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# Home-care providers as collaborators in commissioning arrangements for older people

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## Abstract

In England, care to support people living at home is largely commissioned by local authorities (statutory organisations with responsibility for social care in specific localities) from non-statutory home-care providers (for-profit, not-for-profit, voluntary). This paper explores how managers of these services perceive commissioning arrangements and their impact on home-care providers, the care workforce and service users. Little formal research of providers' experiences of working with local authorities in a commissioning model is available. A qualitative study employed semi-structured telephone interviews with 20 managers of for-profit home-care providers from 10 selected local authority areas in England. Data were analysed using thematic analysis to identify main and subsidiary themes. Home-care providers reported operating in a complex and changeable partnership with commissioners, characterised by: (a) relationships ranging from transactional to collaborative, (b) providers expressing a strong sense of public service motivation, (c) commissioning practices that were complex to negotiate, time-consuming and overly prescriptive, (d) frequent changes in commissioning practices and a perceived lack of strategic planning, which were reported as contributing to uncertainty and tension for providers and confusion for service users. Attempting to operate a market model with tightly prescribed contracts is likely to be unsustainable. An alternative approach based on a collaborative model of joint responsibility for providing home care is recommended drawing on a conceptual framework of principal–steward relationships in contracting.

**KEYWORDS**

care providers, commissioning practice, home-care, market model, qualitative study, relational contracting

## 1 | INTRODUCTION

This paper examines home-care providers' perception of commissioning arrangements with local authorities in England, specifically considering how they experience contracting and the potential impact on home-care providers and service users. Two prominent features are drawn from policy and literature on commissioning to frame the study and provide a context for the empirical findings: (a) policy imperatives to increase home care for older people through the introduction of a market model in social care and (b) challenges

in implementing this approach within home-care services for older people. The paper uses principal–agent theory to extend our understanding of how providers and commissioners operate in a market model.

## 1.1 | Market model in managing home care for older people

Three decades ago, UK policy reforms in community care outlined a pledge to enable people to receive the care they required while remaining in their own home. The rationale for home care was based on evidence suggesting that enabling people to continue living in their own homes, with personalised support, could maintain their quality of life and offer a more affordable solution to the growth of care needs (Gridley, Brooks, & Glendinning, 2012; Harper, 2014). To achieve the ambition of maximising individuals' independence, personalising care and minimising costs, an expansion of home-care services was essential (Cm849, 1989). A market model for sourcing and procuring home care from non-statutory providers in England was introduced to meet the anticipated growth in demand for home care (Cm849, 1989; Knapp, Hardy, & Forder, 2001). Adopting a market model was based on the assumption that contracting home care from non-statutory providers (hereafter referred to as 'home-care providers') would assure gains in efficiency, cost and quality (Hardy & Wistow, 1997; Knapp et al., 2001). Initially this was conceived as a purchaser–provider process, followed by reforms that introduced a commissioner–provider model (Clarke, 2006). Thus, local authorities (organisations that are officially responsible for public services and facilities in a particular locality, including a statutory responsibility for social care) in England act as commissioners of services for the provision of social care, operating strategically as 'service enablers' rather than service providers (Bovaird, Dickinson, & Allen, 2012). Commissioning is part of local government strategic management for social care in England, consisting of a contracting process for securing services for a locality. This is akin to the process of procurement services in other countries. In England, commissioners oversee a contracting process for securing services, with responsibility for understanding the needs of service users across a specific locality, identifying priorities, sourcing home-care providers and monitoring quality of provision using a broad framework, the commissioning cycle, to inform the process (Murray, 2011). Approaches have evolved within different localities, resulting in complex and challenging systems (Bovaird, Briggs, & Martin, 2014; Davies, et al., 2020) and considerable variation in the way the relationship between commissioners and home-care providers is facilitated (Davies, et al., 2020). With the introduction of the Care Act (2014), a greater emphasis on their role of 'shaping' and 'managing' the market within localities was introduced.

Alongside adapting commissioning practice in response to policy championing the benefits of market approaches, local authorities have been managing unparalleled pressures on the social care system with increasing unmet care needs, reduced spending by local

**What is known about the topic and what this paper adds?**

- Home care for older people is commissioned by local authorities in England according to a market model
- employing complex contracting arrangements.
- Relationships between home-care providers and commissioners are often dominated by tight contracting processes and inflexible specifications.
- This study found that home-care providers navigate complicated and time-consuming contracting arrangements with local authorities
- while operating with challenging financial
- workforce and client pressures.
- The relationship between providers of home care and commissioners is changing. There were examples of the contractual model
- with tightly prescribed specifications
- being replaced with a partnership characterised by providers being trusted to assess individual needs
- alter care arrangements and contribute to designing innovative solutions to local challenges.
- Some care providers and commissioners are finding ways to overcome a restrictive market model and actively developing a more trusting partnership based on a shared aim to deliver better quality care for older people

authorities (Care Quality Commission, 2017; Glendinning, 2012) and a system that appears in 'disarray' according to some commentators (for example, Hudson, 2018). The complexity of trading in this context for home-care providers, who operate in a market model often with a contractual arrangement with local authority commissioners, is known to be challenging (Bottery et al., 2018). The practicalities of negotiating contracts, costs and service delivery for vulnerable people are part of any care business practice, but complications arising from commissioners' interpretation of being market shapers and managers as they assess locality needs, draw up specifications and aim to balance budgets, are potentially limitless. Contracts alone are complicated with contract types, such as 'spot', 'block' or 'framework', varying in the advantages they confer and associated costs, whether for the commissioner or for the home-care provider (Knapp et al., 2001; Wilberforce et al., 2011). Contract arrangements vary, employing combinations of types of contracts (Chester, Hughes, & Challis, 2010). The responsibilities of local authorities also involves distributing personal budgets and overseeing the quality of home care for all budget holders, including for individuals who fund and source their own care. Social workers or 'assessors' play a critical role in mediating between commissioners and providers, assessing individual need and co-ordinating care at home for vulnerable older people. It is interesting to note, that, in practice, personal budgets have not been popular with older service users and constitute

a small part of commissioning arrangements (Baxter, Rabiee, & Glendinning, 2013), while demand for services from self-funders is difficult to anticipate (Baxter, Heavey, & Birks, 2019).

Severe financial pressures associated with a lengthy period of austerity in England have compounded difficulties in provision of home care (Farnsworth & Irving, 2012; Glendinning, 2012; Power, 2014). Thus, home-care providers are working in a market model that has been difficult to implement and operating during a funding 'crisis' for social care (Care Quality Commission, 2017). Local authorities have reported relentless pressure to maintain provision while managing dwindling budgets (Bottery et al., 2018). Consequently, spending on home care and the nature of contracting processes are subject to variation between local authorities, resulting in home-care providers trading in an uncertain market that challenges their sustainability, particularly where their activities span local authority boundaries (Chester et al., 2010; Jefferson et al., 2017). Considerable instability is reflected in the 'churn' evident in the market, with 500 new agency registrations and 400 de-registrations each quarter (CQC, 2017). There are multiple challenges associated with this level of turnover, particularly given that new entrants to the market are unlikely to have the same service capacity initially as those they replace, and indeed, may exacerbate issues in recruiting and retaining care workers.

## 1.2 | Conceptual framework

Observing these challenges through the lens of agency theory (Lupia, 2001) can help to explain the mechanisms at work during the process of commissioning home-care provision and provide a context for this study's empirical findings. Employing the concept of a principal–agent relationship reveals tensions between the players involved in sourcing and delivering home care (Van Slyke, 2006). The principal, in this case local authorities in England, contracts with an agent, a provider organisation, who takes on responsibility for providing a service on behalf of the principal. According to the theory, agents are motivated by their own interests, utilising their superior knowledge of the sector, in the form of asymmetric information (Van Slyke, 2006), to their own advantage. Principals, on the other hand, may control the budget to exert pressure by minimising costs to the detriment of the agent (Van Slyke, 2006). The theory suggests that the principal–agent relationship is rarely characterised by interests or actions that align. The principal frequently loses agency, with arrangements that fail to achieve the desired outcomes. Loss of agency can be minimised, first, when the principal and agent share common interests and, second, when the principal is knowledgeable about the agents' action (Lupia, 2001).

Evidence is emerging that the relationship between a provider and the commissioner can, in fact, be characterised by reciprocity and mutual support, rather than competition between public and private institutions (Van Slyke, 2006). Van Slyke (2006) suggests that commissioners and providers may operate using a 'principal–steward' model where shared goals and trust are established as part of a long-term relationship (Davis, Schoorman, & Donaldson, 1997).

Reported variation in commissioning practice (Chester et al., 2010; Davies et al., 2020) has prompted other researchers to visualise commissioning approaches as a continuum from a position prioritising cost minimisation to a partnership model (Rubery, Grimshaw, & Hebson, 2013). The term 'commissioning orientation' was adopted by Rubery et al. (2013) to convey the values and priorities of commissioners' attitudes, with partnership considered a more effective orientation.

Home-care providers in England operate as agents within the commissioner–provider relationship, delivering an essential service in the social care system. However, their voice is rarely heard and little is known about how they respond to expectations from local authority commissioners and service users, while trading in a market context that is constrained by dwindling budgets, increasingly complex cases and relentless demand.

This paper seeks to add to our understanding of the process and impact of commissioning on home-care providers as agents in the home-care system. There are two aims:

- To investigate the perspectives of home-care providers as part of the commissioning process for home care, examining the experience of contracting and delivering commissioned services for local authorities; and
- Explore the attitude of home-care providers to delivering commissioned services for older people.

## 2 | METHOD

### 2.1 | Study design

The research reported here was undertaken as part of a larger study, 'Commissioning Home Care for Older People', to explore local authority arrangements for commissioning home care for older people (redacted for review). Earlier stages of the project included a scoping review of the literature (Jasper et al., 2019), a national survey of local authority commissioning arrangements (Davies et al., 2020) and a qualitative study of commissioners' experiences (Davies et al., 2020). This paper reports findings from a qualitative study of home-care providers, using data from semi-structured telephone interviews with 20 home-care providers in England in 2018. Ethical approval for the research was given by an HRA Social Care Research Ethics Committee .

### 2.2 | Recruitment and participants

The selection of home-care providers for this study was a two-stage process. First, local authority areas were selected based on commissioners' responses to a national survey conducted in the first stage of the study (Davies et al., 2020). Local authorities in England were grouped reflecting their collective approach to commissioning based on responses relating to: contracting arrangements; frequency of

**TABLE 1** Home-care provider topic guide

| Topics | Interview questions |
| --- | --- |
| Background | Tell me about the service you provide<br>a. Services provided<br>b. Client groups<br>c. Size/staff/number of hours provided<br>d. Organisation<br>- part of a national organisation<br>- a company working in just one area |
| Current arrangements | Contractual arrangements<br>- What kind of contract do you have with the LA?<br>- Length of contract<br>- How is your contract arranged?<br>- What do you think about the arrangement?<br>Your service delivery<br>- How do commissioning arrangements influence your service delivery? [consider length of visits/costs/LA arranged or budget holder/self-funder]<br>Essential for commissioning<br>- What do you think is most important for successful commissioning? How does this affect care? |
| Implications of commissioning (staff) | What are the implications of the LA's commissioning arrangements for:<br>- Staff recruitment/retention<br>- Staff pay<br>- Staff training |
| Implications of commissioning (quality of care) | What are the implications of the LA's commissioning arrangements for services that people receive in your area?<br>- Quality of care<br>- Service user experience and outcomes<br>- Capacity in your organisation<br>- Sustainability of provision (Please can you give an example to illustrate salient points) |
| Competition and collaboration arrangements | Thinking about other home-care providers in your area, how is your service influenced by other providers?<br><br>- Number in area<br>- Your relationship with other providers<br>- What difference does the collaboration or competition make to you provision? |
| Relationship with commissioner | How easy or difficult is it to work with your commissioners?<br>- How do you raise issues and concerns with commissioners?<br>- How are you involved in the commissioning process (meetings)? How useful are these?<br>- How does this contribute to the care that users receive?<br>- How does this contribute to sustainability of provision? |
| Local Authority Approach | How would you describe the strengths and weaknesses of your LA's approach to commissioning?<br>What difference does commissioning make to the services that people receive in your area?<br>- Tell us about any developments (e.g. outcomes-based approach—ask what they mean by an outcomes-based approach)<br>- Impact on staff in care agencies |
| Regulations | Thinking more generally, what impact would you say that legislation/regulatory arrangements have on your service? |
| General comments | Is there anything else you would like to mention or add? |

provider consultation; provider contribution to specifications; and the use of providers who subcontracted services as part of their responsibility for the local authority contract (Davies et al., 2020). Second, 10 local authority commissioners representing different ways of working were approached to participate in interviews. Concurrently, managers of home-care providers from these same 10 local authority areas were invited to take part in the study via an email circulation of members of the United Kingdom Homecare Association (UKHCA). UKHCA is the professional association representing 2000 providers from the for-profit, not-for-profit, voluntary and statutory organisations in the home-care sector in the United Kingdom. As a result, 23 managers from home-care providers

contacted the researchers. Of these 23, one withdrew as they did not have any local authority contracts, one provided services for people with learning disability only and one was a duplicate response. Each prospective participant received a study information leaflet explaining the purpose of the research, and an interview time was agreed directly with the manager.

## 2.3 | Data collection

Topic guides for semi-structured interviews were designed (Table 1) by the research team based on previous literature and knowledge of

the sector. These were trialled as part of two pilot interviews with home-care provider managers and changes made to the content and wording of the interview questions in response to their feedback. The questions were open-ended, offering opportunity for interviewees to elaborate and explain their observations and experiences (Breakwell, 2006). Topic guides were designed to focus on managers' experience of local authority commissioning and did not directly probe experience of working with individuals using personal budgets in the form of direct payments. Each interview took 40–60 min to complete. They were audio recorded, transcribed and coded using ATLAS.Ti 7.5 software. The study conformed to ethical guidelines for telephone interviewing with informed consent gained verbally over the phone. This was then recorded formally on a consent form by the interviewer.

## 2.4 | Data analysis

A detailed thematic analysis of the interview transcripts was completed by two researchers (KD ED). Initially, the analysis was conducted independently by each researcher and then codes and themes were agreed following discussion with the research team.

Each researcher adopted a six-phase process to ensure the analysis was conducted systematically (Braun & Clark, 2006). The phases involved familiarisation with the interviews by reading and re-reading the transcripts, generating codes to record summary features, identifying salient themes to categorise codes, reviewing the themes with the research team and an adviser from the provider association, defining the themes and interpreting findings according to relationships evident between the themes.

## 3 | Findings

Twenty home-care managers operating in a wide variety of arrangements contacted the research team to take part in the study (Table 2). Participants were recruited from each local authority targeted and predominantly represented small- and medium-sized for-profit providers ($n = 16$). Respondents represented both urban and rural localities. The majority operated in one local authority area but several had experience of commissioning with neighbouring authorities. Interviews took place between August and October 2018.

**TABLE 2** Characteristics of the for-profit providers as described in their interviews

| | Size of for-profit providers | Staff numbers (at the time of interview) | Operating as a franchise | Type of service delivered | Providers' description of main contract type |
|---|---|---|---|---|---|
| P1 | Small–medium | 35 | No | Domiciliary | Trusted provider |
| P2 | Small | 20 | Yes | Re-ablement | Spot |
| P3 | Small–medium | 101 | No | [a] | Complex range |
| P4 | Small–medium | 100 | [a] | Domiciliary | Dynamic purchase system framework |
| P5 | Small–medium | 58 | No | Health and social care | Unspecified |
| P6 | Small–medium | 109 | Yes | Domiciliary | Spot |
| P7 | Small | 40 | [a] | Domiciliary | Spot and framework |
| P8 | Small | 80 | [a] | Domiciliary | Framework/second-tier provider |
| P9 | Small | 25 | No | Domiciliary | Spot |
| P10 | Large | 170 | Yes | Health and social care | Framework/lead provider |
| P11 | Small | 40 | Yes | Health and social care | Spot second tier |
| P12 | Small | 80 | No | Domiciliary | Framework and spot |
| P13 | Large | 2,500 | Yes | Domiciliary | Trusted provider framework and spot |
| P14 | Small | 20 | No | Health and social care | Dynamic purchase system framework |
| P15 | Small | 60 | No | Domiciliary | Framework |
| P16 | Large | 200 | [a] | Domiciliary | [a] |
| P17 | Large | 170 | Yes | Domiciliary | Framework/preferred provider |
| P18 | Small–medium | 150 | Yes | Domiciliary | Framework |
| P19 | Small–medium | 55 | Yes | Health and Social care | Spot |
| P20 | Small–medium | 60 | Yes | Health and Social care | Spot |

[a]Missing data.

**TABLE 3** Summary of themes

| Main theme | Subthemes |
| --- | --- |
| Theme 1: The relationship between providers and commissioners ranges from contractual to collaborative | (i) Distant or trusting relationships<br>(ii) Shared responsibilities |
| Theme 2: The motivations and values of home-care providers | (i) Motivation: driven by altruistic imperatives or business imperatives<br>(ii) Valuing the care role and staff delivering home care |
| Theme 3: Commissioning practices are complex to negotiate | (i) Contracting arrangements were complex and time-consuming to set up<br>(ii) Operating competitively while also collaborating with other stakeholders |
| Theme 4: Frequent changes in commissioning practices contribute to uncertainty and tension | (i) Uncertainty and risk for home-care providers<br>(ii) Uncertainty and confusion for service users |

## 3.1 | Providers' perspectives of commissioning

Four themes were identified during the data analysis (Table 3). Themes 1 and 2 describe the interface between home-care providers (hereafter referred to as 'providers') and commissioners, and providers' motivation and values. Themes 3 and 4 report the providers' experiences of commissioning arrangements. Each theme is presented together with illustrative quotations from the interviews with home-care provider managers. Managers are denoted as P1-20 in the text.

## 3.2 | Theme 1: The relationship between providers and commissioners ranges from contractual to collaborative

(i) Distant or trusting relationships

Providers described their relationship with commissioners as critical to effective provision of care. They conveyed their experience of working with commissioners as relatively distant or trusting, frequently giving examples of how the presence or absence of good relationships affected service users. Those relationships that were presented as good were characterised by the way providers were actively involved in reviewing care plans, reassessing needs and adjusting care. As P10 asserted in respect of individual service users, *'a more inclusive relationship with the assessment and the ongoing review of that service (by the provider), from the start of that care journey to the end of it'* could help adjust the emphasis of care away from crisis management towards the prevention of emergencies. Occasionally, there were examples of well-established collaborative relationships with the commissioner that supported quality in service delivery:

> They (commissioners) have always been very collaborative both with the provider individually and with

providers as a group.....that helps with the standardisation of care delivery and it helps with the standardisation of best practice. P1

More frequently providers' discourse expressed frustration with limited collaboration with commissioners, characterised as a distant relationship. Providers associated this with difficulties such as delays in instigating home care for service users, late payment of providers' invoices and changeable care arrangements. At times, providers implied that their trust was undermined by a lack of understanding, apparently unexplained actions by commissioners and slow processes within the local authority. Although providers expressed an understanding of the difficulties that commissioners faced regarding financial constraints, their interactions with them had left some providers as perceiving collaboration as tokenistic, and feeling undervalued or even marginalised:

> It's like they don't care. You write to them, no response. The job you do for them, they don't pay you. So the way I see them is like they are trying to just run you out of business, even though you are within the borough. P

(ii) Shared responsibility

A minority of providers reported relationships that enabled them to feel part of a collaborative partnership with commissioners. These were characterised by a sense of shared responsibility for assessing individual care needs and solving problems. The implications of working more closely with commissioners, and their nominated assessors, such as social workers, were expressed as improving the quality of home care for individual service users. These collaborative relationships were characterised by increased levels of trust between the providers and commissioners, with providers permitted to make amendments to individual care plans and respond to changes in service user needs, without necessarily having to seek authorisation from commissioners. This was also recognised as improving the timeliness of service provision and ensuring providers felt valued:

> The difference now is we've got everyone in one place, we've got everyone in a hub. So, whereas before, you would phone a social worker, she would be in a totally different area in a different building than, say, the assessor, she would then be in a totally different building than CCG, they would be in a totally different building to what commissioning was, and you just spent all day phoning around. P5

## 3.3 | Theme 2: The motivations and values of home-care providers

(i) Motivations: driven by altruistic or business imperatives

Most interviewees spontaneously referred to altruistic values underpinning their business model, as exemplified by P11, *'You don't do*

*it for the money, you do it for the reward'*. They explained their reasons for setting up businesses in care, referring to personal stories that had motivated their interest in joining the sector. Providers often expressed clearly formulated values that reflected a desire to provide the best care, with examples of business owners and managers who were driven by their experience of people with social care needs, either as experienced carers themselves or influenced by encounters with people in the community who need support

(ii) Valuing the care role and staff delivering home care

Participants referred to the importance of valuing care staff, often regretting the perception of caring jobs as unqualified and unskilled by the public, referred to as '*the general disrespect of the service and the staff'* (P4). The 'low pay/low status' badge was thought to discourage potential applicants to care services and recruitment and retention were taken as a permanent and ongoing challenge for managers. Providers perceived that they were a solitary voice in recognising the demands on their workforce and that care workers' worth was not reflected in the commissioning arrangements, with an inevitable impact on the quality of care for service users. Many providers reported that social care was increasingly involving more complex aspects of healthcare, without this necessarily being recognised by commissioning practices. Providers also underlined that care workers were responsible for delivering care activities that depended on outstanding personal qualities as well as skills developed through frequent training and careful supervision, regretting the fact that care workers were often undervalued:

> Gradually things have been passed down to a social care team….we are now delivering very complex care packages to very vulnerable people….We're dealing with controlled drugs….doing waking nights for people who are end of life, so the responsibility of that role is immense, and we're doing that in somebody's home. P1

### 3.4 | Theme 3: Commissioning practices are complex for providers to negotiate

Provider managers described contracting arrangements as complex and time-consuming to set up and challenged by the tension between operating competitively while also collaborating with other stakeholders in the locality. Many believed the arrangements to provide services were constraining, exerting a negative effect on service users both in terms of tight contract requirements, lack of flexibility and wholesale changes in arrangements

(i) Contracting arrangements were complex and time-consuming to set up

Providers described procedures to gain contracts as lengthy and time-consuming, requiring multiple steps to prepare for and bid for

a contract. They were perceived as focusing excessively on price rather than quality, described as a 'race to the bottom' (P10). In this case the local authority had evaluated the provider as offering good-quality home care but had negotiated a lower price. The provider clearly felt under pressure to reconsider what they could offer, and make adjustments to the contract, potentially compromising the quality of their service:

> But we got a really high score on quality. So they loved the operational practice, the checks that we do, the behaviours, the quality aspects. We were the highest scoring provider. But this local authority then said to us… we really want to work with you guys but the rate that you submitted is higher than we can budget for. P10

Those navigating online systems with technical language and multiple steps in order to submit a tender, incurred costs in chasing and securing contracts with local authorities, '*There's a hell of a lot that went into that to be honest with you.'* P17.

A few providers offered services to several local authority areas which entailed adopting different systems and meeting different expectations with variations in contract types, processes and tariffs. There were examples where systems were awkward to use for providers, lacking transparency and appearing full of 'ifs and buts and maybes' (P14) creating uncertainty for business organisation. For example, a daily process of 'bidding' for individual cases (commissioning at the level of the service user, reflecting a spot contract arrangement) often left providers unable to plan core activities such as schedules for staff. These were time-consuming to oversee and added to costs for providers. Furthermore, the logistics of managing minute-by-minute billing, as practiced by some authorities (but not all) and the implications for paid carers were also raised as an unsustainable practice for a business and their workforce:

> Carers would go in, carry out the intimate personal care, which might take 15 min, for example, and then husband says, 'oh thanks, dear, yeah, you can go now, I don't want you to do anymore', and then…so we would only get paid for 15 min of that…So, it doesn't take a genius to work out that that's not a sustainable model sort of in the long term. P4

There were many different types of contract, such as framework, dynamic frameworks, spot contracts and tiered services. The impact of different contract types on their businesses was rarely discussed and there appeared to no preferences for a specific type of contract. However, providers were keen to have control over the individual cases they accepted to ensure that their business organisation was not compromised and indeed, opt out of cases they deemed were unsuitable for their staff relating to skills and staff configuration. There were examples where the location of visits wasted time for care workers and contributed to inefficient

working practices related to unnecessary travel. Furthermore, managers expressed a desire to have flexibility about the kind of care they provided and how they supported their service users, for example, avoiding 15-min visits, that limited the level of care they could offer:

> If you are a spot provider at least we have the choice, shall we say, of the package that are offered. Once you're on a framework they obviously will offer you the work and they will challenge you if you don't pick up work. P

(ii) Operating competitively while also collaborating with other stakeholders

Competition between providers for clientele in the state-funded sector was not a strong feature in providers' discourse, with their comments suggesting that this focussed on a desire to be the best in the area, to stand out in terms of reputation and client recommendations, rather than competing between each other for customers. There was also competition between providers for recruiting and retaining staff, with most providers mentioning incentives and benefits that they believed helped them maintain their workforce. In spite of their efforts to retain staff, providers observed that staff would look for better opportunities with other care companies, described as 'job hopping', or indeed leaving the care sector for less stressful employment in other settings. Competition between providers contributed to setting boundaries about the way individual businesses operated to gain the best market position.

> There's collaboration in terms of shared ideas or shared concerns, blah de blah. In the field of practice there's… it's quite…you know, I'm not going to tell them what we're doing, I'm not going to tell them what we're paying because we're all after the same staff. P4

## 3.5 | Theme 4: Frequent changes in commissioning practices contribute to uncertainty and tension

The data showed that providers experienced changes in strategic commissioning that they considered threatened their sustainability. Discussions referred to changes in processes to gain contracts, uncertainties about workflow and inconsistency in local authority decision-making, often seen as linked to limited planning and leadership

(i) Uncertainty and risks for home-care providers

Providers gave many examples of significant changes in contract arrangements involving wholesale reorganisation of commissioning arrangements. Frequently, providers reported that these appeared to lack direction, purpose or clarity, and were viewed as jeopardising

the stability of provision both for their own business and the care provided to service users. On occasions these changes were welcomed by providers, but largely they came with costs, for example, impacting on providers' time in responding to service users who were distressed about changes.

Occasionally there were examples of arrangements that were considered impossible to work with, for instance, one local authority had appointed a preferred supplier who was then subcontracting to smaller agencies, using the incentive of 'selling' opportunities for private work. The provider manager considered this as 'bizarre' and unsustainable for maintaining their business:

> What he did say was that if any private work came up, they would sell packages to people who wanted that private work. P19

Some providers concluded that commissioning lacked a clear strategic pathway in their local authority, observing first, a lack of forward planning in formulating and implementing new models of commissioning, second, limited operational expertise and third, inconsistency of staff managing the commissioning. One provider suggested that long-term planning had been absent for many years, '*I think it was quite possibly lack of forward planning over a considerable period of years*' (P14). Others observed that limited strategic planning was exacerbated by the financial constraints that local authorities now faced, as '*they've been backed into such a tight corner that they kind of lose sight of the bigger picture*' (P16).

Another provider linked the lack of direction to society's attitude to social care, wherein society had accepted a 'reactive' approach to home care rather than a proactive outlook that could enable funding, planning and delivery of care to be more carefully aligned:

> I've seen such a transition over 28 years, it's unbelievable… we're being reactive to rather than proactive and social care really needs a good look at it and somebody needs to make a decision that this is how it needs to be delivered, planned, and funded. P12

There were suggestions that the motives of commissioners in making changes were only financially and politically driven, but the majority of providers recognised that this was pervasive and unavoidable in the current circumstances. However, there was an assumption that this could not lead to genuine savings longer term as failure to implement new models of care or systems was endemic across the sector:

> The model they're using has been used in other parts of the UK and it's failed every time. I think the selling point for the Council was it's cheaper. It's cheaper for them to run it that way. P8

Managing uncertainty created additional costs for businesses, not only financial costs, but also in terms of human resources and personal costs. They described using various methods to alleviate the costs, such as resourcing in-house training, rather than paying for external

trainers. The market was so tight for one provider that they had struggled to make the business viable and were accepting considerable personal costs, in reducing their own salaries drawn from the business.

(ii) Uncertainty and confusion for service users

The implications of uncertainties and delays thought to be related to the lack of strategic leadership by commissioners permeated the system, primarily affecting the quality of care for service users, as illustrated by P2, referring to a recent example, *'It's a very, very long process…It has a massive impact…because of all that wasn't set up correctly that client is now back in hospital'*. Occasional examples were also cited involving changes in contracting arrangements instigated by strategic commissioners, in which contracts were changed or terminated without considering the operational impact on service users. Distressed service users looked to providers to resolve the confusion and offer reassurance, creating unplanned, and potentially unfunded, work for home care businesses:

> So we had a lot of work to do with our distressed clients. They didn't want to lose the staff. They didn't want to lose the organisation. So it's a whole chunk of work in my opinion that didn't need to happen. It doesn't advantage the client, it disrupts the client, it gives them huge concerns. P18

# 4 | DISCUSSION

This paper documents the challenges and issues of home-care providers operating in a market model with local authorities in the English system of commissioning home care for older people. Their perspective gave a unique opportunity to investigate how the delivery of home care for older people is influenced by commissioning practices. The findings revealed three salient features of providers' experience. First, quality of service delivery depended on the type of contracting relationship with commissioners. The contracting relationship between commissioner and provider was mainly considered a distant and transactional arrangement by most providers, with relatively few describing a collaborative relationship involving working collectively to solve problems of service delivery. Second, home-care providers' experience was shaped by their part in a complex system, involving multiple contributors, from professionals assessing home care users with complex needs through to administrators managing contracts. The involvement of different professions, teams and organisations leads to a slow and unresponsive system for those delivering day-to-day care. As the steps in the system may not be very clearly defined and change in response to many factors, this adversely affected both home care users and providers. Third, the findings revealed that providers' attitude in this study to delivering commissioned services was motivated by a desire to provide the best care, underpinned by the values of compassion. However, providers felt their values could

be undermined by commissioning practice that focused predominantly on costs, demanding that providers compromised and readjusted their own practice in response to changes and constraints imposed by the commissioning context. This was considered to have a particular impact on developing the workforce in the care sector, with implications for recruitment and retention and the status of care workers.

## 4.1 | The contracting relationship: distant, transactional contract or collaborative, problem-solving partnership

The introduction of a market model for the delivery of public services such as home care was intended to improve efficiency and cost-effectiveness (Knapp et al., 2001). Relationships between those undertaking planning, procuring, delivering and receiving care were expected to replicate a market system. It was evident that while the terminology used by providers reflected this, there were a variety of concepts employed with little evidence of a consistency in their use. Analysis of the authority-specific interpretations of contracting was beyond the scope of this study. Rather, the conceptual framework of principal–agent theory (Van Slyke, 2006) has been employed to explore some of the overarching features of the contractual relationship between provider and commissioner. It is assumed that in a contracting relationship, agents (in this case providers) will readily exploit arrangements to their advantage, such that principals (local authorities, the strategic commissioners) need to use burdensome monitoring to maintain oversight of detailed contracts. The relationship between commissioners and providers in a US context evolved over time, changing from a principal–agent to a principal–steward model in the context of non-profit care organisations (Van Slyke, 2006). This is also evident in the current study with regard to commissioning arrangements for individual service users in the English context employing for-profit home-care providers. There were examples of providers moving towards collaboration, characterised by providers being trusted to assess individual needs, and alter care arrangements. However, changing to a principal–steward relationship was not universally reported. Many providers struggled with the contractual arrangements at the level of strategic commissioning, often referring to prescriptive service specifications, such as stipulating brief visits, or perceiving that hidden costs of delivering home care were constantly transferred to them. At the level of the individual and strategically, the role of commissioners operating in a market as a consumer and broker for older people with care needs has been difficult to establish as part of trusting co-working partnership (Rodrigues & Glendinning, 2015). Providers find it hard to see commissioners proactively operating as market managers, as indicated in previous literature (Jasper et al., 2019; Rubery et al., 2013), suggesting that commissioners may find this role difficult to understand and integrate with their own conception of monitoring service delivery.

## 4.2 | Home-care providers operate in complex and confusing contracting arrangements with local authority commissioners

Previous studies report complex arrangements in strategic service commissioning, poorly understood in wider society (Bottery et al., 2018), but intended to improve provision. However, these are frequently associated with additional costs and limitations (Rodrigues & Glendinning, 2015). At the level of the individual, the introduction of policy-driven initiatives, such as personal budgets, has proven unpopular with older service users, such that local authorities, as commissioners, may have to be seen as encouraging new approaches while remaining the primary purchaser of home care at an operational level (Wilberforce et al., 2011). More widely, the 'general bewilderment at the social care system' reported by the public (Bottery et al., 2018) is exemplified in the descriptions of complex and changeable contracting arrangements in this study. Throughout the interviews there was a narrative of balancing complex demands and arrangements, in gaining and keeping contracts, fulfilling commissioner and service-user expectations, overseeing the workforce and managing finances. Furthermore, business security was frequently cited as a source of anxiety, with home-care managers acutely aware of the budget constraints that local authorities experienced and how these potentially threatened their own business (Angel, 2018).

Ongoing changes in how home care is sourced and purchased has stimulated a wide array of arrangements for provision (Glendinning, 2012). Revisions for strategic commissioning, set out by the Department for Health (2017), extends the role of local authorities, but continues to expect providers and commissioners to operate in a market model. The turnover in providers is thought to be related to financial pressures and changes in contracting practices (Glendinning, 2012). The results of this study suggest that operating social care simply as a market cannot meet growing demands for home care. Contracting has not provided the answer to the problem of funding home care. Radical alternatives may be necessary but may not be feasible within a typical market model (Bottery et al., 2018). The powerful narrative of a tense and uncertain relationship between providers and commissioners in this study does not support the notion of a principal–agent relationship typical of a market model. The evidence suggests that a more appropriate explanatory model for the social care sector may be one employing principal–steward relationships.

## 4.3 | Motivations and values determining service delivery

For-profit home-care providers in the study expressed altruistic values in delivering services suggesting that more could be achieved by encouraging shared goals, usually considered as public service motivation, in contrast to competition and choice driving service delivery. This is not predicted by the conceptual framework of principal–agent theory, which assumes agents exploit their position as providers, for their own gain. However, the revised conceptual model of principal–steward (Van Slyke, 2006) theorises that motivation for both the principal and steward is determined by shared goals. In this case, the goal of delivering good-quality home care represents an aspiration for both providers and commissioners.

In the current model of care, home-care providers are responsible for improving quality for service users and championing good terms and conditions for paid carers, whether stimulated by commissioners' specifications or determined independently from contracting demands. While providers expressed a practical drive to ensure the system of delivering home care works efficiently, there was also a powerful narrative of endeavouring to make a difference, to contribute to society. They cited values, such as compassionate care for vulnerable people and respecting staff who deliver care. Accounts were often linked to accepting additional costs for the business, tolerating uncertainty and enduring personal burdens in order to provide care. In the context of complicated systems and intractable problems of providing sufficient high-quality home care, providers, as non-statutory for-profit providers, expressed a strong sense of public service motivation in spite of working in a market model of contracting. Indeed, at times they found they were championing the needs of clients in a context where commissioners appeared to be dominated by the principles of value for money rather than public service motivation. The presence of public service motivation in private companies, as reported by managers in this study, indicates a predisposition to work collectively for the benefit of service users. Such motivation may be instrumental to achieving personalised care and supporting the shift from 'time and task' activities to outcome-focused care. The prominence of such values suggests there is room for a balancing, or indeed a rebalancing, of priorities in the delivery of home care, focusing more fully on individual needs, and reducing the prominence of efficiency and cost-effectiveness as key drivers (Denhardt & Denhardt, 2015).

Scandinavian countries have sought in recent years to capitalise on public service motivation in their care workforce by professionalising the carer role (Moberg, Blomqvist, & Winblad, 2018). In doing so, care workers can achieve greater personal development, autonomy and control over work tasks (Abbott, 1988; APPG for Social Care, 2019; Evetts, 1999). This is consistent with the assumptions of stewardship theory, that increasing responsibility and thus motivation leads to higher levels of performance as well as satisfaction with work (Van Slyke, 2006). There is conflicting evidence as to whether auditing and other bureaucratic-laden processes are detrimental to professionalisation (Moberg et al., 2018). The evidence from this study indicates that commissioning arrangements compound the devaluing of the care worker role in England. This was not described as a deliberate ploy, but an inevitable consequence of contract specifications focused on driving costs down and working within a dwindling budget. It echoes previous research which has reported low budgets decreasing provider ability to offer employees attractive terms and conditions, inevitably impacting upon quality (Netten, Jones, & Sandhu, 2007; Netten, Williams, & Darton, 2005).

Providers valued the home care worker role and expressed concern that the role was generally undervalued. This was considered as a barrier to recruitment and retention. Moreover, they believed that valuing the care role, and indeed professionalisation of the role, may act as a buffer to staff turnover; and recent evidence has reported that for care workers who held a relevant social care qualification, lower turnover was prevalent in comparison to those who did not (Skills for Care, 2018).

This paper has presented new insights into home-care providers' perspectives of operating in a commissioning model. It has drawn on a rich data set generated through in-depth interviews with managers of home-care provider businesses. There are, however, possible limitations in the study. First, providers were selected in specific localities through a partnership between the research team and UKHCA. This was based on the profile of local authorities identified from a national survey. Localities were excluded if they had not responded to it. Home-care providers who were not the members of UKHCA were therefore excluded. Not-for-profit and voluntary providers were not represented among those who volunteered to take part and it may be that this reflects the particular composition of providers contracting with local authorities in the chosen localities rather than differences in willingness to participate. Those who participated in the study were self-selecting as volunteers and willing to be interviewed. This may have excluded those struggling to maintain successful contracts with local authorities. While this is important in learning from the findings, investigating the experience of poorly performing businesses would demand a different study design. The second limitation concerns the limited information regarding the stage of the contracting process home-care providers were in, potentially restricting the interpretation of the implications of contract arrangements. Third, issues of social desirability bias, whereby interviewees may respond in ways that reflect well on themselves and their organisations, need to be considered in interpreting the findings. This was partly mitigated by probing interviewees and interpretation of the findings, together with assuring anonymity in the reporting of findings. Finally, in adopting the principal–steward conceptual model, originally based on relationships with non-profit care organisations, there may be limitations for interpreting the way commissioning operates with for-profit businesses. Nevertheless, the study revealed considerable detail and depth from providers' involvement as commissioning partners, which can be usefully considered alongside the perspectives of commissioners in a companion paper (redacted).

## 5 | CONCLUSION

Non-statutory providers now play an essential role in the provision of home care in England, managed through complex contracting arrangements that tend to be rigid and inflexible. This paper presents evidence from the providers' perspective revealing a consensus that the commissioning process is difficult to navigate, restrictive and time-consuming. Where the relationship between providers and commissioners has changed and operates as a collaborative partnership, commissioning practice tends to focus on developing services rather than delivering rigid contracts. The findings from this study, together with the suppositions from principal–steward theory, should motivate policy-makers to reconsider the merits of tightly prescribed, closed contracts for commissioning home care. Adopting a more open contract, together with encouraging a relational approach nurturing the intrinsic motivation of providers, appears to be pivotal to effective commissioning in the future. This could afford opportunities to find jointly agreed solutions to intractable challenges, such as commissioning for outcomes and recruiting care workers. To develop a relational approach, commissioners and providers will need to find ways to overcome the restrictions of a market model and develop a clearer understanding of the hallmarks of a trusting, collaborative partnership.

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