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Abstract

The Care Act 2014 allows eligible people with care and support needs to access funding directly from local authorities in England. Such funds may be used to employ care workers. Others may employ care workers using their own or family resources. This study explores the working-relationships, views and experiences of GPs about older people's directly-employed-care workers (DECWs). Qualitative interviews were conducted with 20 GPs in England, identified by convenience sampling of research-networks and snowballing methods. Data were analysed thematically. Three overarching themes were identified: 1) anxieties about the identity of the DECW, and their relationship to their employer; 2) experiences of relationship-based care, and; 3) tasks carried out by DECWs. Identity mattered because DECWs can appear as an unknown participant in consultations, raising questions about consent, and prompting thoughts about elder abuse. Uncertainty about identity made documentation of DECWs' details in electronic medical records and care plans problematic. Case examples of relational care illustrated the benefits of reciprocity between older person and their employee who sometimes provided continuity of care and care co-ordination for their employer. Participants were alert to the risks of exploitation and insecurity for DECWs whose tasks were thought to span household and personal care, transport assistance and health-related activities. The involvement of DECWs in maintaining older people's health raises questions about the support they receive from health professionals. In conclusion DECWs are well placed to monitor older people's health, provide continuity of care and undertake certain health-care tasks. GPs envisaged such workers as potentially valuable assets in community-based-care for an ageing population. They called for skills-training for this workforce and the development of protocols for delegation of health-tasks and safeguarding of vulnerable older people. Older people employing care workers and

those advising or supporting them should address communications with health providers in employment-contracts and job-descriptions.

Keywords: personal assistants, general practitioners, older people, consumer-directed care, direct payments

What is known about this topic

- The Care Act 2014 allows eligible people with care and support needs to access funding directly from local authorities in England. Such funds may be used to employ care workers. Others may employ care workers using their own or family resources.
- Despite research on older people's use of direct-payments little is known about the implications of an expanding directly-employed care workforce.
- To date no studies have investigated General Practitioners' knowledge of care workers directly-employed by older people and their working-relationships with these individuals.

What this paper adds

- Directly-employed care workers are a potentially valuable asset in community-based care for an ageing population and are well placed to monitor older people's health, provide continuity of care and undertake certain health-care tasks (with support).
- Skills training for this workforce and the development of protocols for delegation of health-tasks and safeguarding of vulnerable older people are recommended.
- Those employing care workers and those advising or supporting them should address communications with health providers in workers' employment contracts and job descriptions.

Keywords: primary-care, general practitioners, older people, consumer-directed care, direct payments

MAIN TEXT FILE

Under the radar: General practitioners' experiences of directly-employed care workers for older people

Background

In England and internationally there are policy moves to encourage (FitzGerald Murphy and Kelly 2019; Gill et al 2018; Christensen and Pilling 2014) older people to exercise choice over care. A strong theme in England is to facilitate their employment of care workers directly, either by self-funding or using a personal budget from their local authority. The Care Act 2014 set out government's plans for care and support designed to promote wellbeing and independence. All adults eligible for publicly funded adult social care in England must be offered a personal budget under the Act. A personal budget can be managed by the local authority, held in an account by a third party or given as a direct-payment. Those wishing to employ care workers using a direct-payment are informed of their rights, legal obligations and responsibilities as employers by the local authority.

There is considerable scope for people to use their budget creatively in employing whom they wish (including family members) and setting out how they wish their needs to be met. These care workers may be employed for short periods of time, irregularly, or work full-time, in a team, or to supplement family care. As with other care workers in England, they are not registered or regulated. Some are self-employed and responsible for paying their own income tax and insurance. In 2017, around 240,000 adults, older people and carers received direct-payments; Skills for Care (2018) estimates that around 70,000 of these employ staff directly, with, on average, each person employing two staff. These figures do not include self-funders who employ care workers using their own resources.

While the introduction of direct-payments has highlighted the development of a new workforce (Manthorpe et al 2011), many older people also use their own resources (or those of their family) to employ directly. These self-funders may not be entitled to personal budgets because their needs do not meet the eligibility criteria for publicly-funded care, or because, in the case of adults living at home in England, their annual income and capital (excluding their home) exceeds £23,250. There has been some research on this group (Skills for Care 2013; Baxter & Glendinning 2015) but no study has examined self-funders' employee relationships from a primary-care perspective. Neither has there been much focus on those with direct-payments, meaning little is known about the implications of an expanding directly-employed care workforce for health-services. In particular, GPs have very variable understanding of adult social care (Mangan, Miller, and Ward 2015), so may not be aware of such developments, which are below their radar. The consequences of this are that significant sources of support may be overlooked by the GP, along with potential risks to older people. There is no guidance about managing working-relationships between directly-employed care workers (DECWs) and NHS staff. This exploratory study reports on the experiences of and views about directly-employed care workers among a sample of GPs in England.

Methods

Members of the User and Carer Advisory Group of the (research unit anonymised) helped shape the study's research questions and methods, its management (including interpretation of findings) and plans for dissemination. Ethical approvals from (Anonymised) were gained (Ref. HR-18/19-8771). A safeguarding protocol was developed should any concerns arise in the course of the interviews. A Project Advisory Group, with experts on social care, workforce, primary-care and gerontology, reviewed the study's methods and debated emerging findings.

A convenience sample of 20 GPs from urban and semi-urban English practices was recruited using snowballing techniques, within a sampling frame which included: affluent retirement areas with high proportions of older people; mixed inner-city areas with pockets of high unemployment and high migration; smaller towns/rural areas; and years of in-practice experience.

Participants were invited by letter or e-mail to take part in an interview and sent a study information sheet. Expressions of interest were followed-up by telephone or e-mail by the researcher (XX). The most cited reason for non-participation was lack of experience or knowledge of personal budgets or people who directly employed home care workers. We recorded age, gender and ethnicity to ensure maximum diversity of the sample.

Most interviews were undertaken face-to-face to capture depth of meaning and gain insight and understanding (Ritchie & Lewis 2003). Written consent was taken from participants. A semi-structured, conversational style interview schedule was developed, informed by experiences Manthorpe & Hindes (2010) and of Woolham et al's key studies (2013; 2015; 2017; 2019), as well as Advisory Groups' comments. The schedule was modified to incorporate new themes identified as the interviews progressed. We followed Patton's (2015) recommendations that questions should be neutral, clear and sensitive to the participant. Prompts were used to aid discussion, including hypothetical scenarios about the duty of care, 'ideal world' care co-ordination, communication and information sharing, or actual (anonymised) examples of overlap, misunderstanding, conflict and dilemmas, and their resolution.

Interviews took place in 2018-19 and were audio-recorded and transcribed verbatim. Field-notes were made directly after each interview to record non-verbal and contextual information. Using principles from theoretical sampling (Guest et al., 2006), we interviewed until data saturation was achieved. Transcripts were read and themes identified by the

research team which included a former GP, former nurse, former care worker employer, and gerontologists.

Analysis

Data transcripts were analysed using a detailed thematic approach, which lends itself to drawing comparisons between groups and with existing evidence (Braun & Clarke 2006). Once data was thematically-coded, extracts were collated and then checked by two research team members (XX & XX). The codes were then organised into broader themes and sub-themes. An inductive (data-driven) approach to analysis was taken, linking themes to the data. Themes were then reviewed by re-examining corresponding extracts, and checking for disconfirming evidence with un-coded, outlying data. An iterative process was followed, whereby the transcripts were revisited throughout the process of coding, theme allocation and written presentation to check each stage of the process.

Findings

Twenty interviews were undertaken, 14 face-to-face and six via telephone. Most participants were women (N=15), participants were of mixed ethnicity (White, N=13; Asian-British, N=4; Asian-Indian, N=3). There was a spread of years of experience in practice from less than five years (N=2), five-to-seven years (N=7), 11-to-20 years (N=3) and 20-years or more (N=8) and with associated age. Most were either GP partners (N=10) or salaried (N=6), the remainder being Registrars or Locums (N=4) and worked part-time (N=17). They were from practices in which the percentage of patients aged 65 and over ranged from 3.8% to 21.8% (average for England 17.3%), whose deprivation scores ranged from 10.2 to 35.7 (average for England 21.8) and whose percentages of income-deprived older people ranged from 11.6% to 40.4% (average for England 16.2%) (Public Health England National General Practice Profiles 2019). Table 2 shows the demographics and practice profiles of GP participants.

The GPs interviewed had a limited understanding of social care funding, and how the means-test and eligibility criteria operated. However, many were able to describe encounters with directly-employed care workers. Three overarching themes were identified: 1) anxieties about the identity of directly-employed care workers and their relationship to their employer; 2) experiences of relationship-based care, and; 3) tasks carried out by directly-employed care workers. Table 1 shows sub-themes within the three overarching themes.

Table 1 Over-arching and sub-themes of the data

Over-arching themes	Identity of Directly-employed Care Workers	Experiences of relational care	Tasks carried out
Subthemes	Knowledge of social care funding	Symbiotic relationships (reciprocity)	Domestic and personal care
	Anxieties about identity	Exploitation and insecurity	Transport
	The unknown person	Substituting for family	Reactivity to health changes
	Safeguarding		Pro-active care co-ordination
	Documenting encounters		

Knowledge of social care funding

Among many interviewed their knowledge about access to publicly funded social care had been derived from patients rather than local government agencies:

“What I hear.... from my patients, is that the social care is dependent on the income and their assets I believe, how much they can afford, and whether they get a paid care (worker) from social services or whether they have to self-fund it themselves”. (GP01)

Despite the availability of direct-payments since 1997 in England, this part of the social care system appeared a mystery to some:

"I can think of one person in our practice who has one of these budgets that they use to employ someone. Again, I'm not very involved with it, but when the paperwork came in for us to fill in, it first came under my nose but I passed it to someone else because they see this other person more...Something came in, but I don't know what it was, and I don't know who it was from, but there was something we were supposed to fill in". (GP14)

Knowledge of employing care workers was more frequently encountered by GPs whose older patients had substantial resources:

"I work in quite an affluent (area), so it's not uncommon when people are really very frail, to actually have privately paid, quite often live-in, carers who they pay for themselves". (GP12)

However, for others there was an acknowledged lack of documentation of care workers and awareness of funding arrangements:

"...which is why I suspect there's probably more patients that do have them (DECWs) but we don't... you wouldn't know about because actually, if sometimes the carer calls and sometimes a relative calls and sometimes the patient calls, there's no obvious place in the notes, it's not going to be an entry from social services saying they've organised a carer or anything like that.....". (GP19)

Anxieties about identity

Not surprisingly, questions sometimes arose when the care worker appeared as an unknown participant in consultations, prompting thoughts about trust, consent and safeguarding:

"I don't know where they (care worker) come from but they are here with the patient, so I guess the patient trusts them, but we don't generally have the time to ask further about that.....the patient takes them with them into the consultation, so obviously the patient has given consent. If the patient doesn't want them to come in, they would ask them to wait in the waiting room outside. That happens sometimes but I'm always assuming, I'm not going to ask for consent because, if they come together, then it's implied, isn't it?" (GP01)

Nonetheless, most participants were not driven by such concerns to make inquiries, and presumed consent and permission were assumed and that it was not the role of the GP to enquire further unless the older person was perceived to be vulnerable:

"I suspect probably the view that you go in there with is (that) unless there's an immediate problem, you probably don't dig around in that relationship, who's there, who they are. The assumption is if the patient is there with that person and they seem to be happy and be looked after then that's okay. I mean you potentially could dig around but is it your responsibility? Do you have even any right to start digging around? If you feel that somebody is vulnerable, then that crosses that boundary....". (GP09)

Among those who provided examples where the older person was not able to make a decision themselves, some thought there was no duty of care to establish the identity of the unknown person:

“I guess it depends on the vulnerability of the individual person and the individual patient..... If there are problems coming up with whatever they’re worried, the family is worried that the care worker steals or neglects them, then certainly then it becomes a safeguarding issue”. (GP01)

However, some concerns were so great that they had engaged with the local authority, whose responsibilities for adult safeguarding appeared to be widely understood:

“In one instance I had a person who allegedly said that she was asked by the (directly-employed) carer to buy a car for her brother who lived in [another country], and she felt quite intimidated that unless she coughed up the money for the car, she will not carry on offering her service. That particular case was then reported to the adult safeguarding, and then one thing led-to-another and the investigation started and the police got involved”. (GP04)

Documenting encounters with the directly-employed care worker

A small minority of GPs reported that they would generally have a record of a patient’s family carer, sometimes of care workers, but that this was not always easy to maintain in the electronic patient medical record system:

“We try to (formally record who the carers may be). It’s in the system, it’s always slightly annoying that it’s not always up-to-date or the right person. Paid carers, I think we would have it recorded where they were the full-time carer. But because there’s a bit of a turnover, sometimes it’s just in free-text in the notes. So it’s not always easy to find....” (GP12)

More common were views that knowing more about a care worker might be helpful but was not part of general information seeking:

“We generally don’t tend to ask too many questions, if someone knows about the patient and calls on their behalf and raises concerns, it’s not something we generally ask a lot about..... I guess that [documenting encounters with a directly-employed care workers if this was required] would certainly be what sort of arrangements there are. How often do they come, what do they do, do they stay overnight, when are they there? Is there a routine? it would also be useful to know if this [care worker] can do A, B, C and D, can they drive, do they have a car, can they drive the patient around? Are they able to administer medication? What about personal care, are they

able to help with the personal care? Obviously recognising the early warning signs [of deterioration] is important". (GP01)

Some situations were complicated where the needs of the patient are met by a patchwork of informal and formal care:

"We've got one patient who is very complicated who her daughter does a lot... they have a real mix of carers, her daughter does a lot of care, they obviously get... they have carers paid for by social services, NHS as well, but they also privately-fund private carers in addition to that to meet the gap because the family are keen for the patient to remain at home, and she's completely dependent". (GP19)

Documenting information about remuneration or relationships appeared over-intrusive to some and some erroneously thought that such workers would have been checked for any criminal record:

"I do think they probably have to have (a check for any criminal record) but I do think they have to have that check, there's no doubt about that and that's quicker than it used to be in my experience ...". (GP11)

Money was identified as a particularly difficult topic. Some GPs felt that asking about funding could be interpreted as checking up on tax and employment permissions, or whether the patient was meeting their employment obligations:

"I don't know that I do think (payment) has to be recorded because that's tricky and there are lots of people working under the radar, and lots of people doing lots of jobs, and rates of pay are dreadful for people who are on low pay. My thought was more not to protect the state from whether it was getting tax or not, but it's more about whether these people are being exploited ... It's all about having things open enough for people to say something if they're being exploited". (GP11)

Relational care

Some directly-employed care workers seemed to be substituting for family members:

"... a lady that is fairly elderly, has been living independently but has just got the very beginnings of dementia. Her neighbour, who is a retired gentleman, whose own mother died about a year ago, has naturally ended up looking in on her. The family I think have helped her formalise that, make it -what am I trying to say - just make it a proper arrangement really with the finances. She's actually paying for him to come in once a day. (The family) live a long way away, and I know that they talk to him regularly and he is very reassured of the fact that he can ring them and they would come down if necessary". (GP16)

In such cases it seemed to the GPs that reciprocal benefits were underpinned by symbiotic relations. Dysfunctional relationships were also memorable, and exploitation and insecurity were problems that some GPs had encountered.

One symbiotic relationship was that of a migrant in an 'employment' relationship which was portrayed as reciprocal rather than exploitative:

"...an Eastern European lady lived for a long period of time with a very, very elderly lady in her late '90s, and basically she's provided her with a room for free and for that her previous cleaner has helped her with tasks and helped her to keep the flat clean and help her with shopping. That was not really even a payment that has gone back and forth, it's more like a mutual arrangement ...when she originally came from Eastern Europe her English wasn't very good at all, and because ... the patient was an English native speaker, she was able to communicate with her and pick up a bit of language too, plus it's a secure place to live. It did work and she lived there for about five-or-six years with the lady until she [patient] passed away". (GP01)

The blurring of employment boundaries was complicated by care workers who had more than one source of employment (as is common among directly-employed care workers, Skills for Care 2017; Woolham et al 2019) and furthermore if such employment was tied to accommodation:

"...in this area that's quite common, especially having private carers that sometimes they don't have either the training or actually they do have the training and they work at the hospital - but they live-in this person's house. They're kind of renting the accommodation but also providing this help". (GP02)

Among several GPs, there was sympathy for both parties about relationships that might indicate mutual dependency:

"Then issues like sickness and poor performance, because then you've got a whole lot of disciplinary stuff, and if you're not well yourself, the fact that if your carer goes off sick, what are you going to do? On the other side of it, if you're a paid carer, obviously you should have the employment rights of anyone else who's got a job too, but when every older individual becomes an employer, there just needs to be much more efficient, better systems of doing it, and I don't know how that gets managed." (GP14)

Dysfunctional relationships between the care worker and older person were reported and evidently memorable. However, when related to clinical treatment or care access the option of

contacting safeguarding services did not appear to have been followed as it had in the examples of suspected financial abuse:

(We had a person) “who lived in 24/7...who was very destructive. This person felt that they had a say over clinical decisions and was actually questioning and criticising clinical decisions that were actually really entirely appropriate. That then produced a very difficult relationship around, who's the patient? Who's making the decisions? Can this other person, who we're not entirely sure what the relationship is, then question? Actually that carer put in a very substantial complaint about the care for this patient and that was...odd. ... But part of the issue possibly was this was their job and had been their job for a long time and actually suddenly, when the patient died, this person was out of a job”. (GP09)

In other instances of apparent exploitation and insecurity that did not relate to the employer's health or care concerns the GP tended to sympathise with the care worker:

“It's really hard for (DECWs) to be sick, if they're the one person (the patient) is relying on. I had one patient recently who was ... a full-time privately-employed carer for somebody, and who needed gall bladder surgery and wasn't able to find a time she could have it. She couldn't get anybody to cover for her. It emerged she wasn't getting holidays at all. I think she was doing it basically so that she could send money home to her own children”. (GP12)

Tasks/roles undertaken by directly-employed Care Workers

What directly-employed care workers were thought to do depended on their employer's health and the worker's own willingness, skills and experience. The mixture of domestic and health-care-related activities suggested to GPs that they often substituted for family care rather than supplementing it:

“.... because the extended family they want them to be there so they can understand what's going on with the patient and facilitate the management and the follow-up”. (GP02)

If companionship was at one end of the spectrum of activities of directly-employed care workers, pro-active case-co-ordination was at the other:

“.....their role is really critical because they're spending a lot of time with the patient at home and that patient might not have anyone else. I see a lot of elderly patients who don't have family locally and they rely on the carer really, and that carer might be the only person that comes in every day if there's no other friends and neighbours around.” (GP03)

For many GPs their experience of directly-employed care workers was that they could easily provide personal care when needed.

The GPs described how some directly-employed care workers helped their employers with health-related tasks. Such accounts often referred to care workers with a background in health service work:

“In my experience actually, for these kind of wealthy residents who’ve got ... a lot of care needs, they will often employ somebody who is health-trained. So they’ll often be nursing trained from the Philippines or whichever other country. So actually they provide nursing care as well as other kind of care around the house.... I suppose you could potentially delegate [to DECWs] any task that you might otherwise consider delegating to a healthcare assistant,” (GP12)

Some GPs believed that such care workers could relieve primary health-care staff, and provide continuity of care and care co-ordination:

“...she deals with everything. I mean I haven’t asked for that, but certainly this patient had a wheelchair, a stair-lift and everything. I’m sure she had to order the medication and administered it and I’m sure that she does all this for him. Again, I don’t enquire about these sort of relationships because I’m sure that they were paid privately”. (GP01)

The experience of some GPs was that this was not only a matter of possessing health knowledge but the ability of some workers to build a relationship that could ‘make things happen’:

“...she (the directly-employed care worker) sort of made you feel like she was kind of on your side as well. I mean of course she was the patient’s advocate, but she was just like “are you listening? These tablets are really important, so what we’re going to do is blah, blah”. So you’d sort of make a joint contract with everyone in the room”. (GP08)

Discussion

Further integration of social care and personal health budgets (see DHSC and NHS England 2019) and the emphasis on Personal Health Budgets in the NHS Long Term Plan (NHS England 2019), combined with greater numbers of older people funding their own care as local authority resources shrink (Baxter et al 2017), make directly-employed care workers an option that older people may increasingly embrace, whether voluntarily or by default. This

study fills a gap by exploring the interface of primary-care and these new working-relationships in practice.

The general practitioners emphasised the fluidity of the role, with most thought to be substituting for family carers rather than supplementing them. This emphasis on substitution made it easier, perhaps, for GPs to see them as emotionally connected to their employer, reliable and acting in a trusted relationship with its attendant insights. Few GPs seemed to be aware that family members may be paid from personal budgets to provide care. Skills for Care (2017), however, noted that almost half (52%) of directly-employed care workers surveyed in one area were working for a friend or family member. Family and friends in such roles were less likely to: have experience of care work; access training; hold care-related qualifications than those working with whom they had no previous connection as a family member or friend (ibid).

Directly-employed care workers were sometimes seen as advocates (defending-autonomy; raising-concerns), as case managers in possession of detailed knowledge and awareness of change, and as collaborators with GPs “in the best interest” of their employer. Some GPs raised concerns (for both parties) about vulnerability or risk, and older people’s reliance upon unknown people (as noted many erroneously thought that such care workers had to be checked for any criminal record). Care workers were potentially ‘tied’ to accommodation, working without employment protection and at risk of labour exploitation (see Christensen and Manthorpe 2017). GPs described working around the need to gain consent to share information, and used case experience to overcome potential problems with implied consent and safeguarding risks. While confidently asserting that they knew little about local authority entitlements to publicly funded social care, most GPs interviewed were aware of local authority safeguarding procedures and responsibilities.

Strengths and limitations of the study: The interviews enabled participants to describe their experiences and views critically, to acknowledge their general ignorance of care funding and to give some detail of encounters. However, semi-structured interviews can rationalise people's thoughts and decisions, without giving an indication of what they really think or any understanding of how they arrived at their decision; we tried to overcome this by using probing conversational techniques during the interviews. All qualitative analysis is open to individual interpretation (Burnard, 1998). Participants were self-selecting, and there may be different experiences among a different group.

The constant comparative analysis (Strauss & Corbin, 1998) of the interviews allowed exploration of views and experiences raised in previous interviews. The iterative nature and unanticipated findings led to question changes as the interviews progressed. The original topic-guides did not enquire about the needs of the directly-employed health-care workers but through interviews with GPs this became an additional topic.

Comparison with other studies: To the best of the authors' knowledge, this is the first UK study of GPs' perceptions of directly-employed care workers supporting older people. Other studies (e.g. Hamilton et al 2016) have discussed the views of interprofessional teams supporting people with severe and fluctuating mental health problems in receipt of a personal budget. The views and experiences of directly-employed care workers and their disabled employers as explored by Shakespeare et al (2018) did not address relationships with health-care practitioners. A recent interview study of 105 directly-employed care workers (Woolham et al 2019) did ask about their views of undertaking health-care related tasks and whether they would be willing to work on tasks delegated by health professionals or to carry out tasks that a health professional had confirmed they were competent to undertake (e.g. support with PEG feeding) and found substantial interest in such work if remunerated and trained. In jurisdictions where consumer-directed care options are newly emerging, such as Australia (Gill et al 2018), this study's findings suggest the value of early

engagement with primary care professionals to explain the new systems of care and to open channels of communication about their potential impact on health care services and usage.

Implications for research: The article provides insight into system- and individual- level influences on working-relationships between GPs and directly-employed care workers. We describe how GPs generally view them positively, despite not knowing much of the details of these arrangements. This suggests that GPs may be open minded about the potential for such workers to undertake health-care tasks. However, GPs need to face the possibility that they may be the only professional in touch with the older person/employer. Indeed the primary health-care team may see them far more often than local authority staff can do in the present climate of resource constraints. The implications of this need further exploration in respect of duty of care and data sharing.

Implications for practice: Meeting health needs and the support and care for older people in their own homes needs to be tailored, and directly-employed care workers may be one way of addressing this imperative, whilst being respectful of maintaining safeguarding and doctor-patient relationships.

Practical issues such as delegation of health-care tasks and regulation of this workforce have been considered in England, with the former being addressed (NHS England) and the latter not being implemented, unlike in Wales. Plans to use personal health budgets to expand the role of directly-employed care workers may need to acknowledge policy options of delegation and regulation (Authors) and could explore health professionals' duties of care in these new contexts.

GPs' awareness of the trend towards directly-employing care workers could be further harnessed. Primary-care settings may be a very appropriate location for information for both employers and their care workers, together with the display of contact details for agencies that

may help with practical matters such as payroll or insurance, referral pathways for concerns, and information about support groups for directly-employed care workers.

Conclusion

This research provides important information to inform policy and practice in general-practice and to realise the potential of directly-employed care workers to benefit older patients, whilst acknowledging potential risks. Future research should explore the development and uptake of policy and protocols shared with the wider clinical team for supporting people to stay as independent as they wish in their own homes, using personal health or care budgets. Developments in social care funding arrangements may need to consider how information about any new arrangements is communicated to NHS practitioners such as GPs who are often heavily relied upon and trusted by older people.

Table 2 Demographics and Practice profiles of GP participants

Indicator	Period																					England		
		GP 01	GP 02	GP 03	GP 04	GP 05	GP 06	GP 07	GP 08	GP 09	GP 10	GP 11	GP 12	GP 13	GP 14	GP 15	GP 16	GP 17	GP 18	GP 19	GP 20	Value	Lowest	Highest
Gender (M/F)	18/19	F	F	F	M	F	M	M	F	M	F	F	F	F	F	F	F	F	M	F	M	-	-	-
Age band in years	18/19	36-44	36-44	25-35	55-65+	36-44	55-65+	36-44	36-44	55-65+	55-65+	55-65+	45-54	25-35	45-54	36-44	55-65+	45-54	45-54	25-35	55-65+	-	-	-
Title	18/19	Locum	Salaried	Locum	GP partner	GP partner	GP partner	GP partner	Salaried	GP partner	GP partner	Salaried	Salaried	GP registrar	Salaried	Salaried	GP partner	GP partner	GP partner	GP registrar	GP partner	-	-	-
Working full-time or part-time	18/19	Full-time	Part-time	Part-time	Part-time	Part-time	Part-time	Part-time	Full-time	Part-time	Part-time	Part-time	Part-time	Part-time	Full-time	Part-time	Part-time	Part-time	Part-time	Part-time	Part-time	-	-	-
Years in practice	18/19	5-10	<5	5-10	20+	5-10	20+	5-10	5-10	20+	20+	20+	11-20	5-10	20+	5-10	20+	11-20	11-20	<5	20+	-	-	-
% aged 65+ years †	2018	9.30%	14.60%	8.20%	12.70%	11.80%	4.60%	10.10%	9.80%	20.40%	5.60%	9.90%	12.70%	7.60%	3.80%	10.40%	10.40%	21.80%	9.30%	10.20%	11.40%	17.30%	0.00%	89.80%

Indicator	Period																					England		
		GP 01	GP 02	GP 03	GP 04	GP 05	GP 06	GP 07	GP 08	GP 09	GP 10	GP 11	GP 12	GP 13	GP 14	GP 15	GP 16	GP 17	GP 18	GP 19	GP 20	Value	Lowest	Highest
Deprivation score (IMD 2015) †	2015	24.2	28.1	33.7	10.6	15.2	35.6	35.7	18	18.5	26	23	10.6	27.9	27.9	21.9	21.9	10.2	24.2	27.3	25.20%	21.8	3.2	66.5
IDAOP (Income Deprivation - Older People) †	2015	29.40%	28.00%	39.90%	11.60%	16.10%	40.40%	36.00%	22.30%	16.10%	32.60%	22.80%	11.60%	31.00%	31.00%	25.10%	25.10%	12.90%	29.40%	21.30%	23.80%	16.20%	3.90%	65.30%

† Data from Public Health England National General Practice Profiles [URL: <https://fingertips.phe.org.uk/profile/general-practice/data#page/0/gid/2000005/pat/152/par/E38000070/ati/7/are/E85125>, Accessed 23 November 2019]

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