1977;1986;1990a) and indicate how I used these to add to my analysis.

3.2 Ontological and epistemological approach

As I mentioned earlier, my PhD supervisory panel included a commissioner from a local authority who was grappling with challenges concerning home care provision for older adults. These challenges, it seemed to me were real, as opposed to merely constructed. The further I got into the topic, the more I felt that I could capture something that reflected this reality, as opposed to claiming that my research was *merely* a construction and that others might construct their own reality in a way which contradicted my claims. I wanted to avoid approaching the research from a perspective of extreme relativism, such as that described by Kenneth Gergen (2015).

> "Now let's rephrase the basic constructionist idea and consider the consequences: if everything we consider real is socially constructed, then nothing is real unless people agree that it is. … it is from our relationships with others that the world becomes filled with what we take to be "death", "the sun", "chairs", and so on". (Gergen, 2015:4-5).

At the same time, I did not want to lay claim to context free objectivity. I was aware that I was part of the social world that I was studying. But saying that my findings, and even

my data, were socially constructed did not automatically imply that they could not represent social phenomena (Hammersley and Atkinson 1995). My aim was to represent reality, as best I could, and I found Hammersley's (1992) "subtle realism" helpful in developing my thoughts on what it was I was trying to do.

A "subtle realist" ontology (Hammersley, 1992) posits that entities exist independently of our understanding of them. At the same time, this approach accepts that researchers can make at best, only an approximation of this external reality. Data collection and analysis are influenced by the nature and perspective of individual researchers, and this made it important to reflect on my personal biases, as part of the research process. In addition, I have used my discussions with PhD supervisors, who are not directly involved in conducting the research, to test my emerging ideas and impressions.

A "subtle realist" ontology means that there can be different, but equally valid, perspectives on the same situation. However, these perspectives should not be contradictory (Hammersley and Gomm, 1997). Following Hammersley (1992), it is possible for knowledge claims to vary in terms of their degree of accuracy. Validity is a question of whether or not a claim accurately represents the phenomena it describes or theorises about. Assessment of validity depends on credibility (is the evidence for the claim convincing?) and plausibility (how does the claim fit with what is already known?).

The approach accepts that research participants also construct the world according to their perspective. I treat participant accounts as constructions but view them as important. This is because such constructions motivate action which has a real, as opposed to constructed, impact on the real world.

3.3 Study design

My choice of study design was influenced by my research questions. For example, the limited previous research into market shaping (Needham *et al.*, 2020) highlighted variation in local authority approaches. But I was interested in *why* such variations occurred. It seemed to me that investigating the experiences, beliefs and attitudes of a potentially large number of different types of stakeholders would contribute to my understanding of at least part of the "why". In addition, I needed to place these in context, to explore the structures which may influence them, as well as the local settings whose

features may also be part of the explanation (e.g., rural, urban etc.). My choice of Bourdieu as a theoretical lens was made relatively late on in my data collection process. I expected that actions would reflect the interaction of structure and agency and I was keen to collect data to enable me to understand this. However, I did not frame my interviews explicitly in terms of Bourdieu's theories of the social world.

Qualitative research was my preferred approach, given its ability to deal with data from multiple sources and messy and potentially contradictory perspectives (Creswell, 2014; Murphy *et al.*, 1998). In this context, where little was known about the topic, qualitative methods also offered me the flexibility to incorporate new knowledge and insights, as the study progressed (Bryman, 1988). My choice of study design was also influenced by my ability to access participants. My data collection was primarily via interviews. This was not my original intention, but a combination of factors meant that I adopted a pragmatic and opportunistic approach, rather than the neat comparative case study design I had originally envisaged.

My initial plan was to include sites in Wales, as part of a comparative case study design. Before starting my PhD I had made contact with a former colleague who had a broad knowledge of health and social care research in Wales, initially to ascertain whether what I was contemplating researching would be duplicating research already in progress. This led to conversations with a number of people conducting research in Wales and then to two local authority staff working in rural settings. I began to formulate a plan to include Welsh sites, as well as some in England and to explore the extent to which rurality and/or the national (i.e. England versus Wales) policy context influenced approaches to market shaping. Initially, the staff members in two Welsh local authorities were keen to participate in my research. At that point they had managed to recruit care workers who were retraining to work as carers, having previously worked in the tourism and hospitality sector. Those jobs were terminated in the COVID-19 pandemic, but once the economy began to open up again, they began to lose these workers. This meant that after initial enthusiasm on the part of those Welsh local authority staff, recruitment proved difficult. I had intended to undertake observational research shadowing local authority employees and others where relevant. But the COVID-19 pandemic and its aftermath meant that staff were working from home, rather than sitting in (shared) offices. This made it impossible

to observe interactions between these staff members. I decided to use interviews, rather than observation, therefore. After several months I had only managed three interviews with Welsh local authority staff, compared with many more in England. The initial enthusiasm at that site had cooled considerably and my key contact went off on long term sick leave. I decided to focus, therefore, on English local authorities, but I had already undertaken a number of interviews with microproviders in Wales. At my annual review panel meeting I explained that I would exclude my Welsh interviews from my study, but the panel members suggested that I retain the Welsh microprovider data for use within my thesis. The microprovider schemes in Wales varied between local authorities but were not substantially different from the various English microprovider initiatives in operation. On reflection, I decided that these interviews would add benefits to my study, as well as enabling me to fulfil my ethical obligations to participants.

3.4 Site selection, sampling strategy and participant recruitment

For the research I began by drawing on interviews from two local authorities, which were predominantly rural[1] in nature. One of these (Site A) appeared to be relatively traditional in its approach, largely relying on commissioning care from care agencies. At this site, a member of staff was very helpful in promoting the study, this combined with its rural nature contributed largely to its selection. I also attended an online meeting of care providers from this site, which was very useful for publicising the research and subsequent recruitment of provider participants. Following this meeting a number of individuals gave consent for me to approach them directly. I chose the other site because it had implemented an initiative which had departed substantially from the "industry standard" (Burns, *et al.*, 2023) model of care. I initially approached one member of commissioning staff at that local authority and they were helpful in publicising the study and contacting colleagues on my behalf.

I aimed to interview many relevant staff members to help me obtain an in-depth understanding of approaches in each site. Recruitment proved to be a challenge in the second site (Site B), and I decided to add breadth by including additional local authorities.

[1] I have used the Government Statistical Service (2017) classification description of "Predominantly Rural" which includes "Largely Rural At least 50% but less than 80% living in rural settlements and hub towns" and "Mainly Rural At least 80% living in rural settlements and hub towns".

As part of this process, I also began to involve some predominantly urban local authorities since this would help me explore the extent to which the approach and related challenges and opportunities, differed from those reported in rural areas.

I constructed a sampling frame for interviews based on the roles of stakeholder organisations and their members. This was informed by a) relevant literature (especially Needham *et al.*, 2020) b) discussions with local authority policy customers and c) snowballing. I kept this under continuous review as my theories about how "market shaping" should and did operate were developing. My aim was to identify key actors and their (potential) involvement in market shaping processes. Since local authorities vary in their approach (Needham *et al.*, 2020), the map of actors differed between them too. For example, in those sites where actions have been taken to pursue particular initiatives (e.g., Care Academies, microproviders etc.), I made attempts to collect data concerning these developments. Similarly, in local authorities where a provider membership organisation operated, I was able to interview their employees, unlike in those sites where these organisations were absent.

I found it really difficult to recruit paid carers. I offered a £20 shopping voucher as a token of my gratitude and asked providers to circulate details of the study. One refused but the others agreed. From this I recruited only two participants, who were both employed by the same organisation. Another interviewee offered to post study information on a Facebook page and based on this, I was able to recruit additional frontline carers. The advantage of this was that I was able to increase my sample of (ex) care workers. However, these interviewees were not drawn from sites which featured in my local authority interviews. Of the total employed carers, five had left the sector, in most cases due to dissatisfaction and so they may have been more critical of home care employment compared with existing employees. For microproviders, contact details were available in online directories and in some cases local authority staff circulated information to them on my behalf. I used a combination of direct emails and acceptance of offers from local authority staff to approach microproviders on my behalf for initial contact. For all participants, following initial email approaches I sent a copy of the study documentation and a consent form. Nobody refused participation, but in many cases I received no reply to my emails.

3.5 Ethical approval and related issues

In June 2021 I applied for ethical approval via Newcastle University's online portal. On 25th June 2021, I received ethical approval from Newcastle University Ethics Committee. Whilst completing the ethics application and during the conduct of my research, I had to give careful consideration to the demands I was placing on participants. I needed to ensure that my interviewees were not harmed in any way as a result of their participation in my research. As part of this process, I had to make sure that agreement to participate was given on the basis of informed consent. I also had to ensure that my approach to anonymity and confidentiality minimised the risk of harm to participants. In order to protect the identity of participants, I assigned an alphabetical site code and a unique numerical identifier to each of them. Information sheets and consent forms were emailed prior to the interview. Due to the remote nature of the interviews, I obtained verbal consent. I made every effort to ensure that interviewees felt comfortable with the interview process. This was especially important for carers, due to the potentially sensitive nature of the topics discussed. Interviewees were informed that they could pause the interview if a break was required, although nobody availed themselves of this.

In addition to safeguarding the rights of individual participants (Webster, Lewis and Brown, 2014) ethical considerations involve broad questions concerning the value of the study to "society". As far as my research was concerned, I was in agreement with those who argue that research should have some value, rather than merely being conducted for its own sake (Marín-González, *et al.*, 2017). I was especially conscious of this, as my research was funded from the public purse and the topic was an important one for local authority staff participating in the local ARC (National Institute for Health and Care Research Applied Research Collaboration NENC n.d.) and beyond. The implications here are that I had an ethical duty to disseminate my findings (Turcotte-Tremblay and Sween-Cadieux, 2018). I gave oral presentations at several conferences and one of these led to an invitation to speak at an event run by a not-for-profit organisation, which was concerned with home care for older adults in rural areas. Attendees included members of the public as well as employees of relevant statutory and voluntary sector organisations. I also published a paper in a peer reviewed journal (McDonald, 2023), but this is unlikely to be read by policy makers. However, having a local authority policy officer on my

supervision panel has enabled me to feed back findings in a way which has had some impact, at least in that local authority, albeit on a small scale.

I have had to balance my desire to disseminate my findings with the need to safeguard the rights of individual participants (Webster, Lewis and Brown, 2014), however. In particular, one local authority introduced an innovative policy to tackle problems relating to quality and quantity in older adults' home care services around a decade ago. This has been subject to an evaluation which reported very positive outcomes, as did a story in a national newspaper which did the same. Yet in order to preserve anonymity of participants I refer to this local authority only as Site B in my thesis.

3.6 Data sources and data collection

3.6.1 Study Participants

My data sources included primary and secondary data, with the former comprising interview data. The latter included internal documentation, sector reports and policy documents. Initially, I read documentation to extract relevant contextual information and to inform topic guides for interviews. I interviewed local authority staff to explore their views on the operation of the home care provider sector in practice and the salient issues for commissioners. In addition, my interviews covered the process of market shaping and its history and context, how the local authority intended to achieve its aims and views on progress towards these aims. I never used the term "market shaping" but approached this in a more oblique fashion. This involved asking questions about what interviewees did and why, as well as exploring the background of the interviewees and the local authority approach, where participants were able to provide answers.

I interviewed care providers from a range of types of organisations, as well as staff across the provider organisation's hierarchy, where I was able to do so. I had expected that elected members would feature in interview accounts and hypothesised that party politics would play a role, with perhaps left of centre local authorities favouring benevolent paternalism and more right-wing oriented local authorities promoting choice and market principles. In practice, participants almost never mentioned elected members and I found nothing to confirm and much to refute my prior expectations. A range of local authority staff were also interviewed to explore aims, processes and progress in relation

to market shaping, from their perspective. I had intended to investigate the service users' perspective by interviewing representatives from relevant carer and user groups. This proved to be very difficult, and I eventually abandoned my attempts and decided to focus instead on staff, especially as there were so many potential groups of relevant stakeholders, and I could not do justice to all of them. After I completed my data collection and most of my data analysis, I convened a focus group with members of an older adults group which had done some work examining home care. The group comments were helpful in that they supported what I thought I was finding. Further details are included in Appendix A.

In total I conducted 117 interviews and included 23 sites. Since my thesis is concerned with market shaping by local authorities, as outlined in Chapter 1, I define a site as a geographical footprint of a local authority. Table 2 below illustrates the number of local authorities included and their rural or urban designation.

Table 2 Local authorities by rural/ urban designation

Local authority type	Sites
Rural	A, B, C, F, H, J, K, L, M, N, O, Q
Urban	D, E, G, I, P, R, S, T, U, V, W

Table 3 below provides a summary of interviewees by role.

Table 3 Interviewees by role

Role	Number
Local authority commissioners*	19
Brokerage Team	2
Direct Payments	3
Social workers	8
Community support	2
Micro intermediary	7
Charity	1
Care agency managers/admin staff	32
(Ex)frontline carers	36
Other	7
Total	117

* Includes 1 former staff member

In addition to site-specific participants, I also interviewed seven other people whose experience was very relevant to my research topic but were not affiliated to a specific site. I present the details of participants in terms of the number of interviewees and sites, as well as their role in each of the relevant empirical chapters for ease of reference. 74 interviews were conducted by video link and 43 were telephone interviews. While one interviewee objected to being recorded and I made notes instead, the remaining interviews were recorded and transcribed verbatim. I transcribed 23 interviews, and the remainder were transcribed by a third party organisation.

3.6.2 Nature of interviews

Physical co-present interviews are often viewed as the gold standard in research (Deakin and Wakefield, 2013). Since these are conducive to building rapport in naturalistic settings, where possible, I chose a technique that most closely resembled face-to-face interaction, using online video interviews. There are advantages to remote interviewing (Lobe, Morgan and Hoffman, 2022). These include the relatively low cost in terms of investment of time and money to the interviewer and often to participants (Cater, 2011). In addition, these interactions enable the researcher and the researched to remain in a "safe location" (Hanna, 2012:241) without imposing on each other's personal space (Seitz, 2015). Remote video interviews enable the participant to exercise some control over self-presentation, for example by blurring or substituting the background setting and or camera effects (de Villiers, Farooq and Molinari, 2022). As with telephone interviews, participants can also exert greater control over ending the interview (Fielding, 2010). Compared with face to face interviews, I had little or no control over any distractions in my participants' environments and I may not even have been aware of them (Chen and Hinton, 1999). In some cases, particularly where staff were working from home and many were, interviewees were interrupted by family members, parcel deliveries, pets and/or the need to attend to domestic duties. Most of the non-frontline staff participants appeared to be accustomed to virtual meetings and interactions. In one case a participant shared their screen and talked me through a map to illustrate the rural and remote nature of the territory they covered during an online interview. However, at other times, participants mentioned places and I got the gist without having a good knowledge of the local geography.

All but two front-line paid carers, and some other interviewees opted for telephone interviews. During telephone interviews I was able to make notes more easily, since the requirement to maintain eye contact was not an issue. However, I needed to listen very carefully due to my inability to access visual cues and contextual data (Novick, 2008). The recording quality was usually worse for paid carer interviews, compared with online interviews. Furthermore, the phone signal was sometimes poor, partly due to the rural location of the participants. I was also conscious that paid carers were often talking as they walked and, in some cases, had little time to spare. Yet nobody ended the interview abruptly. Indeed, discussion of the logistics of issuing vouchers often led to a prolonged conversation in which interviewees shared additional thoughts.

The interviews were semi-structured (Kvale and Brinkmann, 2008) and open ended. I used an outline structure in the form of a topic guide. I modified this and added prompts as my interviews progressed. I also changed the sequencing depending on the flow of the interview and the participant responses (Robson and McCartan, 2016). I tried to develop rapport as a means of gaining trust and enabling participants to share their stories (Duncombe and Jessop, 2012). This meant that both my interview style and questions varied depending on the participants. For example, in some cases front line carers described stress and negative emotions related to work and/or adverse life events. I sometimes found myself sharing some of my experiences with carers in a way which was not inauthentic, nor purely instrumental. I did this as part of a process of displaying empathy and attempting to convey my understanding of participants' feelings, where it felt appropriate to do so. For other interviews, the conversation was strictly work related, with participants less inclined to mention personal emotions. Even in these interactions, however, accounts mostly appeared to present a "warts and all" description, rather than something rosier.

3.6.3 Data analysis

My initial approach to data analysis was based on techniques drawn from grounded theory (Glaser and Strauss, 1967). I thought that that this would help me in my aim of developing a fresh and new (to me anyway) understanding in a way which would encourage me to avoid falling back on my taken for granted assumptions about public policy making. I attempted to code interview transcripts in an inductive manner, but I did

not adhere faithfully to the prescripts of grounded theory. Having said that, there are many variants of grounded theory, with different theoretical underpinnings and approaches (Birks and Mills, 2011). Whilst an "open mind" is not an empty head (Dey 1999), grounded theory places emphasis on theory which is "grounded" in the data, rather than being influenced by a priori ideas and theory. I was aware of the findings of previous relevant research and was influenced by a number of specific research questions. These guided my approach to data collection and analysis. Also, my approach to recruiting participants was opportunistic (see earlier), rather than being guided by emerging patterns in the data. I moved away from grounded theory, therefore, to include a wide range of participants, with the intention of obtaining a rounded perspective on my research questions. My process of data analysis was largely thematic (Gibbs, 2018).

In general terms, thematic analysis is a means of analysing, organising, describing and reporting themes from a data set. This form of analysis involves various stages incorporating familiarisation with the data, assigning codes and developing themes which summarise key aspects of the data. Although these stages are frequently presented as a linear process, they are often used in a more iterative manner (Nowell *et al.*, 2017). Despite this generic "stages" description, there are a number of variants of thematic analysis, and these involve different definitions of what constitutes a theme and how to go about the process (Byrne, 2022). For example, Braun and Clarke (2006) suggest that themes reflect shared patterns of meaning and are outputs from a lengthy analysis process. Alternatively, themes may be considered as labels to summarise data, which are identified early on in the analysis process (e.g., Boyatzis, 1998). Braun and Clarke's approach places heavy emphasis on reflexivity, since themes are viewed as being created by researchers (Braun and Clarke, 2019). It is therefore important for the researcher to reflect on the way they go about going creating themes. Rather than attempting to overcome "bias" or subjective influences, Braun and Clarke embrace "researcher subjectivity as a resource…and reject the view that coding can ever be accurate" (Braun and Clarke, 2023: 2).

Many researchers ostensibly applying this approach use terms such as "emerging" themes or describe how themes were "discovered" (Braun and Clarke, 2023). These research accounts embody confusion, since following Braun and Clarke (2006; 2023), themes are

not “contained” within data, awaiting assistance to emerge. Instead, they are constructed, and the process is heavily influenced by the subjective interpretation of researchers. Linked to this, Braun and Clarke (2023) are critical of terms such as triangulation and member checking, since these might imply an objective “truth” which is at odds with the constructed nature of themes. Braun and Clarke are also very clear that only a relatively small number of themes (two to six) should be created (Braun and Clarke, 2012) and that where larger numbers are identified, this is due to misconceptions about what constitutes a theme (Braun and Clarke, 2016). The danger with larger numbers of themes, they suggest, is also that the analysis has been superficial, rather than in-depth.

In stark contrast, Boyatzis’ (1998) post-positivist approach suggests that themes may be identified from previous research or theory in an *a priori* manner, as well as generated inductively from the data. Boyatzis acknowledges that interpretation is involved in thematic analysis, but he also claims that from this process “social facts or observations…emerge” (1998, p.xiii).

These different perspectives reflect divergent ontological and related epistemological assumptions (Bryman, 2004) at either end of a spectrum. In keeping with my subtle realist perspective (Hammersley, 1992) my approach is somewhere in the middle and is heavily influenced by Gibbs (2018). For Gibbs, thematic analysis is a generic technique, which has been used to inform diverse analytic approaches. In developing a “framework of thematic ideas” (2018: 54) about data, researchers can code using “data driven” and/or “concept driven” codes. The former which is often called “open coding”, starts with the text and attempts to derive an understanding of what is happening, in an inductive manner. The latter brings other, external ideas or concepts to the analysis of the data. These could be informed by previous studies, the relevant research literature more generally, topics in the interview guide or ideas the researcher may have about what is going on in relation to their topic of interest (Creswell, 2014; Maxwell, 2005). Many researchers adopt both of these approaches to coding as Gibbs (2018) acknowledges. Even amongst those who use grounded theory, many acknowledge that the researcher as “*tabula rasa*” is neither a realistic nor useful proposition (e.g., Charmaz, 2014; Thornberg, 2012).

One attraction of Gibb’s method was that it enabled me to combine inductive and deductive approaches. I felt that this was necessary since there is an existing literature,

which appeared helpful in informing coding. At the same time, the market shaping literature is relatively small. Constructing a framework (Ritchie and Spencer, 1994) prior to coding seemed inappropriate and risked an overly narrow interpretation of the data. Furthermore, the existing market shaping literature did not capture the changing context which included the COVID-19 pandemic and the escalation of workforce challenges, beyond rural settings, reaching crisis proportions. Braun and Clarke (2023) are critical of approaches which draw from a variety of potentially incompatible methods, and I was keen to avoid doing so.

Gibbs (2018) is much less prescriptive compared with Braun and Clarke (2012) in terms of the number of themes to be identified. I wanted to keep an open mind to avoid torturing the data until I was able to condense it to say, two themes. I could see how an examination of why people engage in skin picking (an example provided by Braun and Clarke, (n.d.) on their thematic analysis website) might lend itself to reduction in a manner consistent with Braun and Clarke's approach. But I had a number of research questions and a range of diverse groups of stakeholders. I was not sure how well these would fit with the approach outlined by Braun and Clarke (2006; 2023). In addition, I did want to make claims about an external reality and that my interpretation was in some way reflective of that reality, rather than being merely a creative endeavour. Gibbs' approach was very helpful in relation to these aims.

3.6.4 Coding

Gibbs (2018) advocates a flexible stance to analysis, which means that researchers should not become tied to initial codes, in contrast to framework analysis (Ritchie and Spencer, 1994), where a coding template is constructed prior to data analysis, for example. Gibbs (2018) is also more relaxed than Braun and Clarke (2006) about starting coding before data collection is complete. I needed to follow a process which would enable me to begin to analyse data before the end of my data collection phase. This was because I had a large data set comprising a range of diverse groups of stakeholders. It was difficult to keep participant responses in my head to enable me to reflect on them. Indeed, most qualitative researchers code their data during and after collection (Miles and Huberman 1994; Saldaña, 2013) so I was not unusual in taking that approach.

Gibbs does not offer "one best way" of approaching analysis, but instead describes techniques which are available that researchers may find useful. For example, Charmaz (2003: 94-5) suggests that a number of questions should be asked when approaching data analysis as follows:

What is going on?

What are people doing?

What is the person saying?

What do these actions and statements take for granted?

How do the structure and context serve to support, maintain, impede or change these actions and statements?

Charmaz (2003) is an advocate of constructivist grounded theory. However, there is no reason why researchers using thematic analysis following Gibbs' (2018) approach should not think about these questions when analysing data. Transcribing initial interviews and uploading them into NVivo meant that I could start to become more familiar with the data and begin to assign initial codes to sections of the transcripts as part of the data analysis process. For the transcripts which were typed by a third party, it was even more important to read and reread these as part of the process of initial familiarisation and subsequent coding. Additionally, I was using this process to help me think about revisions to topic guides for subsequent interviews, as well as to identify potential interviewees. Furthermore, since interviews were conducted over a 13-month period, I did not want to approach them from a perspective of looking back, in some cases over a year. I found that undertaking reading and coding closer to the interview date was helpful in terms of reflecting on the context at or near that point in time.

In terms of what should be coded, some writers suggest that it is important to code everything (Friese, 2012; Lofland *et al.*, 2006). Others (Guest, MacQueen and Namey, 2012; Seidman, 2006) advise that much of the data can be omitted from the process, since the aim is to devote time to intensive analysis of those aspects which are most salient to the research question. The danger with that approach is that items which may appear less pertinent to the analysis may subsequently prove to be highly relevant. For this reason, I

followed the "[i]f it moves, code it" advice of Richards and Morse (2007). This meant that coding even included statements like "… I've just got a parcel delivery at the door", "excuse me that's my daughter coming home from school…". These highlighted the convenience of working from home. They also raised questions about these new working practices and their impact on home care delivery in a context where co-location and face to face interaction had previously acted to sustain relationships, transmit knowledge and reproduce existing practice.

The process of coding is an iterative one (Murphy *et al.*, 1998) and as time went on, I began to identify more abstract, as opposed to descriptive codes. In particular, Charmaz's (2003) questions were helpful here. Often participants described actions and made reference to contextual factors which supported actions, either their own or those of others. It was relatively easy to assign descriptive codes to these. But asking myself questions about what was "taken for granted" helped me to identify codes which went beyond descriptive elements. Linked to this, asking what was absent and being alert to what participants intentionally or unintentionally avoided (Bogdan and Taylor, 1975; Ryan and Bernard, 2003) was very helpful. For example, most participants did not generally talk about quality or personalisation of care. Part of what appeared to be taken for granted was that the goal was quantity of care and the (often unspoken) assumption was that personalisation was not possible nor even considered. In addition and linked to this as part of the taken for granted landscape, the assumption that care provision was the preserve of care agencies and that more staff would solve the problems in the sector was for the most part, not subject to critical reflection.

As I identified abstract codes, I revisited the data I had coded earlier on in the process, and it was clear to me that these more abstract codes were equally applicable to the earlier transcripts. For example, a coordinator described innovation within his organisation, speaking in glowing terms of the computer system which enabled remote monitoring of staff. He explained how this was indicative of the modern, forward-looking nature of the business.

> "We're growing as a company…they've had to change with the times haven't they? Otherwise, we'll get left behind. Oh, we don't wanna be left behind as a company. We wanna look forward …" [ID22, Site A, Business Manager, Preferred Provider ID1]

In the same interview, this participant went on to explain how, when it came to care that was more client focused and personalised (my terms, not theirs), changes were not possible. For example, a new client requesting a particular time for their morning call would be given an explanation of why this could not be done. No attempt would be made to reflect on whether a forward thinking, growing business could accommodate such requests. I coded this as absence of personalisation and as care as quantity.

> "…they don't understand at all. They think if you just move that one, then I'll get nine o'clock. We can't change that time…" [ID22, Site A, Business Manager, Preferred Provider ID1]

Rereading the transcript, I was struck by the taken for granted assumption that service users should fit within time slots determined by the business. Customer service appeared to involve explaining why things were not possible in order to avoid and/or respond to complaints rather than any consideration of internal processes.

3.6.5 From codes to themes

The process of coding meant that I generated a large number of codes. Following Gibbs (2018), I needed to go beyond identifying codes to developing themes. I did this by grouping some codes which I linked to a "theme". A theme is not simply a summary of these codes, but a concept which conveys meaning beyond a summary. For example, codes such as "discharge pressures", "unfilled packages", "staff sickness" might be summarised as pressures. But developing themes involved looking for patterns in the data, as well as relationships between different actors, settings and so on. I conceptualised these codes as contributing to the theme of "care as quantity". To help add depth, it was important to focus on "why" questions to obtain understanding. In addition, this theme was not universal, and it was important therefore, to develop theory about similarities and differences, as opposed to merely noting their existence.

I grouped codes into what seemed to me like relevant themes. For example under the theme of "Time" I include Length of call, Time and task, Not enough time, Short cuts, Calls exceeding allotted time, Travel to work duration, Eye on the clock, Travel between calls, Staying for full call, Saving time, Minimum call time, Scheduling calls/timetabling, Shift times, (Un)paid hours, Out of/into bed times, Control over time, Rationing time, Assessed need – time, Extra calls added, Training in own time and Time – unrealistic. Other codes

not grouped under Time included quantifiable aspects such as numbers of staff (shortfall, leaving), miles travelled, mileage allowances, pay rates, local authority reimbursement rates, unfilled packages of care, local authority budgets, inflation rate etc. I initially grouped these and the "Time" codes to a new theme of "Quantity". As part of my iterative approach to analysis, I revised and reorganised groupings, moving some of the initial codes which I had grouped under a theme of Time to Quantity. I continued with this process, reorganising, regrouping and thinking as part of the iterative approach I had adopted. The result was that I stopped at a point where I had grouped the data under three themes. These were "Care as Quantity", "Care as a problem" and "Care as dysfunctional".

There were examples of groups of participants whose accounts differed in important ways from some of the others. For example, accounts given by microproviders and some staff from small care agencies did include an emphasis on personalisation and quality. Additionally, in some cases I identified absences by noting what was present and also what seemed to me to be missing, in terms of what I had expected from participant accounts. For example, participants did talk about care as enabler (although not using that specific terminology), but only in relation to younger disabled adults. I coded these references to "care as an enabler" but grouped them to the theme of care as a problem.

Based on these themes, I concluded that market shaping in practice, had become a process of perpetuating dysfunction. It also seemed to me that participants appeared to take for granted this state of affairs. However, I also found that the accounts of microproviders and some small providers were different from those given by the majority of interviewees insofar as the care they provided was described as being fulfilling and of good quality. Only one social worker (at Site B, ID06) had experience of working with microproviders as did some local authority staff working with microproviders. These interviewees also described the care they provided as being much more personalised. At the same time, the accounts of these interviewees when describing care provided as part of the "time and task" contract arrangements tended to reflect the views of other interviewees.

Table 4 overleaf illustrates some of the codes grouped into overarching themes.

Table 4 Grouping of codes into themes

Theme	Codes
Care as a problem	discharges/clients more complex, demanding / expectations, ageing population -timebomb, deficit-based needs assessment, ageism, care as an end in itself, tendering – workload & inflexibility issues. Contradictory - Care as an enabler, but only for Younger Disabled Adults, and for small and microproviders.
Care as quantity	focus on number of (unfilled) packages, many of the codes discussed above concerning time, number of staff short, pay rates, absence of personalisation, quality measured by CQC ratings, % of providers achieving good or above. Contradictory - Care as quality, but only for small and microproviders.
Care as dysfunctional	rushed, unfulfilling, staff stressed, staff bullied, staff leave, staff shortages lead to increased pressure. Contradictory – care as fulfilling and rewarding, but only for small and microproviders.

In analysing my data, I grappled with questions concerning why it should be that the dysfunctional nature of the system should persist and be taken for granted. I was also keen to understand why there were variations in approaches to market shaping in the context of a common national context. I could appreciate that care workers were in a vulnerable position in a context where structures of inequality, power and class placed them at a disadvantage relative to, for example, local authority commissioners and care provider owners and managers. Theories which incorporate what might be referred to

as a relational turn present diagnoses in terms of care relationships which are undermined by economic imperatives and an emphasis on the independent self-interested individual (Gopnik, 2023; Herring, 2020; Lynch, 2021, 2023; Slaughter, 2023). It is argued that capitalist approaches ignore the interrelatedness of society, which is fundamental to "the ways in which the self is co-created, through struggles and negotiations in relationships, for better or worse, both collectively and individually" (Lynch, 2024: 30). Relational theorists point out that in the context of the independent, autonomous citizen, there are no good dependencies (Gordon and Rottenburg, 2024; Herring, 2020). This might explain why the accounts of my interviewees conveyed an understanding of care as a problem. But theorists often fall short of defining interdependence and/or explaining the process by which such interdependencies contribute to the process of self-formation (Gordon and Rottenburg, 2024). Lynch is unusual in that her theorising offers a nuanced approach to relationships in the context of care. This includes consideration of affective relations as they apply to humans and non-humans, as well as the environment (Lynch, 2021).

She describes primary, secondary (usually paid work) and tertiary care relationships with the latter being relations of solidarity that may involve voluntary effort or statutory obligation (Lynch, 2021). She proposes a new sociology of affective care relations to "enhance a normatively-led sociology of inequality, that is distinguishable from, but intersecting with, a sociology of inequality based on class (redistribution), status (recognition) and power (representation)" Lynch, Kalaitzake, and Crean (2021). Her concerns with inequality, recognition and power certainly resonated with my data. However, I had paid less attention to "affective care relations" and thought that attempting to retrofit Lynch's framework would not be appropriate. Theorising relationships in a care context can lead to hypothesising and/or making assumptions about emotions involved in such relationships (in addition to Lynch, see for example Slaughter, 2023; Gopnik, 2023). However, based on my data, an approach which prioritised inequality, status and power, would be more helpful as I did not explicitly focus on affective bonds in my investigation of market shaping. Additionally, treating "affective care relations" as a distinct entity runs the risk of obscuring the impact of the origins of emotions and the structures of power and inequality which shape them

(Matthäus, 2017). Affective bonds were definitely not the focus of my research, and I chose to use Bourdieu's work as a theoretical framework instead.

Lynch acknowledges the importance of Bourdieu for understanding practice and the social world more generally (Lynch, 2010; Lynch, 2024). Furthermore, Skeggs (1997) and Hebson, Rubery and Grimshaw's (2015) Bourdieusian informed depiction of care workers' gendered class-based habitus appeared to be very relevant to my data. Bourdieu's work spans decades, during which his empirically informed concepts were described and clarified. This work comprises much that is relevant to my data including, for example, theories on activity at the local state level (Bourdieu, 2005). Additionally, Bourdieu's approach is relational but, that is very different from saying that care is a relational process; and it goes beyond a view of society as involving interdependency and affective bonds. Bourdieu's relations are conceptualised in terms of a social space in which relations are defined by hierarchy. I could see that Bourdieu's toolbox of concepts (habitus, capital and field) would be helpful in terms of my data. Rather than simply identifying class as important, drawing on Bourdieu, I could identify the various ways in which structures influence behaviours. These structures included those of the home care field, as well as other fields. In addition, these structures appeared to be influential in terms of workers' access to valued forms of capital. I provide a fuller explanation of Bourdieu's concepts (1977; 1986; 1990a) and how these relate to my data in what follows. As I explain in the following, I found that situating accounts within the structures of the home care field was helpful in terms of understanding why dysfunction is preserved and why there is widespread acceptance of this.

3.7 Bourdieu and interpreting findings

3.7.1 Field

For Bourdieu, human action always takes place within a "field", which is a space of social relations (Bourdieu, 1990a). Fields are sites of struggle, for legitimation, with the dominant norms and institutions contested by different social actors with different stakes in the field. Individuals occupy positions within the field hierarchy and are differentially positioned in that hierarchy. Reading and rereading the transcripts, what became apparent was the manner in which participants drew on "taken-for-granted" assumptions to interpret changes in ways which framed and constrained their responses. Although on

some issues, there was a high degree of agreement (all microproviders were much happier, compared with being an employed carer), in other respects there were differing attitudes (especially regarding the desirability of microenterprise). The range of actors within my study reflected a variety of field positions. It was important, therefore, to consider participant responses "as a view taken from a point in the field" (Bourdieu and Wacquant, 1992:101) in order to understand similarities and differences amongst and between groups.

Following Bourdieu, my interviewees' accounts should be interpreted as reflecting hierarchically organised field positions, within historically specific configurations of the field relational structure (Bourdieu and Wacquant 1992:97–98). Fields comprise individuals and groups who occupy positions, which enable them to shape, to a greater or lesser extent, the shared meanings which dominate in the field. Bourdieu's approach is a relational one, which means that an individual or group can be classified according to their relative position within the field (Bourdieu and Wacquant, 1992). These classifications are based on the possession of levels of field specific capital and are hierarchical in nature.

3.7.2 Capital

For Bourdieu, capital (economic; cultural e.g., formal qualifications; social e.g., networks; and symbolic, referring to status or recognition) is distributed throughout society and has an exchange value within the field. Cultural capital takes various forms, one of which is embodied (Bourdieu, 1986). As discussed in chapter 2, certain characteristics such as being female and linked to that, a presumed "natural" facility for caring, on the part of women, can be seen as cultural capital (Skeggs, 1997). Yet, there are always constraints on the exchange value of this form of capital, as the low status of care workers illustrates.

Symbolic capital is key to understanding the ways in which patterns of power and domination operate within a field (Bourdieu, 1977). It relates to an individual's level of status and respect, but this depends on social agents to "recognise it, to give it value" (Bourdieu, 1994:8). If, for example, microenterprise is to thrive, then it seems likely that relevant social agents need to recognise microproviders as legitimate and respected providers, despite their exemption from national regulatory oversight. There was universal agreement that employed carers were not afforded a level of esteem commensurate with the value of the service they delivered. In contrast, low esteem did

not appear to be an issue for microproviders and applying Bourdieu's concept of symbolic capital to the data, I was able to understand why this should be the case.

3.7.3 Habitus

Bourdieu's concept of habitus incorporates both the embodiment of structure (since knowledge, dispositions and competences are acquired in social structural contexts) and provides ground for agency, since structures are never wholly determining. The habitus is an embodied collection of norms, rules, dispositions and codes of conduct that collectively, and largely pre-reflectively, structure our engagements with the social world (Bourdieu 1990b: 19). Individuals develop a "taken for granted" understanding of rules and ways of working, but "when a field undergoes a major crisis …. its regularities (even its rules) are profoundly changed" (Bourdieu, 2000: 160).

The ways in which field actors are perceived by others have important implications for their ability to flourish (or otherwise) within the field (Bourdieu and Wacquant, 1992). According to Bourdieu, "in so far as he or she is endowed with a habitus, the social agent is a collective individual or a collective individuated by the fact of embodying objective structures. The individual, the subjective, is social and collective. The habitus is socialized subjectivity, a historic transcendental, whose schemes of perception and appreciation (systems of preferences, tastes, etc.) are the product of collective and individual history". (Bourdieu, 2000: 211). As part of that history, in a context of neoliberalist market "solutions", the conceptualisation of older adults by social workers and care managers has been depicted as shifting, in a way which leads to the prioritisation of risk management over citizen empowerment and autonomy (Bornat and Bytheway, 2010; Carey, 2016). Bourdieu's work was helpful in thinking, for example, about what a social worker habitus might mean for home care and how changes to that habitus had occurred in some of my sites, but not others.

3.7.4 Bourdieu – bringing concepts together

For Bourdieu, fields exist in a state of flux, but at the same time they are characterised by a high degree of stability (Bourdieu, 1990a). The many changes in the field of home care in recent decades (Lewis and West, 2014) can be seen as changing the distribution of capital in the field as local authorities became commissioners of care from a growing independent provider sector. I found it useful to draw on the work of researchers who

have highlighted the importance of social, economic and cultural capital in acting to constrain home care employees (Skeggs, 1997; Hebson, Rubery and Grimshaw, 2015). But I found that Bourdieu's habitus and field concepts are also crucial to understanding changes in home care. In subsequent chapters I describe field changes in some sites, which involve adaptation to habitus and redistribution of capital within the field. As others suggest, employed carers have limited access to valued forms of capital (Skeggs, 1997), which implies they may lack the "social force" (Bourdieu and Wacquant, 1992: 30) required to introduce field changes. Following Bourdieu (1977), I found it important to examine the accounts of other individuals and groups, to understand such changes, therefore. This includes groups whose members do not engage in specific action related to the change, but which are taken into account, by those who attempt to initiate changes. Linked to this, I found it essential to go beyond social, economic and cultural forms to examine symbolic capital. I used Bourdieu's (1977) concept of habitus and its relation to capital and field to help explain why changes occurred in some places and not others, as well as to theorise the "taken for granted" aspects of the home care field, which appeared to me to be dysfunctional.

An added attraction of Bourdieu's ideas was that they acknowledge both difference and regularity (the habitus is shaped through experience, varying from place to place and time to time), as well as change over time (the habitus is durable, but not eternal), whilst at the same time locating these changes within a wider field (Bourdieu and Wacquant, 1992). Bourdieu is not without his critics. He has been described as better able to explain continuity than change (Crossley, 2001), with habitus involving an "overdetermined" view of subjectivity (Lovell, 2000). Additionally, his work largely adopts a macro perspective in terms of the state and its workings (Mohr, 2013; Mottier, 2002). The result is that he fails to distinguish between the sectors of the state involved in formulating policy at national level and the lower-level state institutions and actors involved in implementing policy (Steinmetz, 2014). Since local authorities vary in their response to national legislation and directives (Johnson, Rubery and Grimshaw, 2021; Needham *et al.*, 2023), it is important to explore regional interpretations of meanings and practices in order to understand this diversity of response. Furthermore, (Bourdieu, 2001) fails to recognise that the state, or elements of it can contribute positively to the reproduction (or not) of the gender order

(Mottier, 2002). With regard to gender, some feminist writers have developed Bourdieu's work applying it to a range of topics which are relevant to my research (e.g., care work (Skeggs, 1997) and the role of gender in structuring fields (Moi, 1991)). Others critique his failure to engage with feminist theory and what they see as his reductionist approach to gender (Adkins and Skeggs, 2004), amongst other things.

I have used Bourdieu's work where I feel that it is helpful to do so therefore, rather than embraced it uncritically in its entirety.

3.8 Approach to empirical chapters

In my empirical chapters I focus on presenting findings and interpretation based on my inductive, thematic analysis. I have included a relatively large, but not I hope, excessive number of quotes within these chapters. In part, this is due to the wide range of stakeholders involved. But it also reflects my desire to present evidence, as part of my attempt to satisfy the criterion of credibility (Hammersley, 1990). In order to avoid repetition, I have situated much of my analysis in the discussion chapter, which follows the four empirical chapters. In that chapter I use Bourdieu to add depth and understanding to what is contained in those empirical chapters. My final chapter contains brief concluding remarks.

Chapter 4 Local authorities and related organisations

4.1 Introduction

As outlined in Chapter 3, I identified 3 themes based on my analysis of interview data. Table 5 illustrates the relationship between themes and groups of interviewees.

Table 5 Relationship between codes and groups

Themes	Groups	Contrary accounts/themes absent groups
Care as a problem; Care as quantity; Care as dysfunctional.	• LA commissioners, social workers and brokerage staff. All sites where these staff were interviewed [A to H] • Care provider organisation owners and managers. All sites where these staff were interviewed [A, C, J, P] • Employed carers (current and former). All sites where these staff were interviewed [A, B, M, O, P, Q, R, S, T, V, W] • Provider representative group chief officers. All sites where these staff were interviewed [B, N]	• Microproviders, other self-employed providers*, third party and local intermediaries, direct payments staff talking about microprovider care. In all sites where interviewed [B, K, M, N, O, T, V]. • One social worker Site B working with microproviders. • Two small provider owners/managers Site A. • Site A and B one LA commissioner and 2 social workers Site A, but in these cases, only for working age adults.

*There were a small number of interviewees (n=4) who provided care via a direct arrangement with service users but did not participate in a local authority supported initiative. I refer to these as "self-employed" in the table above.

As outlined in chapter 2, local authorities have a duty to engage in market shaping. In addition to understanding their local market, local authorities must "stimulate a diverse range of care and support services to ensure that people and their carers have choice over how their needs are met and that they are able to achieve the things that are important to them" (Department of Health, 2017). This duty also entails ensuring "that the care market as a whole remains vibrant and stable" (Department of Health, 2017).

This chapter investigates the issue of market shaping from the perspective of local authority employees and other relevant staff. It does this by examining their attitudes, motivations and experiences. Following on from my research questions I also explore variations in local contexts and where possible, differences between rural and urban settings. In addition, I describe the impact of the COVID-19 pandemic, from interviewees' perspectives. The pandemic was often raised spontaneously by participants and its impact was felt across the home care field. But I was also keen to assess Needham and colleagues' (2023) speculation that COVID-19 may predispose commissioners to approaches which rely on a strong rules approach to market shaping.

4.2 Interviewees and organisations

In this chapter, I draw on the accounts of interviewees who are employed by local authorities or by third party organisations which are contracted to provide support for local authority-related functions. Interviewees comprised commissioning, support planning, direct payments and brokerage team[2] staff and social workers, as well as intermediaries providing support to microenterprise. In some local authorities, this role had been contracted out to a third party and these staff are also included, as is the chief executive of an organisation contracted to provide support to the local authority.

Interviewees discussed in this chapter were drawn from 14 sites and some had roles which were not site-specific (see below for further detail). 10 sites were predominantly rural and the remainder (D, E, G and I) were predominantly urban in nature. Of the 40 interviewees

[2] These staff liaised with providers on a day-to-day basis with the aim of securing packages of care for adults assessed as requiring these packages.

in my "local authority and related staff" sample, 15 were based in one local authority – hereafter site A. These comprised commissioner and brokerage team staff (5), community support services leads (2), social workers (7) and the direct payments lead (1).

In site B, interviewees comprised commissioners (n=3), the direct payments lead (1), social workers (1), a microenterprise intermediary TUPE'd[3] to the council and the chief executive of a countywide rural focused charity, working with the local authority. In addition, I interviewed a former member of commissioning staff who was, at the time of the interview employed by an organisation promoting microenterprise. Site C's interviewees comprised 4 commissioning staff. At Site D, I interviewed 3 commissioning staff who talked about changes they were making to home care commissioning. Table 6 below presents a summary of participants at these sites.

Table 6 Participants at sites A to D

	Sites				
Roles	A	B	C	D	Total
Local authority commissioners*	3	*4	4	3	14
Brokerage Team	2				2
Direct Payments	1	1			2
Social workers	7	1			8
Community support	*2				2
Micro intermediary		1			1
Charity		1			1
Total	15	8	4	3	30

* Includes 1 former staff member

I also interviewed 12 commissioning, direct payments staff and microenterprise intermediaries at other sites (n=10). In some cases, these were able to talk about the

[3] Transfer of Undertakings (Protection of Employment), or TUPE protect rights as an employee when they transfer to a new employer.

approach to commissioning home care generally (n=6). In others, the staff were focused on a specific initiative to develop microenterprise in home care services (n=6). Interviewees' accounts at sites E to N often resonated with my interviews from Site A to D. However, I was only able to interview one or two people at most of these sites, which meant that it was not always possible to collect data about the history and context of the local authority. Table 7 below presents a summary of participants at these sites.

Table 7 Participants at sites E to N

	Sites										
Roles	E	F	G	H	I	J	K	L	M	N	Total
Local authority commissioners	1	1	1	1			1				5
Direct Payments						1					1
Micro intermediary		1			1	1		1	1	1	6
Total	1	2	1	1	1	2	1	1	1	1	12

Seven additional interviewees were not located at a specific site. Of these, four were with staff employed by an organisation which promoted community oriented, participatory approaches within local authorities. These participants had a mixture of expertise covering community participation, local authority networking and home care. In terms of the latter, they had supported the promotion and development of microenterprise in a number of settings. Other participants were a full-time union representative, a Skills for Care[4] staff member and a former social worker with consultancy experience covering national older adults' charities and direct payments in a number of local authorities.

4.3 Sites A and B

4.3.1 Common approaches

My initial interviews were undertaken in sites A and B. Both local authorities had over 50% of their population resident in rural areas. Both local authorities contracted with preferred

[4] Skills for Care is a workforce development and planning body for adult social care in England.

providers, within a tiered model for the provision of home care within the county. Tiers meant that packages were offered to other approved providers when the preferred provider was unable to deliver. Contracts were of a "time and task" nature, as was the case in most, but not all, of the study sites. Both local authorities reported that these preferred providers tended to be small local providers, rather than national corporations. Of course, "small" is a relative term and these providers needed to be large enough to provide care across a geographical footprint as required in the tender documents.

In both cases local authority commissioners appeared focused on achieving market stability in the context of what they perceived were the twin crises of the COVID-19 pandemic and the ongoing workforce shortage. At both sites there was agreement from commissioners that procurement regulations often acted as a barrier to securing provision that met the aims of local authority commissioners. (These views were also echoed at most other sites). These barriers related to tendering processes which could be challenged by unsuccessful providers and ran the risk that the highest scoring bids might reflect an organisation's ability to write bids, rather than to provide home care.

In both sites, problems relating to agency care capacity had been particularly acute in rural areas, but these were now prevalent in urban settings too. At both sites (and in all other sites), relationships with providers were reported to be good, with COVID-19 being described as improving relationships. Both local authorities were reporting home care staff shortages which hampered efforts to secure care. There was agreement that the status of home care work needed to be improved, but no suggestions of how this might be achieved. (Similar views and experiences were reported in all of the other sites).

4.3.2 Care as quantity

Interviewee accounts often focused on quantity in terms of the number of unfilled packages and the minutes of care to be provided. One social worker at Site A described tactics to ensure that care staff remained in clients' houses for the contracted number of minutes.

> "…we write down a task to do within that 30 minutes…. So they can't leave within that time. So what we try to do is say prompt/administer medication. Ensure that client is appropriately dressed for the day and ensure that they've had their breakfast. Ensure that the house is safe. You know, that there's no trip hazard or anything like that and stay and provide some social interaction until the 30 minutes

> are up. So basically you're getting the carers to remain for 30 minutes just to support the client as a lot of the time they're the only faces he's gonna see in a 24 hour period". [ID08, Site B, Social Worker]

This emphasis on filling time with tasks raises questions about the preferences of the service user, which do not appear to be considered in this well-intentioned approach. At Site B the local authority also used "time and task" contracts. A former social worker turned commissioner described the tension created by contracts which specified minimum times in a context of resource scarcity.

> "…we've had a case this week where a provider's been going in. They can do the personal care within 15 minutes. The family have complained 'cause they're not staying for the full half hour. That's really frustrating for me because obviously from a social work background, you know that's Care Act, they've been assessed. They need like half an hour in the morning. The other part of me is thinking that's 15 minutes that could be spent on somebody else when we've got 70 people, 80 people waiting for care, let alone what we've got waiting in our system to come through. You know? So it's oh, it's all these things playing around in my head Ruth. You can imagine what my head's like, can't you?" [ID34, Site B, Commissioner]

Hourly wage rates of providers, as well as local authority rates paid to agencies were a preoccupation. Bonus schemes aimed at incentivising staff to remain in post were being implemented at these (and all other) sites. At various points, non-recurring government funding was allocated to local authorities, but they were given little notice and little time to spend it. At all sites, this was highlighted as a very inefficient way of managing additional resources.

Commissioners at both sites were actively involved in securing additional funding to enable care agencies to increase their pay rates. Generally, however, local authority commissioners did not discuss the working arrangements and wellbeing of front-line paid carers, other than in the context of formal pay and conditions. This is perhaps understandable, since office-based local authority staff have no contact with paid carers. This may also have been because inadequately resourced local authority contracts for time and task-based care place pressures on front line staff, which local authority staff would rather not contemplate. Amongst some interviewees this model of provision appeared to be taken as a "given" which may encourage local authority staff to focus on small changes at the margin rather than major change aimed at disrupting the dominant model of provision.

4.3.4 Care as a problem

Care appeared to be conceptualised as a problem in both sites. This view resonated with interview accounts at most other sites. In a context where commissioners are struggling to secure care packages, this perception is understandable.

> "Levels of complexity of the people needing homecare have increased. Fewer people want to be in care homes, entirely understandably. And it's become much harder to operate undeclared policies of saying 'if it costs more to support you at home, than it would cost in a care home we're going to put you in a care home' which I think to be brutal is how a lot of things worked 10, 20, 30 years ago. But the consequence of that is home care has become a harder thing to deliver because of the nature of the packages that you're having to deliver. And the unpredictability of when the needs will start and when they'll end. Not just the hospital discharges, but people generally who come to need high levels of care, but you can't know how long it'll last, and you may need it in a hurry" [ID01, Site A, Local Authority Commissioner]

The fact that care is conceptualised as being delivered by traditional care agencies may also contribute to a view of care as a problem, as opposed to an enabler. In the quote below, the commissioner compares home care provided by agencies, with another service, illustrating the contrast between care as a problem and as an enabler.

> "I can't overstate really how difficult the last 18 months have been. You know it is exhausting. It's been really, incredibly challenging. …. You know it's [another service] one of those [residential] services that [colleague], and I go to if we're feeling a little bit flat, because it lifts you…. That's what we need to be replicating in the community" [ID34, Site B, Local Authority Commissioner]

If the local authority is unable to secure care packages, then the conceptualisation of care as a problem is understandable. At Site A, social workers talked about managing expectations, in the context of a shortage of home care staff.

> "We have those discussions very much at the beginning of our assessments so that we are creating an expectation. We are explaining. It's not just a bolt out of the blue to say 'right we're looking at a care home'. We're saying 'this is an issue. This potentially is an issue…We'll offer this option as a short term and this is how we will follow it up to make sure we get you home as soon possible' and so it can be very difficult to manage those expectations, because rightly so, they should be going home". [ID11, Site A, Social Worker]

I only interviewed one social worker at Site B and their account focused on experiences of microproviders, a non-traditional form of home care promoted by the local authority. Their relatively upbeat descriptions contrasted starkly with many of the other interviews

with commissioners and social workers where the "market" consisted of traditional agency care and directly employed PAs.

> "They're not racing off to anyone else because I guess they give themselves time between the bookings to get on to the next person, whereas an agency it can be feel quite rushed I think for some people. So that is kind of the main thing and for continuity for the person, because they've got the same person or maybe a few people. If they've got a bigger package of care, it works well because they get to know them, and you know what their needs are. And so, where they've been brilliant actually and it's interesting because the micro providers obviously, the nature of them is that they're not regulated. You know they shouldn't be doing particularly complex things, but actually ironically where it's worked very well with them is when they've been doing very, very complex care for people who've got very high levels of needs…. obviously, it means they're doing very complex care with training provided, so obviously they have to have training and have competency signed off". [ID08, Site B, Social Worker]

There were important differences within and between the sites, however and these are described in the following sections.

4.3.5 Contrasting approaches and histories – sites A and B

Site A recent history and subsequent approach

The approach at Site A appeared to be influenced in part, by an experience of a preferred provider failure which happened some years previously. Interviewees suggested that commissioners had detected poor performance from the provider, but they had taken some time to do this. The experience had led to substantial disruption which included bringing in a different provider and an increased emphasis on performance monitoring.

> "I think we should have been there and spotted it, you know, probably three to four months before it started to manifest into such a serious issue. And then once it did reach that really serious point, we didn't quite have the resource to kind of get them out of it…. So if we were doing proper monitoring exercises we would be in their offices and we'd be going through, you know some of their HR stuff. Are they following their own recruitment procedures? Are they taking references in the way they should? Are they inducting people and training people the way they should? I'd like to be crawling all over some of their own systems and processes and looking for evidence and we just haven't got the resource to do that…. we could see that CQC ratings across our contractor services were poor. …So, we kind of really embarked on a programme to change that…So we had a real a change in terms of just being pre-emptive, really of any issues trying to spot them early on, trying to help providers improve standards, improve ratings and that bit's worked". [ID02, Site A, Local Authority Commissioner]

As described above, there were attempts to help providers improve CQC ratings over time, which appeared to be succeeding. Local authority staff had tried to control providers in recent years using contractual incentives. For example, requiring preferred providers to subcontract care packages where they were unable to fulfil these and including performance-based penalties. The former had been abandoned and the latter were not enforced as problems were viewed as being beyond the control of providers.

The experience of provider failure had led to a strengthened commissioning team whose remit included providing support for recruitment and retention to home care agencies. For example, the local authority promoted Values Based Recruitment (Skills for Care, n.d.) training and the Care Friends app (Care Friends, n.d.). The former is an approach aimed at understanding a candidate's values, behaviours and attitudes. The intention is that employers can then assess whether these are aligned with the values, culture and expectations of the workplace. The latter is an app which makes it easier for staff to refer friends, family and other social contacts and get recognition and rewards for doing so. These rewards increase as each stage of the recruitment process progresses. Staff can also be awarded bonus points at any time where employers choose to do this.

In addition, one of the team helped manage a leadership course for agency managers. Some interviewees described the creation of care academies in nearby local authorities as promising developments, and I agreed to explore these. Care academies aim to provide support for learning and training for aspiring care staff, as well as helping to match skills and experiences of individuals to vacancies. However, the two academies differed enormously in terms of their funding and staffing. Interviewees from two care academies described problems of recruitment and attempts to entice people into home care work. For one interviewee, it was important to acknowledge that the depiction of care as a problem was being challenged using a "day in the life video". But the subject matter was a younger disabled person, as opposed to an older adult.

> "So, a story about a guy who works at [name] Uni and he had an accident, and now, he's in a wheelchair. It's just a terrible story, but he's so positive. I mean, it's changed his life, but he's such a positive person…and it's a fantastic story". [ID25, Site H, Local Authority Care Academy Lead]

At Site A, relationships with home care providers were described in positive terms. However, relationships with the NHS providers locally were much less constructive. The regional NHS Trust had become frustrated with the inability to source care packages and had decided to establish its own home care service. This was in the early stages of implementation during the data collection phase and the extent to which it was impacting on home care supply was not clear. This does contrast with Site B, however, where, for example bidding to a national regeneration fund prioritised establishment of a multi-million Health and Care academy, as part of a collaboration with NHS partners. In contrast Site A's bids to the same fund focused on issues that were not directly focused on social care. This is not to suggest that Site B's approach was superior, but it illustrates the different approaches, relationships and priorities in these different contexts.

Citizen/service user input

Local Authority commissioners did have regular meetings with providers and took soundings from individual managers in relation to specific issues. Yet there was little evidence of consultation with citizens and/or service users. Commissioners did not emphasise choice and/or personalisation, but instead appeared focused on numbers of packages and CQC ratings as a proxy for quality.

Diversity of provision

In addition to commissioning packages from care agencies, the local authority offered service users the ability to take a direct payment and employ their own carers. Perhaps not surprisingly, the head of direct payments was a direct payments enthusiast. However, they reported resistance from local authority gatekeepers. There was no deliberate local authority policy to increase the numbers of people accessing direct payments.

> "You'll get a response from social work as well, 'They're too old, they're not interested'. Excuse me, no. That's not a reason why they shouldn't have a direct payment. Actually, they might benefit from having the same person coming in. Their condition, they're going to benefit from that same person or two people coming in and covering their care. It's not about age". [ID62, Site A, Local Authority Direct Payments Lead]

Social workers' views on direct payments appeared to be influenced by their prior experiences and preconceptions. The choice was largely framed in terms of becoming an employer or choosing agency care, with the former viewed as a heavy burden on older

adults. Social workers were uncomfortable with the suggestion that unregulated sole traders could provide care, even though PAs are not regulated either.

> "Working for a disability company, [Name] and it came on from there really. My boss was registered blind. You know, I got to learn a lot more about disability. … In my you know, small experience of the years I've been working, direct payments tend to work more for younger people and people with learning disabilities …I think with older people. They're not interested in that kind of flexibility. They want somebody else to sort out a package for them. And they want a point of contact, which is usually myself, you know, the social worker or the care manager. For older people, it's less successful…. I think they [microproviders] would need to be regulated in some way." [ID103, Site A, Social Worker]

Local Authority staff turnover - Staff continuity

Local Authority staff turnover has been cited as having a negative impact on care provision (Davies, *et al.*, 2022). At site A, there was heavy reliance on one individual who had had been in post for many years.

> "He is very knowledgeable. He knows his stuff. He has been there a million years. I think the county would be in a bad way without him". [ID88, Site A, Local Authority Ex-Service Lead]

This individual had been instrumental in limiting the information supplied to providers about potential clients. Underpinning this appeared to be an attempt to protect these individuals from being identified. But this also implicitly embodies an assumption that care would be delivered in standardised, as opposed to personalised, calls. A disadvantage of staff continuity and reliance on key individuals, is that learning from external sources is curtailed. For example, in Site B, an initiative had been implemented to introduce new forms of microenterprise provision. It had been in operation for several years (see below) and was operating in many other local authorities. Policy makers at Site A, were unaware of microenterprise and/or were convinced (incorrectly) that this form of provision was illegal:

> "They can't possibly do that... you have to be [CQC] regulated…if you're not a regulated service, you cannot do that… Our nonregulated we have them, but they do mainly cleaning, or they might do a bit of enabling or something like that." [ID09, Site A, Local Authority Commissioner].

The argument that this initiative was illegal, was based on the mistaken belief that the only exception to the rule that personal care providers need to be CQC regulated activity

related to PAs employed directly by service users. At this site, the reliance on key individuals, may explain this shared belief in the illegality of the Site B initiative.

> "So [name]'s got you know, greatest expertise on the Care Act and he would challenge all aspects of social care to make sure we're complying with it". [ID02, Site A, Local Authority Commissioner].

Subsequently, the commissioning staff learned that there were unregulated sole traders already operating within the local authority, which suggests that the market shaping duty of understanding the market is not being adhered to. In addition, the very experienced and knowledgeable staff member referred to by several interviewees acknowledged that the local authority was not compliant with the Care Act, contrary to the accounts and beliefs of colleagues.

Local Authority staff turnover - Staff discontinuity

At Site A, I also interviewed a head of a service which had provided community support. This involved "anything that wasn't social work" including signposting for "those with low level needs, you know, and it's not a crisis. It's not safeguarding. It's nothing major. They are not in danger..." [ID88, Site A, Local Authority Ex-Service Lead]. This service was aimed at preventing the escalation of problems. Social networks were an important component of this, both in terms of service users and staff. The service aimed to connect individuals to ensure that support was provided, often by local people and in a personalised manner.

> "We were looking at people who didn't want to work in an agency but were happy to do a few hours…. The social worker would say 'Oh. It's too much for them. My client wouldn't want that.' I'd think, well give them the choice though. Actually, give them the choice. Tell them we'll come and have a chat and I'm sure we'll convince them. [If it were my mum, I would say to her] 'Don't go with an agency, because you are just one of many. Go with that lady up the street who is always dead friendly and chats to you and this other woman if they are prepared to be paid.'" [ID88, Site A, Local Authority Ex-Service Lead]

The service lead ensured that they were in attendance at key meetings, and this, combined with colocation with other staff such as social workers was described as ensuring the service was considered as an option by key gatekeepers. However, this individual had been retired for over a year at the time of the interview.

> "When I was there, I knew the social work team managers and I knew my staff and there was always a really good dialogue between them. I wasn't frightened to say,

> ‘Look, you have forgotten about us. Why haven’t you got [us] in early again?’” [ID88, Site A, Local Authority Ex-Service Lead]

Meetings were now being held online and staff were working from home which risked losing some of the mechanisms which contributed to the effectiveness of the service. In the context of challenges created by the COVID-19 pandemic, the local authority was implementing a new initiative to support communities as discussed below.

COVID-19 and community support

The local authority initiative was aimed at ensuring that residents were safe and well during the pandemic. This involved support for voluntary groups and communities across the local authority footprint and the service continued to develop throughout the data collection period. My interview with the head of the service at Site A was one of the first that I conducted, and I was, at the time, filled with enthusiasm for capitalising on the goodwill of volunteers. I was, however, quickly persuaded by the lead for the new service, that sustainability required substantive posts. The service lead’s views were based on their experience of volunteers returning to paid employment as the economy began to open up. With regard to care for older adults, the service lead suggested that the local authority should bring back the posts of travelling wardens.

> “They went round so that they knew who was vulnerable and things like that and they would go and check on them. I think if we had them travelling wardens again it would really reduce the need for the home care provision you know”. [ID5 Site A, Local Authority Community Support Service Lead]

The new approach to community support emphasised bricks and mortar community assets. The service lead did provide examples of care and support which focused on the positive, as opposed to the problematic nature of care, but these were in relation to younger disabled adults.

> “We've got a couple of people with Down syndrome. We’ve got a couple of people with learning disabilities and a couple of people with mental health…. We’ve got one young lad and he's got cerebral palsy and he's in a wheelchair. But we've got an all singing all dancing changing room. You've got to see this changing room, it’s unbelievable. …it's not just about teaching them how to serve a coffee, it's given them confidence, people skills, and then we'll write CVs with them and we're trying to get them into some meaningful employment, if that's what they want”. [ID5 Site A, Local Authority Community Support Service Lead]

COVID-19 and direct payments

The pandemic had also resulted in behaviour changes amongst direct payments staff. The direct payments lead acknowledged that there had been a tendency to underestimate the capabilities of older citizens.

> "I think we underestimated people. I suppose you get set in your ways that we need to see their space, I need to know she's understanding what I'm saying and what her responsibilities are. Actually, we've just got to put our trust. Nobody has come back in two years, nearly two years and said, 'It's gone terribly wrong and I didn't understand my responsibilities as an employer.' For me, that's proof in the pudding". [ID62, Site A, Local Authority Direct Payments Lead]

The experiences of the pandemic had caused staff to reflect on their beliefs and behaviours. For example, the team were now allocating more time to clients who were experiencing problems. They did this by not driving many miles to visit older adults in cases where the visits would previously have been justified on the basis of their older age.

Site B

Diversity of provision

In Site B, the market comprised greater diversity of provision, since in addition to the larger CQC regulated providers and employed PAs there were hundreds of very small providers, operating on a self-employed basis. Many of these sole traders (hereafter microproviders) were involved in the provision of personal care for older adults. As sole traders, they were not required to register with the national regulator.

Most CQC regulated providers were members of a provider representative organisation which was part-funded by the local authority. In contrast to Site A, local authority interviewees described a history of "combative" [ID29, Site B, Local Authority Senior Officer] relationships with providers. Various factors had contributed to this, as I explain below. In Site B, rather than adopting an incremental approach to improvement, the local authority had engaged in a more disruptive set of actions.

Citizen/service user input

In contrast to Site A, "improvement" was viewed more broadly than CQC ratings. This policy emphasised choice and personalisation. B's approach was reported to have been informed by consultation with citizens. Another large-scale consultation exercise about social care was taking place just after my data collection phase had finished. The local

authority had taken steps to improve its direct payments service as part of the microprovider initiative introduce many years earlier. The direct payments lead at Site B described attending a meeting of service users several years ago which had been a revelation in terms of the way the local authority communicated with and conceptualised its direct payments service users. It had led to changes in the direct payments service and ongoing efforts to consult people as often as possible and act on their feedback.

> "….it was so enlightening, to listen to people… I reworded a lot of our letters. I made sure that I gave people more time…. if you can engage with service users, get them to be bluntly honest with you, about the commissioned care service, what do they feel is missing? And if they could pick any carer, what would that look like? Because that then will develop how you look at who you're hiring or how your project is going to go forward". [ID12, Site B, Local Authority Direct Payments Lead]

Disruptive change

Site B's approach should be viewed in the context of responses to a severe weather event almost a decade ago, which exposed gaps in formal support systems in rural communities within the county. These responses also highlighted community assets, which could help in the process of recovering from the weather event and redesigning service and support systems.

> "we discovered that there were groups of people working in local communities for either no money or small amounts of money. Just supporting people locally on an *ad hoc* basis… we collected those groups of people together to learn from them about what they were doing …. it was from things like dog walking to shopping to actual supporting someone, getting them to bed, maybe sleeping the night in someone's home because they were unsafe… care and support tasks during the daytime... we learned from what was already happening in [the county] and pulled together in a coordinated way, a network of micro providers" [ID35, Site B, Local Authority Commissioner].

As a result, a network of local community agents, employed by a countywide charity was established. These agents formed part of a structure of support across the county, helping the development of social networks for older adults, as well as facilitating their access to services ranging from dog walking to personal care. The local authority consulted residents about home care provision and received feedback indicating that services were not personalised, and choice was limited or non-existent. There were also problems specifically in rural areas, where it was proving difficult to find agencies willing to supply home care for older adults.

Subsequently a decision was taken to make changes in response to the problems concerning scarcity of supply in rural areas. This involved the promotion of a scheme to encourage individuals to become self-employed carers. Building on this small microenterprise initiative led to changes over time. The programme was led initially by an individual who had grown up in a rural community and remained there ("I do live in a village. I've always lived in villages" [ID87, Site B, Former local authority officer] in contrast to the lead commissioner at Site A who lived in a large city. The Site B commissioner described coming into the sector from a banking background in which the fast-moving market for financial products predisposed staff to act quickly. This contrasted with what he perceived as the slow pace of change in local authorities. The arrival of a new director of social services who gave him permission to experiment on a small scale led to a process of trial and error, which culminated in the development of microenterprise in one part of the local authority.

> "We had a problem that we had no home care provision in a very rural patch here… [microenterprise solved that problem] so we needed to grow it... at the same time as you change the practice, it was about spreading the thing. So, for me it became a strategic thing because I wanted it to be something that just wasn't in one team, it had to be across all of our teams across the whole of the county". [ID87, Site B, Former local authority officer]

For this to be successful, microproviders needed to be viewed as legitimate by local authority and NHS staff, who acted as gatekeepers in terms of access to care. This meant engaging staff in dialogue and, for example, getting social workers to change from a deficit-based approach to assessment of need towards an asset-based model of care (National Institute for Health and Care Excellence, 2019). These developments were part of a broader plan to provide care that was more personalised and located closer to the clients it served. After an initial exercise to map community assets, the local authority entered into a formal arrangement with a third-party organisation "Spark" [pseudonym] focused on encouraging the growth of microenterprise. As part of this, in addition to personal care provision, microenterprise more generally was encouraged so that included for example, local community provision of other services (e.g., gardening, handyman, dog walking etc.).

> "… my previous director came in and basically said, you know, rip everything up. I'll give you permission to think differently…. for our [traditional] home care providers, initially there was some opposition… we would publish 'this is how many micro providers we've got' … where they came from …. But I think it made them [traditional

care provider organisations] up their game a little bit. And that's not a bad thing…" [ID29, Site B, Local Authority Senior Officer].

This meant that at the time of my interviews, there was an extensive network of village agents [n=60], mostly employed on a full-time basis, by the county-wide charity in addition to hundreds of microproviders providing care and support. Initially these staff were funded by resources allocated in response to the severe weather event and funded over the years from a combination of various sources including lottery money and grants. At the time of the interviews, they were funded from social prescribing budgets (NHS, n.d. b). The village agents attended hospital ward rounds to act as a bridge between NHS staff, patients and local microproviders to facilitate the timely discharge of patients back to their own home. This contrasts with Site A where social workers spoke about managing expectations downwards. A county wide charity, which had a broadly similar remit to that in Site B was in place in Site A, but it had different priorities.

Carer wellbeing

The microenterprise intermediary employed by the local authority was in regular contact with microproviders, particularly during the set-up phase of their business. Unlike other interviewees who often focused on the quantity aspects of care, he emphasised the benefits to microproviders of this new way of working.

> "We are seeing people come through who have actually worked in very poor conditions previously who are now able to be, you know under their own steam, be in much better condition through the programme". [ID03, Site B, Local Authority Microenterprise Lead,]

Local Authority staff turnover

As outlined above, it was the arrival of a new staff member at Site B, combined with a new director which helped create the impetus for change. The microprovider intermediary who was employed by the third sector organisation initially for several years had been TUPE'd over to a local authority contract and was continuing to work on promoting and supporting microproviders. However, the staff member who had introduced the microprovider pilot and the director had both left the local authority. Meanwhile other staff were questioning the wisdom of the microprovider approach.

> "… the whole marketplace is changing, and it has needed to change. And I think micros have enabled some of that change to take place, so it's about giving people the opportunity to be self-employed and be able to work within their local

> community. Services that are closer to people. So, there's real advantages to the micro provision…. the concern I would have is the impact that the micros have had on our core care provision and capacity…. if we didn't have the micro providers, would we have so many people waiting on unmet needs?" [ID34, Site B, Local Authority Commissioner]

COVID-19 impacts

Relationships with providers

Local authority commissioners acknowledged that they had not consulted care agencies as part of the process of implementing the microenterprise initiative. This added to tensions between the local authority and its traditional providers. However, relationships with providers were described now as having improved. This was reflected in the fact that some traditional agencies were now happy to work with microproviders. Perhaps more importantly, the local authority had designated the provider membership organisation as a trusted assessor. This designation involves the provider carrying out assessments of need and builds on an initiative to facilitate the timely discharge of patients from hospital (Care Quality Commission, 2018). This initiative at Site B was a collaboration between the membership organisation, the local authority and the local NHS Trust, building on the lessons from similar schemes elsewhere. The aim was to ensure a timely and effective discharge process, which builds positive relationships with the professionals and organisations involved.

Relationships with NHS partners

Relationships with NHS partners were reported as historically being characterised by a "blame culture" [ID35, Site B, Local Authority Commissioner]. One impact of COVID-19 was described as improving these relationships considerably. The Director of Community Services for the local NHS Trust had moved over to work closely with local authority commissioners. New care and support roles had been created which entailed staff being employed by the NHS trust but working for home care providers.

> "We've also recruited health support workers who are working with a provider. So they are currently paid and work under the terms and conditions of our health trusts. But they're actually working under the management and supervision of one of our [home care] providers. And so that's a real collaboration of joint training, joint conversations, joint supervision and where we can see a workforce that actually originally had applied for jobs in our acutes and through different conversations, we've pulled them into a different space, and we've had some great outcomes". [ID35, Site B, Local Authority Commissioner]

In addition, in response to hospital discharge pressures, the local authority office-based staff were asked to become home care workers temporarily as part of the local authority support to care agencies. This was reported as helping to change their outlook, in addition to assisting short-staffed providers.

> "We've actually gone out to our workforce across social care, and we've asked for volunteers to step down from their current roles and train up to be a home care worker. We've put staff that have worked in administration or managing change, so those sort of change teams.... We've trained them, put them on a fast-track training course which has been jointly provided through health, social care and that provider and they are having an experience of a lifetime. And if you talk to those staff, they'll come back into their old roles a completely different person because they've experienced the real life. And the pain of how that is to work with an individual of what all of our services are made up of, you know, for the safety of those individuals that they were supporting. They've got that practical experience that will change the way they work forever, and we need to do more of that". [ID35, Site B, Local Authority Commissioner].

As mentioned above, a multimillion-pound bid for regeneration funding to establish a health and social care academy had been submitted and the funding was subsequently approved.

4.4 Commissioning approaches beyond Sites A and B

I interviewed a number of local authority staff in sites beyond A and B, but in some cases, these had a relatively narrow remit concerning microenterprise and/or pilot initiatives. I was only able to interview a small number of commissioners at each of the sites outside of the two main local authorities.

4.4.1 Urban sites D and E - Reducing the number of providers, trust based approaches

D and E were predominantly urban sites, and both were in the process of changing their approach to home care. In the case of the latter, the contract for service provision had been awarded to a single provider in a defined geographical footprint. This contract included trusting the provider to undertake care assessments. The emphasis was on continuity but also on saving time. I was only able to conduct one interview at that site and this was my shortest of the whole study at 30 minutes in total, due to interviewee diary pressures. This commissioner's background included working for many years in private sector home care provision, which may have influenced their belief that care agency staff are best placed to assess care needs.

> "…. reablement hospital discharge, domiciliary care and extra care[5] so they do all of the care elements within their zone. We wanted to make sure that the person didn't have to change providers at the end of four to six weeks and so we wanted to have that continuity. And so, whether you have reablement whether you was having, cos that service also do emergency responses, cos that service also do things like the assistive technologies, so telecare. So, if somebody had a fall it's still the same provider that goes out. The same provider they have in the day they have in the night, the same provider if they went into extra care in that area. So, we keep that continuity. … We implemented it after the first wave of the pandemic. So, we also give providers part time funding for an OT. So, they all have their own OT. And then we've added to that during the pandemic we've added a Trusted Assessor role. So, we pay them, and they have a full time Trusted Assessor who looks at the needs of the person, and whether or not they're delivering to that requirement and if they need the whole of the time… So we've taken about 1400 hours out of the system in a week. About 10%. Now that's freed back up into the market straight away." [ID95, Site E, Local Authority Commissioner]

The policy was also based on a belief that having a large number of providers does not increase the ability to fill packages, but merely elevates competition and churn between providers. Moving to a small number of providers might be interpreted as the local authority attempting to exercise greater control over the market (Needham *et al.*, 2023). At the same time, the contracts are designed to give providers much greater discretion and to trust their judgement. Service user input is not a priority in this system and appeared to consist of liaison to explain to service users and/or family members why time is not needed. There is flexibility to reconfigure the calls to remain within the agreed total number of minutes, by shortening some and lengthening others if the assessor deems that this is appropriate. In terms of market diversity, this did not appear to be a priority here.

> "We couldn't do that if we just had this wide market with 33 providers, we couldn't do it. But we've trained them and we have oversight of them". [ID95, Site E, Local Authority Commissioner]

At Site D the local authority had undertaken a large-scale exercise to consult with various stakeholders including citizens and providers. The aim was to give service users and providers greater flexibility and autonomy over how support was provided. In all sites, local authority commissioners met online with neighbouring local authority counterparts to share information and discuss home care issues. However, in some sites, local authority

[5] Extra care is a type of assisted living which offers more support than sheltered housing and is CQC regulated.

commissioners had sought to learn from other local authorities which had similar relevant characteristics (e.g., urban or rural contexts). Site D staff had liaised with other local authorities which had adopted an Asset Based Community Development (ABCD) approach (Blickem *et al.*, 2018) particularly in an urban setting. ABCD is intended to help move away from top down approaches to activities which reflect community engagement in the development of healthy and sustainable communities (Foot and Hopkins, 2010). The intention was to commission home care as part of a broader system incorporating prevention and personalisation. The initiative was a partnership between the local authority, the NHS and the voluntary sector. This would involve awarding block contracts without rigid specifications concerning specific packages of care. In this approach, a provider would be responsible for services within a geographical footprint as part of a more system-wide approach, which emphasised prevention. There would be three providers within the footprint and the approach was based on providers collaborating within that footprint. The local authority commissioners had also been working with key gatekeepers amongst local authority staff to help them to adapt to this new way of working.

> "… we're not going to say, 'A carer is going to come in three times a day at these exact times and time lengths in order to do that.' We're going to say. 'We'll write down your outcomes and your needs and your outcomes, and then we'll ask you and the provider to go away and have that conversation of how exactly are you going to support me to meet those outcomes?' …. there's a lot of work going on around strength-based assessments and strength-based reviews and kind of, it's a changing mindset for the social workers, a change in the way that their providers are going to work. You know, a bit more shackles unleashed, a little bit more kind of responsibility to work with service users." [ID28, Site D, Local Authority Commissioner]

> "So you know, this is about commissioning and our procurement. But it's also about our kinda social work conversation. So we're trying to break it down into two phases at the moment. So the first we're looking at a recommissioned offer for the home care across the city. So that's going to be going to tender in the coming weeks. And you know, maybe in the next, you know, very shortly the next couple of months where we're looking at moving from your traditional time and task approach to a more flexible model. It's you know those principles of ABCD in practice and how we can change our current sort of top-down order type approach to a much more, you know developmental type model where we were looking at working with our providers. Not that we don't already but working more closely with our providers in the more iterative sense so you can be more flexible to people's needs". [ID30, Site D, Local Authority Commissioner]

The lead commissioner here had a role which also involved public health procurement and his colleague had a community development background, which may have contributed to the path taken here.

This approach involves a high degree of trust in providers to work for the public good. The focus on continuity and saving time in Site E suggests a top-down approach to provision in contrast to Site D, which is much more rooted in community participation and prevention, at least in terms of aspirations. Diversity of provision with regard to the number of commissioned providers is low in this approach, but diversity may also be conceptualised in terms of a personalised service. Along with service user and community input generally, choice and personalisation are key aspects of this approach.

At both sites interviewee accounts suggested a view of care as a problem. But at D, the proposed model, which is based on radical changes to the traditional model offers a vision of care as an enabler. It is important to note that Site D, was in the process of letting tenders for the work during the data collection phase and I have limited information about what has happened since. (I did learn at the service user focus group that the model was running into implementation problems. See Appendix A for more details.) This approach raises questions about how accountability and stewardship are secured in contracts in which rigid specifications are avoided.

4.4.2 Rural site C – History of piloting initiatives

Another site (C), this time predominantly rural, aspired to move away from time and task-based contracts. They also struggled to fill care packages and this problem was particularly acute in rural and what they termed super-rural areas. One of the four interviewees explained that they had a history of implementing pilots and were very open to new ideas. They were piloting a novel approach to home care. This was in response to an offer by a local hospice provider who wanted to help alleviate the shortage of home care options for citizens in a specific very rural area. The intention was to avoid rigid time and task-based contracts and to trust the provider to deliver appropriate care. The provider was reported to have faced a steep learning curve when contracting with the local authority, compared with its health-related work, which involved less scrutiny in terms of rigid times and task specification. A key issue was that the provider's assumption about the ability to recruit staff in the local area proved to be unfounded. The result was that the provider

was having to spend much more money on travel costs than was budgeted for. The commissioners were engaged in ongoing discussions about how to resolve this issue.

This site had also been involved in a two-year pilot to promote microenterprise along the lines of Site B. I was unable to speak to the local authority lead for the pilot who, despite repeated approaches and an introductory email from her colleague, did not respond to my emails. An employee from "Spark" suggested that the pilot had not worked well, which raises questions about implementation, as well as what the local authority might learn from pilot initiatives.

> "in [rural county site C above] we had a great number of enterprises, but the social workers didn't use them. They didn't feel professionally safe to be creative. They were quite traditional…they didn't want to think outside the box really and they didn't trust them. They perhaps didn't trust the enterprises because they knew they're not CQC registered. That type of thing". [ID80, Employee of third-party organisation promoting microenterprise]

4.4.3 Sites F and G – aspiring to personalised care

In site G, which was predominantly urban, the interviewee expressed concern about the problems they faced in home care. In addition to issues of staff shortage and constrained budgets, they expressed a desire to move away from the traditional agency approach to care.

> "how do we manage somebody's outcomes? The only way to do that in a way that doesn't mean you've got somebody getting offered sort of 11 o'clock in the morning and going to bed at six o'clock at night, is to try and move into a more micro delivery arrangement… that's certainly on our on our radar and on our plan". [ID31, Site G, Local Authority Commissioner]

However, despite this aspiration, there were no firm plans to take action to achieve this. The interviewee referred to COVID-19 and workforce shortages as diverting local authority staff time. In addition, the fact that this was a small local authority and had relatively few staff was cited as limiting their capacity to plan and implement large scale change.

Site F, being a larger rural local authority was very different, but the commissioner reported having reached "crisis point" in an account which resonated with that of Site G's position. The local authority aspired to move towards more personalised care and had convened a "change group" to focus on home care. However, it was reported to be

thinking “very traditionally” [ID91, Site F, Commissioner]. In contrast to Site G, the rural and remote nature of many communities within the local authority was described as contributing to a strong and well-established community development officer network. Despite the “traditional” approach of the change group, there was also an initiative to introduce and expand microenterprise.

4.5 The growth of microenterprise outside of Site B

4.5.1 Common aspects of the approach

In many local authorities, staff were seeking to promote the development of microenterprise, along the lines of site B. In all sites where this was happening, staff advised microproviders to have minimum call times of one hour and to limit their geographical area of operation to constrain driving time and fuel costs. The local authorities promoting microenterprise had introduced quality standards developed by Spark, or in house where Spark was not involved. Adherence to these by microproviders added to the legitimacy of these providers in the eyes of commissioners and their staff. In addition, first hand experiences of dealing with microproviders had helped to contribute to greater acceptance and appreciation of their skills, adding to their legitimacy.

All but two of the study local authorities implementing microenterprise had entered contracts with the same third-party organisation as site B (i.e., Spark). These arrangements involved, amongst other things, funds to cover the employment of a locally based intermediary to provide advice and support to microproviders. In two sites the intermediary role was occupied by a local authority staff member, but elsewhere intermediaries were employed by “Spark”. This intermediary role, independent of the local authority, was important in helping microproviders to develop social networks, link to potential clients and gain acceptance and legitimacy from relevant stakeholders (as discussed further below).

A key aspect of microenterprise implementation was ensuring that direct payments services were aligned with and able to facilitate payments to microproviders. Certainly, local authority staff reported issues had arisen and direct payments had not always run smoothly in all cases, but problems had been overcome as learning was ongoing. There was also some evidence that direct payments staff had underestimated the capabilities of older adults. COVID-19 was reported as contributing to a reappraisal of this perspective

and revised ways of working by direct payments staff. This resonates with experiences at other sites described earlier.

> "And you know, sometimes you look at the age of a person and you're calling them and you're like, ohh, how are we gonna? Honestly, they're on the ball they're, you know, they're scanning and they're doing this and then you talk to a younger person and they're not so confident so it's yeah, it has been quite surprising actually with the digital knowledge of the over 80s I'd say. They're on it". [ID97, Site J, Local Authority Direct Payments Lead]

The accounts of local authority staff where microenterprise was being implemented described care processes in much more upbeat terms compared with traditional agency care. In addition, positive stories were told about the wellbeing of microproviders and the advantages of retaining funds within local communities. Where interviewees did highlight the problematic nature of home care, this was mostly in the context of contrasting the inferior traditional model with microprovision.

There were some problems with microenterprise identified by local authority staff. For example, microproviders are free to set their own rates, although the local authority standards suggest charging a "fair" rate. In one site, the intermediary complained that some dog walker providers were charging the same rate as microproviders of personal care for older adults. In some cases, microproviders had taken on too much work initially and this had caused them stress. In addition, some microproviders had chosen to travel further afield, which was contrary to the intermediaries' advice. Occasionally, microproviders were reported as feeling uncomfortable with marketing their services. In most cases, individuals adapted to new ways of working, but a small number were reported as leaving the field entirely.

4.5.2 Variations in approach

Most of the local authorities in the study which had implemented a microenterprise initiative had liaised with site A, but the extent to which they adopted their approach varied as did the rationale for the initiative.

Improving quality and choice

In one site [N, rural], where the initiative was in its early stages, the intermediary had no knowledge of the history and rationale for the policy.

In four cases [I, J, K, L], the initiative was reported to be a response to the wishes of (potential) service users and citizens more generally. In site K the intermediary was a local authority employee and "Spark" were not involved in the process. Here, the microproviders were referred to as PAs, despite the fact that they were self-employed. The local authority team had adapted an electronic noticeboard system from another local authority and microproviders who met the local authority quality standards were listed on this. These standards included 14 modules of mandatory training. Potential service users were reported to be keen to have personalised care and the previous arrangements involved advertisements in shop windows and carers who may not have appropriate training, insurance and Disclosure and Barring Service clearance. The social workers welcomed the new initiative.

> "The social workers, they were quite pleased to have it because there was an awful lot more involvement before the notice board went up because they were having to contact PAs directly. The direct payment team, they have a separate team called the [name] so that team will manage direct payments and personal budgets on someone's behalf if they can't manage them. But as part of those checks they would require like the PA obviously to have insurance. So that would be the social workers that would have to make all those checks. Whereas now we've got the PA noticeboard set up, we do the checks for them. So the PA's are on the board and it's a lot easier for the social workers to pass that information over to the like the service user. So there's actually less involvement for the social worker than what there was before. So yeah, they're quite pleased that the noticeboard has been set up". [ID109, Site K, Local Authority Microenterprise Lead]

This local authority had a team of five full-time staff to support the initiative at the time of data collection. The business case was based on retaining money in the local economy, stimulating small business growth and savings compared with agency care. In addition, microproviders were reported as being happier and having greater control over their lives.

In another site (I), the only predominantly urban local authority implementing the microenterprise initiative, the policy was introduced several years ago in the context of a new way of working across the local authority. This aimed to help people and their communities by moving from a crisis focus to a prevention orientation. The initiative involved implementing strengths-based capacity building, which was intended to increase the breadth of support and services available to local people. The emphasis was on the importance of building supportive personal relationships and developing more resourceful communities.

In common with Site B, the microenterprise initiative was part of a broader programme of change aimed at prevention and upstream support, as opposed to merely addressing "downstream" immediate care needs. The policy was described as making a big impact on microproviders, some of whom included gardeners and handymen and all of whom were involved in a system of community support.

> "So this is part of a massive transformation journey that we've been on all about trying to get out into the community a lot more and seeing what there is in the community to help themselves. So we started off with a year's pilot. I think it was about 2016, and then it went two years. Then we got funding for the third year and then it was decided it was going to be part of our main offer. So now it's taken a lot of hard work and a lot of change of hearts and minds 'cause social workers are absolutely naturally averse to anything that's not regulated for obvious reasons. But we've done really well. … we've had about two issues raised in six years. And as my boss said, 'get it in proportion. He said 'we have about five or six raised with all the agencies and companies that we use a week', so he said that's extremely low. … I had a lady who was a graphic artist who was furloughed and none of the work was coming in and so do you know what she said? I've always fancied supporting people in the community, she said, so we had a chat online and we set it all up anyway. She got a couple of clients someone else asked her to take someone on and she rang me said 'I've never been happier. I love it'. And anyway, when furlough ended, when she had to go back, she rang me said 'I've decided I'm not going to do it' so she said 'I've resigned. Now she said I've got all my contacts so I can do freelance and she can still work three days a week on doing this' and she's happy…. [somebody else] he lost his wife and he had three young children and he spent ten years bringing them up. And then when he went to go to work, he was a bit nervous, so the job centre asked me to speak to him and we got him on there as a handyman and he built his confidence up over two years. He was fine and then he just rang me today to say thanks so much. He said I've got a job at my old company. I've got the confidence back now and he went back to work… [another man] they sacked him because he had a period of mental ill health and just sacked him. So after he'd gone through his tribunal and won, he was rock bottom... But you know [name, gardener] is one of our most successful micros and he has always in the summer's got a five-week waiting list, last time I spoke to him. And his career's just blossomed literally. Just taken off". [ID92, Site I, Microenterprise Development Manager]

In this context, microenterprise was seen as a good fit with the local authority's "bottom up" community support system, as it was in Site M, which had a recent history of building co-production, (as opposed to consultation) into its approach to service delivery and commissioning. Site L, another rural county had introduced the initiative as part of its move towards outcome focused care. As in many sites, getting gatekeepers on board was viewed as a key component of implementation here.

> "So, I decided in the end to actually contact the principal social worker and I spoke to her, and I said that, you know, I've tried for a couple of months and I'm not seeming to get anywhere. She understood what I was doing. She could see the real benefits. So, she actually sent an email out on behalf of the project. I kind of worded something and she sent it out to all the teams and asked managers to get in touch with me. And from there it started some conversations and so it's kind of, you know, you kind of have to look for your way in. And if one way doesn't work, you have to kind of find another way. So I started identifying allies and thinking, right, how can I keep that message coming across? That this is actually beneficial to them in terms of their practice, their work, but also the fact that it's going to make a significant impact on people that they're supporting. And so, I got into the Advanced Practitioner Forum, and I did a couple of presentations there and I got really good attendance…. I've used a lot of my background as well in terms of that knowledge and having that real understanding of health and social care. And, you know, being able to think of it in terms of both angles. I think that's you know, really worked as well." [ID86, Site L, Microenterprise intermediary]

The differing local authority contexts meant that intermediaries had to adapt their role to suit the local environment. For example, in rural settings where the rural countywide charity's focus was dissimilar to that at Site B, the absence of a single county wide charity prioritising care meant that intermediaries had to work harder at developing local networks. The fact that these individuals had different backgrounds also appeared to contribute to variations in their approach.

Responding to supply shortage

There were other variations in the ways in which local authority staff and intermediaries approached microenterprise. In some sites (F, O) the policy was prompted by an inability to meet the demand for care, in the context of a workforce shortages especially in rural areas. In both sites, there were aspirations to have greater personalisation, but the inability to source care in rural and remote locations appeared to be the spur for policy adoption. In other words, the circumstances in which site B developed its approach had changed and so too had the challenges to which local authorities were responding. Furthermore, in site B, the intermediary's influence was linked to the top-down endorsement of senior staff, which enabled them to gain acceptance amongst key gatekeepers such as social workers. Elsewhere, this was not always the case, with relatively junior staff given responsibility for leading the microenterprise initiative. This meant that focused efforts to reorient staff to new ways of working were often absent.

> "… it would need a bit of time and space for us to look with our social workers at that … with regards to the microenterprise where to be honest… our social care colleagues, you know they just haven't got that space at the moment. You know, they're just desperately trying to find people who can help people get up and out of bed into the toilet, and that type of support and … hopefully as time goes on and we do get like [Site B] with hundreds of micro enterprises, which is what we'd all love to see". [ID91, Site F, Local Authority Commissioner]

Despite this, the inability to fill care packages was leading social workers to beat a path to microproviders, in the absence of alternative providers.

> "[Microproviders] do it because they genuinely care. They genuinely want to make a difference and that's hard to keep that professional boundary and to say, well, no, I've done my hour now. Or you know, I've got to move on to my next client and things so. But yeah, we do support our enterprises through that and encourage them to, you know, to set fair working hours and a fair price and things like that. And we are encouraging the social workers again to recognise that that is necessary, that you know that they're doing this themselves. They're working part time for a reason. They're working self-employed for a reason. They may have other commitments that they have to work around and things like that". [ID90, Site F, Microenterprise intermediary]

4.6 Summary

In this chapter I describe common approaches and variations in policies and practice concerning local authority market shaping duties. In some cases, local authorities appeared to adopt an approach which aimed at ensuring quantity of supply. Elsewhere, initiatives which sought to stimulate greater diversity of provision, service user input and personalisation were in evidence. In terms of the reasons for variations between local authorities, there was some evidence that particular individuals had a key impact on aspects of market shaping. Added to this, recent history was also influential in terms of current approaches. It was not possible to ascertain the historical context in all sites. However, in some cases, expansion of market diversity reflected a recent history of changes to care, based on greater community involvement and a desire for community asset-based approaches. This contrasts with "top down" approaches which appeared to adopt a well-intentioned paternalism.

There were also differences within local authorities, with some commissioners focusing on preserving traditional agency care, alongside colleagues who promoted microenterprise. Direct payments staff enthused about direct payments but described colleagues whose preconceptions resulted in reduced access to direct payments for older

adults. Interviewees occupied different roles and different spaces in the hierarchy and their views may reflect this. In addition, individuals confront structures which influence their way of seeing the world. For example, the conceptualisation of older adults by social workers and care managers has been depicted as shifting, in a way which leads to the prioritisation of risk management over citizen empowerment and autonomy (Bornat and Bytheway, 2010; Carey, 2016). Interviewee accounts suggest that where this is the case, work needed to be undertaken to change perceptions. At the same time, there is some evidence that supply shortages were leading social workers to contact microproviders, in the absence of alternatives. Furthermore, it may be unfair to single out social workers as having ageist attitudes, when such beliefs are widespread and ageism has structural, as well as individual, aspects to it (Chang *et al.*, 2020; Abrams *et al.*, 2015).

The extent to which local authorities demonstrated trust in providers varied. In two cases, local authorities gave providers Trusted Assessor status. There were also attempts to trust providers by moving away from time and task and towards block contracts. At the other end of the spectrum, in one site, a commissioner appeared to view their role as examining provider HR and recruitment processes, in a way that suggests attempts at micromanagement, rather than a commissioner/provider relationship. This site was an outlier in that respect.

The COVID-19 pandemic was reported as improving relationships with providers in all cases and with NHS partners, in all but one case. Furthermore, COVID-19 had helped to challenge ageist assumptions amongst some local authority staff. However, it also added to pressures on frontline care staff, increasing the likelihood that they would leave the sector, which added to pressures on remaining staff. In addition, many local authority staff were working from home, with no plans to return to office bases. This raises questions about the effectiveness of local authority policies and services which rely on social networks and informal channels of communication to achieve their desired outcomes.

In terms of rural versus urban environments, there was some evidence that it may be easier to introduce microprovider schemes in rural areas where traditional agency providers have refused to take on local authority contracts and/or local authorities might be more motivated to implement such policies. A policy to promote microenterprise

solely in rural areas, however, raises questions about why it should be that choice and personalisation are not available to older adults requiring home care in urban settings.

The themes of “care as a problem” and “care as quantity” were present in many interviewee accounts. Overall, various factors contributed to what appears to an outsider, or to me at least, a dysfunctional system. At the same time, most local authorities were working hard to preserve this system, rather than attempting radical change. These themes and findings were echoed in accounts of provider organisation office and managerial staff, and I discuss these in the next chapter.

Chapter 5. Home Care Agency owners, managers and administrative staff

5.1 Introduction

As outlined in the previous chapter, local authorities adopted and/or supported a variety of measures as part of their "market shaping" activities. These were aimed at improving the supply of home care available to older adults. Local authority activities raise questions about how far "market shaping" policies and related initiatives are impacting on the organisations employing front line carers. This chapter investigates this issue from the perspective of provider administrative and managerial staff, as well as business owners. It does this by examining their attitudes, motivations and experiences. It also explores variations in local contexts and where possible, differences between rural and urban settings.

5.2 Interviewees and organisations

In this chapter, I draw on the accounts of interviewees whose roles do not primarily involve direct provision of care. Table 8 includes participant roles and sites. All of the six sites included, with the exception of P were predominantly rural in nature. As illustrated below, most providers in my sample were based in one site A. In two local authorities (site B and Q), many providers were members of a provider representative organisation. I would have preferred to speak to providers directly, especially from site B, where microenterprise was operating across the county. As I discussed in chapter 3, the difficulties in recruiting participants meant that I was unable to do this. However, the inclusion of two interviewees employed by provider membership organisations created an opportunity to broaden the perspectives within the sample.

Registered managers are "in day-to-day charge of carrying on…. regulated activities…. The purpose of the registered manager requirement is to regulate the person managing the regulated activity on a day-to-day basis at the location where the regulated activity is provided, rather than a more senior manager who is not in day to day charge at the location" (Care Quality Commission, 2024b). I was often referred to them when approaching organisations, but as Table 8 illustrates, I spoke to a range of participants in terms of roles. (*Indicates provider numerical ID).

Table 8 Care Agency and related staff by role and site

	Sites						
Roles	A	B	C	J	P	Q	Total
Manager/coordinator P1*	3						3
Director P2	1						1
Registered Manager P3	1						1
Director/RM P4	1						1
Director/RM P5	1						1
Director/RM P6	1						1
Registered Manager P7	1						1
Registered Manager P8	1						1
Director P9	1						1
Business Manager P9	1						1
Director/RM P10	1						1
Registered Manager P11	1						1
Manager/coordinator P11	1						1
Non-exec P12	1						1
Registered Manager P12	1						1
Deputy Manager P12	1						1
Regional Manager P13	1						1
Registered Manager P14	1						1
Director/RM P15	1						1
Director P16	1						1
Registered Manager P16	1						1
Manager (NHS)	1			3			4
Provider membership org.		1				1	2
Registered Manager P17	1						1
Registered Manager P18			1				1
Registered Manager P19					1		1
Total	25	1	1	3	1	1	32

The vast majority of interviewees involved in care provision were female. Where an interviewee was male, I have stated this in the quote label.

Providers varied in size, legal form and business model. In two cases providers were subsidiaries of organisations operating in various parts of the country. One provider was licensed by a franchise agreement with a much larger organisation with national coverage. All other providers were locally based, and most were private limited companies, although at one site (J) an NHS organisation was involved in home care provision. Several were "preferred providers" earning income from local authority contracts. There were 10 that were not preferred providers, but all but one of these was approved to undertake local authority commissioned work and did so, to varying degrees. The extent to which providers were reliant on income from the local authority varied, with several taking on local authority packages which preferred providers had declined to accept. In addition, providers may also receive Continuing Healthcare income. This relates to individuals with long-term complex health needs who qualify for free social care arranged and funded solely by the NHS. The commissioning of this care may be undertaken by local authorities on behalf of local NHS partners and several providers were in receipt of such income. Despite these differences, there was universal agreement that recruiting and retaining staff was a huge problem, as I explain below.

5.3 Recruitment and retention

5.3.1 Labour market experiences

All providers reported experiencing problems attracting new front line staff members. The emphasis was on staff numbers in a context where most providers were losing employees faster than they could replace them. The inability to recruit workers had led employers to adapt practices in terms of where and how they advertised vacancies. This meant, in many cases, trialling alternative means of advertising and raising the profile of care work. Activities included attending job fairs and building links with local colleges and other organisations to attract new entrants to the sector. Often word of mouth and Facebook were reported to be as effective or more effective than using platforms which relied less on social networks.

> "…our existing staff recommend posts to their friends who need more or need work. They recommend us. We've got familial groups. We have two sisters that work

> together or a mother and daughter that work together. They're coming in through word of mouth rather than us actively recruiting. Prior to that we used to recruit on Indeed which is like a jobs board. Prior to that we used the Jobcentre. But both of them, I would say I wouldn't want to go back to that. I know a lot of people have been recruiting on Facebook. I'm not sure that I'd want to do that, but I think we'll have to because that is really the only way forward". [ID59, Site A, Registered Manager and Co-Owner, Non-preferred provider ID06]

Using innovative ways to publicise the need for more staff was not always appreciated by local authority commissioners, however, as this interviewee explained.

> "When I put my cry for help on Facebook, I contacted [regional TV] News, [regional] everywhere, the [county town] pages, all the local pages…I just said who I was, what the problem was.… I got a massive response from that, and it was so positive. And then, I had a meeting with the council a few days after, I was all excited and said, 'Look, this is what I've done to try and help.' And they said, 'Oh, about that, you really shouldn't have done that.' And I said, 'Why?' And they said, 'Well, you mentioned how many people were waiting for care packages, and that comes bad on the council.' And I said, 'Well, if the council were actually doing something to help me, even more so, you wouldn't have 30 odd people waiting for a care package.' [ID19, Site P, Registered Manager, Preferred provider ID19]

Several interviewees stated that some job applications were submitted as part of a requirement to demonstrate job seeking behaviour to benefits offices, rather than reflecting a sincere desire to work in the sector.

> "Or the Jobcentre has sent them. And you know when you're interviewing them, they're not interested, and they're never going to be interested. But because they have been for an interview, the Job Centre will leave them alone for a few weeks. And it gets frustrating". [ID21, Site A, Deputy Manager, Preferred provider ID01]

There was some evidence that recruitment was more difficult in rural areas. However, one interviewee suggested that turnover was not always a bad thing for care provider organisations, especially in the context of what might be considered "rural backwaters" where staff were likely to be older and (as presumed by the interviewee) therefore less amenable to learn new ways of working.

> "[City] we find it pretty straightforward and easy to recruit. We get a really good high calibre of staff… it's much easier in [City] to recruit than it is in [rural county Site A]". [ID56, Site A, Registered Manager and Owner, Non-preferred provider ID04]

> "… the likes of [city], where I am today, the staff picked it up like that [clicks fingers]. They're very savvy with I.T. and things like that. Obviously in [rural town] it was a different story completely...I do believe that that had a bit of an effect on some the

staff that [local manager] did lose. Not all a bad thing… Even the office team up there, like, … one of the care co-ordinators is nearly 60. And you just don't see it anywhere else, do you know what I mean? Again, not being… But it's normally a younger person's job. Because it's not an easy job, in fact it's probably the hardest job within this business, is the co-ordinating side of it". [ID72, Site A, Regional Manager, Preferred provider ID13]

Generally, however, interviewees viewed turnover as undesirable and problematic. Furthermore, there was universal agreement that the problems relating to recruitment were unprecedented and becoming increasingly difficult to solve. This led to a preoccupation with numbers of staff and of unfilled care packages.

5.3.2 Responses to local authority initiatives

This focus on numbers was reflected in various local authority initiatives to resolve or reduce the problem (as discussed in Chapter 4). In site A, where the local authority was promoting Values Based Recruitment (Skills for Care, n.d.). and the Care Friends app (Care Friends, n.d.), there were mixed views regarding these initiatives. In some cases, managers suggested that they were using Values Based Recruitment. In other sites, interviewees argued that it was only by bringing people into the organisation that views could be formed by both the employer and employee on their suitability for the job. The Care Friends app was described as potentially beneficial as an aid to recruitment and retention in some sites. However, most providers already used their own tailored rewards/incentive scheme.

"We have had a bigger response on Facebook and refer a friend than we ever had from Care Friends". [ID21, Site A, Deputy Manager, Preferred provider ID01]

"I think it's [Values Based Recruitment] for the inexperienced, quite honestly. When you come in, when you do the induction, they get the values of your company… If we push our values, you do that in the recruitment, you do that in the induction, when you go out and do the spot-checks, it's all part of the values. Are you following the [provider name] values, etc?... so, I just think at times it might be the in word at the moment." [ID60, Site A, Registered Manager, Preferred provider 07, Male]

"We've looked at it [Care Friends], and we honestly don't feel it's for us. Because of the way we already sort of like recognise and give back to the staff. I mean, we have a lot of schemes going where if they refer a friend, refer a family member, etc., they get £300, which has worked extremely well, and we do have a lot of family members, mothers, daughters, brothers, who actually work for the company". [ID78, Site A, Co-owner and Registered Manager, Preferred provider, ID15 Male]

"We use Indeed, which is very expensive and, if I'm being perfectly honest with you, like … I'm not saying it's completely ineffective, but it's not the most successful way

> of recruiting. Social media really is the, and the refer a friend, is a way more successful means of recruitment. … I was at a jobs fair at [place]... It's not cheap to go and register at that jobs fair, seemingly. The merchandise, the staff, the branch manager's time. We had the regional training manager with us as well, so that's like three people out of the business for the day. But if you get five care workers out of it then, at the minute, it's worth it". [ID72, Site A, Regional Manager, Preferred provider ID13]

For smaller providers, the cost of the Care Friends app was viewed as prohibitive. Similarly, there were mixed experiences with exit interviews, which were being promoted by two local authorities. Some interviewees stated that these were useful, but others reported that staff left without giving notice, which made it difficult to conduct these sorts of interviews.

> "Not [exit interview] with the person who leaves. I might write myself a list and say, 'Don't ever take anyone like that on again.' I will review it in my mind". [ID59, Site A, Registered Manager and Co-Owner, Non-preferred provider ID06]

> "Some we've had they haven't completed their notice, so we haven't been able to do that. But what we've started doing now is, if they do put their notice in, is to do an exit interview. Generally, the feedback of the company is generally good. It's normally because they've gone on to, say, their training or if they've gone on to the care home for nightshift or whatever, it's because it suited their personal lives better". [ID24, Site A, Business Manager, Preferred provider ID01]

Providers, to varying degrees, welcomed local authority initiatives to introduce a retention bonus. For some, this represented a much-needed injection of resources. For others, the terms of the initiative were seen as conveying an inability to trust providers to make decisions about how best to use the money. There were also complaints about details of the scheme, which in site A specified that only front-line staff were eligible. The timing was criticised by some interviewees, as was the variation in scheme design between neighbouring local authorities. This was viewed as creating inequality and adding complexity to implementation. In some cases, interviewees reported that staff, some of whom were reliant on benefits, reduced their hours, which was an adverse and unintended consequence of the schemes.

> "We have quite a few branches as you know, so yeah, we have got that. And the retention bonus is good". [ID76, Site A, Registered Manager, Preferred provider ID14]

> "Obviously, the bonus they receive is going to the care staff, so I think that's made a difference to them. It is a thank you and it's nice to get recognised for them". [ID81, Site A, Registered Manager, Preferred provider ID12]

"…for a provider like me, if my staff were working with a client in [this county], and then went over the border into [city], they wouldn't have got paid that time. So, that would have been something we had to calculate. Then there was also added in that if you had more clients that were privately funded than local authority funded, they wouldn't give you the money for that…. we are never really fully consulted. We have things done to us". [ID70, Site A, Registered Manager, Non- preferred provider ID11]

"I think it's stopped people working as many hours. Because they know that if they do the base hours, they're still going to get this extra £1.50, plus the 50p pay rise. …So some people have actually been not as willing to help because they're working, but they're going to get more pay. They don't need to do double the shifts. So I think it could have had a bit of an adverse effect". [ID75, Site A, Care Coordinator, Non-preferred provider ID11]

5.3.3 Adapting to a tight labour market

Generally, provider approaches involved tinkering at the margins, rather than anything which promoted radical change. Preferred providers who were required to fulfil local authority care packages had a larger pool of employees to draw on to provide cover for sickness and inadequate capacity, compared with smaller organisations. However, asking staff to cover additional calls came with risks. Smaller organisations, which were not preferred providers tended to be more able to avoid staff burnout.

"They need enough hours, earning enough money but not too many hours that they're going to just burn out and say, 'I hate that job. I can't do that any more,' and then you lose them. You lose your good ones and that's no good. We have to keep that balance right". [ID75, Site A, Care Coordinator, Non-preferred provider ID11]

"I think generally speaking, staff are just burnt out. It has been a long 18 months, and there's no end in sight, really". [ID26, Site A, Business Manager, Preferred provider, Male]

"…they might be contracted 16 hours but they [our coordinators] might be putting 35 hours work on them. If they're claiming benefits, it has an impact on their benefits". [ID21, Site A, Deputy Manager, Preferred provider ID01]

Local authority contracts for preferred providers included targets and/or penalties and bonuses in relation to quantities of care calls, which were intended to incentivise providers. However, interviewees reported being highly motivated to deliver required numbers of care packages, regardless of these aspects of the contract. They also described how these targets and penalties were not enforced by commissioners, since problems relating to contract volumes were viewed as beyond providers' control. Nevertheless, local authorities were also reported as pressuring preferred providers who were unable to meet capacity requirements.

> "There is an incentive there to take as many calls as you can as a business point of view. If you don't take them, then they bring you in and threaten to put you down to tier two or three". [ID64, Site A, Owner, Preferred provider ID09]

One interviewee was unusual in suggesting that the workforce crisis was an opportunity to rethink the nature of the care workforce. His role as the CEO of a provider membership organisation and his relatively recent entry to the field may explain his inclination to take a more strategic view of the field. The fact that his membership organisation also included microproviders, as opposed to traditional providers may also have influenced his perspective. The other interviewee from a provider membership organisation reported trying to influence change by ensuring home care representation in Integrated Care Board (NHS England, n.d. c) decision making bodies. These were rare exceptions in a context where interviewees appeared to take for granted existing arrangements rather than suggest changes to them, however.

The extent to which providers were willing to adapt their requirements to suit prospective employees also varied. For example, some providers were inclined to accommodate potential staff members whose available hours were lower than would normally be required. Others suggested that the effort required to employ and manage staff would be disproportionate to the benefits gained and therefore not worthwhile. In one case, an interviewee (ID26) suggested that fewer hours would mean greater staff numbers and therefore, less continuity for service users. However, that same interviewee's comments about personalised care (discussed further below) suggested to me that this response may also have been about minimising managerial effort and disruptive change. Interviewees also highlighted issues of fairness, suggesting that if new staff were for example, freed from the obligation to work alternate weekends, then they would enjoy preferential terms compared with employees of long standing.

> "If someone could only do five hours a week, we wouldn't employ them. It really isn't worth it. That just means by the time you go through the training, the mentoring, the supervision, the appraisals and all the other tasks that we're going to do, five-hour weeks, it's just not worth it". [ID26, Site A, Business Manager Preferred provider ID02, Male]

> "So, 'what's your availability?' and we try and work around that. We can't always work around that, especially if people say, 'Well, I don't want to work any weekends.' So, that's okay, if you're on a zero-hour contract, but we can't always guarantee the work because if somebody's working an alternate weekend, and you're not working

any weekends whatsoever, that's not always fair". [ID19, Site P, Registered Manager, Preferred provider ID19]

"We've got carers who work two days a week. We've got carers who don't work any evenings, some don't work mornings. Some don't start until four o'clock. I've got one that's just for the term, three days a week because that's to do with her partner's shifts and childcare. We've got people who only work weekends. People who don't work weekends. People who just do more domestic work rather than the personal care side of things. Really, there is a lot of flexibility in the role". [ID24, Site A, Business Manager Preferred provider ID01]

Some interviewees described how the workforce shortage had led to them overlooking breaches of standards to avoid confrontation, which may lead to staff leaving.

"All the young ones, they want these big acrylic nails with patterns on the ends of their fingers. I say, 'You can't do that. You can't wear that. It's not safe. It's not professional.' Do they understand that? No. Is it a deal breaker? Am I going to lose a good carer over that? Now I know in my heart I should just say, 'Look, it's a deal breaker'. But if they say, 'Well I'll just leave' which they're likely to, then I'm creating another problem for myself". [ID59, Site A, Registered Manager and Co-owner, Non-preferred provider ID06]

"We used to do spot checks to make sure carers were wearing full uniform. They didn't have trainers on. They was representing the company in a very professional manner. And at the moment, if they go to work in leggings, and they go to work in trainers, I don't care. They're going to work, so leave them alone". [ID19, Site P, Registered Manager, Preferred provider ID19]

Additionally, in most cases, providers were willing to take on staff with no prior experience. For some, this was due to the severe workforce shortage, but it was also linked to the ability to avoid staff bringing poor practice from other providers.

"I know there are a lot of people, the first thing they'll say, 'Have you got experience?' If they say, 'no' they'll say, 'I'm sorry.' I don't get that. I never ask them if they've got experience because somewhere down the line you've got to start". [ID55, Site A, Registered Manager, Non-preferred provider ID03]

"I do prefer that people have got experience because at least they've got the ground level. But sometimes they can come with experience, and they think they know it all and that becomes a bit difficult so you have to say to them, 'Actually, how you've done it in the past, we're just wiping it clean and this is how we want it done. This is how we want to care for someone and support someone'. It's got its pluses and its minuses, hasn't it, about taking someone with a lot of experience and someone with none?" [ID56, Site A, Registered Manager and Owner, Non-preferred provider ID04]

5.4 Reasons for workforce shortage

There was universal agreement that care work was viewed by many as unattractive, and several reasons were given for this by all interviewees.

5.4.1 Low pay and status

Pay rates were viewed as too low. This was problematic insofar as paid carers were unable to survive on their wages and this was exacerbated in the context of a "cost of living" crisis. Furthermore, what providers described as their inability to raise wages, made it very difficult to compete with other employers outside of the home care field. Low pay was seen as reflecting a perception that care work involved unskilled labour. This was contrasted with the reality, which was that care required a high level and a broad range of skills. Comparisons were often made to NHS terms and conditions and the favourable pay rates of other occupations which were less demanding.

> "I do know somebody who works at the [name] Hospital as a healthcare worker. She's not as qualified as my staff, and this is another thing that really is a bit of a bugbear for me, is that you hear people saying that, who don't understand the workforce, that we have, that we need people who are better trained, better qualified, and have a better career path. They don't understand what my, well, I can only speak for my staff, what my staff need to get into somebody's home. Now, they're lone workers, they've got to use their judgement every minute that they're in that house, and they're dealing with different circumstances, and different personalities, and different conditions, right? They've also got to administer medication, or secondary administer it. In a hospital setting, the healthcare worker isn't allowed to do that. It's clinical staff only that do that. So, our staff are less paid, more qualified, and have got more responsibility, right?" [ID70, Site A, Registered Manager, Non-preferred provider ID11]

There was universal agreement that care work was undervalued and should be afforded much greater esteem. However, interviewees were not forthcoming with ideas about how to do this, beyond focusing on pay rises and improving the basis on which carers were paid, as discussed below.

5.4.2 The nature of employment contracts

In many cases, the fact that employees were paid for hours of care delivered and not guaranteed shifts, was viewed as a key barrier to recruiting and retaining staff. Most providers reported being unable to pay on a shift basis, due to the nature of local authority contracts which limited provider resources available for staff wages. The fact that competing sectors were able to offer paid shifts added to the problem.

> "Amazon again have come in and the shifts are whenever you want, 'Come in at this time. Leave at that time. You tell us when you want to work', basically. It's really so flexible that, again, it's something we can't compete with, that kind of flexibility". [ID65, Site A, Business Manager, Preferred provider ID09]

Many providers operated “guaranteed hours” contracts, which required employees to be available for more hours than they were contracted for to secure their guaranteed hours. There was some agreement that many staff preferred zero hours contracts and in one case, an interviewee reported that written contracts were the exception rather than the norm at their organisation. Employers varied in terms of pay and conditions. For example, some providers expected new recruits to undertake training in their own time and others did not.

> “We don't pay them when we are training them. Because we don't have a fund for that we don't have capacity for that”. [ID57, Site A, Business Manager, Non-preferred provider]

> “One girl came and wanted a contract because she was buying a house. They wouldn’t give her a mortgage without a contract, so I gave her a contract and that’s it. Other than that, they’re all on zero. They don’t want contracts”. [ID55, Site A, Registered Manager, Non-preferred provider ID03]

The peripatetic nature of the work meant that most providers required workers to be car drivers. This reduced the pool of potential applicants and added to costs borne by the employee. In a context where some carers were retiring, one interviewee suggested that this made it difficult to recruit young people, who were often unlikely to own a car. Although the need to be a car driver was greatest in rural areas, this requirement was also applicable to most providers operating in urban areas.

> “Very difficult to recruit young people into home care in the [rural] county because they quite often don't have cars and you can't rely on public transport” [ID32, Site B, CEO, Provider membership organisation, Male]

Generally, providers reported relatively low rates of mileage payments and paid only the minimum statutory sick pay during sickness absence. In one case, staff were entitled to a full wage for the first week of sickness absence per year. This provider was also unusual in paying mileage rates of 45 pence per mile compared with 25 pence from many other providers. They were able to offer these favourable conditions due to their refusal to accept local authority contract rates. This was made possible by the local authority’s inability to source care packages from other providers at local authority rates.

The requirement (subsequently withdrawn) for home care workers to be vaccinated against COVID-19 was reported as creating problems and providers were relieved when this was abandoned.

> "Out of all of our staff, there are only two that aren't vaccinated and are refusing to be vaccinated. This was a difficult one in a sense for the two that aren't vaccinated because we had served HR legal letters on them when we were told that by the first of April everyone had to be vaccinated and then the government did a U turn. I know it's still in consultation, but you know they're not going to force them to be vaccinated now. We had recruited two staff to replace them. We've had to backtrack on that. I wish the government had said a lot earlier that they were going to do this backtrack". [ID56, Site A, Registered Manager and Owner, Non-preferred provider ID04]

5.4.3 The nature of care work

Interviewees agreed that home care work involved providing a hugely important service and that this could be rewarding. However, the work was also viewed as physically demanding, especially in the context of an ageing workforce. It was also described as emotionally challenging, with employees providing care to service users with mental and physical health issues. It required workers to exercise a high level of skill and responsibility. In addition to working unsocial hours, employees were obliged to travel in bad weather and during the hours of darkness. This was viewed as unappealing generally, and even more so in winter and in rural settings. COVID-19 and related PPE requirements created an added burden in terms of both time and levels of comfort for paid carers.

> "I wouldn't say pay comes into the mix all of the time. I would say more often than not it is travel. It is travel. Using their cars to travel between care calls. Wanting to work under one roof. They go. They do their shift. They leave. They are not darting around the doors. …And I think sometimes people, for one reason or another, just think, 'I have had enough.' And a lot of our staff have been here a long time. And I think just people come to the end of the road. They just haven't got it in them anymore. And that is fair enough. You can only give so much. I think it takes a strong constitution to just keep going". [ID63, Site A, Registered Manager, Preferred provider ID08]

> "By the time you get in, take you coat off, wash your hands and put your PPE on, you've lost five minutes" [ID24, Site A, Business Manager, Preferred provider ID01]

Furthermore, although carers did receive thanks and compliments, these tended to be outnumbered by complaints from service users and their families.

> "So then you might ring and say, 'Look, we're going to be a little bit late', and they go mad. Or the poor staff member who goes will get it in the neck. But you can understand. But I think it has been bad for call times lately. Especially, you know, we had storms, and then there was cars broke down, there was trees down on roads. Some of the poor staff get their ears bashed". [ID76, Site A, Registered Manager, Preferred provider ID14]

5.4.5 The nature of local authority contracts

Interviewees viewed the "time and task" nature of the contract as imposing constraints on the way services could be delivered.

> "If you just gave us the 20 people who you've got in hospital and said to us, 'This is what we need. This is what they need', we could do it. We could fit them. If you left it to us to organise rather than saying, 'Mrs Jones wants a call for 45 minutes at 8 o'clock. Mr Smith wants a call for 30 minutes at 9 o'clock,' we could go out and talk to these people and we could fit them in where they actually wanted the calls. We could do the tasks that they actually wanted doing and they needed doing. I just think it's very prescriptive the way it's all done. It's not as person centred as we would like it to be". [ID65, Site A, Business Manager, Preferred provider ID09]

Care appeared to be conceptualised in terms of numbers of calls and call times. Workers were described as having to rush from one call to another, which created a stressful working environment. In one case, where the provider was involved in a pilot intended to move away from such arrangements, the focus was on calls, their length and number, rather than moving towards more "outcome based" delivery. In addition, (as mentioned in Chapter 4) the rural context of service delivery created recruitment problems resulting in very high travel costs for the provider, which had not been anticipated. More generally, the fact that local authority contracts were based on packages delivered and did not (fully) reflect the travel time and costs incurred was also viewed as problematic. This was considered especially challenging in rural contexts but was also applicable in urban settings. All providers complained that local authority rates were too low, and many described private clients as subsidising local authority funded service users.

> "The private clients that I have, subsidise the local authority-funded work, that's the truth, right? We've got two clients that are funded by the local authority, [this county] local authority, and what we get for those packages, the only reason why I took them on is because they were within half a mile of where my private client run is. And it was easy to put them in. But I could not run a service on that. I'd have to have about double [the money]". [ID70, Site A, Registered Manager, Non-preferred provider ID11]

5.4.6 Bad practice of care providers

The imbalance between the demand for care and providers' ability to satisfy it meant that generally providers were not in competition with each other for work. However, they were competing for staff, and they often contrasted their own organisation's relatively favourable working practices and employment conditions with those of other providers. Where bad practice was described, this was viewed as symptomatic of specific providers,

rather than characterising competitors more generally. Often accounts included specific examples, based on interviewees' experiences. Such practices included inadequate training and supervision of staff, poor management styles and even illegal activities.

> "Because I've been in a situation, I worked for [name], which you know is one of the biggest domiciliary care providers in the country and I would look at a rota and say like, right OK Joe Bloggs is on shift from seven o'clock in the morning till ten o'clock at night. That's a hell of a long shift. Are we looking at here, like breaching Working Time Directive? Because when I've looked at it you've got that for four, five days. No, we don't pay for the time in between. So when you're looking at it, you're looking at this starting seven o'clock, finishing at ten, but they'll have an hour gap and half an hour gap, and all these gaps. So the actual calls, which was the only thing they were paid for, it'll equate for about eight hours, but be out the door for 13 hours a day". [ID98, Site A, Registered Manager, Non-preferred provider ID17]

Generally, providers were full of praise for their employees, but occasionally interviewees admitted to staff cutting short call times. This was justified in terms of this being beyond their control and because providing some care was better than none at all. In some cases, interviewees described instances where their own employees engaged in bad practice, which had implications for service users and challenging this could result in tensions. Such practice could also have implications for other staff who were already under enormous pressure due to workforce shortages.

> "If we're being honest, probably right now, most care calls are being cut shorter than they would normally be simply because of the pressure to get care covered in a reduced workforce capacity basis. But that's just the way it is. You know, we don't benefit from that because if we get paid for half an hour care, we still pay our staff for half an hour, so everyone is still earning and being paid what they should be. It's just the pressure of doing the job in this climate. It's, yes, challenging". [ID26, Site A, Business Manager, Preferred provider ID02, Male]

> "I've got a repeat offender, who goes to calls early, so they can finish at six every night. So, she may be doing an eight pm bed call at six thirty. I say, 'If you can do that and you can bring your calls forward, you've got too many gaps.' So, we have changed the run around and she's now out until eight, and there's no getting away from it". [ID21, Site A, Deputy Manager, Preferred provider ID01]

5.4.7 Workforce shortage

For some interviewees, the problems involved in recruiting staff meant that they were attempting to maintain a steady state, rather than pursuing growth. In one case, a provider sought to achieve an equilibrium by employing fewer staff, caring for a reduced number of service users and was content to remain at this scale.

> "I [now have fewer than half the staff] and we are probably operating financially better now than we were a year ago. Where we were bringing in [£X] a week. We're not doing that now. We're doing a fraction of that, right? But if you look at the work-life balance for the staff, it's better because they get every other weekend off. It's very rare they have to work, like come back out of home to go back to work later on, in an evening". [ID70, Site A, Registered Manager, Non-preferred provider ID11]

However, more generally staff sickness and shortages led to increased pressures on existing staff. It could also lead to more complaints, which demotivated staff as discussed above. Providers described having to balance contractual obligations with avoiding staff burnout. The compartmentalisation of roles appeared to facilitate prioritisation of short-term goals (service delivery) by care coordinators over medium- and longer-term objectives of maintaining staff wellbeing and retention. One interviewee described how being an owner who was heavily involved in the business helped to avoid this sort of compartmentalisation. In many places, this pressure on front line staff threatened to undermine service delivery and place increasing pressure on staff who remained in post.

> "I used to do a care coordinating position years ago, so I understand where my coordinators come from, because I've been in their shoes. You know when they're shouting and bawling". [ID21, Site A, Deputy Manager, Preferred provider ID01]

> "…those managers who have been promoted, they're not making those judgements in their head. They're just bullying people. If they leave, it's really not their problem. It's somebody else's problem to re-recruit and keep recruiting. Whereas for me, I've got profit levels, I need to maintain a certain amount of business to stay in business". [ID59, Site A, Registered Manager and Co-Owner, Non-preferred provider ID06]

5.4.8 Disclosure and Barring (DBS) checks

Efforts to recruit staff were hampered by delays in obtaining DBS paperwork. Some providers described arrangements in the NHS, where staff moving within the service are not required to undergo a new DBS check. This was contrasted with home care, where DBS checks were not only required, but subject to lengthy delays. Although this was not viewed as a major factor, compared with others, it was still having a disruptive impact on recruitment.

> "we try as much as we can to get the DBS, but yes it has [caused delays]. We have three staff in the pipeline. They've gone through their recruitment process. ... and I think about out of the three of them, two of them have done their training and the third one is doing her training now. But we're waiting for their DBS. At least I can say we have two months waiting for the year to come through, and they keep telling you

this stage it's coming. It's coming, it's coming and we wait". [ID69, Site A, Registered Manager, Non- Preferred provider ID10]

"I had all these staff- so I lost about 112 hours per week, in [place], because I couldn't get the DBSs through. That's a massive issue within the local authorities, because if you've got 12 staff waiting- what happened as well, was, some of the staff just found other work in the meantime, because they kept them waiting...When you're waiting three months for a job, would you wait three months for a job if somebody gives you the same wage two weeks later? You wouldn't". [ID60, Site A, Registered Manager Preferred provider ID07]

Taken together these factors were viewed as having a highly negative effect on providers in terms of their ability to recruit and retain staff. They also had implications for the ways in which care was delivered as is discussed in the following section, which focuses on care delivery.

5.5 Care delivery

5.5.1 Focusing on quantity

For preferred providers, there was a strong focus on accepting and delivering as many care packages as possible. Care was conceptualised and planned in terms of quantity of time and staff required, as well as the number of calls to be provided to service users. Frequent reference was made to the pressures created by tight call time specifications. This often led to care being rushed and carers being late.

"You're on the clock. You're just sitting waiting to leave all the time thinking, 'I've got to get my next one.' It's too much pressure for the staff as well because they know that they can't do their job properly and they're just thinking, 'I'm going to be late for my next client.'" [ID75, Site A, Care Coordinator, Non-preferred provider ID11]

Electronic systems were in place for constructing, maintaining and amending rotas and information was communicated to staff via mobile phone technology. The move away from paper-based approaches was reported as largely welcomed by staff. However, in rural areas inadequate 4G coverage could create problems. This emphasis on quantity was also reflected in the view that IT systems were able to prove call lengths if challenged.

"The carers are loving it to be fair. They know that everything that's on their phone is correct. Basically, if the clients ring up and say they were only here 10 minutes. They were in and out for a call. I can bring that call time up. I have a look on the computer. And see that they weren't. I've got proof because it's got a unique number on the file. It can't be copied. Can't be forged. It can't be anything. I know that carer's done 30 minutes at that call, which has been really, really good, for us anyway". [ID22, Site A, Business Manager, Preferred provider ID01, Male]

> "… we support very rural communities…. broadband speed in [county] is dire in some areas you know you know you struggle to get 3G rather than 5G. And that itself is a large is another business problem which has yet to be resolved". [ID115, Site Q, Director Provider membership organisation, Male]

The nature of care required was described as having changed over time, with clients being more dependent now and carers undertaking more complex tasks compared with the past. This was seen as adding to the problems faced by providers, rather than something which should be welcomed as enabling people to remain in their own home. Where clients were less dependent, this was also viewed as problematic.

> "We go in and district nurses ask us to take over. We do things now that I didn't 20 years ago. We do blood sugars, and we do morphine, and we do all these different kinds of things now that I didn't years ago.... but we're just not valued". [ID64, Site A, Owner, Preferred provider ID08]

> "…since we started 21 years ago, we used to go round, make lunches, put people to bed, light fires. Now it's end of life, it's looking after dementia". ID65, Site A, Business Manager, Preferred provider ID09]

> "It's changed a lot over the years. And the recognition, the local authority to recognise that their population is ageing, and they need to address that…a lot of people want to be at home". [ID59, Site A, Registered Manager and Co-Owner, Non-preferred provider ID06]

> "Most of your clients are frail. It's hard enough trying to get somebody able bodied up, washed, dressed, fed and watered within a certain amount of time. If you've got somebody really frail and they've got complex needs, there's just no way. If you've got someone with dementia, you're having to take your time and explain things…Trying to get that over to people that pay for the services is a nightmare, for the councils and stuff like that and social services". [ID75, Site A, Care Coordinator, Non-preferred provider ID11]

> "We generally find, the ones that are more independent are the ones that are more demanding." [ID24, Site A, Business Manager, Preferred provider ID01]

5.5.2 Personalisation and care

The implications of this focus on care as quantity was that, in most cases, services were not tailored to individuals. When interviewees did refer to service user preferences, this was usually in the context of clients and/or family members having unreasonable expectations. Such expectations included wanting to choose the times at which they were helped to get out of and/or into bed. Interviewees reported that clients must fit into existing rotas and that this was explained to them in response to their complaints.

> "It's ridiculous, to be honest. We're not running hotel services. This is care. If you had care in any other environment, then ultimately, there would be more flexibility attached. I think that's a commissioning issue and a brokerage team issue whereby they're setting up providers, not to fail, but to struggle at the outset, because the expectation has been set that if you want a care call at seven o'clock, you'll get one at seven o'clock …. Well, that's not going to work". [ID26, Site A, Business Manager, Preferred provider ID02, Male]

The response to what were perceived as unrealistic expectations was reported as being to lower them, by one interviewee who had just returned from holiday and given the matter a lot of thought prior to the interview.

> "There's a kind of ethos within the market at the moment, you're lucky to get a service at all. Because there's hundreds of people that aren't getting anything, so you know, be grateful for what you've got and we're just slowly driving down expectations on the basis that, you know, be grateful, and it's hardly the most aspirational message in the world". [ID85, Site A, Owner, Non-preferred provider ID16, Male]

Two interviewees, one of whom had spent his whole working life within the same large, preferred provider described their organisation as taking a "person-centred" approach, but this appeared to involve explaining why care could not be personalised. A non-executive director from the same organisation, when asked whether they discussed outcomes for clients, appeared to be surprised. Their response suggests that they conceptualised this in terms of measurement and the ability to quantify, rather than considering outcomes that might be of importance to individual service users. Linked to this, a focus on immediate service delivery and growth appeared to take priority, over service user priorities. Occasionally outcomes for individuals were mentioned, but interviewees described these in terms of completed tasks and/or outcomes of assessment processes, rather than describing personal outcomes that an older adult wants to achieve.

> "What outcomes do you measure you know? Surveys, but you know, those could be quite unreliable. We have the annual survey of all our carers and indeed their relatives…In a sense, although aspirationally, we need to spend more time doing that, at the moment, you know we're spending a lot of time thinking about how to continue to deliver the service to the existing packages. And indeed, where possible, expand the number of packages" [ID71, Site A, Non-executive director, Preferred provider ID12, Male]

> "They'll zap into you and all the tasks we've discussed that you want are on there [mobile phone]. They've got to complete every task. I do an outcome, a task. It takes a long time to put it on". [ID55, Site A, Registered Manager, Preferred provider ID03]

In keeping with the view of care as quantity, most interviewees tended not to mention care as a relationship, although there were some exceptions to this. In a small number of cases providers reported tailoring care to individuals. This was helped in one case because the provider's income sources comprised a combination of self-funders and what was termed "heroic packages". The latter referred to being a provider of last resort, with higher remuneration than the local authority standard rates. In another case, a provider explained that personalisation was not always easy in the context of commissioner specifications, which described service user needs in terms of blocks of time and general tasks and avoided providing information about service user characteristics and wishes. The manager contrasted this approach with another local authority, which was much more helpful in facilitating a more personalised approach to care.

> "Brilliant. The social workers from [city] and [town] are fantastic, a lot of support. They contact you directly. Whereas in [Site A], I really struggle because everything has come out on a prescription, the work, and you aren't allowed to speak to any of their social workers. You just speak to a brokerage person, so you don't build a relationship up at all with [Site A]. I choose to take the majority of my work from [city] rather than [Site A] for that reason". [ID56, Site A, Registered Manager and Owner, Non- Preferred provider ID04]

> "And getting the information off social workers, the gaps in the information is like…you know at times. We can go in and the packages aren't safe, and my staff aren't safe". [ID70, Registered Manager, Non-preferred provider ID11]

In one site, provision was organised around local teams and continuity was more likely to happen. However, the focus appeared to be on informational, as opposed to relational, continuity. In addition, the approach was intended to minimise travel time and costs and facilitate an efficient approach to service delivery, rather than promoting the development of caring relationships.

> "We try and get the same carers on each area, so they are getting the same ones mainly because they don't want to tell everybody where their cups are and where their sugar is". [ID24, Site A, Business Manager, Preferred provider ID01]

> "The coordinators have divided that area into little areas so that they're not going to like different areas inside the area so they're not travelling as much. Because the carers don't want to travel. They want as little travelling as possible. So it makes it easier for them to get round". [ID22, Site A, Business Manager, Preferred provider ID01, Male]

As mentioned earlier, one provider was operating at a much-reduced scale, which enabled more tailoring of care. These were the exceptions, rather than the norm. Amongst other providers there appeared to be a taken for granted acceptance that it was not possible to provide personalised care, within the constraints of existing structures.

Paid carers were viewed as interchangeable in a context where organisational needs trumped relational care. Where providers were able to recruit new staff, this could create negative feedback from service users, who, perhaps understandably, wanted to retain existing carers. Recruitment of new, younger staff members also brought specific problems in some cases.

> "We're filling those holes with younger ones. But they [service users] don't see it as that. They just see it as 'that carer's mine'.... we're finding out that the younger ones that come on haven't got the life skills, that the older ones have. Like I had one where they put everything in a pot of tea, instead of putting everything in separate like. And put the sugar in the milk inside teapot with tea bags… Another one didn't know what a butter knife was." [ID22, Site A, Business Manager, Preferred provider ID01, Male]

This interviewee also highlighted the benefits of a break in continuity, which gave the opportunity to bring a fresh perspective, particularly in the context of service user decline.

> "Cause if someone's going in like every day, they don't see the changes … they might be needing a bit more equipment in or whatever …" [ID22, Site A, Business Manager Preferred provider ID01, Male]

5.6 Managing local authority relationships

Almost all providers reported that relationships with commissioners were constructive and supportive. As mentioned earlier, all providers complained about the low rates paid by local authorities. At the same time, most seemed to take for granted that this was beyond the control of local authorities and the issue did not appear to adversely impact on relationships.

> "We've always pushed for more money so that we can pass that on to the staff… But funding will always be an issue because obviously, you know, we can appreciate that the council, they only have so much money to spread around". [ID78, Site A, Co-owner and Registered Manager, Preferred provider ID15, Male]

In some cases, the local authority sounded out providers at monthly meetings to discuss issues as a group, as well as being in contact with providers outside of these meetings. Providers which were smaller and did not enjoy preferred status (and the two are probably related) were more likely to find fault with local authority approaches. For

example, in the case of the arrangements for paying a retention bonus (see above), some providers complained that local authorities did not consult on the approach and that this had caused them problems, or in one case a refusal to participate in the initiative. Some of the larger providers were also critical of aspects of local authority approaches. Even in these cases, however, relationships were described in positive terms.

> "We're not the kind of people who go, 'These commissioners are terrible people'. But they need to listen a bit more to the people who are actually on the front line. They need to listen to people who are doing it because we've done it for the last 20 years. We've worked with these carers for the last 20 years…. But we find we do have a good relationship [with the local authority]. They've got a job to do just like us." [ID65, Site A, Business Manager, Preferred provider ID09]

Where providers operated in neighbouring authorities, the variation in approach between local authorities was also discussed. Previous research has highlighted the low trust environment which characterises commissioner/provider relationships (Needham *et al.*, 2020). I was pleasantly surprised, therefore, to hear positive accounts, which often involved interactions with named individuals. At the same time, it made me wonder to what extent cordial relationships with local authority individuals were indicative of trust between commissioners and providers. As mentioned in Chapter 4, one provider had been given trusted assessor status by their local commissioner and in site B, where providers were members of a body which represented their interests, this organisation had been given this status.

> "Initially it was just new hospital discharges [in Site E] … if you assess somebody in a hospital bed, you're going to get a much different outcome from somebody in their own home and their own environment. So get them back home, get them back into their own living room, in their own armchair, and then, 'Right, let's see how can they manage now?' I mean, the hospital social worker still had to put a package of care in, but the amount of reduced care that we had from that, which actually in turn frees capacity up, was actually really, really positive. Because they would come out with four calls a day, but by the end of the five days it would be determined that, 'Oh, she definitely doesn't need a dinner call. By the time I get there, she's up now and she's feeling much better, she's in the kitchen making her own lunch', and they would just assess it that way. And then from that, whatever that last assessment was when they were home, was the long-term care package. Some people went on self-caring, Ruth, as well. Once they were home and they were back in their own surroundings, they actually didn't need care, so they went on self-caring." [ID72, Site A, Regional Manager, Preferred provider ID13]

This development appears to be a more tangible expression of trust, compared to merely being trusted to deliver services in line with contractual requirements. Although for the provider above (ID72), the scheme was initially introduced as a pilot and then extended across the whole of Site E, when it was proved to save resources, which suggests that trust is not unlimited.

5.6.1 COVID-19 and commissioner relationships

There was general agreement that COVID-19 had helped to enhance both the frequency of contact with local authority staff and quality of relationships with them. In some sites COVID-19 was reported as improving relationships which were already very positive. Elsewhere the move to more cordial relations was a relatively recent phenomenon. The experiences of the COVID-19 pandemic were viewed by providers as creating greater awareness and appreciation of the work they had undertaken amongst local authority staff.

> "I almost feel that the local authorities really felt the value of the home care more so than ever at that point… they've been absolutely amazing through COVID, they really, really have. With the communication, obviously the incentives that they gave around, retention of staff and things like that, you know, they're one of the outstanding ones in terms of the support that we were given throughout the pandemic". [ID72, Site A, Regional Manager, Preferred provider ID13]

5.6.2 Local authority approaches and local authority staff as individuals

At times managers distinguished between the local authority approach and individual employees. In some respects, the former could be viewed as unhelpful, but this did not impact adversely on individual relationships. Brokerage team members were viewed as supportive, despite what was described as shortcomings of the brokerage system, by some non-preferred providers. Similarly, local authority workforce shortages, particularly in relation to social workers were reported as hampering provider operations. Yet relationships with individual local authority staff were described as cordial.

> "Honestly, they're fantastic, I've got nothing but respect for them [named individual commissioners] … the care planners, the social workers and the care managers, you've got more chance of finding Lord Lucan… I would say 95% of all issues with adult services is because of that". [ID60, Site A, Registered Manager, Preferred provider ID07, Male]

5.7 Provider representative organisations

The two interviewees employed by provider member organisations were not faced with operational pressures and appeared more able to comment on relationships across the field. In one case, the interviewee referred to the adverse impact on relationships created when the local authority promoted the growth of microenterprise. Over time, a situation had developed wherein some providers were working with microproviders, and relationships between the local authority and providers were now viewed as much improved. Evidence of this trusting, collaborative relationship was (as discussed above) that the provider organisation had been assigned trusted assessor status by the local authority.

> "I feel really positive about the relationship between providers and the local authority because we're acting as that conduit, you know. And the local authority are also very, very comfortable with us being a thorn in their side as well. Because of course, we need to hold on to that autonomy and reserve the right to criticise the Council if we want to and they're fine with that". [ID32, Site B, CEO, Provider membership organisation, Male]

In the other membership organisation, relationships were reported as initially improving, the interviewee noted a tendency for the local authority to revert to pre-pandemic, dysfunctional ways of working which could undermine the positive progress on relationships which had been achieved.

> "It's going back to old ways. So there there's a lot of good things which the council did very quickly, good support networks through their contract monitoring teams, of which a lot of that took a lot of pressure off providers. So that providers were able to focus on the day job, if you see what I mean. And what we're hearing now from our members and those who are non-members or part of other networks, is that actually, it seems that our councils are going back to old ways of working. They've come back as though the pandemic was a blip, and we've learned nothing from it. And so they're going back to all types of systems and all types of audits and the world's moved on". [ID115, Site Q, Director, Provider membership organisation, Male]

This interviewee was also critical of what he saw as a lack of strategy and sustained action concerning the sector on the part of the local authority. He had secured a place on several decision-making groups within the developing Integrated Care System structure and these were not allowed to make decisions unless a social care provider representative was present. This interview was one of the last I conducted so it is not clear whether the issues

raised were unusual or whether they reflect a more general trend which I did not capture due to the timescale of my interviews.

5.8 NHS Providers

When reference was made to the NHS, this tended to be in abstract terms and largely as a competitor for staff or responding to discharge pressures. In Site A, however, plans by the local NHS Trust to establish their own home care service caused unease amongst home care providers. This was the subject of much discussion amongst providers and the initiative was not supported by the local authority. Providers also complained that NHS staff enjoyed a special status in the minds of the public and that this was not extended to home care workers.

> "now, because we're struggling to find staff, so that people can be discharged, they have a lightbulb moment, they say, 'Alright, well we're [NHS Trust] going to employ our own.' So, they're creating a bigger problem" [ID70, Site A, Registered Manager, Preferred provider ID11]

> "It's disgusting that we're struggling to get carers in and then the NHS are going to try to basically trump us by offering more. It stinks, it absolutely stinks to high heaven". [ID60, Site A, Registered Manager, Preferred provider ID07, Male]

> "On the roads in [nearby city], they painted on, Thank you NHS. Our carers are driving every day through these roads with, Thank you NHS and thinking, 'Well hang on. We were the ones going into these houses not knowing what was happening at the time', at the beginning, nobody knew". [ID65, Site A, Business Manager, Preferred provider ID09]

5.9 Staff motivation

The context of care as a problem and a focus on quantity raises questions about interviewees' reasons for entering and remaining within the sector. Amongst the owners, previous experiences of care being provided to friends and family had spurred them into establishing their own care business.

> "When [my mother-in-law] died, my husband was really upset at the standard of care that she'd had. He was retiring from his job, and we thought we could do a better job than that…. Geriatric care was really very poor. I think it hasn't changed much over the years to be honest. Seeing my clients now and what happens to them in hospital, I have no hope in that system at all. But I do know that my carers can give really good care at home". [ID59, Site A, Registered Manager and Co-Owner, Non-preferred provider ID06]

Along with non-owners, these interviewees mostly described their motivation in terms of altruistic, rather than business factors. This might be expected in a context where being

seen to prioritise profit over care quality would not be socially acceptable. At the same time, I had no reason to disbelieve accounts, especially as almost all interviewees had a background in frontline care provision.

All of the interviewees had worked in the field for several years and many reported starting out as frontline carers and moving on to office-based roles. Amongst non-owners, the initial motivations for entering the field were diverse, but often reflected a limited choice of alternatives and/or a desire to leave their current employment rather than a long-term career choice. Bankruptcy, redundancy, limited academic success, wanting part time work and divorce were amongst the reasons given for initial entry to the field.

> "…there's a lot of people when the [factory] closed, that they went into the care sector, because they had brought their families up, there was a good team ethics within the [factory], everybody looked after each other and they looked after each other's families and things like that. It just seemed to be the way I wanted to go". [ID60, Site A, Registered Manager, Preferred provider ID07, Male]

> "I didn't have any qualifications… one of the girls I met told me about the company that I work for now". [ID75, Site A, Care Coordinator, Preferred provider ID11]

> "I worked in scrapyards, I worked in bars, I worked in catering. Then I became the manager at the pub. And then I got divorced, and I left that, and I went to the home. But I was kind of already helping out at the home". [ID76, Site A, Registered Manager, Preferred provider ID14]

Experience as frontline care workers was viewed as helpful, as interviewees were regularly involved in providing care, when frontline staff were not available to deliver the service. This also meant that they had become accustomed to the practices of the organisation and the workings of the field more generally. They were not entirely uncritical of what might be perceived as adverse aspects of the workings of the field. Yet, in many cases, a taken for granted acceptance of the inability to improve sector conditions, other than to make small changes to pay and conditions, was evident in their accounts.

Most of the interviewees had been in post, or with the same organisation for several years. Some had moved from other care organisations due to adverse experiences. Most preferred to stay with their current (good) employer, rather than expressing a desire to move for career progression. Although the pressures of work added to stress and

detracted from job satisfaction, interviewees could not envisage a working life outside of the field.

> "The other week, I said to my husband, 'Do you know what? There's no care in care anymore, it's all paperwork.' Nothing like when I first started... You never hear the positive side of care, it's always the negative, the bad publicity, 'that carer works there, and they stole money', you never hear any of the good stuff. And he said, 'Well, what are you going to do? Because you don't know anything else now'. And that's just it, what can I do? So, I'll be stuck. (Laughter) [ID24, Site A, Business Manager, Preferred provider ID01]

5.10 Relationships with other providers

As outlined above, generally, interviewees did not see their organisations as competing for work with other home care providers. Although they were competing for staff.

> "To me, if I can't provide care for somebody because I haven't got the staff, but someone else can, but they're kind, I'd rather that care be provided, because that could be my mam." [ID60, Site A, Registered Manager, Preferred provider ID07, Male]

There were examples of collaborative behaviour between organisations. This included buddying up with staff at other providers. In addition, in one case, a provider who was offered preferential access to the DBS route, in a context where all providers were experiencing delays refused to accept this on the grounds that the sector as a whole was suffering and the problems with delays needed to be resolved for everybody. It is worth mentioning that none of the providers had lost out to competitors in recent tendering rounds. Although as described above in Site B, some providers were unhappy with what they saw as an absence of a level playing field regarding microenterprise provision.

5.11 Making sense of provider accounts

Provider accounts are replete with descriptions of the problematic nature of care. Even the ability to support adults who, in the past, would have required residential care is viewed as symptomatic of challenges to be faced, rather than as something to be celebrated. The view of care as a problem, as opposed to an enabler, resonates with the accounts of local authority staff discussed in the previous chapter. Similarly, interviewees focused on quantity of calls, of staff, of time and of money. This quantity-oriented practice was reinforced in accounts where personalisation was implicitly and explicitly discussed as not possible. It also added to pressures on frontline staff, increasing the likelihood that they would leave the sector, which added to pressures on remaining staff. Overall, various factors contributed to what appears to an outsider, or to me at least, to be a dysfunctional

system. At the same time, providers were working hard to preserve this system, rather than attempting radical change.

Previous research has highlighted the importance of trusting relationships between commissioners and providers. As discussed above, relationships between these groups were described in positive terms. The increase in the frequency of contact and responsiveness of commissioners, particularly during the height of the COVID-19 pandemic can be conceptualised as helping both groups to build their social capital. Taken for granted acceptance of what seems to me to be a dysfunctional system can be explained in terms of individuals becoming habituated to this state of affairs.

Although providers complained about the time and task nature of contracts, these, together with preferred provider and trusted assessor approaches to commissioning benefit the larger organisations who derive income from these arrangements. The presence of larger "production line" providers also facilitates and perpetuates commissioning which focuses on these larger organisations and a quantity approach to care. As discussed in chapter 4, field structures encourage commissioners to view solutions to care problems in terms of the reproduction of the system, rather than radical change. Similarly, continued participation in the field by providers reproduces, rather than challenges its regularities and rules.

5.12 Summary

With reference to the thesis research questions, provider accounts suggest variable responses to local authority "market shaping" policies and related initiatives. Larger providers who enjoyed preferred status were more likely to view these in positive terms. Interviewees universally reported that COVID-19 had strengthened commissioner/provider relationships. Generally, the development of trusting relationships did not extend to local authorities working with providers to co-design services (Needham *et al.*, 2020). But the designation of Trusted Assessor status for some, suggests a level of trust beyond merely trusting providers to deliver home care services. The pandemic and its consequences were also described as making recruitment and retention of staff more difficult. There was some evidence that recruitment, retention and service delivery were more challenging in rural contexts, but providers in urban areas were also struggling with these issues. The themes of care as a problem, care as quantity,

care as dysfunctional and market shaping as maintaining this dysfunction, highlighted in the previous chapter, are also evident in provider accounts.

As discussed in chapter 4, at Site B, commissioners had pursued a more radical approach to home care several years ago, which did not merely reproduce existing arrangements. This development is discussed in more detail in the next chapter, which focuses on front line carers.

Chapter 6

6.1 Introduction

As outlined in chapter 4, local authorities adopted and/or supported a variety of measures as part of their "market shaping" activities. Together with the activities of care provider organisations (discussed in Chapter 5) these aimed at improving the supply of home care available to older adults. The foregoing raises questions about how far "market shaping" activities and related actions are impacting on front line carers. This chapter investigates the issue from the perspective of current and former paid carers. It does this by examining carers' motivations and experiences. It also explores variations in local contexts and where possible, differences between rural and urban settings.

6.2 Study sample

A total of 36 participants were interviewed from 12 sites, as illustrated in Table 9 below. Five of the sites were predominantly rural in nature. Seven (P, R, S, T, U, V, W) were predominantly urban. Sites M and O are located in Wales.

Table 9 Carers' roles and sites

Roles	Sites												
	A	B	M	O	P	Q	R	S	T	U	V	W	Total
Employed carers	2						1	1	1				5
Ex-employed carers					1	1					2	1	5
Microproviders		8	8	5									21
Self-employed carers						1				1		2	4
Microprovider support		1											1
Total	2	9	8	5	1	2	1	1	1	1	2	3	36

Only three carers were male (IDs 44, 51 and 66). The sample covered a range of ages and included three migrant workers (IDs 42, 44 and 105). All but five of the interviewees had left their employing organisation. Of these, one was a student working part-time (ID105) and another was a former asylum seeker (ID44) with very limited options for alternative employment. Another (ID07) was a relatively new entrant, having changed career and was undertaking care work alongside retraining for an unrelated profession. The remaining two were long term employees of a care agency (IDs 66, 74). In five cases, interviewees had left the home care field altogether. Within Site B, a local charity had been established with the aim of supporting villagers in a rural area. They had established an initiative to

promote microenterprise but were not affiliated with the local authority programme. Once they became aware of the local authority scheme, they began to receive support and guidance from the local authority microenterprise intermediary.

In one case (ID99), an individual moved to the NHS which offered paid shifts as a member of the bank staff. In three cases, ill health meant that participants were unable to remain in post within industry standard forms of provision. Further details are included in Table 10 overleaf. Where participants had established themselves as a business, as part of a local authority initiative I refer to these as microproviders. In Site B, I refer to providers established as part of the local 'bottom up' initiative covering a small number of villages, as microproviders [ID 116 was instrumental in establishing and supporting the initiative and ID117 provided care, in addition to supporting the scheme more generally]. In addition, there were a small number of interviewees (n=4) who provided care via a direct arrangement with service users but did not participate in a local authority supported initiative. I refer to these as "self-employed" in Table 10.

Table 10 Carer and ex-carer participant details

ID	Role	Site	Age	Origin if non-UK
66	Employed carer	A	42	
74	Employed carer	A	46	
7	Employed carer	R	unknown	
44	Employed carer	S	36	Sub-Saharan Africa
105	Employed carer	T	30	North Asia
39	Micro Provider	B	65	
41	Micro Provider	B	52	
42	Micro Provider	B	36	Western Europe
43	Micro Provider	B	33	
45	Micro Provider	B	58	
49	Micro Provider	B	39	
50	Micro Provider	B	57	
117	Micro Provider	B	77	
51	Micro Provider	M	32	
52	Micro Provider	M	40	
53	Micro Provider	M	58	
73	Micro Provider	M	49	
77	Micro Provider	M	43	
79	Micro Provider	M	41	
83	Micro Provider	M	40	
84	Micro Provider	M	57	
13	Micro Provider	O	54	
36	Micro Provider	O	58	
54	Micro Provider	O	47	
58	Micro Provider	O	48	
61	Micro Provider	O	55	
18	Ex-employed carer	P	45	
99	Ex-employed carer	Q	58	
107	Ex-employed carer	V	59	
110	Ex-employed carer	V	62	
108	Ex-employed carer	W	74	
100	Self-employed	Q	36	
106	Self-employed	U	75	
111	Self-employed	W	62	
112	Self-employed	W	35	
116	Micro Support	B	66	

6.3 Motivation to enter care work

Amongst interviewees there was a range of reasons given for entering care work. Often motivation was related to individuals having limited financial resources and academic

qualifications, which contributed to and combined with an absence of alternative employment options.

> "I was very young, and it was just a job. As awful as that sounds, I knew I would be able to get a job. I lived in a tiny little village called [name]. It is a little pit village. There wasn't a lot of work. There were always jobs in care work and that was what made me go into it". [ID18, Site P, Former care agency employee, Social Worker]

> "My older sister was living in the UK, so I came here with my husband. …and a couple of years after, I got pregnant, and I had to change jobs because they [factory] wouldn't give me the right shifts to work at a different time with my husband. When I started looking around, this agency came with a carer job… I said to her, 'It's not something I want to do'… they said go and have a look, because at the moment we don't have anything else." [ID42, Site B, Former care agency employee, Microprovider]

"Ana" [ID42 quoted above] had only a small social network in the UK, as a recent immigrant. But in several cases, friends and family members encouraged entry into the sector. These findings resonate with previous work highlighting the importance of social capital as a factor influencing entry to home care employment (Skeggs, 1997; Hebson *et al.*, 2015) and are also consistent with the accounts of managers discussed in the previous chapter.

> "She [mother-in-law] just said that I seemed to have all the right traits and the caringness to be in care and 'cause I've never actually thought about it as a career which most people from what I've heard don't think about care as a career. I just thought I'd give it a go and yeah, here I am." [ID43, Site B, Former care agency employee, Microprovider]

The life events and circumstances of individuals also influenced their choice to enter the care sector. For some workers with childcare responsibilities, care work was described as sufficiently flexible to be compatible with their domestic obligations. In some cases, relationship breakdown and/or single parent status were cited as motivations for entering the care sector.

> "It was cos I needed childcare. I used to work in a shop. And of course, when I got pregnant, I left. It was a case of you can go back for so many hours, but then finding somebody to look after the baby. My husband worked in a shop as well, so he was working during the week, and I worked at the weekend at a nursing home. And it extended from the weekend. Little bit more, a little bit more to be more hours and more hours. 'Can you do nights?' It extended. And I stayed in the same place for 16 years." [ID111, Site W, Former nursing home employee, self-employed "cash in hand"]

> “I was living in a privileged position, being able to not work and bring my kids up and send them to school and commit to private school… [After my divorce] I was living in a largish house, four-bedroom home with not enough income to provide for bills and everything... And so going into care because it was a way of earning money straightaway and a reasonable amount. Although it wasn't actually particularly well paid per hour, it was just I could do a lot of hours…I really didn't have qualifications apart from a couple of GCSEs I did when I was getting divorced.” [ID99, Site Q, Former care agency employee, now NHS HCA]

A number of interviewees described an inability to continue to work in their current role and a need to change jobs as prompting the move to care work.

> “I used to work for my local council on the bins, doing all the recycling and stuff like that. And whilst I was working there, I had a really, really, really bad accident and I don't know if you can see it. I severed my nerves, my tendons, and everything, and I couldn't use my right arm. So, I signed up with a company called Remploy… for people with disabilities. So, they were like, ‘We want to know your background and everything like that’. So, we sat down, we chatted, and they were like, ‘Where do your parents work?’ I was like, ‘My dad works for a tyre-fitting company, my mum's a nurse’. And they were like, ‘Oh, have you ever thought about nursing?’ And I was like, ‘Not really’. I said, ‘But my nan's a nurse, my uncle's a nurse, my auntie's a nurse’. And it went into this thing like, ‘Why don't you try and work in care?’ So, I was like, ‘Okay’." [ID51, Site M, Former care agency employee, Microprovider, Male]

> “I was made redundant from my job in retail. I thought because I’d done catering and retail you know, I’d get another job quite quickly, but I found myself unemployed. Then I did some various courses, you know, schemes that the government have, to tide me over while I was applying for jobs and stuff like that. …And I asked if I could do a health and hygiene course and they offered courses, and I could get them free through the council. And I went on the course and happened to see the man that owned the care home that I went to, and he remembered me from my previous job. So he used to come in to where I worked in retail. And so he remembered me from there. So I just asked him was there any jobs going. He said ‘oh send your CV in’ and then before I knew it I was I was there. And so, so that's how I fell into care then 'cause I've never thought about doing it before”. [ID83, Site M, Former care home employee, Microprovider]

Chapters 4 and 5 described approaches taken and supported, which were aimed at improving recruitment and retention. The fact that home care work was perceived as low status was highlighted as a barrier to entry. However, rather than making it unattractive to job seekers, for some interviewees, this perception provided encouragement that entry to the sector would be easy. For example, in one case, a lengthy illness and subsequent loss of confidence led to an individual applying because of the perception that jobs in the sector were plentiful and obtaining one would not be a challenge.

> "[Many years ago, after spinal surgery] I put a lot of weight on and … I lost all my confidence and I thought who's going to employ me? … So I thought, well, these caring jobs are coming up left, right and centre… I got the job before I'd even filled out application form in…." [ID36, Site O, Former care agency employee, Microprovider]

New entrants to the field of home care are not blanks slates. Instead, their attitudes are influenced by prior conceptions and experiences of care and care work. This meant that in the context of negative societal stereotypes of ageing and care work, some participants had to overcome their negative preconceptions in order to work in the sector.

> "I was like, 'I don't think I will like it. I don't think I will be comfortable seeing intimate parts of the people so it's not for me really'." [ID42, Site B, Former care agency employee, Microprovider]

> "I worked with horses all my life. For nearly 40 years I worked with horses. Had one fall too many. I thought I've gotta do something different. I thought what can I do? And I didn't know what I could do. So my sister in all her glory said to me why don't you try care? And I thought there's no way I can do care. There's no way on God's earth could I help out and do care. I couldn't imagine it". [ID39, Site B, Former care agency employee, Microprovider]

Although some local authorities and care providers expressed enthusiasm for Values Based Recruitment (Skills for Care, n.d., see chapters 4 and 5), as illustrated in some of the quotes above, many participants described experiences which suggested that employers used less selective approaches. Furthermore, for many interviewees the occupational selection process was characterised by expediency, rather than a long-term career plan. Having said that, most interviewees remained in the sector for a number of years following their initial entry.

One interviewee described her expectations that a home care job would be less stressful compared with working with demanding customers in retail, although she found that the reality was not in line with those expectations. Similarly, one former care worker described how her mother

> "…used to think we had it easy being carers, me and my sister. My mum decided she had had enough of being a welder and started being a carer. She didn't last two minutes, doing home care" [ID18, Site P, Former care agency employee, Social Worker]

These views were atypical, however. One participant (ID07) had left a highly paid job to retrain, intending to work in home care on a part time (16 hours) basis alongside her

studies. The reality was that juggling the two proved to be very difficult, although, this appeared to be due to unreasonable demands by her employer, rather than unrealistic expectations on her part. At the same time, in common with most interviewees, this individual described positive features of care work, despite many negative aspects.

6.4 Becoming a care employee

In what sounded like a relatively short space of time, employed carers developed a "feel for the game" (Bourdieu, 1990a; 67) during their working experience in the home care sector. The nature of the job, often working alone and given a high degree of responsibility from an early stage contributed to the relatively rapid development of a sense of what was required and appropriate in the home care setting. In some cases, adapting to this new environment was accelerated by "in at the deep end" working conditions.

> "I got two half an hours with the same lady and all I had to do was make her a sandwich and I was mortified when I actually got put out into the community. It was somebody with vascular dementia. It was a really difficult call" [ID74, Site A, Employed carer, Preferred provider ID08]

Engaging in care practices, over time meant that workers adapted to the field and their experiences, and the constraints of the field affected how they carried out the home care role. An ability and willingness to perform as required does not mean, however, that employees necessarily endorsed the practices which the constraints of the job forced them to undertake. Recognition of the taken-for-granted world as problematic creates opportunities for challenge and change, but in the context of a largely female workforce and low levels of union membership, collective action by workers is difficult (Johnson, Rubery and Egan, 2021).

For individuals one option is to leave the sector, although the "taken-for-granted" nature of field experience means that many remain in care work, despite the unhappiness it causes them. It might be expected that new entrants are less likely to take these conditions for granted and one interviewee (ID07 see below) who had only worked in the sector for a few months talked at length of their sense of shock at the working environment which involved almost constant pressure to work extra hours and cover additional calls. This contrasted with the account of a worker with ten years' experience (ID66 below). In both cases, however, they remained in post, despite their obvious dissatisfaction and their articulation of the desire to leave.

> "I think even the ones who are higher up, who can see the big picture, they're probably so constrained by those challenges that I've outlined. Lack of staff, lack of money, lack of willingness for anything to change. And increasingly, the number of people who need care. They might be put in a position where they're forced to treat people in a way that drives them away…. what can [care companies] do? I doubt very much if there is any other way of covering these calls… He [husband] says, 'You're going to have to put your foot down... you don't need the money that much. Don't let them exploit you.' And I know he's right, but it's how to make that happen. I'm still not quite sure". [ID07, Site A, Employed carer, Preferred provider ID13]

> "I'm constantly [thinking of leaving]. It's just where to go really…. [after the factory closed] I was unemployed for about six months, so I was pretty much willing to try anything at the time…and it was the first job that I was offered, so I took it and I just took a one day at a time really and ten and a half years later I'm still here..." [ID66, Site A, Employed Carer, Preferred provider ID08, Male]

As outlined below, there are also positive aspects to home care work, which explain in part why paid carers remain in the sector.

6.5 Working in home care

6.5.1 Positive aspects

Care work as worthwhile

Generally, interviewees enjoyed providing what they regarded as a valuable service, which made a difference to the lives of service users. In addition, many described working with older adults as a rewarding experience. In some cases, this was contrary to prior expectations. For example, Ana (ID42 above) who approached the work with trepidation quickly overcame her reluctance to working in the sector.

> "I was like, "Okay," so I went to the training, and I completely fell in love really. I really love this job." [ID42, Site B, Former care agency employee, Microprovider]

> "I have just been in such a bubble, because I had worked in business for 25 years, so I had no idea what went on in the community, I suppose, that I'm living in. So, four months in, and I would say I really love it, but there are a few downsides". [ID07, Site A, Employed carer, Preferred provider ID13]

This sense of enjoyment was enhanced in contexts where carers were able to develop relationships with clients and get to know them. Some carers also reported that they gained knowledge and purpose as a result of some of these relationships.

> "… the majority of my service users are over 80. Most of them are in their 90s. And they are stuck in their homes. They don't see somebody from one visit to the next. And to be able to go in and talk to that person and find out about their life and just see how they light up. When they tell you about it, you know to build up a relationship with somebody. You've got to be able to have respect and trust to work

with these people, because I mean I'm wiping their bottoms, I'm emptying their catheter bags and cleaning up their vomit. I'm showering them and you know, I'm washing their intimate areas. So you need to have a good rapport with them. And I can honestly say that even the ones that are really cantankerous, I do have that… It's just brilliant. I just I love going in and learning about people and hearing about their lives. I wasn't born here where I live and having them tell me about what our town used to be like years ago and the bank was here, and the market was there and just seeing them come alive. You know, instead of being this person, that's just sat in front of the television from morning till night." [ID74, Site A, Employed carer, Preferred provider ID08]

Varied and relatively autonomous work

An aspect of the work which was described in positive terms by several interviewees was the degree of autonomy afforded to home care workers.

> "Pretty much being your own boss and like you're not having somebody breathing down your neck all day sort of thing. Watching what you're doing, and as long as you turn up where you're supposed to go and do what you're meant to do and report any concerns, and nobody bothers you. So that's a plus side." [ID66, Site A, Employed Carer, Preferred provider ID08, Male]

In some cases, paid carers had previously worked shifts in care homes. They contrasted those environments with what they viewed as a more autonomous and varied occupation in home care settings. A number of interviewees described poor quality care in care home settings.

> "Day staff said we needed to get so many of them up. We started getting some of them up at quarter to five in the morning. … you start getting old people up and bed bathing them at quarter to five in the morning. They're the sort of things that I didn't agree with. You're showering them and they're crying. It's horrible, horrible…Some of the things that you see, they're horrible." [ID107 Former nursing home employee]

> "You even had to train yourself to go to the toilet in your break time. You know you couldn't go other times. They'd be wondering where you'd gone. You had to be fully available for people, not keep people shouting, people ringing the bells. You know, you get to the point where, you're on first break which is half 10 for quarter of an hour. So you have to wait to go to the toilet in your break time or your lunch time. But then in your lunch time you're also expected to answer the bells and the door. Not leave the premises in case somebody had a fall. Obviously, you couldn't go out. Umm, so you spend 12 hours a day there." [ID111, Site W, Former nursing home employee, self-employed "cash in hand"]

However, the description of home care employment as not as bad as care home work is hardly a ringing endorsement.

The negative aspects of home care work, as described by participants, were numerous.

6.5.2 Negative aspects

Pay and conditions

A number of reasons were given for the desire to leave paid employment in the care field. One of these was the overall pay rate, which was seen as poor, compared with competing employment sectors. Linked to this, the rates of pay were viewed as woefully inadequate when judged against the requirements of the job and the complex nature of care and support to be delivered. Additionally, pay rates were described as comparing unfavourably to jobs with much less responsibility.

> "I did do some COVID work as well. I sat at home, basically phoning people up and I was getting £15 an hour. And you just think, 'Why am I doing the other job?' really" [ID36, Site O, Former care agency employee, Microprovider]

> "I'm being paid less than my son, who works in the local pub. To do something which has life-impacting outcomes. You know, good or bad. If I do something wrong, I could give someone the wrong dose of warfarin or something. Not good. And if someone collapses in front of you, you've got to know how to give CPR and how to ring the ambulance and what to do." [ID07, Site A, Employed carer, Preferred provider ID13]

In addition, the practice of only paying carers for the time spent within clients' homes was viewed as unfair, in some cases creating unhappiness and/or resentment.

> "… the managers treating us like rubbish, or like something they trod in, speaking down to us. Not paying us a proper wage, that was the biggie…What they don't do, is they don't pay you for your in between, in between the call time." [ID13, Site O, Former care agency employee, Microprovider]

> "I'm afraid once you actually work out what you're earning. It's very poor. So I mean they say they pay minimum wage but like a lot of care companies, it's not just [that one], they don't pay for travelling. They don't pay for travelling time. They don't pay for supervisions." [ID108, Site W, Former care agency employee]

A number of interviewees highlighted the impact of these arrangements on quality of life, with employed carers expected to "hang around" between calls, in the absence of paid care slots for them to fill. For example, one carer described how, in order to be paid for his guaranteed hours he needed to be available for many more hours, which adversely impacted on his ability to enjoy life outside of work. Although he also went on to suggest that this state of affairs was unavoidable.

> "… you know it's just not sustainable for us. You cannot just keep seeing things from the company's point of view because it's us who's having to deal with it at the end of the day, you know … The companies, I don't blame them cause they're already

> giving us just as much as what they can.... And then our funding comes from high up sort of thing…" [ID66, Site A, Employed Carer, Preferred provider ID08, Male]

Another carer who had left to work as a Healthcare Assistant for an NHS trust contrasted the shift payments in NHS contexts with home care pay arrangements. Where service users lived in rural areas, there could be insufficient work to occupy paid carers, resulting in them having to hang around between clients.

> "I ended up leaving because I was finding in the rota at times, I had like a two-hour window in the day … you probably then do another couple of calls. And then sometimes in the afternoon, and I've been stuck at [place] and then have two hours break before I'd have a call somewhere … up in the village…. I think there's the recognition for the NHS… I [now] do a 12-hour shift" [ID99, Site Q, Former care employee, now NHS care staff]

In the context of inflationary pressures, the low pay rates were seen as increasingly difficult to tolerate.

> "But they have just given us a pay rise, they've just given us a 50P pay rise so I think we're on something like £9.70 an hour now. …With everything going up now, it's like wow…so I don't see any benefits from it, you know?" [ID74, Site A, Employed carer, Preferred provider ID08]

As discussed in Chapter 4, local authorities had distributed resources to care agencies for payment of retention bonuses to be paid to staff who remained in post until a specified date. Whilst care workers welcomed additional pay, this was perceived as an unwelcome attempt to control them.

> "To be honest. The word on the street is anyway some people are saying that they feel like it's like manipulation. It's obviously trying to stop people from going, isn't it? And so staff, that's the way people are seeing it. I cannot see anybody going anywhere until they've got it like. But there again it might end up having, like the opposite effect. There might just be a massive drop in staff. As soon as that's paid out." [ID66, Site A, Employed Carer, Preferred provider ID08, Male]

Furthermore, the fact that not all staff were eligible for bonuses was viewed as unfair.

> "… the staff in the office have had a hell of a job because they've had to try, and you know dealing with their own families and working from home…and they are desperately trying to cover these calls and they're working with very reduced staff because they had COVID…you know they need recognised for their effort as well you know not just the carers that are out on the ground but the ones who are trying to organise the care themselves and get everybody out. People working from home and they're having to come out to provide care themselves. It's a bloody hard job. You know, it really is on both sides." [ID74, Site A, Care agency employee]

The low status of care work

All of the interviewees described home care work as being of low status. Additionally, there was universal agreement that the status of care work was not commensurate with the importance of the work or the skills of paid carers.

> "And the clients respect you. They really do. But if you say I'm a carer [to other people]. Oh, so you're nothing, you know." [ID36, Site O, Former care agency employee, Microprovider]

> "I'm sure you've seen on the news and read the articles where they can't, they just cannot get carers. We've got 1.3 million unemployed. You know, we could have carers if they were recognised for the skills they have and the dedication they show and paid accordingly. Appreciated, because they're not." [ID108, Site W, Former care agency employee]

Participants felt aggrieved that the public held NHS carers in high regard, but this did not extend to home care workers.

> "With COVID, the GPs didn't have to see patients. … But we still have to go to work. And I can't stand the district nurses…. They're here to support us supposedly but they don't. We support them. We do everything that they're supposed to." [ID112, Site W, Former care agency employee, self-employed]

As discussed previously, local authority staff and home care agency managers described the mismatch between the level of esteem afforded to employed carers and the value of the service they delivered. Amongst those who left employment to become self-employed carers, low esteem did not appear to be an issue. I return to this point and explain why this should be the case, later in the chapter.

Training and career progression

Policy makers have suggested that a lack of opportunity for career progression and/or the absence of a defined career path act as barriers to recruitment and retention in the sector, as the Government's response to the Health and Social Care Committee's (2022) recommendations on recruitment, retention and training illustrate:

> "…. we are also taking significant steps to address some of the structural challenges facing the care workforce. These include limited career progression opportunities, a relatively low take-up of professional qualifications, and limited access to learning and development. Addressing these problems will help improve the sector's ability to recruit and retain staff in the longer-term, improving its resilience to meet increasing demand". Health and Social Care Committee (2023:4)

This has also been seen as part of a process of professionalising the workforce, thereby increasing the status of care workers (Hemmings, Oung and Schlepper, 2022). In the context of relatively low hourly pay rates, career progression is the only way for employees to increase income, apart from taking on additional hours. Yet only one interviewee expressed a desire for career progression, and he was a former asylum seeker who was desperate to increase his income. He described how his academic qualifications were not recognised in the UK. He had little money and limited social networks which made it very difficult to progress beyond frontline care work.

> "When I came to this country, I had a masters in economic policy and planning. I was doing a PhD in public health… the system ties you in... Because development is something which is very difficult.… when you try, maybe to become a senior carer …. You have to be backed by your employer. Sometimes the employers accept but they don't process anything. 'Oh yeah, yeah, yeah, we shall support you', but they are the ones who was supposed to enrol you. But they don't. Sometimes they give you a condition you should have worked for us for four years". [ID44, Site S, Care agency employee]

For most participants, greater seniority was viewed as unattractive and burdensome, with the benefits of additional pay and responsibilities likely to be far outweighed by disbenefits.

> "I wouldn't have a schedulers job for all the money in the world because they've got to try and get all the work covered and if they can't cover it then they're actually then going out to do it themselves while also doing the out of hours". [ID74, Site A, Care agency employee]

> "They asked me early on if I wanted to be a senior carer and I said 'no chance. I'm not having a phone over the weekend and middle of night and everything, no and yet you're trying to do your job. You're in middle of putting someone socks on and the phones ringing. And then you've got to go out the room because it's confidential. But they can still hear and oh, it's no. I'm not having any of that. When I go in that house that client is my responsibility. I assume so'. That's what I said. But they don't get paid very much more. I'm sure they don't for doing senior care". [ID36, Site O, Former care agency employee, Microprovider]

Similarly, the suggestion that care workers should be given greater opportunities for training and development as part of a process of professionalisation (Hemmings, Oung and Schlepper, 2022) was not regarded with enthusiasm by interviewees. Care workers described being required to undertake training in their own time, which added to their unpaid workload.

> “They expect you to do online training for nothing. And you know they're not the only company that does”. [ID108, Site W, Former care agency employee]
>
> “They’re a bit crafty. We do the training on the social care TV … you have the different segments, and they pay for that social care TV you know. They put it down on your account and they might give you an hour [paid] to do four of five different subjects. Uh, yeah, so you know, yeah. So it is crafty.” [ID36, Site O, Former care agency employee, Microprovider]

This contributed to a sense that training was for the benefit of the organisation, as opposed to the individual. These views chime with recent evidence that increased training is not associated with improving retention, and “is even likely to slightly increase job separation of domiciliary frontline staff” (Vadean and Saloniki, 2023: 9).

Time and task care

All interviewees described the time and task nature of agency employment as creating pressures on them. For some, there was an acceptance of their inability to change what they perceived to be a dysfunctional system. This appeared to be linked to a “taken for granted” view of the field as being beyond their control and an acceptance as unavoidable, of the poor practices which characterised it. These created unhappiness amongst carers who often had to shoulder huge burdens as a result of this dysfunctional system. The inability of agencies to recruit sufficient numbers of staff was reported as creating pressure on existing frontline employees to take on additional care calls, often at very short notice. Sometimes these calls were slotted into an already packed timetable. These factors led to many staff feeling bullied and exhausted, which in turn, led to some of them leaving the sector altogether.

> “I wouldn't never go back never. I'd sooner go and bloody scrub the roads or go on the bins…. you haven’t got time. You have got all your nerves thinking. Please hurry up. Please hurry up, hurry up and finish that cup of tea. Please hurry up and finish your breakfast so I can wash the dishes up, so it's all done when I leave. And that’s all you’re doing in your head and you know, thinking I gotta put the bins out I can't do this I gotta get that and then they say could you get me some milk today and you're thinking ‘oh shit when am I gonna get that?’” [ID39, Site B, Former care agency employee, Microprovider]
>
> “I was so stressed working for that company. I would start my day, and I'd know I’d have 20 calls for that day, and I'd start doing my morning routine and I'd think, "Right, I haven't got to rush this morning because I haven't got any extra calls.’ And it would get to about nine o'clock, and all of a sudden, I'd have four new calls put on for that morning. And I'd be like, ‘Why is this getting put on me now?’.” [ID51, Site M, Former care agency employee, Microprovider, Male]

Employees were quick to learn the appropriate rhythms for care work practices in a context where call time allocations were rigidly specified, with performance against these monitored. However, as illustrated above, the scheduling of calls was often reported as being unrealistic for the tasks to be performed and/or the travel time scheduled between calls. This way of working left employees feeling unfulfilled in terms of the nature of the care they were able to provide. In addition, it created a stressful environment for employees who were expected to bear the pressures of a system over whose timetable they had little or no control.

IT systems, which monitor time spent in service users' homes implemented by many providers were reported in chapter 5 as freeing front-line carers from paper-based systems. Elsewhere, these have been described as increasing both work intensification and staff surveillance (Moore and Hayes, 2017). Generally, participants were not unduly unhappy with these systems in terms of surveillance and control. However, there were complaints that as information provision and recording tools, they were unreliable, and this added to workload. (As an aside, I found out later at the focus group that NHS staff are unable to routinely access service users' records where these are in agency digital formats, compared with the former system of paper notes. See Appendix A).

> "… there's so much information on them now [phones] that they're freezing all the time, they're not working. Ideally when they're working you get to look back. Say I went to see Mrs Bloggs this morning and I've not been to her for a few days. In theory I should be able to look back on her notes for the past few days to see, well, what's expected and things like that. But because there's that much on the phones are clogged up and they're just not letting you look back so then you've got to phone the office and say 'Can you give me a rundown of what I do here and do we have meds?' You know, whatever." [ID74, Site A, Care agency employee]

Care work as physically and emotionally demanding

Participants described care work as difficult, in terms of the physical demands of the job. Dealing with human waste has been identified as requiring care workers to manage dirt and disgust (Twigg, 2000). Yet, employees appeared to take this aspect of the work in their stride, even those who had dreaded this part of the job most, before entering the field.

> "… even when it came to changing the nappies and sometimes, they were a real mess. It was more about not letting her feel like it was awful. You know, assuring her that everything was fine because she'd look at me sometimes and go. 'What's that?' She didn't even understand what it was that she'd done. I'd say 'don't worry about

it. It's fine', you know and get it changed and clean her up." [ID106, Site U, Former care agency employee, Self-employed]

However, many interviewees were aged in their late '50s or over and commented on the difficulty of ageing and ailing bodies to sustain a physically challenging workload in the context of demanding employers. In some cases, employees had caring responsibilities for ageing relatives including parents and spouses, which impacted on their ability to deliver care as an employee.

"… my mum is in her middle, creeping up, end 70s, so I also look after her." [ID50, Site B, Former care agency employee, Microprovider]

"I've also been looking after my husband who's disabled". [ID111, Site W, Former nursing home employee, self-employed "cash in hand"]

"They're never going to be able to help my back and it actually has come back again cause I am in quite a bit of pain." [ID83, Site M, Former care agency employee, Microprovider]

The COVID-19 pandemic and related PPE requirements created additional tasks for employees, with no extra time given to perform these. Furthermore, in the absence of economic capital, COVID-positive employees were obliged to return to work once they tested negative. This was regardless of their capacity to do so. Generally, care workers did not have access to sick pay beyond their entitlements under the Statutory Sick Pay scheme (Unison, 2022).

"I am immune suppressed, but because nobody knew what they were doing and the company didn't do furlough, they wouldn't furlough us. And because they said you can't work from home…. When I got it in 2020 and I was really poorly, I was off work for four weeks and still wasn't 100% but I had to go back …I just couldn't afford to not be at work, so I had to go back. …I thought I'm gonna have to go to work, but gosh it took me forever. I mean I couldn't walk very far, and I think it was like basically go to work come home, sleep, go back to work, come home, sleep." [ID74, Site A, Employed carer, Preferred provider ID08]

Care work, for employees was described as also being emotionally difficult. During the working day the stresses and strains of time and task created tensions for employees. Often these spilled over into employees' downtime, making it difficult for them to relax.

"I remember being on anti-depressants for a lot of the time…. they need to treat their staff like they are humans, not machines. That is a big thing. Realise that life happens, people do get poorly. It is a very stressful job. Realise that the pressures they are putting on their staff are too much, way too much." [ID18, Site P, Former care agency employee, Social Worker]

> "Really stressful actually. I didn't find anything about it calm or measured…. I would never do it again. I would never do it again. I think the emotional draining that you get with caring. There's no financial recompense that is enough for me to do it for strangers anymore, ever. Couldn't do that again." [ID110, Site V, Former care agency employee]

For some carers, the requirement to cover due to staff shortages left them feeling vulnerable and stressed due to lack of information about the service user and their routines.

> "You should really be getting a little summary of the person before you get to their house. No, that doesn't happen. You get their name, number, address, possibly their date of birth, who their GP is and their family contact. And the key code to their house." [ID07, Site A, Employed carer, Preferred provider ID13]

> "… if you look after people with dementia, you get quite a lot of incidents. I've been chased around the house with a kitchen knife by one lady." [ID108, Site W, Former care agency employee]

Some participants described how, as new entrants to the field, their reluctance to say no to additional work resulted in them accepting huge workloads which were unsustainable.

> "I walked into [former employer] and they took full advantage. I was doing between 71 and 82 hours a week to the point where I was nearly hospitalised with exhaustion…I said well these guys can't go without so I've got to do it cause no one else is going to… I was always working, and I almost lost my whole entire family because of it, because I was just so, I was either always at work or sleeping. That was literally it. There was never any family time or anything." [ID43, Site B, Former care agency employee, Microprovider]

> "I always felt like I couldn't say no. I always did everything, and I've been at one point out doing sort of 70 hour weeks because I felt like I couldn't say no. I made myself quite poorly so now looking back now, if I was to start again, it would be a case of no. I would put my foot down. I'd say 'I can work from this to that, but I'm not doing any extra'. Because you've got to allow yourself to have a time out, time away from work to unwind." [ID74, Site A, Employed carer, Preferred provider ID08]

Some employers were described as being more accommodating and less prone to bullying than others. The preparation and training for new entrants also varied widely between employers. In some cases, this meant that staff felt their induction period was inadequate. Being thrown in at the deep end meant that staff had to learn quickly, but this added to stress. Developing relationships with service users was highlighted as a positive aspect of the role (as discussed above), with some carers even visiting former service users in care

homes. But the death of service users was also upsetting, with some paid carers feeling insufficiently prepared for the emotional impact of this.

Travel

Linked to the time pressures and low pay aspects of the job, the requirement to be a car driver and have access to a car, at times added to worker frustrations. For those in rural areas, there was generally no other means of transport available. Even in urban settings, workers were mostly required to drive between calls. In two cases, carers were driven to calls in a pool car for some calls. Although this could result in time spent waiting around between calls, for which they were not paid. The context of rising fuel prices and inflation more generally exacerbated these frustrations.

> "… like we get 25 pence per mile, which is crap really….we are quite rural. I mean [county] and it is quite a rural area, so we do travel quite a bit. And I did three calls yesterday … that's quite a bit of mileage to get from one house to the next house to the next house. [ID74, Site A, Employed carer, Preferred provider ID08]

> "I know they need the care, I couldn't say no. I'd do it, and then I'd be putting so many miles. I was doing so much mileage on my car. I think I did 60,000 odd miles in a year. It was ridiculous, really. And I was just getting so stressed. I wasn't feeling depressed, I was just feeling overworked all the time. And I'd never felt like that before." [ID51, Site M, Former care agency employee, Microprovider, Male]

Organisational malpractice

The pressures to deliver care within constrained budgets were described by several interviewees as incentivising agencies to attempt to cut corners. Descriptions of employing organisations varied, with some being viewed as decent employers and others, much less so. However, assessment of employers appeared, at times to be based on relatively low expectations and/or limited experience of alternatives. In interviews, some participants reflected on their relationships and interactions with employers in ways which suggested that they were reconsidering the extent to which employers' behaviours were benevolent.

> "They're good to be honest. She's been the best boss I've ever had….They're the only employer I've ever known who gives you an Easter egg at Easter. …when I handed my notice in and she said you've got to work all these weeks and I said, well, I have had no holidays and she looked at me and went 'no chance…. you should have worked six weeks [notice on a zero hours contract], but I'm doing you a favour and working you five weeks'. She likes being very much in control." [ID36, Site O, Former care agency employee, Microprovider]

In some cases, staff described being asked to undertake tasks which gave them cause for concern. Some participants described exposure to illegal activity such as undertaking tasks for which they were not trained, or falsifying documentation.

> "I did a med count. They were down by six tablets, so I contacted the manager, and the manager told me to lie on a legal form. That was my last straw with that place, and I handed in my resignation the next day" [ID43, Site B, Former care agency employee, Microprovider].

> "They started mistreating us as the carers.... They were asking us to do things we were supposed to not do… it was against the law. … I couldn't do anything. I was just like an insect in there. If something goes wrong, I'm the one who's got problems and I don't want that." [ID42, Site B, Former care agency employee, Microprovider]

The issue of employers exercising undue control over them was raised by a number of interviewees and perhaps not surprisingly, this appeared to demotivate them.

> "I didn't want to do care anymore, really didn't. Especially when the pandemic was on because we were treated shoddily. And you know, I took it into my own heart. I was off for four months on sick because of how we were treated in work. … I just realised that if I didn't get out, I would be off again. And it was always like, yeah, it's just all about management being in control of you and you know, very much like that. And you weren't. You couldn't make decisions on your own. You had to go through them all the time and decisions we made when we were all qualified to do the job. Because we did the qualifications that you're expected to do and I just felt yeah, no, it was time to leave. But then this [microenterprise] came along and. I'm really happy now." [ID73, Site M, Former care agency employee, Microprovider]

Employers' control over employees' time

In addition to the demotivating effects of managers' unwillingness to trust staff to exercise judgment, control of employees' time was a major cause for complaint. Last minute schedule changes added to the sense of uncertainty and denial of predictability experienced by workers, in a context where employers exercised power over other people's (service users and workers) time. In addition, the bullying and coercive tactics described above which led to workers accepting additional calls and/or shifts also contributed to a loss of control over timetables and life outside work.

> "'Can you cover this shift, can you cover that shift?' They would pester you and pester you, and if ever you said no to them, they'd cut your hours for the next week, to sort of punish you, if you like. It was just so stressful, so I left that job. I couldn't be doing with it anymore." [ID13, Site O, Former care agency employee, Microprovider]

> “Say tomorrow morning she's only put me down for like say, three hours finishing at 10:00 o'clock in the morning. If I get to 8 o'clock, they can always add more on, so you can't plan anything because you're expected to keep that date open. You know what I mean?... I work Tuesday, Wednesday, Saturday. Because she's taken me off working on a Friday, I used to do four days and now I'm down to three. So that's it. They control how much money I earn, you know. I want to be in charge of that.” [ID36, Site O, Former care agency employee, Microprovider]

This lack of control and predictability is important because it has material and psychological consequences for employees, as ‘Jack’ (ID66 above) explained.

> “It's just exhausting. I mean like mentally exhausting. … Over the Christmas I worked all the bank holidays… I came out with £50 less than what I would do any other month…. over the Christmas there's that many cancellations. … . They only pay for the jobs that you've done…So when it comes to getting paid, you're not even like breaking even on what you would have had anyway.” [ID66, Site A, Employed Carer, Preferred provider ID08, Male]

6.6 Leaving care agencies

The views and accounts of front-line carers resonate with themes discussed in earlier chapters. Being pressurised to take on additional calls in the context of rushed and stressful timetables is consistent with the view of care as a problem as opposed to an enabler. In this context, service users were depicted as problems requiring responses rather than individuals whose outcomes were to be prioritised. Where participants did talk about service user wishes, it was clear that balancing these with service delivery timetables was not always easy.

> “… there are more and more people come on the books. You know, we've got more and more service users needing more and more help. We had one lady who just had one call a day. Now she gets three calls a day. Things like that, yeah. You know it's kind of difficult, I mean you could put it down to not having the staff or put it down to people living longer. You know needing more complex care”. [ID74, Site A, Employed carer, Preferred provider ID08]

> “… being able to go to the individual house and caring for them, respecting them, respecting their independence. It's quite like it's a quite hard job. You need to understand your role first, how you are supposed to carry out your policy, and then how can you respect the individual this one’s independence? …so many issues will come up because we were visiting the different client house and then they don't like the way we treated them so many times we will get into the like issues”. [ID105, Site T, Care agency employee, International Student]

Additionally, the agency approach to care delivery, in employees’ descriptions can be seen to support a quantity, as opposed to quality, view of care provision discussed in chapters

4 and 5. The negative aspects of the role mean that staff leave, creating shortages, which increases pressure on staff, who remain. The efforts by local authority and care agency staff to sustain this dysfunctional system leads to more staff wanting to leave and so it goes on.

As outlined above, most of my carer interviewees had left their employing organisation. In three cases, ill health meant that they were unable to remain in post. However, they were able to operate as self-employed carers, working fewer hours and with much less travel required. Generally, self-employed carers were much happier, compared to employees and this is discussed in the next chapter.

6.7 Interpreting accounts and understanding change

The accounts of front-line care workers resonate with those of local authority staff and agency managers discussed in Chapters 4 and 5 in terms of the perception of a focus on care as quantity, rather than considering the quality of care. Linked to this the depiction of care as a problem, with front line workers increasingly asked to solve this problem by undertaking additional calls and/or shifts is at odds with a view of care as something enabling. Again, the "care as a problem" depiction resonates with the views of other stakeholders, as previously discussed. The description of pressures leading to staff leaving and agencies engaging in bullying and dubious or in some cases illegal practices suggests that the system is highly dysfunctional. Yet, as discussed earlier, stakeholders across the home care field are engaged in sustaining this dysfunction. The costs of this in terms of employee wellbeing are borne by front line workers, some of whom remain, despite the emotional and financial toll on them. Carers' accounts also highlight the gendered and class based factors which contribute to their entry into the home care field in a way which resonates with Skeggs (1997) and Hebson, Rubery and Grimshaw's (2015) depiction of a gendered class based habitus. Childcare responsibilities and relationship breakdown were cited by a number of participants as motivating them to enter the care sector. Many chose to remain even when they no longer had these responsibilities. I return to this issue in chapter 8.

6.8 Chapter Summary

In this chapter I have discussed the views of those who provide or have provided front line care to older adults. I also explained why care workers leave employers and the field more

generally, as well as shedding some light on why they remain despite high levels of dissatisfaction. The problems identified by paid carers resonate with the views of local authority staff and home care providers discussed in Chapters 4 and 5.

There were differences though between front line carers' accounts and those of other field actors. For example, the control over workers' time by employers appeared to be a factor in explaining key aspects of worker dissatisfaction. Yet this did not appear to be a concern for local authority policy makers or care agencies. Additionally, the views of front-line carers differed from those of many other stakeholders with regard to career progression and training. Carers did not express a desire to engage in additional training, especially since they would have to do some or all of this in their own time. Marginal gains from enhanced hourly pay rates were not deemed sufficient to incentivise staff to seek career progression. Additionally, agency work involving additional duties was not viewed as desirable in a context where workforce shortages created huge problems in staffing rotas. Local authority bonus schemes risk "crowding out" intrinsic motivation (Jacobsen, Hvitved and Andersen, 2014) and although the extra money was viewed as helpful, these attempts at worker control were not welcomed.

In common with local authority staff and care agencies, front line carers described increased workload arising from pandemic related PPE requirements. The chapter suggests that similar problems have been occurring across rural and urban areas. However, the issue of mileage appeared to be a greater problem in rural areas. In addition, with much of the work concentrated in urban areas, staff in rural settings could find themselves having to spend unpaid time (sometimes hours) waiting around between calls.

Chapter 7 Alternative models of provision

7.1 Introduction

As discussed in Chapter 6, a number of participants had left their employers due mainly to dissatisfaction with their working conditions. Many had opted to work as paid carers on a self-employed basis and most of these were encouraged to do so by local authority initiatives promoting microenterprise. In Chapter 4, I discussed local authority initiatives to promote microenterprise in home care for older adults. In Chapter 2, I briefly mentioned that provider forms vary, and that some may be more motivating for workers than others (Burns *et al.*, 2023). In this chapter, I describe issues raised by self-employed providers, two of whom had opted to become self-employed for a short period when the organisation which employed them ceased trading. I return to this issue later in the chapter. But most of what follows is concerned with self-employment for a longer period of time. I also briefly discuss evidence from organisations which deviate from the industry standard, time and task form of provision.

7.2 Becoming self-employed carers

As outlined in the previous chapter, front line carers expressed frustration with working arrangements, and this helped to provide a push for them to leave employing organisations. In some cases, individuals described providing care in a self-employed capacity, in a context where there was no formal infrastructure to support them. It was difficult to assess the extent of these sorts of arrangements since, as discussed in Chapter 3, my recruitment involved snowballing and using directories on websites, rather than a representative sample of the workforce.

Of those who entered self-employment (26, see Table 10) the majority (20) were encouraged to establish themselves as sole traders by local campaigns designed to motivate and support them to do so. For the remainder of the chapter, I describe these as microproviders. In two cases, participants described being motivated to expand in the future and to employ staff, but none of the others had such aspirations. In addition to the formal local authority supported schemes, there were other examples. In one case a local community activist (ID116) had helped to establish a charity (see previous chapter) which encouraged and supported community members to become self-employed carers. Another interviewee had become self-employed prior to the local authority establishing

its scheme but had joined it on learning of its existence. In addition, in four cases, carers had established themselves in the absence of local authority schemes and for two of these participants, the service took the form of an informal “cash in hand” arrangement.

As discussed earlier, home care workers have limited access to resources such as money, qualifications and contacts who can help them gain more elevated (in terms of income and status) forms of employment. It seems unlikely that many would spontaneously decide to establish themselves as businesses, although this does happen. Indeed, their experiences of low pay and status might be expected to narrow their perception of what is possible and predispose them to avoid disruptive change of the magnitude involved in becoming a microprovider. However, in addition to these “push” factors, there were strong pull factors which explained their decision to become self-employed carers. The most important of these were the local authority campaigns to encourage and support self-employment.

7.3 Local authority initiatives

As outlined in Chapter 4, local authority initiatives were very influential in terms of their contribution to the growth of microenterprise, and these comprised a number of features as I explain in what follows.

7.3.1 Publicity campaigns

Raising awareness of self-employment as an option for care work was crucial to the emergence and spread of microenterprise. Microproviders described having seen publicity, which gave them an impetus to investigate further. In some cases, word of mouth was helpful in alerting individuals to the opportunities, with friends and acquaintances, some of whom were already microproviders, drawing attention to publicity campaigns.

> “… a man named [name] randomly popped up on my Facebook with an advert saying, ‘Do you work in care? Would you like to start your own business?’ And stuff like that. And he was doing it around [rural area] where I live. So, I just thought, ‘Well, if this isn't fate, I don't know what is’." [ID51, Site M, Former care agency employee, Microprovider, Male]

> “I saw a notice in my doctor’s surgery talking about being self-employed, thought about it for a little while, I met a lady called [name] from [microenterprise initiative], had a chat with her. Then a few months later, just before our first lockdown I decided to become self-employed, put in my notice, left my job and then it was

lockdown and there I was. It all worked out, so it's fine." [ID52, Site M, Former care agency employee, Microprovider]

"I'm very new to care. I trained over the COVID 2020. I was in a totally different industry. I'd never done any care in any way. Well, other than your own family life, but I hadn't worked for the care industry. I had my own business that we lost with COVID. It was something that I was interested in and my colleague, she was obviously looking for work as well, and it didn't suit her, but she saw the advert for the micro-carer, and she knew that that was something that I'd said I'm really interested in just doing that. It's something that I would like to do." [ID61, Site O, Former non-care business owner, Microprovider]

7.3.2 Microenterprise intermediaries

Participants reported lacking confidence and being fearful about the prospect of becoming self-employed, despite the attractions this offered. This is understandable in the context of life experiences shaped in part as an employee which constrains expectations and aspirations. The support from intermediaries, either externally or in one case local authority-employed (as discussed in Chapter 4), was viewed as essential, especially in the early stages of the move to self-employment.

"I wasn't too keen on it. I was like, 'Oh'. I doubted myself, when really, I'm more than capable, but you have that confidence thing, don't you? like, 'Am I able to do this?' Like I say, with [local authority intermediary] at the end of the phone or a quick email message, like I said, they'll find the answer for you and then guide you through". [ID13, Site O, Former care agency employee, Microprovider]

"It was a big thing that I had them [intermediaries] … they weaned me off them, if you know what I mean, and they've actually gone now. They were just amazing." [ID61, Site O, Former non-care business owner, Microprovider]

Microproviders reported being provided with information and advice which was invaluable in helping them to increase their knowledge, skills and confidence. Changes did not happen overnight, but over time microproviders were able to grow in confidence as they engaged in new practices, both caring and business related.

7.3.3 Quality frameworks

Participants described undertaking structured training and demonstrating compliance with minimum standards which underpinned the micro initiative. This meant that they were able to be included in online directories demonstrating their compliance with the quality framework.

"We have to work to certain standards, and you know we have to make sure that everything is proper and in place so at least through that website, you know

everyone's gone through that same system". [ID83, Site M, Former care agency employee, Microprovider]

This contrasted with self-employed carers who did not participate in the local authority initiatives.

> "That's [training] a real problem for us at the moment. We haven't been able to focus on this and it's getting started and COVID has made this all very difficult…. There's some people have done some basic courses, but in my mind, and our minds, not enough. And we do need them. Even though they're self-employed, need might be a bit strong, but we seriously want them to feel they're also part of a support network". [ID116, local charity volunteer promoting microenterprise]

> "… obviously we've got a clean DBS. I'm NVQ level 2 in health and social care and [colleague]'s got you know she used to work at the County [hospital] so she's got her nursing qualifications. We do really need to be looking at ongoing courses, because I suppose we could both do with a refresher in moving and handling. Because everything's always constantly changing. So yeah, that's something that we need to be looking into, just to update". [ID100, Site Q, Former care agency employee, self-employed carer not part of a local authority initiative]

7.3.4 Microenterprise as a community

Membership of a WhatsApp group created by the local authority also gave new microproviders an opportunity to engage in discussion with other members of the microenterprise community. With so much work to go around and with microproviders keen to stay on their local patch, the microproviders did not appear to regard others as competitors. Instead, longer serving microproviders spoke at events to encourage others to join. This support network of microproviders was important as a discussion and knowledge exchange forum. This compares favourably with PA employment insofar as the direct employment of PAs has been described as exposing them to risk due to the weakly formalised employment conditions they experience and the relatively isolated nature of their work context (Christensen and Manthorpe, 2016; Manthorpe *et al.*, 2020).

The WhatsApp group was also essential in most cases, since microproviders would use their local microprovider network to seek cover for holidays and other absences. In addition, microproviders reported using it to highlight people needing care.

> "I've spoken to people that have been thinking about coming into it and showing them my own books and saying, 'It's as simple this, you get a diary and you do this and you write down, then you add everything up and just keep it simple.' Then it's not quite as daunting". [ID52, Site M, Former care agency employee, Microprovider]

> "… we've got a micro providers WhatsApp group that's been created where if another carer's been approached by a client that they can't do so that all of us can see there is a client that needs so and so hours a week and then we'll communicate with each other. Then if one of us can do that package or possibly two of us then our information gets passed on to the family and then the family will get in touch." [ID43, Site B, Former care agency employee, Microprovider]

7.3.5 Direct payments

As outlined in Chapter 4, it was also important for local authorities to ensure that their direct payments policies were aligned with the requirements of the microenterprise initiative. Microproviders reported mixed experiences with regard to Direct Payments. However, where they had experienced problems, they were viewed as teething troubles, rather than fundamental flaws in the system.

> "I think there's one gentleman that, he doesn't pay himself, I think [place] Council pay from their direct payments. I think there's been a bit of a hold-up there, with money." [ID79, Site M, Former care agency employee, Microprovider]

> "… in some cases, the client's contribution will get taken out by direct payment and then they'll pay me. But sometimes, that first payment can take up to eight weeks, and especially, over Christmas, I was waiting nearly nine weeks for a payment, because they were obviously closed during Christmas and New Year and everything, and nothing was getting done. And it was a bit frustrating, but I wouldn't just say, right, I'm not providing care for you because you're not paying me….. I think this direct payments thing, because it's only early days, I expect there to be faults and delays, and stuff like that. So, I can't really say it's not working." [ID51, Site M, Former care agency employee, Microprovider, Male]

7.4 Rural context

As discussed in Chapter 4, staff shortages were not confined to rural areas. At the initial site (B), the rural nature of the context created both a problem and an opportunity. Rural areas have been described as possessing strengths that encourage entrepreneurial projects, such as informal cooperation networks (Galvao *et al.*, 2020). Rural entrepreneurs are also seen as facing multiple barriers and a different institutional environment compared with their urban counterparts (Fanjul, Herrera and Munoz-Doyague, 2023). However, in this case these barriers (e.g., lack of human capital, poor transport infrastructure) meant that established providers were withdrawing or had withdrawn services from these areas, in a way which helped the development of microenterprise. This enabled the model to become established in rural areas before spreading to urban settings. In addition to providing benefits for rural dwelling service users, participants who lived in those areas were motivated to join the scheme.

> "I went to work for an agency, and I worked for them for 12 months. They introduced the local run to me, which was great, because I live up a quiet valley. It's difficult to get care there. So, I worked with them for 12 months, and then they said they were pulling out. So, me and the other girl that were on the runs, regulars, we decide to leave the company and set up on our own." [ID79, Site M, Former care agency employee, Microprovider]

> "… if you're based in the village, you want to offer care, it seems like a really attractive prospect to set up as self-employed and be able to just offer care very, very locally and not have a long commute and lots of commuting in between your visits. And so it can be a pull factor towards self-employment …. there was an example where a care agency recently which was covering a very rural village, stopped covering that village. And so, a couple of the staff members got in touch with me at that point to say, 'you know my options are I can either carry on working for the agency, but I'm now gonna have like a 45 minute, one hour drive to work back from work and I'm gonna be here there and everywhere and you know, far away from where I live. But I don't wanna do that. I wanna carry on working locally'. And the risks for the people who were being supported by this agency were that there was literally going to be no care in that area once they pulled out…. So those people coming through us, you know they've maintained the support that's available in that village, and they've been able to carry on in care… The only difference is now that they're self-employed rather than employed…." [ID120, Site N, Microenterprise Intermediary]

There was also a suggestion that in small rural communities, word of mouth spread more easily, which could help promote microenterprise, as long as standards were maintained, and users were satisfied with the service received.

> "… and if you're not good, you're not gonna get any employment, are you? And it's word of mouth, especially round here. You have a code of conduct in employment as well, but with this you know we have to make sure that we're all trained and everything. So I'm very happy." [ID73, Site M, Former care agency employee, Microprovider]

Traditional providers initially did not perceive the development as a threat, therefore. Furthermore, the context of scarcity meant that microproviders did not have to engage in large scale marketing campaigns or compete with other providers for business.

7.5 Becoming a microprovider

The growth of microenterprise can be seen as involving the development of a new way of working and of being, by individuals who had previously been employed carers. This involved engaging in new practices and these practices were described as giving them much greater control over their work and life more generally, compared with being an employee.

7.5.1 Temporal power

For carers whose practices have been shaped by the time and task arrangements of organisational employers, the switch to self-employment involved developing new ways of working, in a context where employers no longer exercised control of their time. Taking control of their own time meant working to a timetable which reduced or removed the stresses of rushing from one visit to another. Self-employed carers were much freer in terms of their ability to agree call times. Many reported that intermediaries had advised them to consider adopting a minimum call time of one hour and remaining within their local area to minimise travel time and related costs. Most took this advice on board, and this removed or reduced the stress of driving long distances and/or frantically dashing to the next call.

> "My time is my own. If I want to stay and have a cup of tea at the end of what I've done, I can do that. I haven't got to madly rush. I work my rota and if I'm going to be late with somebody, I can just give them a ring if an emergency happens or something like that. But I always make sure I factor in a gap anyway. At the moment I'm doing 30 hours with one client. I've only got two clients at the moment because I'm so busy with this person at the end." [ID41, Site B, Former care agency employee, Microprovider]

> "I love the fact that I can, if somebody needs a bit more time, if somebody's taking a bit more time, or they're not so well that day, then I've got that time that I can spare, and it doesn't really matter. That's really important to me. I don't want to be rushing around. I can be more flexible as well with the people that I support, which is really nice." [ID49, Site B, Former care agency employee, Microprovider]

This ability to exercise control over workload and timetables meant that for some microproviders with domestic caring responsibilities, self-employment was an attractive option. Childcare responsibilities have been seen as constraining employed care workers' options (Hebson, Rubery and Grimshaw, 2015), but for some microproviders, self-employment enabled participation in fulfilling work in a way that was not possible as an employee.

> "I had to have the flexibility. I got divorced and I just had to have another way of earning an income while my daughter was at school… you know people say no, I can't work, I've got kids…. you know you can do it and pay a mortgage and have a nice life if you're prepared to put the hours in. And prepared to work hard. I'm not afraid of working hard, and if you do enjoy your job, it's not a chore, is it?" [ID77, Site M, Former care agency employee, Microprovider]

> "I couldn't work twelve-hour shifts [in the care home]. I had to take her to school... It was hard to work around…. [Now] I can work from 9:30 to 2:30 and have a good income". [ID51, Site M, Former care agency employee, Microprovider, Male]

Although the ability to exercise greater control over their workload was appealing, microproviders also needed to earn a living. Some described how in the early stages of running their business, their desire to generate income meant that they took on too much work. This created stress, but also provided a useful learning opportunity.

> "Initially when I first started up, I was doing probably four visits a day, for some people seven days a week. But now my friend's joined as well, so we're able to sort of apportion the work out so we get a bit more time off." [ID45, Site B, Former care agency employee, Microprovider]

Additionally, the worsening situation in terms of workforce capacity meant that microproviders were increasingly confident of the availability of work and the demand for their services in the short and medium term, at least, which helped them avoid committing to unrealistic workloads.

7.5.2 Personalisation and continuity

The longer call times were described as enhancing the quality of care provided. In addition, microproviders were delivering services in a way which was much more tailored to service users' individual preferences. These services were based on discussions with service users and their families, as well as the availability and preferences of providers.

> "It's certainly more personalised, the fact that I can spend the time I need without rushing around to get somebody up in the morning and get their breakfast, which I could never- well I did it, but it wasn't in a personalised way. It was all rush. You're not flinging them around but you're aware that you've only got a certain amount of time to do this." [ID52, Site M, Former care agency employee, Microprovider]

> "Allowing people and enabling them to be at home. They are the centre. I used to find, and I'm not dissing care agencies, but I used to find with some care agencies it was, 'We can't do that for them. We can't do that for them. We can't do that.' There were lots of loopholes, almost, that the client had to fit into. But with us, as microproviders, it's just me. As long as it's safe and as long as I'm not at harm and they're not at harm, we can do it." [ID41, Site B, Former care agency employee, Microprovider]

> "We ask the client what it is they're looking for, what they want to gain from having us. We go from what the client wants more than anything else because at the end of the day, it's them at the forefront, isn't it? More than anybody." [ID79, Site M, Former care agency employee, Microprovider]

Care was described as characterised by relational continuity enabling microproviders to develop meaningful relationships with service users over time. Other microproviders might provide temporary cover, but this often involved some unpaid shadowing to be introduced to clients and their routines.

> "…for him with his mental health issues, an agency wouldn't work, you know because he likes to know the person knows enough about him and his routine, and if you try and change that routine in anyway it makes his mental health a lot worse. … they could do a shadow shift or two so that they knew the routine and everything. So it would be easier for him. I went for a couple of shifts with a girl and then I did about ten visits that week for her, to cover". [ID45, Site B, Former care agency employee, Microprovider]

> "It's lovely. Yeah, it's just like family, uh, they say the same. It's not having 15 faces a week turn up to your house and then them having to explain where everything is again and not getting any, um not connection but any you know building up friendship with the carer. It's just 'ohh here's another face. Who is it tomorrow?' They're happy that it's gonna either be me or [colleague]. And it's the same for us. It's yeah, it's really nice". [ID100, Site Q, Former care agency employee, self-employed carer not part of a local authority initiative]

7.5.3 Adapting to COVID

Microproviders were not immune to the challenges created by COVID-19. Local authority staff and care providers (see Chapters 4 and 5) described COVID-19 as reducing demand, with some service users fearful of allowing agency staff into their homes. In chapter 4, some local authority staff also described microproviders as working collaboratively with established providers in some cases filling gaps created by COVID-related staff shortages in those providers.

Microproviders reported continuing to work with existing service users and taking on new clients during the COVID-19 pandemic and in many cases working extra hours and/or taking additional precautions to do so.

> "During COVID I planned to work 25 hours a week. Towards the end I was working 60 plus hours a week…At the very beginning of COVID [intermediary name], the gentleman that advises us all, we all got pretty much told unless it's to go to work, do not leave your house and a lot of our micro providers gave up seeing family members. I know of one micro provider bless her heart that actually moved into a Premier Inn the whole time so that she could go to her clients, without the risk of being around even her own family. A lot of us gave up seeing our families so that we could support these clients… I think they were obviously not keen on us coming in as well, but I think we were the lesser of two evils." [ID43, Site B, Former care agency employee, Microprovider]

> "So COVID to me is second nature working with it now and I've sort of that said, it does come with its challenges cause if we get COVID, cause we're on our own as such it's a bit more difficult for somebody to cover the clients. But then we have plans in place for that should that happen, so there's always alternatives. But yeah, I absolutely love it. It's really good." [ID79, Site M, Former care agency employee, Microprovider]

COVID-19 was described as adding to workload, in terms of the requirement for PPE. For some microproviders this increased costs since they were unaware of the availability of free PPE from their local authority.

> "I was buying my own PPE, which during COVID, is phenomenal, it's through the roof. And then, I realised that my local council was giving away free PPE to micro-enterprises to help them out." [ID51, Site M, Former care agency employee, Microprovider, Male]

In common with local authority staff and care providers (see Chapters 4 and 5), some microproviders described COVID-19 as making service users more isolated and less likely to engage with the outside world. Some microproviders had begun to adapt their care to try to alleviate this problem. In one case, COVID-19 had been life changing for one of the microproviders, prompting their decision to enter the care sector.

> "They've been used to just having me and another girl going to them, and because they're living pretty isolated lives, really, you know, they have got very insular…. It's because of COVID really that, you know, I think they used to get out and about more and they used to have friends calling round. But it's difficult now. They don't want to be calling, and they've got institutionalised, really. They've got used to being stuck at home, which is such a shame. So, I try and break up their day a bit, if I can, you know, cheer them up a bit and leave them feeling a bit happier than they were when I arrived." [ID53, Site M, Former care agency employee, Microprovider]

> "COVID has been terrible, but certainly, for me, it's made me slow down. I'm doing a nice job where I meet lots of nice people. I probably wouldn't have- it was always something that I thought of. You would just keep going on the rat race, boom, boom, boom, sort of. It really made me- it is a slower pace of business. Isn't it?" [ID61, Site O, Former non-care business owner, Microprovider]

7.5.4 Charging for care /care as a business

Apart from in site O, which sought to impose a ceiling on micro prices, microproviders reported being encouraged by local authority intermediaries to charge a "fair" price. Some microproviders helped service users and sometimes other community members to claim benefits which would help them to pay for care.

> "I go out and I give talks and meet people. I run the memory group, I do attendance allowance forms…. I've done over 250, nearly 300 since I've been here [in this village] and I explain to people, that that can go towards paying for care. It's not that we've got to give them a full day's care. It's an hour perhaps 3 times a day and people can have that money that's nearly £370 a month that goes towards paying for care." [ID117, Site B, Non-care background, Microprovider]

In Site O, there were some complaints about the policy which sought to cap charges at a much lower rate than the neighbouring authority (£13.28 vs. £16.13). This was the direct payment rate, but some microproviders charged a higher rate to self-funders. As discussed in Chapter 4, these rates appeared to be based on attempts to control costs rather than reflecting the work undertaken by microproviders. Neighbouring councils offered higher direct payment and therefore microproviders' rates, but site O microproviders did not appear to be aware of this. However, they did suggest that site O's rates compared unfavourably to payment for other kinds of work within the sector and outside. In addition, some microproviders complained that attempts to control charges levied by microproviders was at odds with their status as self-employed individuals.

> "It's really difficult because I enjoy my job, but it's not financially viable to be getting £13.28. Whilst it sounds a lovely hourly rate, £13.28, you don't get any- you know, your expenses, that's in your own time. So, when you add all that up, the travelling to the person's house, the travelling back. It probably takes me half an hour to get to somebody's house and back. And then if you look at my petrol, my wear and tear on my car, it's not a good wage…. I'd never take on a half-hour role for that reason. I've got more self-worth than that. Because if you think, by the time I leave the house, even if I'm close to the nearest one, it's going to take me 10 minutes, 20 minutes to get to. So, in theory, you're doing two hours work for £13.00. It's pointless. It's less than minimum wage." [ID54, Non-care background, Microprovider]

> "My own personal opinion is that you should be able to set your own rate. You know, I'm not sure that somebody should be able to tell you, well, this is all we'll pay you. I'm sorry, but if you want our service, you'll pay what we think we're you know, worth. £13.28 for a micro carer direct payment. However, if somebody chose to use an agency, I think the rate for an agency payment is 18 pounds something. So there's a £5 difference between an agency and a micro carer, and to be honest. I don't agree with that, and I know they'll say agencies have, you know overheads but even so, a microcarer still provides the same service. And if you go through an agency, you'll go to a manager who will then delegate that work to somebody who sets the rota, to somebody who looks after HR, to somebody who does contracts to somebody who goes out and does the actual work. But as a microcarer, that one person deals with it all and they're still expected to provide the same service, so I'm not sure how they warrant that £5 an hour difference…. see a PA, alright, so they get a lower rate,

> but you see the rates. I mean my dad's PA was on £11.40, or £11.20 an hour. So you know and then she has five weeks holiday. How much would a microcarer on £13.28 have to put away to accumulate 5 weeks paid holiday? You know, if they're £13.28 their hourly rate would be less." [ID58, Site O, Former care agency employee, Microprovider]

In addition to the advice about charges, microproviders described being conscious of operating as part of a community of microproviders, which meant being aware of what a fair rate might be in that market. This could rein in providers, and one intermediary described suggesting to them that their charges were too high. In this site, a number of self-employed providers were operating prior to the local authority initiative, and this could act as a benchmark for incoming microproviders.

> "I say we don't want people to be on minimum wage. Definitely not. And if you're self-employed, then yes, you should be earning over and you should be having a reasonable lifestyle. Definitely, 100%. But that [£20 an hour] is not fair and reasonable. But you know, they still do what they want to do. Some people coming on board like 'Oh yeah yeah. Well actually I was thinking about £16 an hour'. Brilliant. Because even after their overheads, which part of my role is to make sure they don't have lots of overhead. Some people are 'oh I need a website, I need this'. I'm like 'no, no, no, no, no, you don't. Don't spend any money'." [ID94, Site J, Microenterprise intermediary]

But it could also encourage microproviders to reflect on the value of their services in a way which disrupted the constraining influence of their life and work experiences prior to becoming self-employed.

> "I thought that was OK, but he [intermediary] said 'cause my training and everything that I've done. He said he thinks I could do £15 an hour, so £15 an hour weekday, £20 weekend…I'm still below the, there's an agreement with the authority and between enterprises. If it's a direct payment that it's £16 something an hour. So if it's direct payments, we get a little bit more. … I'm a fool honestly, because I've only ever been minimum wage at every job I've done... But for what I was putting in I realise now, it wasn't enough. You don't realise you know. Cause I like doing it... But you don't realise how you know now I feel a lot more appreciated and stuff than I did" [ID83, Site M, Former care agency employee, Microprovider]

> "I simply just put on the WhatsApp group 'Hi guys. I'm a new micro provider. I haven't got a clue what I'm doing'. And just simply asked everyone else if they wouldn't mind telling me what they charge and then I tried to go in the middle cause there's obviously some people that charge way too little and undercharge themselves but then there's also a lot of people, especially now that are charging a ridiculous amount…. So how I try and do it is I just try and keep it in the middle. But

then I also think well would I be happy paying that if it was my mother?" [ID43, Site B, Former care agency employee, Microprovider]

This contrasted with self-employed providers who did not participate in local authority initiatives. In two cases, the paid carers had not increased their charges for several years (IDs 106 and 111). Another participant's charges appeared to be very low in a context where self-employed providers are responsible for their own sick pay, pension contributions and holiday pay.

> "It's just I was one of six children, and I was always like the little mother one. The one that looked after all the others. I think it's just the way I am…. But as the petrol's gone up it's looking like…But you know I'll just have to wait and see." [ID106, Site U, Former care agency employee, self-employed "cash in hand"]

> "I charge £12.50 an hour. That's enough for me. I'm not doing it to make money. A lot of people have only got their pensions to live on. So, I don't want to charge more." [ID112, Site W, Former care agency employee, self-employed]

One participant described having previously used the website of a third party which enables carers to match with service users. But this involves the provider paying commission to the third party, which increases the costs of provision in a way which does not happen in local authority supported initiatives.

In some cases, microproviders reported feeling uncomfortable using formal written agreements and submitting invoices, as well as having interactions which highlighted the business nature of the service. This may be perceived as a clash between caring practices and business practices. It may also reflect long standing practices of avoiding talking about money, which have helped shape their views prior to becoming self-employed. Microproviders recognised implicitly and at times explicitly, that the nature of care provision as agency employees is compromised due to the demands of business and the need to remain a going concern. Yet, in their role as employed carers, they were protected from the business transactions which underpin paid carer and service user relationships.

> "I hate taking money from them which is why I'm not a great businesswoman. That's the bit I hate, but what I've said with my clients is, 'Just put it in an envelope with my name on, leave it in the file there, and I'll just pick it up on Friday.' On a Friday, I just fill the form. I hate taking it, honestly. Anyway, I just fill it in, I say, 'Only sign it now if you're happy.' We have a laugh and a joke about it, she'll be like, 'No, I'm not signing it. You haven't done' I'll be like, 'Come on, get it signed woman.' Not really, I'm joking. She signs it and she'll go, 'I'm more than happy.' That's how I work it with

them. It depends on the individual, doesn't it?" [ID13, Site O, Former care agency employee, Microprovider]

Over time, they developed practices which enabled them to incorporate this aspect of the relationship into their working life. Furthermore, the value of formal written agreements became apparent when conflicts arose, and this helped microproviders to overcome their reticence to use these. Additionally, microproviders reported making changes to these, prompted by instances which caused them to reflect on their shortcomings. Being part of a community of microproviders meant that the experiences of others also encouraged them to ensure that they paid attention to written contracts, which could protect both parties.

"In the very early days, this talk that they gave, they said, 'You need to make sure you've got a watertight contract.' I did. I took a contract from them and made it my own, as it were, so it covered every eventuality. I've not had any problems as yet… any new microproviders that I've spoken to, I've said, 'You make sure you have that contract in place, because you leave yourself wide open otherwise.' The other thing I do is, on mine, I get paid every two weeks, so that I don't leave it too long before I get paid, just in case anything like that [I gave an example of a client refusing to pay] does happen." [ID49, Site B, Former care agency employee, Microprovider]

"I mean, that's when you thought I've gotta draw the line and say, look, we're here to do X, Y and Z in the contract. This is what we're here for. This is what we were discussing when we came out to meet originally. We cannot do anything extended other than that, unless we amend the contract the working contract. And that's just the sort of legal way of like being, you know, that you can't be thought asking for unexpectedly, doing things, you know". [ID79, Site M, Former care agency employee, Microprovider]

7.5.5 Engaging in other business practices

All but two participants had a history of employment in care work. However, when it came to running a business, the situation was very different. In three cases, microproviders had previous experience of self-employment in other fields. One of these individuals had managed their own cleaning company but had returned to care work during the pandemic due to the sharp drop in demand for house cleaning services. Another had made and sold gift sets during a period of ill health, which left them temporarily unable to resume care work. The third saw their business collapse during the pandemic and had to quickly adjust to working in a completely different sector. This participant was unusual in that they had no experience of previously providing care and had retrained to work in the sector. These

interviewees were not fazed by the "paperwork" requirements accompanying self-employment.

> "I started like my own little making gifts and stuff so putting gift sets together. So I've been self-employed since I think 2019." [ID83, Site M, Former care agency employee, Microprovider]

> "I've run quite a few businesses. I had three, I currently have two, just small ones, ticking over. I had a big business the self-employed side, that's where I was strong, that side of things. It's not a problem, accounts, finance. That's my head. I come from quite a different industry to the care. … Obviously, you don't go into any job like that without full training and all that, but the business side you can just find out and get on with it." [ID61, Site O, Former non-care business owner, Microprovider]

For others, this aspect of their role was daunting. Becoming self-employed involved new tasks in addition to entering into contracts with clients and submitting invoices. These included completing tax returns, keeping accounts and setting up business bank accounts. Interviewees described how the support systems established by local authorities were key mechanisms in the early stages of business development. These included the provision of ongoing one-to-one advice from the intermediary employed by the third-party organisation or the local authority, as well as local WhatsApp group membership for care microproviders within the community.

> "Even a tax return, that's what I was dreading the most, doing the tax return. I was like, 'My God, all these numbers. I'm no good with numbers. I'm absolutely rubbish with numbers.' They give us the guidance. They got somebody to talk us through it and there's somebody there to check it if you want to. I did it, I've done it, and I'm like, 'It's not that bad'." [ID13, Site O, Former care agency employee, Microprovider]

> "That was my most scary you know. I knew I could do the caring side. That's just fine. But what I did what happened was I opened a business account with NatWest. With that came a free app. It helps you with all your accounting and it also does invoices and it's so easy… there's always help along the way. Somebody will help you show you how to go along… and you know when you're your own boss you can make life as easy as hard as you want." [ID84, Site M, Former care agency employee, Microprovider]

In addition, to varying degrees, microproviders were facilitated to access start-up funding from various sources to enable them to cover initial costs.

7.5.6 Acquiring and evidencing skills and credentials

Compared with being an employee, for self-employed carers, there is a much greater emphasis on the individual and their competence. Local authority schemes (as discussed

above) involved compliance with minimum standards, with microproviders taking responsibility for meeting these requirements. As part of the compliance process, microproviders ensured that their training was up to date and they often undertook training in addition to the minimum required. In some cases, self-employment motivated individuals to develop new skills ranging from learning to drive, to caring for patients with complex medical needs.

> "I don't drive at the moment. I'm learning… my clients are in my village… so I can walk to there…. I have bought a car ready to drive so … I will go further afield then". [ID73, Site M, Former care agency employee, Microprovider]

> "… social workers … they've offered me training if I was going to work with somebody that has a particular need…I was going to work with somebody that had epilepsy. They said, 'Yes we'll organise to do some training with you', so they were quite helpful then". [ID52, Site M, Microprovider, formerly employed care worker]

All microproviders reported being fully vaccinated against COVID-19, and vaccination status might be conceptualised as conveying that these individuals follow socially desirable behaviours and possess attributes which reduce the threat to the older adults they serve.

7.5.7 From surviving to thriving

Participant accounts of working as agency employees are replete with descriptions of negative emotions (see Chapter 6). However, what is noticeable in the accounts of microproviders is the expression of positive emotions in relation to their status as self-employed carers. Factors such as the nature and impact of care work, the control over one's workload and timetable, the reduced requirements to travel and the ability to achieve a good work life balance were linked to feelings of happiness and satisfaction.

> "I'm so relaxed now, so chilled. My home life is so much better. The relationship with the kids is so much better. Whereas, like before, I'd be coming home from work at eleven o'clock at night, I wouldn't see them, and then I'd be gone before they wake up. And now, I see them every day, every morning, get to go to school with them, pick them up. Ask them how their day has been, and it's just amazing. And cooking, I get to cook them food, and I love cooking. I'm really, really good at it. And I can make really good meals. So, I get to give them nice, proper homecooked food, which is much better for you than the processed chicken nuggets and chips rubbish." [ID51, Site M, Former care agency employee, Microprovider, Male]

> "I get joy from people being happy, so I'm quite happy to go in and make people happy…. I love it, to tell you the truth. I don't think my other business will come back. I've sort of moved on and love doing it. … [Service user asked] 'Why do you do this?'

> In a way, she sort of looked down on it, you know what I mean? That's what she was saying, 'Why?' and I said, 'Because I like it, and you pay me, and I enjoy it.' I said, 'I don't do things unless I get something out of it. I feel I get something out of coming here and being with you.' She sort of looked at me and smiled... I just said, 'I genuinely- I wouldn't do it if I didn't enjoy it'." [ID61, Site O, Former non-care business owner, Microprovider]

If microenterprise is to thrive, then it seems likely that relevant social agents need to recognise microproviders as legitimate and respected providers, despite their exemption from national regulatory oversight. There were signs of recognition and respect from others, and these involved a variety of field actors. Microproviders were encouraged to include references from other clients in their portfolios and these portrayed the microproviders in glowing terms. Microproviders also reported that friends and family had expressed pride in their achievements.

> "It's ridiculous at my age [starting a business] it's crackers, but it's really good, you know…. [My husband] says I'm so proud of you". [ID36, Site O, Former care agency employee, Microprovider]

> "I've got enough references [from clients] … I was like 'bloody hell you lot make me look good'. So it was nice. …I'm quite proud of that to be honest". [ID39, Site B, Former care agency employee, Microprovider]

Interviewees reported preparing portfolios to show to prospective clients, which included their formal qualifications and vaccination certificates, which might also be conceptualised as likely to increase the trust and esteem afforded to microproviders. However, the extent to which service users were keen to see these varied. Often clients preferred to take on trust the microproviders' ability to carry out the services required.

A combination of personal experience and word of mouth helped to increase referrals to microproviders. As outlined in Chapter 4, local authority staff members who acted as gatekeepers also appeared to value the microproviders. However, in some cases, an increased appreciation and awareness may have been due to an inability to find traditional providers to fulfil care packages.

> "I built a reputation as well, while I was working with [the care company]. It's followed me then amongst the social workers and other professionals. So I'm well established within [name] Council really". [ID79, Site M, Former care agency employee, Microprovider]

> "… as soon as I launched it, I was being bombarded because there's so many people without care packages. I mean, there's [this council] alone there's hundreds…I knew

> the care system, I knew it was bad and I knew agencies were struggling and all that ... but I didn't realise how bad it was. I've even had people, you know, like a social worker, writing to me asking if like somebody could go on a waiting list" [ID83, Site M, Former care agency employee, Microprovider]

In addition to acknowledgement of value at the level of the individual microprovider, recognition of the legitimacy of microenterprise as an occupation was leading to increased awareness and trust amongst stakeholders across the field. Since all microproviders reported receiving requests for support on an ongoing basis, it may also have been that the crisis in care was encouraging some local authority staff to contact microproviders, even if it was as a last resort solution to their problems.

As discussed above, there may be advantages for microproviders in rural areas, since competition from larger providers may be limited or non-existent. However, variations in local policies, as experienced by carers cannot be entirely explained in terms of the rural or otherwise nature of the context. In both rural and urban contexts, self-employment appeared to bring much greater freedom, fulfilment and happiness for workers and a more personalised service for clients. New practices undertaken by microproviders can be seen as contributing, over time, to changes in their expectations and actions. By participating in these new practices care workers began to feel much more content with the space they occupied within the home care market, and they enjoyed the esteem of relevant stakeholders, which made them feel valued. The, at times implicit, aim of local authority market shaping activities appeared to be to retain workers by helping them survive as employees within the sector. In contrast, compared with agency employees, microproviders were not merely surviving but appeared to be actively thriving.

7.6 Temporary self-employment

Two participants (IDs70, 75) were unusual in describing experiences of opting to become self-employed on a temporary basis. This occurred when the owners of their employing organisation decided to close the business. The registered manager consulted with the staff, and many agreed to work in a self-employed capacity in order to preserve the continuity of care for service users. The intention was to establish a new community interest company to employ the staff. At the time of my interviews, the new organisation had been in operation for almost a year.

The number of employees had reduced from 20 to eight at the time of my interviews. In part, this may have been due to the duration of the self-employment period, which was initially anticipated to be three months. But CQC registration took almost six months, because of COVID-19 related delays. It is also likely to be due to factors such as the daunting nature of self-employment and a desire for more certainty regarding income and related benefits.

> "'You're going to have to make adjustments and go self-employed. If you don't want to do it, you don't have to stay.' Everyone had their own meeting, because everybody's circumstances are different. Some, it didn't meet some of their needs and that was fair enough. Most of the staff stayed. All of the clients stayed, so that was lovely for us, to know that. It showed what a good job we were doing. Yes, I was just glad when it, because it's just that uncertainty of not having an employer behind you, knowing that you're on your own, basically. You've got your own insurance. It's quite scary actually, thinking 'Well, if anything goes wrong it's all on your head.' At least if you've got an employer behind you, you've got a backup. [Manager's name] is always there to support you all the way and keep you on the right track, but we didn't have that. It worked out in the end, which was great." [ID75, Site A, Care Coordinator, Non-preferred provider]

This provider's clients were almost all self-funders and a minimum call time of one hour was in operation. Fees were much higher than local authority rates. Interviewees were unusual in that they emphasised the quality of care provided. The willingness of staff to operate on a self-employed basis to preserve continuity and care quality is perhaps indication of the dedication of staff concerned. The lengthy quote below gives an example of the ways in which this provider prioritised the outcomes which were important to the individual service user. This account suggests that care is something enabling and facilitating in very stark contrast to the accounts of providers in Chapter 5.

> "I promised her I would get her home. And I went away, put the team together, and went back on the Friday, to be told by the hospital staff that she was going back to the care home where she'd had the fall. And I said, 'Hang on a minute. I've been asked to provide a care package for her at home.' 'Oh, well, she doesn't have capacity.' And I said, 'Well, who decided that?' The social worker decided that, and so I asked about the circumstances of this assessment. [The client] had nobody present with her. She didn't have her hearing aids in, so she couldn't answer the questions. I then had a fight on my hands. I mean, I could have walked away at that point, Ruth, right? Because it's not my business. But I made a pledge to this old lady because I looked her in the eye, and she wanted to go home. She thought she was going to be dying fairly soon, and I promised her I would get her home. And I never go back on a promise, unless there's a really good reason for it.

So, I then had a fight on my hands, and had to speak to [her godson], her lasting power of attorney who never met me, didn't know me from Adam, and he was relying on listening to NHS staff and social workers giving him advice. And anyway, to cut a long story short, we got her home on the 27th of March 2018. There'd been loads of resistance by the NHS to getting her home because they thought she was just giving up, didn't want to eat and drink, and so she should have been left where she was.
We got her home on that day, and we'd been told, leading up to her arriving, that she hadn't been eating and drinking all weekend. She just wanted to give up. When we got her home, she had thrush in her mouth because she'd had numerous water infections. Didn't want to eat and drink because her mouth was sore. So, for a while, we had, which again, was a first, subcut fluids, in the community, which the GP agreed to. The district nurses weren't that keen, just until we could get the right level of fluid into her.
Now, that was in 2018. I told you she just died on the 1st of January 2022. That lady was cared for in a profile bed in her living room for nigh on four years. She didn't have a pressure sore. She never went back into hospital. Yes, she had recurring water infections, and the odd chest infection, but the level of care she got from my team of staff was far superior to what she would have got anywhere else. She was in her home surroundings. She used to have her neighbours popping in.
We would get her dressed and hoisted into a wheelchair and when the weather was nice, take her out for a walk, in the village that she was really well known in, and people would stop and say hello to her. Rather than being in a room, in a building where her basic needs were met, but she was isolated, right? Now, that- how do you put a price tag on that, right? And I know the family, and [client] used to tell us every day, how much she valued that, right." [ID70, Site A, Registered Manager, Non-preferred provider]

7.7 Self-managing teams

There is evidence that care provision which differs in important respects from "the industry-standard model" (e.g., minimum 60 minutes visit time, self-employment, salaried self-managing teams) can contribute to worker motivation and greater personalisation (Burns *et al.*, 2023). I only conducted one interview with a participant employed by an organisation operating a self-managing teams model. This involved employees collaborating to make decisions about how best to support clients to achieve the outcomes which were important to them. It also included taking responsibility for organising rotas and ensuring that staff were available to deliver care in accordance with agreed schedules. The registered manager for this provider explained that almost all clients were self-funders, and a minimum one-hour call time was in operation. Fees were much higher than local authority rates. All staff were employed on a salaried basis and were entitled to one week's sick pay, unlike most other organisations included in my study. The participant described the process of self-management as requiring a fair degree

of adjustment for all concerned. This interviewee was unusual in talking about the values of the organisation in a way which did not refer to Values Based Recruitment (Skills for Care, n.d.) or rely on platitudes.

> "One of the team members from my team literally in another setting I would have been 'Oh my God. I'll kill them. I'll throttle them'. She came back and went 'that [new annual leave policy] doesn't fit with our values. That's not in with our values. We are compassionate. We listen. We own our own learning. That doesn't fit with our values. That terminology you're using doesn't fit with our values', and she challenged it … We had a meeting with her. I raised it on her behalf. She raised it with me. She sat and she eloquently put forward exactly what her thoughts were. Our CEO and our COO listened. We had [name] in from our finance and she puts everything out … She went 'yeah, I agree with you', and we got to the end of it. The policy was changed". [ID98, Site A, Registered Manager, Non-preferred provider]

The fact that her response in another setting would have been "I'll throttle them" may well be due to her 30 years' experience mainly within standard model agency provision. But the response also demonstrates how employees (or team members) felt able to challenge "top down" edicts in a way which resulted in changes to organisational policy. Having said that, there are downsides to this model for some team members, with self-management being perceived as burdensome and undesirable by some individuals.

> "She didn't like it. She wanted to be told and she said I wanna be told what I'm doing when I'm doing it. Walk out the door, turn off my phone and that's it. Ignore it. And it was like you can't do that within this team. She said and I accept that she said 'so, it's not for me' and it is that sometimes it just isn't for people". [ID98, Site A, Registered Manager, Non-preferred provider]

7.8 Summary

This chapter has focused mainly on self-employed providers, but it also includes some evidence relating to non-industry standard organisational forms. The contrast between experiences and accounts of employment by larger care agencies (see Chapter 6) and those of self-employment and/or self-managing teams is stark. Although the example of personalised care provided by an organisation which had transitioned from a larger, but still relatively small organisation also suggests that it is possible to provide good quality, outcomes focused care. It may be easier to accomplish this in a relatively small organisation, but also the non-industry standard models discussed in the chapter almost always have one-hour minimum call times. The themes which characterise accounts in

previous chapters such as care as a problem and care as quantity were largely absent when participants spoke about these revised working arrangements.

With regard to the "market shaping" role of the local authority, as discussed in Chapter 4, the policy of promoting microenterprise involved a number of local state and non-state actors, to varying degrees. The emergence of microenterprise cannot be understood, therefore, as the aggregate of a set of individual isolated lightbulb moments or spontaneous revolt. Amongst microproviders, the ability to make changes to the practices of care delivery, compared with being an employee enabled them to gain skills and credentials and build social networks, whilst at the same time making a living. The advice and support of intermediaries helped microproviders to reflect on practices, such as length of visits and hourly rates, in a way which disrupted expectations which might have hitherto constrained their expectations and actions. It also acted to place downward pressure on charges in some cases and where this was conveyed as a mandatory ceiling it created tensions. Attempts to constrain charges raise questions about what represents a reasonable hourly rate in a context where all study participants agreed that home care work is undervalued, yet commissioners and intermediaries appear to use existing rates as a benchmark for fair rates.

Self-employment which did not involve participation in a local authority support initiative appeared to be associated with less advantageous working entitlements amongst my interviewees. It also meant that self-employed providers did not necessarily adhere to the same standards as those participating in formal schemes.

In rural areas, the microenterprise initiatives were able to gain momentum, since compared with urban settings, large agencies were often unable to provide care there even prior to the recent workforce shortages. In addition, the word-of-mouth information (positive and negative) about self-employed providers was cited as a factor in helping microenterprise in rural areas, where local knowledge may be more immediately available compared with urban settings. For microproviders living in rural areas, self-employment was attractive since it reduced their requirement to travel large distances, compared with agency working.

Self-employment was “scary” in a context where individuals were not actively considering this option, and participation in self-managing teams is not for everyone. Furthermore, in the context of a national shortage of care workers, local authorities may view microenterprise expansion as undesirable if this results in employees leaving care provider organisations (as discussed in Chapter 4). Paradoxically, the shortage of care workers may lead to a greater willingness amongst local authority gatekeepers to connect microproviders with clients, in the absence of other alternatives. For risk averse social workers and commissioners, for example, the response to a perceived crisis appeared to be adaptation of routine practices. Since the home care workforce crisis is unlikely to be resolved in the short or medium term, this may help microproviders to become more established in the field, especially in rural areas. However, there is a difference between embracing microenterprise in a crisis and system wide initiatives to promote more “bottom up” approaches to supporting older adults to remain in their own home. These issues are discussed in more detail in the following chapter which brings together the findings from all of the stakeholder interviews.

Chapter 8 Discussion

8.1 Introduction

Drawing on the previous four empirical chapters, in this chapter, I discuss the themes I identified from my thematic analysis of my data. In my empirical chapters I suggest that market shaping appears to involve many activities directed at preserving a system which is inherently dysfunctional. In this chapter, I elaborate on this and examine why this should be the case. I also outline differences and similarities between local authority approaches, generally, as well as in the context of rural and urban local authorities, in line with my research questions. I address these issues by bringing in Bourdieu's (1977;1986;1990a) concepts of field, capital and habitus, which I outlined in chapter 3. I then go on to discuss how and to what extent my findings resonate with the relevant literature that I summarised in Chapter 2.

This chapter also contains my discussion of the strengths and weaknesses of my study, as well as my suggestion that my claims are plausible and credible.

8.2 Market shaping – thematic analysis

8.2.1 Care as a problem and care as quantity

In Chapter 4 I explained how accounts of approaches to home care from local authority staff appeared to convey that care was a problem, rather than something enabling or facilitating older adults to live life according to their wishes and potential. Participants described complex needs and increasing requirements for care as creating problems. In addition, much of the content of participant accounts focused on difficulties. There were many factors raised by interviewees. For example, commissioners complained about the procurement system which imposed requirements to periodically conduct tendering exercises. This was seen as hindering attempts to engage in the development of meaningful partnerships with trusted providers. In some cases, commissioners had learned how to write and assess tenders in a way which increased the likelihood of success for their preferred providers. Generally, however, they did not raise the time and task nature of contracts as problematic, though there were some exceptions to this which I discuss later in the chapter.

Interview accounts also tended to focus on problems in securing care in a context of an ageing population generally, as well as hospital discharge delays more specifically.

Participants reported managing expectations downwards. This involved explaining to older adults that their choices and wishes could not be accommodated. Such choices might pertain to preferences for getting out of/into bed and continuity of care (as discussed in Chapter 5). But they could also include the location and type of care (residential versus home care) depending on availability (see Chapter 4). When I talk of choice and preferences, I am not suggesting that older adults were asked in any detail about these. Instead, choice was mentioned in terms of the "problem" of older adults' expectations and the unrealistic nature of these.

Assessments of need tended to focus on deficits and these fed into care plans. The latter were constructed in a manner which corresponds to local authority commissioners' contractual arrangements and importantly, budgets. Individual service user outcomes and strengths did not appear to be a priority, and it is difficult to envisage how they could be within such a system. Furthermore, in addition, problems were framed in terms of provider capacity. During my fieldwork, local authorities and providers were struggling to match the supply of care with assessed need. This may explain why many spoke about care in a way which did not depict it as a positive and enabling service. Participants often described capacity as a problem in rural areas only, prior to recent events which included the COVID-19 pandemic and people leaving the labour market. This suggests that even when workforce shortages are not acute, care is conceived primarily in terms of provider capacity. The absence of personalisation and choice and the desire to focus on individual outcomes was not routinely raised as an issue, let alone an aspiration. Participant responses also indicated how a model of provision which was deemed acceptable in urban areas was problematic in rural settings, as well as the persistence of this problem over several years. A focus on urban settings may be understandable given that the vast majority of England's population live in towns and cities (Office for National Statistics, 2024). But it raises questions about the ability to support ageing in place (Centre for Ageing Better, 2021). Furthermore, the depiction of the rural as exceptional and characterised in terms of its deficits was present even in accounts provided by participants in counties classified as predominantly rural. In some cases, providers suggested that rural workers were deficient compared with their urban counterparts (Chapter 5). According to participants, this might be because they have traditionally been able to acquire work easily

in a context of ongoing labour scarcity. Additionally, rural based staff were also depicted as older and slower by one provider, with long service viewed as an undesirable characteristic of rural backwaters, rather than something contributing to stability. Perceived capacity deficits prompted local authorities to take action to introduce models of care which were less reliant on an urban workforce in some instances, but not others. In the foregoing I describe these variations in approach, and I elaborate on some of the factors which appeared to explain these variations.

The framing of problems in terms of matching supply and assessed need appeared to be linked to the ways in which care is commissioned and provided within the home care field. The time and task nature of the system meant that problems were conceptualised in terms of delivering call numbers in line with local authority contracts. This meant that both "problems" and therefore, "solutions" were conceived in terms of quantity. Providers complained of staff shortages, and local authority responses involved initiatives aimed at improving recruitment and retention. These include increasing call remuneration rates, introducing bonus schemes and promoting Values Based Recruitment (Skills for Care, n.d.) and Care Friends Care Friends, n.d.) initiatives. The focus was on numbers (of calls, staff, minutes etc), which meant that the values of employing organisations in practice were not discussed. Where quality was mentioned, this was in connection with CQC ratings and numbers of providers being assessed as good or better.

Some smaller providers and in particular microproviders appeared more committed to delivering care which was more personalised than that which characterised traditional care agencies. Minimum call times of one hour for most microproviders was mentioned frequently as something which enabled paid carers to develop meaningful relationships with service users. In addition, some smaller providers engaged in dialogue with local authority staff to tailor packages and match staff to individual service user needs and wishes, but this was a rare occurrence. It also required local authority commissioners to be supportive of such an approach, which was not always the case. The accounts of microproviders contrasted with the descriptions given of care provision by local authorities and larger providers. Another contrast was evident in accounts which featured working age adults. Care here was described in upbeat terms as something facilitating and

enabling individuals to live their best lives. This was a very different and much more positive conceptualisation of care compared with accounts relating to older adults.

Care was described in more positive terms by microproviders and some small providers, compared with most other groups of participants. In addition to the ability to provide more personalised care and have more control over one's time, interviewees highlighted the satisfaction gained from developing meaningful relationships with clients. In care which was characterised by time and task commissioning and service delivery, relations of interdependence between employers and employees appeared to impact negatively on the ability to form meaningful relationships between the latter and clients in many instances.

8.2.2 Care as dysfunctional

Taken together paid carers' accounts presented a picture of care as rushed and unfulfilling. In some cases, employees had been asked to engage in action which was unsafe and/or illegal. This had led to individuals leaving the field altogether. Participants reported being bullied or emotionally blackmailed into taking on additional work. Providers reported having to cut calls short and feeling very stressed. Some agency managers reported asking rota staff to avoid overloading staff. Yet this raises questions about how those care agencies would fulfil their contractual obligations in the short term without applying pressure to staff in a context of workforce shortage. Taken together, the accounts of many local authority and care agency staff presented a picture of attempts to maintain a system under pressure. As efforts increased, this appeared to encourage some staff to leave, with additional pressure placed on remaining employees. In some cases, agencies had chosen not to take on additional packages and even reduced packages in some cases. But often agencies viewed growth as a key business objective.

8.3 Market shaping, field, capital and habitus

The suggestion in the foregoing that market shaping involves preserving dysfunction raises questions about why this should be the case, as well as why there should be such widespread commitment to and acceptance of this approach. As outlined in Chapter 3, following Bourdieu (1977;1986;1990a), I found it helpful to view home care as a field. Fields comprise individuals and groups who occupy positions, which enable them to shape, to a greater or lesser extent, the shared meanings which dominate in the field.

Bourdieu's approach is a relational one, which means that an individual or group can be classified according to their relative position within the field (Bourdieu and Wacquant, 1992), with structures helping to shape the relationships between field actors. These classifications are based on the possession of levels of field-specific capital and are hierarchical in nature. In addition to the concepts of field and capital, I found Bourdieu's "habitus" helpful in explaining local authority approaches to market shaping, as I will explain in this chapter. As described in Chapter 3, Bourdieu's concept of habitus incorporates both the embodiment of structure (since knowledge, dispositions and competences are acquired in social structural contexts) and provides ground for agency, since structures are never wholly determining. The habitus is an embodied collection of norms, rules, dispositions and codes of conduct that collectively, and largely pre-reflectively, structure our engagements with the social world (Bourdieu 1990b). "These dispositions are acquired through experience, varying from place to place and time to time. This 'feel for the game'. . .. enables an infinite number of moves to be made, adapted to the infinite number of possible situations which no rule, however complex, can foresee" (Bourdieu 1990b: 19). Individuals develop a "taken for granted" understanding of rules and ways of working, but "when a field undergoes a major crisis …. its regularities (even its rules) are profoundly changed" (Bourdieu, 2000: 160).

8.3.1 Maintaining dysfunction

Local authority commissioning and care agencies

An important aspect of the preservation of dysfunction in the home care field is the view of ageing and, related to that, of care, as a problem. The habitus of field agents is formed by their participation in various fields and ageism is not confined to the field of home care. However, participation in the field of home care is influential in the perpetuation of ageist stereotypes. This helps to encourage a perception of older adults, which downplays their agency and independence. Local authority commissioners and other local authority staff such as social workers, as with other members of society, are prone to ageism. For example, direct payments staff highlighted the problematic assumptions made by local authority colleagues about the inability of older adults to make choices about direct payments (Chapter 4). In one case, this included a direct payment lead interviewee who had underestimated the capabilities of older adults. It was only their experiences during the COVID-19 pandemic which had made them reflect on their assumptions and they had

changed their practices following these experiences. Similarly, examples of care as an enabler and descriptions of facilitating individuals to reach their potential (Chapter 4) were applied to younger disabled adults. These contrast with a view of care as a problem, with older adults perceived as less capable than their younger counterparts. My findings resonate with research highlighting ageist assumptions and risk aversion, in a context where social workers' habitus encourages reproduction of the field and its rules (Peillon, 1998; Houston,2002).

The rules and regularities of the field are also important here. Amongst many local authority commissioners, the taken for granted assumption appeared to be that the preferred provider agency model should be the default option for home care provision. This meant that instead of seeking to transform the field, local authority commissioners were often engaged in reproducing its rules and regularities. For example, rather than endeavouring to make radical changes, in the context of workforce shortages, local authorities appeared to increase efforts aimed at retaining the existing models of provision. (Although local authority commissioners were focused on care provided by large care agencies, this was not invariably the case. I discuss this in more detail later in the chapter).

Amongst local authorities, there were various approaches to "market shaping" in operation regarding home care for older adults. For example, the changes in progress in two urban sites (Sites D & E) were very different from each other. The former were aimed at moving towards an asset based, outcomes focused service and the latter involved a single organisation providing care across a whole pathway (i.e., including rehabilitation, subcontracting etc.) within a zonal arrangement. In this latter site (E), the aim was explicitly to help the provider to maintain and improve staffing levels and reduce the number of unfilled packages of care. In site D, contracts were awarded to three providers in each zone. In both cases the local authority contracted with large providers, with smaller providers unable to tender with the local authorities due to the specification requiring providers to cover relatively large areas. The impacts on the distribution of capital in field were likely to be favourable to those agencies which already enjoyed an elevated position within the field hierarchy. These approaches help to consolidate the position of more powerful incumbents within the field. Viewed from the perspective of field positions,

incumbents enjoy greater access to valued forms of capital. Whilst some interviewees from larger providers appeared to view growth as an imperative, from the perspective of smaller organisations, their smaller size was the only way they were able to tailor care and ensure continuity of provision. Yet an increasing emphasis by commissioners on arrangements which benefit preferred and therefore larger, providers may mean that smaller agencies are unable to remain within the market. This state of affairs may contribute to the "substantial churn" in the home care market in England, with hundreds of agencies registering and deregistering each year (Care Quality Commission, 2017: 24).

Bourdieu's work has been depicted as better able to explain change than continuity (Crossley, 2001) and many activities described could be conceived as habitual behaviours. This goes beyond the view of care agencies as the default option to include other aspects including regular meetings timetabled for local authorities to discuss issues with other local authorities within the region (Chapter 4). This habit of meeting with neighbours, regardless of the differences between them (e.g., urban and rural) may be helpful in the context of a common national funding regime. However, it could be argued that rural local authorities have more in common with their rural counterparts than with their predominately urban neighbours. It might make sense therefore to also attempt to learn from other local authorities which share similar relevant characteristics. In some study sites, there were examples of this, with some rural local authority staff visiting the predominantly rural Site B to learn about microenterprise *in situ*. In addition, one rural and coastal local authority commissioner team visited a coastal local authority, resulting in its adoption and adaptation of their microenterprise initiative. A number of these attempts may have been motivated by the twin "crises" of workforce shortage and a pandemic, but I found evidence that some of this learning predated these problems. In some other sites, however, there appeared to be much less appetite for learning from elsewhere.

As discussed in Chapter 4 and above, local authority commissioner interviewees were often preoccupied with numbers of unfilled care packages. Responses to these frequently focused on improving financial incentives, which meant increasing pay and offering retention bonuses. Local authority initiatives were often based on feedback from care agencies, which usually emphasised the need to increase funding to enable employers to

raise hourly rates. This response appears to be understandable in a context where agency workers are struggling, in terms of their access to economic capital. Furthermore, low levels of unemployment and the availability of alternative employment options, which offered greater access to economic capital, meant that increasing remuneration for home care workers was viewed as an imperative in all sites. Local authority commissioners were not preoccupied with the impact of other aspects of the agency model on frontline staff. I am not suggesting that local authority staff are uncaring or lack empathy. However, from their position in the field, local authority staff direct contact is often with agency owners and managers and this social capital helps to build relationships which do not necessarily explicitly prioritise the wellbeing, as opposed to availability, of frontline workers.

In writing about groups (e.g., local authority commissioners, agency managers), I do not intend to convey that, group members should be viewed as largely interchangeable. My research highlights variations in the behaviour and attitudes of for example, bureaucrats and these appear to have had an impact on the policies pursued by local authority commissioners. Bourdieu (2005) describes how local bureaucrats exercise discretion when interpreting, as opposed to merely applying, rules and regulations. In his examination of housing policy in France he describes how "In the battle for monopoly control, regulations are the [public] servants' main weapons, alongside their technical and cultural competence, where this is relevant" (Bourdieu, 2005: 129). Public servants are never merely applying regulations, but instead exercising discretion. For local public servants

> "it is not a pure, and free, subject who steps up to occupy that margin for freedom that is always afforded to [public] servants to varying degrees, depending on their position in the hierarchy. Here, as elsewhere, it is the habitus that steps in to fill the gaps in the regulations…. more generally, executive offices in large bureaucracies owe a number of their most characteristic features, which are never laid down in any bureaucratic regulations, to the dispositions imported into those offices, at a particular moment, by those who occupy them: functionaries 'fulfil their functions' with all the characteristics, desirable or undesirable, of their habitus." (Bourdieu, 2005: 130-131).

So, for local authority commissioners whose habitus has been shaped by a traumatic experience following provider failure (Site A), we might expect this shaping to influence their approach to commissioning and this appears to be the case in my study. This contrasts with the commissioner's experiences in Site B, of working in another field where changes were introduced much more quickly. The commissioner there had grown up in a village and continued to live in one. Their formative and ongoing influences are likely to

have contributed to a view of commissioning which is more attuned to community-based solutions to rural issues. The habitus is key to shaping how individuals perceive the world and therefore the ends and means that might be reasonable when encountering challenges within the field. For the city dwelling lead commissioner in Site A, the preferred solution was for older adults to move out of rural areas so that agencies would be able to support them more easily. At Site E, the lead commissioner previously spent many years working as a registered manager for care agencies. It is perhaps no coincidence, therefore that their approach to change involved trusting agencies to deliver care across a whole pathway. In contrast at Site D, commissioners promoting whole system changes to focus on community assets had a background in community development and public health.

Despite these differences in the way in which the habitus of group members has been formed, working in local authorities may mean that staff have attitudes and behaviours in common due to occupying similar roles, albeit in different local authorities, in the home care field. These roles may require staff to engage in similar practices and thereby develop competence in the field. This process of engagement in practice contributing to learning is viewed by Bourdieu as embodied, rather than a cognitive exercise. "[W]hat is 'learned by body' is not something that one has, like knowledge that can be brandished, but something that one is" (Bourdieu, 1990b: 73). This embodied, pre-reflective, enduring nature of habitus is helpful in explaining why habitual behaviours persist. It also means that merely promoting awareness raising is unlikely to result in local authority commissioners immediately engaging in more radical change, in the absence of other factors. Recommending training (Needham *et al.*, 2020), for example, might imply that local authority commissioners are empty vessels requiring "knowledge" to fill them. Habitus is enduring and is reinforced through practice. This means that local authority staff are not empty, but full of embodied "knowledge" acquired in the field and by participation in other fields and over time.

Local authority commissioners possess symbolic capital, by virtue of the offices which they occupy. This means that their "knowledge" is taken for granted. Local authority staff at Site A, for example, participated in practices which involved deferring to a staff member of long standing. It was taken for granted that this individual had complete knowledge of the law and that the local authority was fully compliant with the duties of the Care Act. Neither of these was correct. At Site B, as outlined in Chapter 4, a relatively recent entrant

to the field was able to contribute to change by allying with a local authority director who possessed a high degree of symbolic capital. In addition, according to Bourdieu, bureaucrats are able to mobilise non-state actors. In my study local authority officers collaborated with care providers, especially where these were preferred providers. In some sites (e.g., Site B and D) the approach was informed by public consultation as well as alliances with non-state actors such as local charities. The latter were trusted by community members and were able to mobilise social and symbolic capital in addition to accessing economic capital in some cases.

Previous research has highlighted the importance of trust between commissioners and providers (Davies *et al.*, 2022). As discussed in chapters 4 and 5, relationships between these groups were generally described in positive terms. The increase in the frequency of contact with and responsiveness of commissioners, particularly during the height of the COVID-19 pandemic can be conceptualised as helping both groups to build their social capital. This also contributed to an ability to maintain and/or increase other forms of capital. Engaging in interactive practices appeared to aid relationship building which helped maintain dysfunctional systems. Taken for granted acceptance of what seems to me to be a dysfunctional system can be explained in part, in terms of individuals becoming habituated to this state of affairs. But habitus must be understood also in the broader context of field structures, which influence field practices.

8.3.2 Care agencies within the field

Although there were variations in approach amongst local authorities, commissioners generally employed some sort of preferred provider system for local authority contracts. Providers sometimes complained about the time and task nature of contracts. However, these, together with preferred provider and trusted assessor approaches to commissioning, benefit the larger organisations which derive much of their income from these arrangements. The presence of larger "production line" providers also facilitates and perpetuates commissioning which focuses on these larger organisations and a quantity approach to care. (I use the word larger here to denote organisations which have the capacity to deliver local authority contracts over a geographical footprint as required in tender specifications). The continued focus on time and task care commissioned from existing providers can be understood in a context of field structures which encourage commissioners to engage in reproduction of field rules and regularities. Similarly,

continued participation in the "game" (Bourdieu, 1990a) by providers reproduces, rather than challenges its regularities and rules. Whilst agency provider interviewees described problems in a way which makes them sound powerless, the presence of large providers helps to make more radical alternatives unimaginable. As Bourdieu writes it "is through the weight that [firms] possess within [a] structure, more than through the direct interventions they may also make … that the dominant firms exert their pressure on the dominated firms and on their strategies" (Bourdieu, 2005:195). The fact that smaller providers and newer entrants to the field, were most likely to complain about what they saw as dysfunctional aspects of care commissioning and provision arrangements provides some support for this argument.

Providers occupy positions within the field hierarchy and are differentially positioned in that hierarchy. Preferred provider status might be viewed as functioning "as a form of credit, it presupposes the trust or belief of those upon whom it bears because they are disposed to grant it credence" (Bourdieu, 2005:195). For other providers, where they receive income from local authority commissioners, this is an indication of their access to symbolic capital, since they are trusted to provide care. Furthermore, these providers are required to register with CQC and participate in their regulatory regime, which contributes to their access to symbolic capital. However, they are positioned at a much lower level within the field hierarchy than preferred providers whose gaps they are called upon to fill. The actions of care agency administrators can be conceived as involving habitual practices, focused on filling care packages. The response of these staff to workforce shortages appears to be to accentuate existing practices in a way which pressurises employees to take on additional hours and undertake extra calls within these contracted hours. The danger for the agency is that its longer-term interests are not considered, but from the position of administrative staff in the field, their practices make perfect sense. They enable the agency to operate, as far as possible within the terms of its contract. There was agreement amongst agency managers that paying for shifts, as opposed to hours would make it easier to recruit and retain staff, but there was also a taken for granted acceptance that local authority contracts did not provide enough resources to cover this in most cases. Similarly, agency administrative staff reported explaining to individual clients and family members why choice could not be exercised about for example, the timing of calls, in a way which suggests that it is important to describe to clients the rules of the game. There

is no indication that they viewed this state of affairs as problematic. For many, the desirability of growing the business was also taken for granted. This is not to suggest that these behaviours were unreasonable or irrational, given the rules and regularities of the field of home care.

8.3.3 Employed carers and dysfunction

Bourdieu's work is helpful in explaining why workers remain with their employers, despite their dissatisfaction. Situating responses in the context of "a set of historical relations "deposited" within individual bodies in the form of mental and corporeal schemata of perception, appreciation, and action" (Bourdieu and Wacquant, 1992: 16) helps explain why care workers remain in post, despite unsatisfactory care provision and employment practices. A habitus formed in the care sector involves taking for granted the rules of the home care field. Based on my interviews, this includes an acceptance that funding available for home care is inadequate and that local authorities and employing organisations are unable to make radical changes to improve services. For care workers who contemplate alternative employment, "the economic and social world presents itself not as a universe of possibles equally accessible to every possible subject…but rather as a signposted universe, full of injunctions and prohibitions, signs of appropriation and exclusion, obligatory routes or impassable barriers" (Bourdieu, 2000: 225). Thinking about the future is constrained by the structures and practices under which the habitus is formed and linked to that, limited access to valued forms of capital.

Bourdieu's work has been developed by feminist writers who argue that gendered relations play a significant role in field formations (Moi, 1991). As mentioned in chapter 5, one interviewee was unusual in suggesting that the staffing crisis was an opportunity to rethink the nature of the care workforce. His views may have been in part due to the nature of his role as CEO of a provider membership organisation and also the fact that he was a relative newcomer to the care sector. He explained how care delivery was, in part, designed around workers' availability and this was largely influenced by women's responsibilities outside of the home care field. Responsibilities as primary caregivers in the domestic field appear to be a contributory factor in encouraging women to enter the home care field. But many workers choose to remain when home and family circumstances change. The habitus continues to operate long after the objective

conditions for its emergence have disappeared (Bourdieu, 1990b). Women's role as caregivers in the domestic fields places constraints on their ability to accumulate capital in the other fields (Vincent, 2016). It has been suggested that fields contain "specific and antecedent temporal structures" and that the interaction between these affects the redistribution of capital within fields; and that synchronisation between fields affects one's orientation towards fields (Vincent, 2016: 1180). This means that different individuals will have different orientations depending on their circumstances. For some frontline carers, home care was described as sufficiently flexible to enable them to balance their responsibilities in relation to other fields, especially when compared with care home employment. For others, home care agency demands were not sufficiently flexible to enable them to balance other responsibilities and commitments. Additionally, as discussed in Chapter 5, providers varied in terms of their willingness to accommodate employee desires regarding work schedules. As the participant accounts in Chapters 6 and 7 demonstrate, carers adapted their practices and preferences, based on their temporal room for manoeuvre. Where individuals experience disadvantages as they synchronise their own lives with their environments they often conform with, the taken for granted field rules (Vincent, 2016) which perpetuate disadvantage, and this may explain why some remain. But as I discuss in more detail below, others made choices which they saw as better suited to their needs and desires.

As part of the employment process, care workers experience the exercise of control over their time by others. For Bourdieu (2000) "temporal power is a power to perpetuate or transform the distributions of the various forms of capital" (227) and this power over other people's time is manifest in various ways ("adjourning, deferring, delaying, raising false hopes, or, conversely, rushing, taking by surprise", Bourdieu, 2000:228). The unpredictable aspects of the employment context can make it difficult to plan for the future, and aspirations may be curtailed in a context where others exercise control over your time and your universe is "signposted" (Bourdieu, 2000: 225). Following Bourdieu, for care workers who adapt to the demands of the world which has made them what they are, they take for granted the greater part of their existence. Moreover, because even the harshest established order provides some advantages "that are not lightly sacrificed, indignation, revolt and transgressions …. are always difficult and painful and almost always extremely

costly, both materially and psychologically" (Bourdieu, 2000:231). Since the costs of "revolt and transgressions" are high, it is unlikely that care workers will engage in these activities as a collective. As individuals, for many, dissatisfaction leads to exit from the field or to another employer. Yet, as I found in a context of support from local state actors and their partner organisations, individuals may not be forced to choose between loyalty, revolt or exit.

8.3.4 Explaining field changes

There are constraints created by national policy and funding settlements, but local variations in response to these challenges were in evidence. These reflect, in part, the different local histories and geographies of my study local authorities. But differences also reflect variations in the way the habitus of individuals have been shaped. The habitus structures, (though not determines) the approach of policy makers and other local authority staff, as well as paid carers and those who manage them and the organisations which employ them.

8.3.5 Local authority commissioning and care agencies

One of the ways that change occurs, according to Bourdieu's is when habitus is out of alignment with the changing rules and regularities of the field. Bourdieu (2000) uses the term "hysteresis" to describe this state of affairs. Such a situation is often created by a crisis, which requires adaptation of the habitus. In Site B, for example, a crisis in the form of a severe weather event created an imperative to make changes in ways which threatened the distribution of capital in the field. The response included a consultation with local residents, as well as the participation of a county wide charity, which prioritised care and support to help older adults remain in their own home. This was important in providing citizens with a voice and mobilising as part of a process of public consultation. The approach here was less "top down", therefore, compared with Site A. But it was also helpful that a relatively new entrant, whose habitus had been formed in a different field was predisposed to making changes. In addition, this individual was able to successfully lobby a new director of adult social care, whose habitus had been shaped by engaging in practices in a variety of different local authorities.

The rural nature of much of the local authority footprint was also helpful insofar as the initial implementation of the changes focused on areas where existing care agencies were

unable to provide care. This meant that it was not seen as a threat by large providers until it had become established in these areas and had started to spread beyond these. Furthermore, the rural countywide charity's focus was on supporting older adults and its priorities were different from for example, Site A's rural countywide charity. Rather than seeking to preserve a dysfunctional system, the approach at Site B was intended to actively disrupt the existing market. In this site, the process of change was initiated almost a decade earlier, in a context of relative stability of supply, and an ability for supply to meet demand for care, apart from in some rural areas. As part of the microenterprise initiative, commissioners, social workers and direct payments staff were engaged in ongoing dialogue. In addition, the approach involved small pilot studies which meant that wholesale change in practices overnight were not required. The weather crisis element was also likely to have been helpful in encouraging staff to question their taken for granted practices, since these now seemed out of alignment with a field where exclusion of non-regulated microproviders was resulting in inferior care or no care at all. Over time, local authority staff engaged in practices which resulted in their acceptance of non-regulated microproviders.

In all sites where microenterprise was being promoted by local authority commissioners, traditional agencies were suspicious of and, in some cases, very hostile to the policy. This might be expected since these developments threaten the ability of incumbents to accumulate capital. In a small number of cases, encouraged by local authority commissioners, some traditional agencies were collaborating with microproviders. This was prompted by desperation due to an inability to fill care packages and whether such collaborative approaches would continue in a less constrained labour market remains to be seen.

As described above and in Chapter 4, Sites D and E, were attempting to make changes to commissioning, but often these focused on awarding zonal contracts to established providers. However, I also found that some local authorities were seeking to emulate the development of microenterprise, along the lines of site B. All but one of these local authorities were predominantly rural and often these initiatives were prompted by an inability to meet the demand for care, in the context of a local rural workforce shortage. I had expected that the relatively junior status of staff charged with implementation in most

sites would hamper progress and result in failure. Indeed, as discussed in Chapter 4, this had already happened at one site (C). In Bourdieusian terms, staff had limited access to symbolic capital in contrast to site A, where the intermediary's influence was linked to the top-down endorsement of senior staff, enabling them to mobilise symbolic capital. However, for risk averse social workers and commissioners, for example, whose habitus is thrown out of alignment with the field ("hysteresis" Bourdieu, 2000), the response to a perceived crisis may be adaptation of the habitus. My research provides some support for this, especially in sites where local authorities had implemented a microenterprise initiative.

8.3.6 Change and frontline carers

As discussed in Chapter 7, carers who became microproviders were much happier compared with working for provider agencies. They described practices which involved adapting over time to their new role. These included "business" aspects such as invoicing and using written contracts which in some cases challenged their caring habitus. By degrees, however, they developed practices which enabled them to incorporate these aspects of the relationship into their working life. Furthermore, the minimum one-hour call times enabled them to provide what they viewed as a much better and more personalised service. This increased their satisfaction and ability to mobilise social capital as part of their interactions with health and social care professionals. In addition, word of mouth helped to enhance their reputation amongst relevant stakeholders. The ability to make changes to the practices of care delivery, compared with being an employee enabled them to accumulate economic, social and cultural capital. The advice and support of intermediaries helped microproviders to reflect on field practices, such as length of visits and hourly rates, in a way which disrupted their expectations which might have otherwise constrained their access to sources of capital. Furthermore, in some cases, paid carers were unable to remain as employees due to physical incapacity. Their ability to convert their labour into valued forms of capital was constrained by illness and disability, especially where employers were unwilling or unable to agree to more flexible work schedules. The effects of (care) work on ageing bodies are not necessarily negative, especially since embodied knowledge is accumulated over time (Bourdieu, 2000). Furthermore, the older workers I interviewed were often less constrained than their younger counterparts in terms of responsibilities relating to the domestic field.

Changes to field rules, which enabled carers to exercise control over when and how they delivered care helped them to accumulate economic capital and social capital as well as cultural capital. Self-employment created incentives for carers to undertake additional training and acquire new skills. Feedback and recognition from service users, as well as family and friends suggested much higher levels of esteem compared with being an employee. COVID-19 vaccination might also be interpreted as contributing to esteem since it was largely viewed as a socially desirable, if not essential, behaviour. Recognition by others, of microproviders as trusted and respected providers can be seen to have increased their access to symbolic capital. Bourdieu's conceptualisation of esteem as symbolic capital, linked to economic, social and cultural capital (Bourdieu, 1984) draws attention to the practices which contribute to esteem. In Site B, involving key gatekeepers in practices which facilitated the recognition of microenterprise as legitimate, ("to give it value", Bourdieu, 1994:8) was an important part of the process.

At this site, the policy required ongoing dialogue with and new ways of working for staff, such as commissioners, direct payments officers and social workers, whose habitus had been formed in the context of traditional provision of care. Following Bourdieu (1990b), the enduring nature of habitus means that attempts to introduce and endorse unregulated providers is likely to be challenging. At the same time, a combination of dialogue and continued exposure to microproviders amongst staff helped embed the policy over time. In addition, community agents and a support infrastructure which helped microproviders to accumulate capital and in particular, to mobilise symbolic capital, contributed to changes in field hierarchies.

My research suggests that in a number of sites, social workers engaged in new practices, gradually developing an acceptance of microproviders. Beyond the original site, in some local authorities, growing awareness of and respect for the services of microproviders suggests that they were able to mobilise symbolic capital. This access to symbolic capital is important for longer term sustainability of these businesses. As discussed in Chapter 4, in some areas where microenterprise was being encouraged, it was not clear that practices focused on field changes to support these initiatives were in place. Yet, in the context of a habitus which was no longer aligned to the field, social workers, were gradually adapting their practices. Against the backdrop of a national shortage of care workers, local

authorities may view microenterprise expansion as undesirable if this results in employees leaving care provider organisations (as discussed in Chapter 4). Yet I found that the shortage of care workers had led to a greater willingness amongst local authority gatekeepers to connect microproviders with clients, in the absence of other alternatives. This appeared to be helping microproviders to become more established in the field.

Taken together my data highlight the importance of thinking relationally to understand the emergence of microenterprise in the field of home care. The interaction of changes to field structures and altered practices of care challenged the "taken for granted" (Bourdieu, 1989) acceptance of traditional transactional forms of care provision, based on time and task contracts. This was especially true in site B, with its well-established community infrastructure of care and support. From the point of view of local authority commissioners, whose field positions encourage them to pay attention to care supply beyond microenterprise, fears of field destabilisation may help prevent more radical change. In Bourdieu's terms, the growth of microenterprise represents only a "partial revolution" (Bourdieu, 1993: 74) since it does not challenge the fundamental axioms of the field. However, for low paid home care workers, most of whom are women, a revolution that is only partial may be better than none at all.

8.4 Comparing my findings with existing literature

8.4.1 Local authority commissioners and culture

My suggestion that care is viewed as a problem resonates with the House of Lords' (2022) characterisation of some local authorities as viewing older adults requiring care and support, as problems to be solved, rather than individuals who could be facilitated to live their best life. Such local authorities are also depicted as applying "top-down and paternalistic approaches" (2022: 17). I found that local authorities which involved citizens and adopted, to varying degrees, a more system wide approach, were most likely to promote greater diversity and choice of care provider. Site B is a key example here, but elsewhere there were instances of sites engaging citizens and implementing initiatives to promote more personalised care.

With regard to the relatively small body of research examining market shaping, Needham and colleagues (Needham *et al.*, 2023) suggest that paying attention to culture is important. They also describe how their findings did not confirm their prior expectations

of conformity to one of four cultural types. Even within "sub-markets" (e.g., older adults home care, working age adult support) there were variations in approach between local authorities. However, services for older adults were particularly likely to involve what they term "strong rules" (2023: 657). They suggest that using "cultural theory explains the types of market shaping, the tendency to cycle between approaches over time and the instability of hybrid models. External pressures on the care system – including a lack of funding and workforce shortages – mean that the expected rewards from a particular rule-relationship configuration are not being realised, creating pressure to pursue new configurations" (2023:656). My research suggests that responses to external pressures such as workforce shortage and lack of funding may lead local authorities to apply greater effort to make existing arrangements work, rather than abandon them, in some cases at least. Needham *et al.*, (2023) refer to "rules in contracts and monitoring), which can be tightly specified or permissive" (2023: 643). They suggest that the disruptive pressures created by COVID-19 "may incline many LA commissioners towards strong rules approaches" (2023: 657). I found that, increased contact between local authority commissioners and providers helped build social capital in a way which contributed to established providers' ability to mobilise symbolic capital. This helped maintain a focus on quantity, as opposed to quality. This also meant that contrary to Needham and colleagues' (2023) predictions, local authorities were more understanding of the reasons for agencies failing to comply with rules and in cases where contracts included penalties, these were not applied. Local authorities need to hold providers to account, and providers compete with each other in the market for care. Field relationships are underpinned by a degree of tension therefore, but there is "an objective complicity which underlies all the antagonisms" (Bourdieu, 1993: 73). Stakeholders are committed to participating in the field and are complicit in the problems experienced therein. For example, most local authorities pay below the sustainable rate for home care (National Audit Office, 2021b) with some interviewees highlighting the need for self-funders to cross subsidise local authority commissioned care. In such circumstances, adopting stronger rules and related sanctions would risk increased hostility in the field. In contrast, field rules and regularities appeared to be taken for granted in a way which did not threaten field hierarchies.

Grid-group cultural explanations of policy making (which is what Needham *et al.*, 2023 used) have been criticised for their emphasis on individual actors (Mahmadou, 1999), thereby ignoring the impact of structures on action. Needham and colleagues' research (2023) does not explain how "cultures" change and gives no indication of the role of individual policy makers and other relevant actors in this process. They also suggest that hybrid models, combining two or more cultural types are likely to lead to instability. My research suggests that various local authorities are using hybrid approaches to commissioning. For example, in Site B, home care is commissioned using what Needham and colleagues (Needham *et al.*, 2020) would term a "managed market" model. Contracts with a relatively small number of agency providers are in place, alongside strong relationships with traditional providers. At the same time, microprovision has proliferated, facilitated by local authority support. The latter approach is characterised by weak rules and weak relationships (between the local authority and provider in Needham and colleagues' (2020) terms). The resentment which was voiced once established providers saw that microprovision was expanding beyond the areas which they had declined to serve had spurred the local authority to communicate with agencies and encourage them to work with microproviders. This process (changes to agency staff and microprovider habitus) took time and was ongoing. The external pressures created by a pandemic and a national workforce shortage were causing some local authority commissioners at Site B to question the wisdom of the microenterprise policy. But it had not led to a decision to adopt an alternative commissioning model. This suggestion that hybridity leads to failure also ignores non-state actors. These include for example, (county wide) charities and citizens, as well as providers. The existence of hundreds of microproviders, as part of a system of county wide support, which is popular with citizens and service users cannot simply be abolished in favour of an alternative model.

Needham and colleagues (Needham *et al.*, 2020) make a number of recommendations. These include that local authorities should make "purposive and strategic decisions about market shaping" (2020: 6) and that "commissioners should be looking to stimulate the open market and partnership approaches" (2020: 3). The latter approach is described as involving "weak rules, strong relationships" and the former "weak rules, weak relationships". This appears to suggest a hybrid approach to commissioning (i.e., open

market and partnership models), despite the authors highlighting the tendency of hybridity to lead to failure. But beyond that, according to Needham *et al.* (2020: 640), it should be noted that a key aspect of partnership approaches is the inclusion of communities in a co-design process. In addition, trust, transparency and long-term investment must be fostered if partnership approaches are to succeed. It is not clear how this would be achieved in practice, but I found some examples of local authorities which were attempting to do this. Certainly, there appeared to be trusting relationships between local authorities and providers, especially where the latter were preferred providers. But there was also a danger that such relationships reproduced field rules and regularities rather than disrupting them. Needham *et al.*, (2020: 6) suggest that

> "Achieving personalised outcomes requires sensitivity to the wide range of outcomes that people want from care and support and will require considerable flexibility and scope for variation in the support provided, as well as sensitivity to the difficulties of measuring and attributing outcomes in complex systems".

But it is not clear how local authorities should proceed here. To be fair to Needham and colleagues (Needham *et al.*, 2020), their study examined market shaping generally and not as it related to older adults specifically. They did find examples of local authorities "that were taking a strategic and more outcomes-oriented approach to commissioning, particularly for working-age adults" (2020:5). Yet there is no detail on how these operated nor their impact. This finding resonates with my research which suggests that working-age adults are conceptualised very differently from older adults, with the former viewed as more capable of exercising choice and describing outcomes which they are important to them.

Needham and colleagues (2020) suggest that as part of an open market model approach to market shaping, local authorities should stimulate the emergence of a diverse range of providers and PAs. They also need to help match people who want to access this sort of support in this way (including self-funders) to providers (Needham *et al.*, 2020). In Site B, village agents performed an important role in such matching processes. Yet this sort of formalised and well-resourced structure was unusual compared with other sites. Needham and colleagues (Needham *et al.*, 2020) also suggest that the local authority has a role in facilitating smaller providers to access help with business support and relevant care regulations. There also need to be quality assurance processes which are

proportionate to the level of risk involved. I found lots of evidence that where local authorities were promoting microenterprise, workers were much happier, and care appeared to be more personalised. Many had been helped to access business support and comply with care regulations. But I also found that risk was perceived differently by different local authority staff within and between local authorities. What represents a proportionate quality assurance process is likely to vary depending on the perspective of individual local authority staff. Having said that, I found that in some sites, local authority gatekeepers and other staff were adapting their views of risk in a context of expanding microprovision. A combination of incremental changes to practice and desperation due to habitus being out of alignment with the field in other sites was responsible for these changes, which suggests that problems regarding risk perception are not insurmountable.

Needham and colleagues (Needham *et al.*, 2020) recommend that local authorities should be explicit about making different offers to different parts of the market. Apart from in Site B, where the local authority delayed engagement with traditional providers, other interviewees where microprovision was expanding reported communicating with care agencies at an early stage. Although this did not necessarily meet with the approval of those agencies.

Needham *et al.* (2020) view support and training for local authority staff as important for their ability to discharge their market shaping duties. They also point out that there are many available tools and initiatives intended to help with this. However, local authority staff have not engaged with these as intended. Needham and colleagues (2020) suggest that local authority staff turnover and workload have impeded progress here. My participants did not mention such resources, nor did they express a desire for training. A view of local authority staff as accumulating embodied knowledge is helpful in understanding why this might be so. Linked to this, the processes my participants described suggested learning via practice, responding in a habitual fashion to issues as they arose.

Needham *et al.* (2020) suggest that local authorities should recognise self-funders and direct payment holders as co-commissioners and ensure that individuals and families are able to navigate the care market. This makes sense in a context where individuals often need care at times of crisis and usually have little or no knowledge of the home care field's

rules and regularities. As discussed, village agents in Site B helped older adults and their families to navigate the care market. At Site B the direct payments lead also described obtaining and acting upon feedback during meetings with direct payments recipients. However, although in some sites local authorities had engaged with citizens and service users, I found no evidence that engagement with self-funders and direct payment holders as "co-commissioners" was happening in a systematic or sustained manner.

Needham *et al.* (2020) highlight the importance of funding in the social care system, to enable local authorities to move beyond short-term allocations that inhibit effective planning and partnerships. This appears to be a sensible suggestion and short-term allocations were raised as a problem by some interviewees. However, the variation between sites in terms of planning and partnerships did not appear to be caused by uncertainty regarding financial settlements in the long term. Similarly, Needham and colleagues (2020) note the workforce shortages nationally as requiring national and local action. But in my study, variations in local responses to such shortages were evident. Not all of this variation was due to "exogenous factors" (Jasper *et al.*, 2019) such as the local labour market conditions and/or the rural versus urban nature of the setting.

8.4.2 Local authority commissioners - endogenous and exogenous factors

Jasper *et al.*'s (2019) discussion of endogenous and exogenous factors influencing the home care market is relevant here. The former factors relate to things within the control of commissioners, such as contractual arrangements. In terms of the latter, they suggest that "the recruitment and retention of the home care workforce is likely to be related to the challenge of providing assistance to service users in rural areas as well as local employment conditions" (Jasper *et al.*, 2019:189). In my study sites, local authorities were often involved in reacting to problems created by "exogenous factors", but the response to these varied. As discussed above, some local authorities adopted initiatives which went beyond a focus on traditional providers, especially in rural areas. The shortage of home care staff, which had been identified as a problem in rural areas had spread to urban settings before I commenced my research and these challenges appeared to worsen during the initial research phase. Towards the end of my PhD, a commissioner in a large predominately rural local authority told me that workforce shortages were now reducing. It appeared to them that problems experienced were now mostly resolved, in a context of

increasing numbers of migrant care workers entering the UK. In rural areas, however, the difficulties securing care provision, which stem from the rural nature of the context (Hart and Lavis, 2017; Reid et l., 2020) are likely to persist, since these were evident prior to Brexit, when migrant workers faced fewer entry restrictions (Independent Age, 2016). This view also highlights the quantity approach to care, with success being defined in terms of numbers (of staff and (un)filled care packages), rather than service quality and outcomes.

Jasper and colleagues (2019) describe poor progress by local authorities towards outcomes based commissioning. They suggest that consideration of service outcomes should relate to individual service users. In Wales, legislation places a heavy emphasis on local authorities to ensure that individual service user outcomes are considered and that solutions must be co-produced with service users (Welsh Government, 2014). Assessments of need must include "what matters" conversations, as opposed to merely focusing on deficits, but an evaluation suggests that progress has been disappointing (Llewellyn *et al.*, 2021). My research illustrates the difficulty of addressing personalisation in the context of a time and task, "quantity" approach to service delivery. National policy and funding regimes are hugely important in terms of their impact on the rules and regularities of the field. Yet some local authorities had prioritised outcomes at the level of the individual service user and others had not. The microenterprise model in which care can be provided in a much more personalised manner is one means of addressing service outcomes which are important to each service user. There was a difference in my sites between local authorities which had introduced microprovision as part of a broader system of support (e.g., Sites B, I, J) with a remit including everything from prevention to crisis response, and those which were introduced in a context of limited and/or fragmented system wide support (e.g., Sites C and F). Engaging in conversations to elicit preferences about outcomes may be preferable at an earlier stage compared with, for example, when hospitalised and not wearing hearing aids (see Chapter 7). However, whilst system wide change may be desirable, compared with for example, piecemeal implementation of microprovider initiatives, it is likely be much slower and more difficult to embed. Site D's approach which incorporates ABCD (Blickem *et al.*, 2018) aims to focus on individual outcomes and is based on whole system change, but this was not in place when I ceased my fieldwork. The local authority staff member leading the initiative had left their post

several months after my interview. Furthermore, my focus group participants suggested that this initiative was running into implementation problems, with staff engagement in new ways of working being especially problematic (See Appendix A). Self-managing teams and small agencies may also facilitate outcomes based care (Chapter 7), although a key aspect of those models in my sites was also an insistence on minimum call durations of one hour. Fees for these providers were much higher than local authority rates. However, my "industry standard" (Burns et al., 2023) model provider participants described how self-funders subsidised care paid for by local authority budgets and the care they provided was often characterised by a lack of personalisation and continuity.

Jasper *et al.* (2019) suggest broadening the commissioning role to include a range of partners (e.g., NHS commissioners, integration, housing, voluntary sector organisations). This would be one way of encouraging local authorities to go beyond internal sources or neighbouring local authorities when formulating policy. In site B, commissioners worked in partnership with a county wide charity, as well as soliciting the views of citizens. This appeared to be helpful in a context where a new model of care challenged relatively powerful incumbents. Yet, following Bourdieu (2005), since bureaucrats may mobilise non-state actors in pursuance of their own agendas, such processes would need careful consideration of how best to address power imbalances amongst stakeholders. Furthermore, I found that in Site B, a great deal of effort had been expended on engaging local authority staff in new ways of working. In Wales where the evaluation found that staff had difficulty engaging in "uncomfortable conversations" (Llewellyn *et al.*, 2021: 55) there appeared to be little or no recognition of the durability of existing practices and the need to support staff to begin to change these.

8.4.3 Frontline carers and worker wellbeing

The emphasis on filling care packages in my sites meant that working conditions for paid carers were not a focus of commissioner attention. In a context where the impact of a trade union campaign to guarantee minimum employment standards for workers had proved disappointing (Johnson, Rubery and Egan, 2021), my findings help to explain why this should be the case. Although some local authorities promoted Values Based Recruitment, it was apparent that the values of some providers in practice as employers departed substantially from their espoused values. Local authority commissioners were

generally aware of this, but given the inadequately funded contracts for care, they chose not to challenge these providers.

My research resonates with that of Skeggs (1997) and Hebson, Rubery and Grimshaw's (2015) descriptions of a gendered classed habitus as providing some explanation of the reasons why working-class women enter and remain in the care sector. Frontline carers described a range of motivations for entering and remaining in the home care field. Factors such as caring responsibilities (for children and/or other family members) in the domestic field and the lack of access to the "right" sorts of capital helped attract (mainly) women and a habitus adapted to field structures "full of injunctions and prohibitions, signs of appropriation and exclusion, obligatory routes or impassable barriers" (Bourdieu, 2000: 225) helped to retain them within the field.

My research also goes beyond those Bourdieusian informed studies to illustrate the importance of field structures which help to perpetuate a particular model of care, which limit access to capital for frontline workers. In addition, drawing on the temporal nature of field structures and the varying circumstances of individual workers to synchronise paid care work with their obligations outside of the field helps to explain why some workers are attracted to home care agency work due to its flexibility and others leave because it is insufficiently flexible for their needs. For older workers, a diminution of caring responsibilities in the domestic field may enable them to leave the field or seek more favourable options within it. Yet a habitus formed in the field may mean that workers remain, especially if duties within the domestic field are reduced. This may explain in part the fact that the social care workforce in England is older than the economically active population (Skills for Care, 2023). At the same time as caring bodies age, in a context of a physically demanding job, workers may be unable to remain with care providers. However, as my research demonstrates, providing a more flexible model can enable these workers to remain in the field, but on terms which give them greater control over their working conditions. The fact that older workers may have more experience, accumulating embodied knowledge is not always a good thing, however, especially where this knowledge has been acquired delivering poor quality care. Where microproviders participate in local authority initiatives, they are required to adhere to minimum standards. But outside of these arrangements self-employment comes with no such

obligations. This is one of the many reasons why local authority support appears to be important for microenterprise development.

With regard to caring for service users, I found some evidence that coping with "leaky bodies and unsettled minds" (Bolton and Wibberley, 2014:685) was initially offputting for some workers, but this was not something which led them to leave the sector. Instead, interviewees were more likely to cite factors such as "emotional blackmail" (Allard and Whitfield, 2023; 8) and "burnout" (Allan and Darton, 2021) as contributing to dissatisfaction. The literature suggests that improving pay and employment conditions involving full-time or guaranteed hours contracts reduces turnover within the sector (Vadean and Saloniki, 2023). My findings were that paid shifts were preferable to guaranteed hours contracts, since the latter impacted adversely on employees' quality of life. Guaranteed hours arrangements could also constrain employee earnings in a context where such contracts require workers to be available for extended periods of time with uncertainty over call timetables and last-minute changes being a routine, rather than exceptional occurrence. Zero hours contracts were not raised as a problem by my participants. This resonates with other research suggesting that zero-hours contracts "do not appear to pose a problem for many care workers, at least while demand for workers is so high" (Resolution Foundation, 2023). Rather, in the context of high demand, as I found in my research, workers report that being pressurised to take on additional work *is* a problem (Resolution Foundation, 2023).

Furthermore, interviewees expressed no appetite for promotion and were often negatively disposed to further training. This is understandable given that many were expected to undertake all or the vast majority of this in their own time. Managers did report, however, that the nature of the work was an important factor in new entrants leaving the sector. In some cases, as discussed in chapter 6, in the absence of alternatives, paid carers remained in post, despite high levels of discontent. I only interviewed two migrant workers and one international student who was in the UK temporarily. The migrant workers, a white European woman and a black African male carer respectively, reported less favourable treatment from their employers compared with British nationals. The latter also experienced racist abuse from clients. This resonates with the literature which documents the unfair treatment of migrant workers, especially where such workers

are non-white (Equality and Human Rights Commission, 2022; Saloniki *et al.*, 2022; Turnpenny and Hussein, 2022). My data collection was undertaken prior to recent changes to visa regulations which resulted in an increase in care workers from overseas arriving and abuse of these workers from a range of sources (Citizens Advice, 2024; Unison, n.d.).

8.4.4 Learning and practice

My research sheds some light on the ways in which local authorities engage in learning. In local authorities which had implemented a microenterprise initiative, local authority staff had visited Site B (and in some cases, other sites) to learn about its operation in a real-world environment. This suggests that things have moved on in the last 20 years (cf. Wolman and Page, 2002), with some local authorities actively attempting to go beyond a reliance on neighbouring local authority contacts to seek out information. This is understandable in a context of crises which disrupt the alignment between habitus and field. At the same time, I also found evidence of local authority officials relying on informal peer networks and particularly neighbouring local authority contacts to acquire and use information to help make decisions. In addition, in some cases, local authorities deferred to trusted individuals, rather than looking outward for advice and information. This resonates with a view of learning as embodied knowledge reinforced by practice and habitual processes, in way which resembles Wolman and Page's (2002) descriptions. Furthermore, where local authority staff had engaged in site visits, the staff charged with implementation often lacked the symbolic capital to initiate field changes comparable to those in Site B.

8.5.5 Rurality and care

My findings resonate with other studies highlighting the home care challenges arising from the rural context (e.g., the mismatch between the rural demand and urban care supply pool, geographical remoteness issues). But I was also able to identify ways in which some of these rural specific factors may be helpful in creating incentives and opportunities for change. For example, initiatives such as microenterprise may be easier to implement in rural areas, which have been abandoned by traditional providers. It may be that such policies encourage rural residents who have left the care sector due to heavy demands, including driving long distances, to return. Additionally, where paid carers reside in rural

areas, an ability to focus on service users who live relatively locally may help retain these carers within the sector. I found good evidence that both of these things were happening.

To summarise, my findings resonate with much that is in the literature, but there are areas of contrast too. Some of this contrast relates to interpretation. For example, like Needham *et al.* (2020), I found variations in local authority approaches to market shaping, but I drew a different interpretation due to my application of Bourdieu's concepts. These concepts are helpful in explaining why, contrary to Needham and colleagues' (2023) predictions, local authorities do not appear to be adopting more rule-based approaches.

In some cases, the mismatch between the literature and my work may be a reflection of both my study design and sample. Additionally, my findings challenge the oft repeated mantra that enhanced training opportunities and career progression are needed to improve workforce and recruitment and retention (Health and Social Care Committee, 2023; National Audit Office, 2021b). This may be because I based this finding on the perspective of carers who occupy lower positions in the field hierarchy, rather than the policy makers and industry bodies who enjoy a more elevated position. I discuss the implications of my approach in the following section.

8.6 Strengths and limitations of my research

8.6.1 Study sample and design

A strength of the study is its contribution toward understanding factors which influence local authority approaches to market shaping duties. It is the first ever study to examine this specifically focusing on home care for older adults. In addition, the use of Bourdieu's work to theorise home care as a field helps to shed light on the broader context in which home care "market shaping" is expected to take place. In particular, it draws attention to issues of power and hierarchy, as well as explaining why so much effort is expended by local authority staff on preserving a dysfunctional system. In addition, I consider it a strength of the study that I was able to undertake a large number of interviews with a range of stakeholders across a broad geographical area. Having said that, although I included a wide range of stakeholders, there are important omissions. For example, almost all of my carer interviewees had worked in the home care sector for a number of years. It may well be that with regard to the issue of "leaky bodies and unsettled minds" (Bolton and Wibberley, 2014: 685), new entrants to the sector are most likely to leave because of

these factors. Most of my frontline carer interviews were with people who had left traditional care agencies. It may be that I would have obtained a more positive view if I had managed to interview additional care agency employees.

I was unable to recruit PAs and I did not interview elected members, although this latter group was not mentioned by any of the other stakeholders. Furthermore, I had such difficulty in obtaining the views of advocacy groups for older adults that I dropped them from my study design. I did conduct a focus group with five members of one such group when I had completed my interviews. This group had undertaken its own examination of home care based on member feedback and available literature. The group provided support for my findings insofar as they viewed the current system as deeply flawed and were keen to investigate alternatives to the binary choice between agency care and employing a PA which many older adults in their region faced. They viewed both of these options as highly unsatisfactory. Group members described variations in approach between local authorities on a range of issues including support for direct payments and consultation (or not) with citizens and service users. Appendix A provides more detail about this.

Much of my recruitment relied on participants making contact with me. It may be that individuals who have had negative experiences are more likely to be proactive in contacting researchers. Furthermore, the result of my opportunistic approach to participant recruitment is that for some sites I had very small numbers of interviewees. This made it difficult to trace the genesis of specific commissioning and market shaping approaches in these sites. In the one predominantly urban site which had implemented a microenterprise initiative years earlier (Site I), an interviewee described a history of community involvement and "bottom-up" approaches. This local authority was a member of a national network of local authorities involved in such approaches. Yet I was unable to ascertain why they had chosen, many years prior to my interview, to participate in this. Additionally, I would definitely not attempt to draw any conclusions concerning local authority "cultural types" (Needham *et al.*, 2020) based on interviews conducted online and by telephone. As I explained in my methods chapter, I would have preferred a case study approach which included some element of observation. Having said that, there is a danger that to do this justice I would have had to limit myself to two cases. The result

might have been that I found key differences between the sites but was unable to explain the reasons for these. In addition, there would be a risk that one or both of the sites was so atypical as to constrain the ability to learn from those sites.

My original design was for a longitudinal study involving repeat interviews over time. As I expanded my sample to include additional stakeholders and geographical areas, I came to realise that I would not be able to do justice to this approach. As a lone researcher there were limits to my time, which constrained what I was able to do and in addition it proved difficult to recruit interviewees and securing a second interview might have been more difficult still. Having said that, with my amended design, I was able to recruit a sizeable number of interviewees from predominantly rural local authorities.

A strength of my research is the relatively large volume of data I was able to collect and interpret concerning microenterprise. At the same time, one of the study limitations is that I did not examine other forms of provision, beyond microenterprise and traditional agency approaches in any detail. I conducted interviews with a manager whose organisation operates self-managing teams and a minimum call time of one hour (as with microenterprise). But since I have only one interview, I cannot make claims about this model which are based on more robust data. Similarly, worker co-operatives were not included in my study, due to the opportunistic nature of my recruitment process.

8.7 Judging knowledge claims- Interpreting my findings

In line with my subtle realist approach, I suggest that my findings are a representation, rather than a reproduction of reality. Representation is selective, with findings emphasised or omitted according to some viewpoint. There can then be “multiple, non-contradictory and valid descriptions of the same phenomenon” (Hammersley 1992: 51). All researchers bring their own perspectives and prejudices to bear on their investigations and I am no exception. I engaged in reflection as part of an ongoing process during my PhD. Based on my reading of the literature, I initially sympathised with local authority commissioners, and this may have been influenced by my work as bureaucrat in the NHS. Early on in my reading I conceptualised the commissioning process as one in which the constraints imposed by an English national regime were so great that commissioners were being set up to fail. Without more money, I asked myself, what could local authorities do to improve the situation? As I got deeper into my data collection and expanded my literature review,

I began to question my assumptions, especially since I found a wide variation in local authority approaches. I read about the importance of trusting relationships between commissioners and providers, nodding in approval. Perhaps this was because I think of my personal style as a former NHS manager as being more collaborative than confrontational. But as time went on, I began to question my conviction that more trust is necessarily a good thing. This is especially the case where trust is developed in a way which enables the maintenance of field of rules and hierarchies which can impact negatively on older adults and paid carers. I became increasingly interested in local authority microenterprise initiatives. Perhaps I was drawn to this topic as it provided more positive narratives compared with other aspects of home care. My purpose in spending time on this topic was not to imply that this is the "one best way" to tackle what is undoubtedly a complex issue. Instead, I suggest that this example helps to illustrate a high degree of variation in local authority approaches. It also demonstrates what is possible and the factors that contribute to local authorities engaging in changes which go beyond reliance on traditional care agencies.

I suggest that my findings have a reasonable degree of credibility, where credibility is judged on the basis of how knowledge claims are produced (Hammersley, 1990). In addition, when assessed according to the criterion of plausibility (how does the claim fit with what is already known?) (Hammersley, 1990), I argue that my claims fit well with the existing evidence in relevant respects. They also depart from what is known in some cases. I have discussed findings above in the context of published research and have presented evidence which I think demonstrates my claims, although it is for readers to judge the extent to which my research is credible and plausible.

Chapter 9 Closing remarks

9.1 Introduction

My research questions were focused on increasing understanding of local authority approaches to market shaping duties, specifically concerning home care for older adults. I also examined issues that appeared to be specific to rural local authorities and where possible compared and contrasted these with urban settings.

In what follows I consider how my findings relate to practice, as well as the implications for research and theory.

9.2 Implications for practice

Local authorities have experienced budget cuts over several years (National Audit Office, 2021a) and their financial situation is likely to worsen in the short and medium term (House of Commons Levelling Up, Housing and Communities Committee, 2024; Ogden and Phillips, 2023). Some local authorities are already experiencing what might be termed a funding crisis (Harris, 2024). For both rural and urban local authorities, there is a danger, that responses to crisis will involve working even harder to preserve a dysfunctional system. I found that a crisis could create strong incentives to engage in change which challenged the existing provider models. Some local authorities which experienced home care supply problems in rural areas did depart from the perpetuation of a dysfunctional "quantity" approach to care. The implication of this is that preserving dysfunction does not have to be the default approach to local authority market shaping duties. Furthermore, despite the problems associated with the rural context, there may be opportunities to initiate approaches which result in more personalised care. Such initiatives may also flourish in urban areas, and I found examples where this appeared to be the case. However, initiating such policies may be easier in rural settings, due to the disinterest of agency providers, at least at the start of the process. In the absence of change, many older adults may have few options in terms of home care and in some cases may not be able to access such care at all.

9.3 Implications for research

Local authorities are now required to participate in a "meaningful and independent assessment of care at a local authority and integrated care system level" (Care Quality Commission, 2023). As part of this process, the CQC will assess the performance of local

authorities against Care Act (Care Act 2014) duties. Research is needed to examine the implementation of this initiative and its implications for home care quality. Ideally such research will involve in depth comparative case studies and observation of practice. It will also be important to include a range of urban and rural settings. Given that researchers approach their studies with intellectual and disciplinary baggage, it is desirable that research teams are interdisciplinary in nature. In line with the principles of realist evaluation, there can be "multiple, non-contradictory and valid descriptions of the same phenomenon" (Hammersley 1992:51). An interdisciplinary approach might increase the likelihood of generating descriptions that reflect multiplicity in a way which does justice to the complex subject matter.

It will also be important to include a wider range of stakeholders than I managed to recruit. In particular, given the very limited research on the practices of elected members in the home care field, it would be helpful to involve them in future research. I did not interview NHS commissioners in my research, nor did I examine relationships across for example, Integrated Care Systems (NHS England, n.d.). I cannot comment on the impact of these relatively new structures on the home care field. But it would be helpful to have a greater understanding of their impact, as well as the ways in which this varies between locations.

My research examining microenterprise highlights the benefits of this model of care, as does an evaluation which quantifies these benefits (Bedford and Phagoora, 2020). However further research is needed to investigate microenterprise and other non-standard models, since the research in this area is limited. In addition, considering these models as part of a broader context, as opposed to isolated from broader field rules and regularities would be very helpful.

The contribution of my research is the presentation of novel empirical evidence, selectively applying relevant theoretical tools. My main focus has not been to extend Bourdieu's theory, but rather to use it in the development of an empirical analysis. There remains significant scope for more theoretically driven research that applies and extends Bourdieu's concepts at the local state level.

9.4 Implications for theory

9.4.1 Habitus and field changes

This thesis contributes to theory development by providing an empirically grounded description of changes to the habitus (in this case of care workers) which is a more complex explanation than a process of hysteresis (Bourdieu, 2000) impacting directly on the habitus of care workers. Bourdieu rarely demonstrated empirically the specific circumstances under which the habitus is likely to be modified, adapted and/or disrupted (Crossley, 2001). His concept of a habitus clivé is concerned with change in the habitus. But this involves an ongoing process of grappling with internal contradictions, often in the context of social mobility. This concept describes how individuals feel torn between wanting to adopt the behaviours, networks and rewards of new forms of practice and the costs of leaving behind their old ways of being in the world with the attendant impact this has on their kinship and friendship ties and life in general (Friedman, 2016). This might apply, for example, to becoming middle class and the internal tensions relating to class loyalties created by the requirement to dispense with valued forms of working class practice (Bourdieu,1999). These tensions are present over a long term, rather than being resolved quickly. Bourdieu developed this concept in the context of his own discomfort as the son of a postal worker who became an internationally renowned academic (Bourdieu, 2004).

Bourdieu also provides an explanation of change promoted by hysteresis, a period of rapid change which results in the habitus being out of alignment with the changing rules and regularities of the field (Bourdieu, 2000). In my thesis, I describe a process of change involving adaptation of the habitus of care workers as they become microproviders. This is not a case of a habitus clivé, since workers are not torn between loyalty to the old as they adapt and embody new practices. Instead, they embrace new ways of working and despite being hesitant and uncomfortable with regard to “business” practices (e.g. invoicing clients, formal written contracts), there is evidence of a habitus which adjusts to the field conditions they face.

My thesis does not rely on the explanations outlined above but suggests that adaptations can be understood in terms of a muti factorial process. Firstly, as employees, care workers are unhappy with the requirements of their role in the home care field. This is not due to

rapid change, but field conditions which are highly unsatisfactory from the perspective of the workers. Care workers, however, 'take for granted' field conditions and continue to reproduce field rules and regularities. In one site (B) a crisis (a severe weather event) helped to spur changes which threatened field rules. A new entrant to the field, who did not take existing structures for granted was able to mobilise symbolic capital to facilitate changes to market structures due to the top-down endorsement of senior staff. As part of this, paid carers were encouraged to become self-employed providers of care and given dedicated support over an extended period. This was an acknowledgement that the employed care worker habitus does not predispose individuals to becoming self-employed. It was also prompted by the novel nature of many of the practices required.

It was not sufficient, however, to provide direct support to microproviders. In addition, social workers, who felt uncomfortable with recommending unregulated providers were given training and time to adapt to new practices. Contact with these new providers helped to build social capital and over time, microproviders were able to mobilise symbolic capital as they gained esteem from local authority professionals and clients. The crisis helped initially, creating momentum for change. But the change involved adaptation of the care worker habitus, rather than a rapid process of habitus being out of alignment with the field. Similarly, social workers were given time to resolve their feelings of unease at working with unregulated providers.

In contrast in some sites, the process by which market structures were changed was facilitated by the desperation of key actors whose habitus had become out of alignment with the field. Microprovider initiatives introduced by local authorities in a context of an inability to source care were not necessarily underpinned by dialogue and training for social workers to enable them to adapt to these new market structures. Instead, in the context of rapid change and an inability to source care, social workers began to engage with microproviders, due to desperation. A process of hysteresis was important for the success of the microproviders in these sites. But this was because it facilitated acceptance of microproviders by social workers, whose habitus had to adapt quickly, rather than having a direct impact on the habitus of microproviders. The acceptance by social workers of unregulated providers, suggests that a risk averse social work habitus can change rapidly if field conditions under which the old habitus was formed change rapidly. The ability to

engage in new forms of practice was key to the creation and expansion of new market structures. This means that problems regarding risk perception concerning unregulated providers are not insurmountable.

The fact that microproviders were prevalent in one site also helped with initiatives to change structures, since it demonstrated that change was possible. This was in contrast to the taken for granted acceptance of the status quo. Although in sites where this policy was emulated, rapid change meant that social worker habitus was modified quickly. A combination of incremental changes to practice for social workers in the original site and desperation due to habitus being out of alignment with the field were responsible for these changes. Microprovider practices helped to spur the growth of new structures within the market. These practices involved provision of personalised care, but they also included operating as a business. In the case of the former, the habitus of microproviders was well aligned with this form of provision. With regard to the latter, the market structures meant that adaptation of the habitus was required so that microproviders came to embody these new practices. In contrast, for managers and owners of most care provider organisations, a habitus formed in the context of "time and task" care in the home care field helped to reproduce field rules and regularities.

9.4.2 Habitus and the local state

The thesis also demonstrates the importance of ostensibly neutral local state bureaucrats in the process of shaping policy in this case on care markets, but it seems reasonable to assume that this impacts on policy more generally. Drawing on Bourdieu, my findings suggest that local authority commissioners enjoy a relatively elevated status by virtue of their position within field hierarchies. This helps explain the reproduction of field rules and regularities, especially where commissioners have long experience of working in the field. At the same time, the conditions under which habitus is formed vary between commissioning staff. In my research factors such as the rural or otherwise context of bureaucrats' upbringing, their employment history (in care providers or public health for example) and the length of service within the field all appeared help explain variations in their approaches to market shaping.

9.4.3 Market shaping and the local state

The thesis also makes a contribution to theory about market shaping and local state activity. Like Needham *et al.* (2020), I found variations in local authority approaches to market shaping, but I drew a different interpretation due to my application of Bourdieu's concepts. Needham et al.'s work attributes variations to 'culture' (2023). Bourdieu's concepts of habitus, capital and field are helpful in explaining why, contrary to Needham and colleagues' (2023) predictions, local authorities do not appear to be adopting more rule-based approaches.

Viewed from the perspective of field positions, incumbents enjoy greater access to valued forms of capital (Bourdieu, 2005). In the context of a field of home care, established providers enjoy access to symbolic capital. In addition, COVID-19 helped to increase their stock of social capital, particularly regarding relationships with local authority commissioners. Furthermore, commissioners' habitus has been shaped by market structures which involve traditional providers and "time and task" care. This enables these providers to shape, to a greater or lesser extent, the shared meanings which dominate in the field. Local authorities need to hold providers to account, and providers compete with each other in the market for care. Field relationships are underpinned by a degree of tension therefore, but there is "an objective complicity which underlies all the antagonisms" (Bourdieu, 1993: 73). Stakeholders are committed to participating in the field and are complicit in the problems experienced therein. For example, most local authorities pay below the sustainable rate for home care (National Audit Office, 2021b) with some interviewees highlighting the need for self-funders to cross subsidise local authority commissioned care. In such circumstances, adopting stronger rules and related sanctions would risk increased hostility in the field. In contrast, field rules and regularities appeared to be taken for granted in a way which did not threaten field hierarchies. The presence of large providers helps to make more radical alternatives unimaginable and in the context of COVID-19 local authority commissioners appeared to do all they could to support these providers. Applying a more rules-based approach would run contrary to that approach. Rather than attributing local authority actions to 'culture' my research suggests that relationships of power and inequality which characterise the home care field are a more convincing explanation.

Market shaping has been conceptualised in terms of contractual relationships (Jasper *et al.*, 2019) and cultural types (Needham *et al.*, 2023). My research suggests it is important to go beyond a narrow focus on commissioning approaches to examine the rules and regularities of the home care field more broadly. As discussed in Chapter 7, my research suggests that Bourdieu's work is helpful in conceptualising market shaping in relation to home care for older adults. In particular, viewing home care as a field highlights issues of incumbent power and inequality, which are not often considered in the home care literature.

9.4.4 The home care work context

Additionally, in a context of universal agreement concerning the lack of esteem afforded to care workers, Bourdieu's concept of symbolic capital is useful in terms of conceptualising ways in which esteem might be increased or curtailed, depending on field configurations. The theory (and accepted wisdom) that enhanced career structures and increased training opportunities are required (National Audit Office, 2021b) is at odds with my research findings. Theory which fails to give a voice to those at lower levels of field hierarchy is likely to produce "solutions" which are flawed, or partial at best.

9.5 And finally….

I am mindful of Machiavelli's advice that "how one lives is so far distant from how one ought to live, that he who neglects what is done for what ought to be done, sooner effects his ruin than his preservation" (Machiavelli, 2022: ch15). My research has focused on increasing understanding of "what is done" and I have deliberately avoided moving from "is" to "ought" by producing a list of recommendations. Having said that, if I were in need of home care, I would certainly want to avoid "time and task" based services and I would never want to become an employer. I suggest that older adults need not be forced to choose between these two unsatisfactory options. My focus group participants were certainly of the same opinion. There are examples of local authorities whose market shaping approaches actively ensure that more personalised services are available for older adults who need them. In my study, these local authorities were more likely to consult citizens and were often predominantly rural in nature, although this was not always the case. Whether other local authorities will adopt such approaches remains to be seen.

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Appendix A Focus Group Summary

Participants

The focus group comprised five women, all of whom were aged over 60. Four of the participants [IDs 1 to 4] had been involved in sourcing care for friends and/or family. The fifth member [ID 5] had a background working on older adults' projects. Members were all resident in the same city [Site D], but some had experience of liaising with/working in local authorities in other areas.

Quality and quantity of home care

There was general agreement that home care provision was problematic, both in terms of the overall supply and the quality of care provided. There was also agreement that carers were undervalued and were often treated badly in terms of their ability to deliver meaningful care. The fact that other sectors were more financially rewarding was also raised as a contributory factor to recruitment and retention problems in the field.

> "There was an advert for LIDL, and they were paying £14 an hour and you know flexible hours and things like that. Who's going to work for 9, 10 pounds an hour when you can get 14 and not have all the hassle. …. Staff are not valued, and they're just not seen as important. I mean look at the way they were treated during COVID". [ID1]

> "They don't get the same as social services staff. They get the pensions. They're not usually on buses. You see carers waiting around on buses endlessly when you're driving around. Then the buses don't turn up so they're late for the next one, then they're late for the next one". [ID2, Former community matron]

> "I was amazed how many carers opened up to me about the terms and conditions and without exception, I felt they were all passionate, committed, but felt detached from their value system which was very important to them and it's a shame they couldn't get that point across to the people doing the rotas and doing all this. It was a real barrier in almost 90% of the cases I was speaking to individuals about. And some of them did end up leaving, because in their words, they were fed up knocking their head against a brick wall. They'd tried everything they could. They'd tried to rise to the greater good. But every one of them said 'Eventually, you can't keep being the better person if the system has inlaid traps where you can't be heard and acknowledged'. A lot of them weren't after more money. …. A lot of them it was a value system whereby they were giving, and I witnessed it myself, giving not just the care we had asked for but engaged a lot more as well of their personal self with my parents [it] was endearing and comforting and beyond their remit. But those values weren't in the tick boxes that the managers and the system and the market have. And to me that was a huge barrier because a lot of people said they were going to leave…because they were saturated with being the good person…. It is about

money. I'm not getting away from that at all. But there was an intangible essence about them that wasn't being recognised. And it's such a force for good. It really is." [ID3, Former NHS and local authority employee]

One participant suggested that the use of mobile phone technology to record data and monitor staff placed a burden on paid carers. It also reduced the time available to deliver hands on care. Another drawback was that other professionals had no access to these phone records, and this detracted from continuity of care and information sharing more generally.

"When carers come in, they've got a half an hour visit and they've got to put things on their phone and a lot of them are my age and it doesn't come naturally to them. And they've actually done nothing because it takes them so long so then you have to report back to management that they're not actually doing what they're supposed to be doing. I know that from nursing. I did the IT bit at home because I'd never have got through the work but not everybody does that. They shouldn't have to. Because it's on an IT system the care manager comes in to do a review of their care or a nurse and 'Can I have a look at the carer's notes?'. 'Well there are none. They're all computerised'. 'So I can't see what's been happening?' 'No. Not without putting an application form in'. So you're leaving notes to the carers 'Please can you tell me what's been done' and some of them do and some of them don't." [ID2, Former community matron]

Variations in approaches of local authorities

Participants described their local authority [site D] in positive terms, due to it having involved them in previous commissioning rounds. Participants supported this approach but, they suggested, it was not easy to assess competing bids in a context where bidders were aware of the need to convey desired values in their bids.

"When we did this kind of work with the council on commissioning, they had all kinds of statements about values and personalised care, and we would go through all these applications, and you knew half the time they were just saying the right thing. It was really difficult to know how that would be put into practice". [ID4, Former social worker]

The fact that contracts were based on time and task delivery was not raised as an issue by participants during their involvement in the commissioning process. The local authority had not involved them in discussions about whether it would be possible to write tender specifications and construct contracts in a way which did not rely on time and task care. However, the attempt to move to an Asset Based Community Development approach in this site was also welcomed and the older adults group had

been involved in the planning and design phase of that. Nonetheless, there were concerns that the initiative was stalling at the implementation phase.

> "'We're gonna take an Asset Based Community Development approach and we're gonna try and get staff across the board to understand what's involved'. But what's happening is 'I haven't got time' so then it starts to be a bit rocky because you're not getting staff rowing in the same direction. You're not getting everybody with the same set of values because in some ways that's what it is. Getting people to sign up to the same set of values and in some ways questioning about how they're doing something and whether it meets these values". [ID5]

In addition, there was an assumption and an acceptance that local authorities generally were unable to ameliorate the problems of the sector.

> "Skills for Care, 20 years ago were trying to train more care workers. It's always been a very undervalued, very badly paid job and I don't see how local authorities can shape markets unless a) they've got some vision. And I'm sure there are some councils that have some vision and b) they've got the money to pay or c) they actually get together. And of course the whole nature of councils and social care it is privatised it is a market so you can't say like you can in the health service 'all GPs must provide this or that'. It just doesn't happen with social care and it won't. I think shaping a market is an interesting one because with councils they probably haven't got the time and they haven't got the money so just be grateful for what you can get. I think they try. I think [our council] does try. [ID4, Former social worker]

There was also agreement that some local authorities were much more helpful than others regarding direct payments and recruitment of personal assistants.

> "I've got experience of trying to get a Personal Assistant and I was told by the council 'We can't do that because we haven't got the staff that know how to do that. Sorry, I can't help you'. Where I was working just 10 miles down the road I was working very, very closely with social services at that point 'You can, you can get one'. But I gave up the battle in the end because it was too hard." [ID2, Former community matron]

Care as a problem and an enabler

There was agreement that older adults living in their own homes often had complex needs which, in the past, would have resulted in them moving into residential care. But there was also agreement that care was not focused on enabling older adults to "live the best life they can" (House of Lords, 2022: 17).

> "… we can't deny that people living in their own homes now tend to have much, much more complex issues than they ever had in the past, so some degree of

> professional personal care is needed. But how can you provide that in a way that it's connected with the rest of that person's life? You hear this 'I can't come on Monday, because my carer's coming'. That's fair enough up to a point but if that coming on Monday was really important to that person's life and their other social connections then if you can't organise the care in such a way that it enables the person to continue their life as much as possible then you're not really achieving what we set out to achieve" [ID5].

Linked to this, participants also suggested that outcomes which were important to individuals (which could include choice of bedtime) were not prioritised in a system which is focused on problems, as defined by local authority bureaucrats and social workers.

> "He didn't want to go to bed at half past six at night because a carer was coming then. So rightly or wrongly, I took the council package but slowly sliced off the people that weren't serving his interest. They would have been saving my time but never mind. But I employed somebody privately for the bathing situation because predominantly the carers were female, and my dad didn't want that. So I did find a carer myself and paid for it myself….and that system worked for me". [ID3, Former NHS and local authority employee]

> "I did this lovely person-centred assessment and the [LA] manager said 'Do you want to come and work for us?' But then I was told 'he'll not get that. That's a wonderful assessment but in reality, it'll not happen. Because it [our provision] is deficit based'". [ID2, Former community matron]

> "…. people go in [to social work] for all the best motives, they want to help people, they want to do their very best, they are faced with a system which is deficit based. … [ID4, Former social worker]

Alternative models of provision

Participants discussed the problems of traditional agency care at length. I suggested that employing a PA was another option, but participants saw this as undesirable. Linked to this, some participants suggested that direct payments were mostly not suitable for older adults. However, this was based on an assumption that such payments would be used to employ a PA, and nobody wanted to become an employer.

> "[Local authority approach is] 'Well you can do this but actually we can do all that for you'. And it's probably very well intentioned. I'd be saying thank you very much because I don't want to go into that kind of [becoming an employer] minefield. Maybe if you're a young disabled person it kind of becomes part of what you learn how to do and manage it".

The participant who was a former social worker also suggested that PAs were more likely to put services users at risk of abuse.

> "As a professional, it [unregulated status] would put me off straight away" [ID2, Former community matron]
>
> "The potential for abuse is really, I mean I've known people who have got a really dodgy character as a personal assistant because it's a good source of money. Well, it's exploitation and abuse [of the service user]. …. you want that protection of an agency that has got some kind of regulation rather than somebody who may work out really well, but who may not and then you are just left to the wolves". [ID4, Former social worker]

However, another participant suggested that there was potential for abuse in any model of provision and that this was not applicable to unregulated providers alone.

> "I did at one point employ* a male personal assistant for my father cos he didn't obviously want me to bathe him, and we ended up having a great relationship. He was so dedicated to male personal care. I would have paid him my whole salary. But you do need an advocate. My dad and I established a code word so that even when whoever was there if he said that code word to me, I knew that career wasn't coming back again. And similarly, there was a code word for the ones he really loved. But he had me as his advocate". [ID3, Former NHS and local authority employee]

*The carer was self-employed and paid on a 'cash in hand' basis so this was not strictly an employer-employee relationship.

Participants had very low expectations of local authorities. There appeared to be a taken for granted acceptance that they could not improve the situation in home care. This led to a discussion about alternative forms of provision based on individual advocacy and/or shared community support.

> "It's still labour intensive you still need an advocate, so I don't know how you get round that. It's breaking down each step to get to where you want to be. [ID3, Former NHS and local authority employee]
>
> That's really interesting but if you think about the growing number of people who are ageing without children, who don't necessarily have advocates. How many of us would want to call on a friend or extended family to do that really hard work? So to have a system that's predicated on that, seems totally ridiculous to me. And I've spoken to people, people who are in the system, experienced people. I distinctly remember the Director of Adult Services in [the city] saying 'I could not get the care for my father that I wanted'. His father lived somewhere else. But to actually know that people who know the system, who know the buttons to press can't actually achieve what they think should be achieved, we need to look at it from a much broader perspective in some ways. [ID5] ……
>
> …. I remember seeing a programme a good few years ago [place] about how the people there didn't trust local authorities so they'd actually set themselves up the

residents there they were looking after each other cos they wouldn't have anything to do with the council…and it seemed to work. So that was a very informal way of helping everybody out. [ID5]

Is that what they did years and years ago when you lived in a village? Everybody helped out? [ID2, Former community matron]

Yeah. Well, there's something in that isn't there? [ID1]

Yeah. Working in the ethnic minority areas and the depths of the deprived areas in [this city] that was what you saw. People were helping one another. I mean the problem there was with the ethnic minority areas it's a bit too enclosed and you do end up with problems there as well because er it can be a problem. [ID2, Former community matron]

But the reality is neighbours and friends, and family will only do so much. And if you're talking about personal care, it's a big ask from the neighbour down the road you know. [ID5]"

Summary

As with many participants in my study, there appeared to be a consensus that the home care system was problematic. Yet, there appeared to be a taken for granted acceptance that little could be done to improve things by the local authority. Discussion about direct payments and their suitability for younger, as opposed to older, adults was based in large part on assumptions about direct payments being used to employ PAs. Becoming an employer was viewed as very burdensome. Assumptions about direct payments and becoming an employer are understandable, given that in Site D, there was no microprovider initiative. The microprovider model would seem very relevant to the discussion about "residents looking after each other" and "friends and family members only doing so much". Additionally, the resistance of professionals to unregulated providers was evident within the group and this resonates with comments from local authority staff in my sample. I found the news that Site D's progress with its Asset Based Community Development programme was stalling disappointing, but this is perhaps not entirely unexpected.