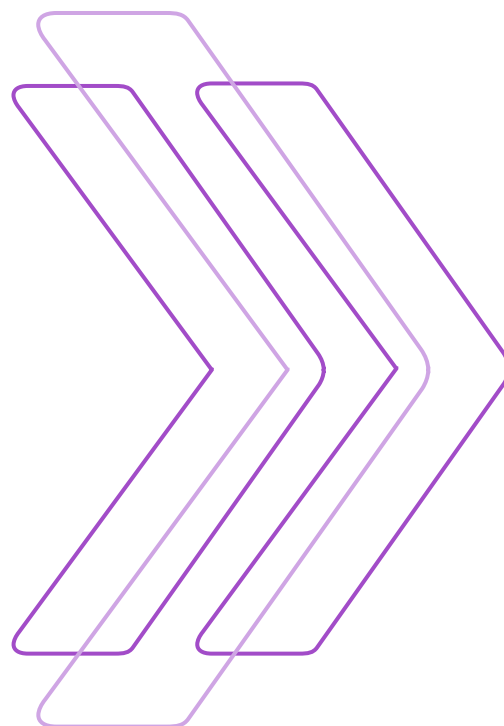


New models of home care

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1 Introduction

Policy-makers have outlined their ambitions to provide joined-up care closer to home and enable people to remain independent and in their own homes (NHS England et al 2014; NHS England 2014a, 2014b; HM Government 2012). Home care will be a central component of realising these ambitions. However, there are serious concerns about the state of the home care market and the quality of care service users receive (Humphries et al 2016; CQC 2013; Holmes 2016).

Home care (also called domiciliary care) is social care provided in people's own homes, and may include help with washing, dressing and preparing meals. Service users include people with disabilities and older people. Care may be delivered for a short period of time following a stay in hospital (eg, reablement) or long term, for ongoing support needs. Like all social care, home care is means-tested, which means that some individuals will be eligible for care paid for by the local authority and some individuals will pay for care themselves, with others using a combination of the two. Individuals who are eligible for local authority-funded care may choose to receive a direct payment or personal budget, which they can spend as they wish, or have the local authority arrange care on their behalf. Eligibility for local authority-funded care is also dependent on a needs assessment, and tightening eligibility has meant that home care is increasingly restricted to those with more complex needs (Age UK 2013).

In 2015, more than 350,000 older people in England were estimated to use home care services, 257,000 of whom had their care paid for by the local authority. A further 76,300 younger people with learning disabilities, physical disabilities or mental health problems were also estimated to be using publicly funded home care in 2015 (Wittenberg and Hu 2015).

Most home care, including that paid for by the local authority, is provided by the independent sector, and home care providers who deliver personal care (such as help with washing) are regulated by the Care Quality Commission (CQC). Outside of this, many people will rely on family or friends for some or all of this support. Local authority-funded home care is usually commissioned via a competitive tendering exercise for the tasks which need to be completed and the time that will be required to complete them. Providers are paid on a

rate-per-hour basis. This is commonly referred to as 'time-and-task' commissioning.

As well as their duties to meet the assessed needs of individuals who require care, under the Care Act 2014, local authorities also have a duty to ensure that there are sufficient services, of a sufficiently high quality, to meet need for home care. As the single largest purchaser of home care, local authorities have significant influence on markets and there is wide variation between them, exemplified in wide variation in the rates paid for care.

There have been several research reports looking at what people want from care delivered in their home and exploring what good-quality care looks like, with strong common themes (Healthwatch 2017; Maybin et al 2016; CQC 2013; ADASS et al 2017.2017); SCIE 2014; NICE 2016). These include the following.

- **Person-centred care** – caring for all the person's needs together in a holistic, integrated way. This may include communicating with others who are providing support and care for the person to ensure that care is joined up.
- **Valuing and involving people, as well as their carers and family members** – ensuring that people are able to express their preferences, views and feelings. This may include ensuring that people have choices and that their views about how to make improvements are sought, listened to and acted on.
- **Continuity of care** – ensuring that care is consistent and reliable. This may include ensuring that people have a properly reviewed care plan, that care workers are known to the person and limited to a small number of people visiting, providing reliable and flexible visit times, planning for missed or late visits, and ensuring that people are able to contact services between appointments.
- **Personal manner of staff** – a caring and compassionate approach to care. This may include effective communication, getting to know the person and building relationships to ensure that care happens the way the person likes it.
- **Development and skills of staff** – ensuring that staff are equipped with the training, supervision and experience to do their jobs effectively. This may include regular meetings for staff, personal development and training on particular conditions such as dementia.

- **Good information about services and choices** – ensuring that people know where to get advice and understand their choices about local care options, including quality and financial advice.
- **Focus on wellbeing, prevention, promoting independence and connection to communities** – to be able to stay in their own homes and be supported to do things themselves. This may include linking people to be able to contribute to their local communities and social groups.

Challenges faced by the home care market have been outlined elsewhere (Age UK 2017; Humphries et al 2016; CQC 2013) and represent a somewhat different picture to the principles outlined above. The fragility of the home care market has been raised as a concern by the CQC, which has highlighted large churn among providers registering and deregistering (CQC 2017). Concerns have been raised about quality and there have been increase in the number of complaints and a fall in satisfaction (Local Government and Social Care Ombudsman 2016; Humphries et al 2016; NHS Digital 2016). Home care providers employ around 670,000 people and there are around 90,000 vacancies across social care at any one time. More than half of care workers are employed on a zero-hours contract and turnover for domiciliary care staff is at 36.8 per cent (Skills for Care 2017b).

Demand for home care is forecast to increase significantly. Older users of local authority-funded home care are predicted to rise by 82 per cent, from 257,000 in 2015 to 468,000 in 2035. Users of privately funded home care are projected to rise by 49 per cent over the same period while younger adults with learning disabilities using home care are predicted to rise by 51 per cent (Wittenberg and Hu 2015). At a time when population projections might indicate a rise in demand for social care, the amount local authorities are spending and the number of people eligible for local authority-funded home care are falling (Phillips and Simpson 2017).

Against this backdrop of varying quality of care and rising demand, some innovative models and approaches to commissioning and delivering home care are emerging. This report explores those new approaches and considers their potential to provide care that is more closely aligned with what people want.

Purpose and approach

This report summarises the evidence on innovations and models of home care that demonstrate potential in the following key opportunity areas:

1. Technology and digital
2. Co-ordinated care planning
3. Recruitment and retention
4. Autonomous team working
5. Alternative approaches to commissioning
6. Personalisation
7. Integrated care approaches
8. Community assets and connections
9. Family-based support and communal living

In our findings for each of the key opportunity areas, we include:

- a brief description and examples
- findings from our evidence review
- further potential benefits where evidence is not yet available
- contextual factors, including potential barriers and enablers to implementation.

Our findings are based on a literature search in each of these key areas carried out by the Information and Knowledge Service at The King's Fund. The extent and quality of evidence we were able to find about new home care models was limited and as such, we have included a wide range of evidence sources, incorporating findings from self-reported outcome measures, local evaluations and grey literature. We have taken this evidence at face value and have not undertaken thorough checks or critiques.

Alongside the literature search, 10 interviews were carried out with providers and commissioners who have implemented innovative approaches to home care. These interviews focused on the important elements of innovative approaches, as well as enablers and barriers to adopting them.

Findings overview

Table 1 provides a crude overview of our categories of innovative approaches to home care. The red, amber and green colours indicate whether the approach has been widely adopted and evaluated, and whether it has potential to improve quality, provide cost savings and be scaled up. Amber indicates that we cannot draw conclusions from the evidence or that the evidence is mixed, so does not necessarily indicate lesser potential. It is important to say that this table should be interpreted alongside the greater detail and nuance within each of the categories outlined in the rest of this report. There is some overlap and many of the examples could fit into several of the categories. Despite these caveats, some important themes are illustrated in the table.

Table 1 Overview of innovation in adult social care

Model	Examples	Wide usage	Evaluated	Higher quality	Cost saving	Scaleability
Technology and digital	Assistive technology Monitoring in home	Yellow	Green	Yellow	Yellow	Yellow
Co-ordinated care planning	Connecting carers	Red	Red	Yellow	Yellow	Yellow
Recruitment and retention	Values-based recruitment	Yellow	Yellow	Yellow	Red	Yellow
Autonomous team working	Buurtzorg Wellbeing teams	Red	Yellow	Green	Yellow	Yellow
Alternative approaches to commissioning	Outcomes based Integrator models	Red	Yellow	Yellow	Red	Yellow
Personalisation	Direct payments Personal budgets Individual service funds Integrated Personal Commissioning	Green	Yellow	Green	Red	Green
Integrated care approaches	Kotitori Gesundes Kinzigital PAISS Capable	Green	Green	Green	Yellow	Yellow
Community assets/connections	Local area co-ordination Community Circles Social prescribing Microenterprises	Green	Yellow	Green	Yellow	Yellow
Family-based support/communal living	Shared Lives Homeshare Green House Evermore	Green	Green	Green	Yellow	Yellow

Wide usage?

The extent to which these approaches have been adopted and are widely used varies in lots of ways and for a number of reasons. Despite some being long established in policy rhetoric, such as outcomes-based commissioning, the extent to which we were able to find examples of them in practice was limited. Traditional approaches to commissioning were commonly cited as a barrier to spreading innovative models of care. Providers aiming to change the way care is organised and experienced by service users found inflexible and risk-averse commissioners unwilling to move away from a time-and-task approach, restricting their ability to enable staff to work in different ways or to provide more flexible and person-centred care to service users. In the case of technology, while there is an array of alarms, sensors and apps, there is limited evidence about the extent to which they are integrated into statutory home care delivery or indeed, the extent to which there is demand for this.

Evaluated?

Large-scale, rigorous evaluations were few and far between and, in some cases, where evidence does exist it is unclear how this fits in with wider contextual factors in delivering statutory home care services in England. For some, we know that evaluations are under way and have not been reported yet; for others it would be very difficult to evaluate their impact.

Higher quality?

Some alternative models of providing care at home – for example, Shared Lives and the US Capable programme – have robust evidence to demonstrate improved quality and/or impact. Others show great promise. However, it is important to highlight the contrast between the columns in Table 1 related to quality and cost saving. Many approaches demonstrate potential to improve the quality of home care services but, in the context of historical policies to drive down the cost of home care, it might be very difficult for innovative providers to compete on a per-hour basis with current time-and-task approaches to commissioning (where local authority hourly rates are often below what is recommended as a minimum). Improving the quality of home care should be seen as part of a wider move towards integrated, preventive approaches to health and care that incentivise better outcomes for individuals.

Cost saving?

While some new models, such as technological adaptation, may be considered to have potential to reduce demand or usage of formal care services, there is little evidence to date that this is happening. Cost saving may be an unrealistic aim of some or all new models of home care, particularly if home care budgets are considered in isolation and in the short term. Instead, our research highlights the need to consider social care as part of a wider health and care system, with many approaches demonstrating potential for investment in higher-quality home care services to lead to cost savings in other parts of the system, such as health. The benefits of investment in home care, if achievable, are likely to be felt in different parts of the system further down the line.

Scaleability?

The lack of green boxes in this column reflects the difficulties faced in implementing innovative approaches at scale. There are many examples here that have existed for some time, notably alternative approaches to commissioning and family-based support such as Shared Lives. Despite this, finding examples of these approaches being implemented in practice was more difficult than we had anticipated and the extent to which they could be scaled up was questionable. In the case of family-based support, though the benefits of these approaches are clear, there is likely to be a limit to the numbers of people for whom this approach is appropriate, and in the number of people willing or able to provide this type of care.

The sections below outline more detail about new approaches to home care and evidence for them in each of the key opportunity areas.

2 Findings

Technology and digital

Currently, attention is focused on using digital technology to connect users and then facilitate information flow between them, their support networks and their carers. This can support more responsive home care and telecare for the individual as well as new business models for home care providers and the use of web-based platforms to strengthen users' social networks. Technology can be used for prevention, to support paid and unpaid carers, and to improve productivity and quality by enabling new ways of working.

While there are multiple examples of technologies and tools that may be very effective at promoting independence, preventing falls and helping to manage risks, the impact these have on changing the approach to statutory home care services is limited and there is a question about the extent of demand for them. These technologies do not remove the need for care services. They should be viewed as an enabling tool for care workers and service users where new ways of working have been developed, as a preventive tool and in supporting informal carers. As highlighted by our interviewees:

... it's not the tech that's going to revolutionise the care industry, it's the quality of care and upskilling this workforce that we have and giving them new sets of training standards and new ways of educating them and upskilling them every three months and I think the tech will be the enabler for that. It will be a process whereby we can provide them with the tools and the skills necessary with the tech that can make them... well, allow them to deliver a job much more effectively.

So I think, yeah, tech is going to be the enabler here. But I think... it really frustrates me when people think that tech is, like, the be-all and end-all solver of things because... especially in the care industry, it is literally the... if we don't have the workforce, we don't need the tech. So we really need to do something more about that.

Monitoring in the home and assistive technology

Assistive technology is a term that covers a broad range of tools that support people to maintain or improve their independence and continue living at home. It can prevent falls, promote independence and personal control, help manage

potential risks, as well as reduce workload and stress on carers (Bonner et al 2012; Age UK 2012; Audit Commission 2014; Alzheimer's Society 2015).

Connected assistive technologies can enable telecare and telehealth through increasingly detailed remote monitoring and the reactive provision of home care or clinical support. Examples include:

- the use of passive devices that track users and generate information about their activity at home
- devices to provide alerts and then guide users in carrying out essential tasks
- the analysis and sharing of information with users' carers and support networks.

There are many examples of different kinds of sensors being used to achieve a roughly similar goal: understanding a person's level of capability and their safety in their own home. More established uses of the sensors facilitate rule-based alerting systems. For example, the Belong extra care housing scheme in Cheshire uses bed pressure sensors and alerts care teams if the person has been out of bed too long (possibly indicating a fall); in Staffordshire, wireless support systems use room sensors to warn if a child with autism has been in high-risk areas of the home for too long (Voluntary Organisations Disability Group/National Care Forum 2013).

The latest schemes feature novel sensing devices and use the data they generate to build a statistical model of a person's routine, which means they can provide alert services when important deviations from the routine occur. The Howz system, for example, uses devices placed between appliance and plugs piloted nationally by energy company EDF, while Canary Care door sensors are being piloted alongside other innovations in the Care City test bed. Evaluations of both schemes are forthcoming.

Issues with assistive technology include a lack of ongoing support for the use of the technology, inappropriate choice of equipment for personal capabilities and circumstances at the assessment stage, and a failure to keep its use under constant review. There are also issues with the lack of integration and interoperability of different technologies and the data they generate. The consequences of these issues involve a fall-off of its use after initial uptake (Voluntary Organisations Disability Group/National Care Forum 2013).

Many of the examples in our evidence review are discrete examples of the deployment of individual products and services. This implies that the overall challenge is in integrating the technology into home care assessment and working practices, managing and curating information so that it reaches the

right people in a support network in actionable form, and ensuring that ongoing support for its use is in place. Remote monitoring in particular raises potential privacy concerns and works best when beneficiaries are well-informed about monitoring and its purpose, give their consent and actively participate in its use (Age UK 2012). Acceptability-based studies in the 2000s found passive monitoring to be unacceptable in contrast to video monitoring like CCTV. In a review of evidence for technology-based tools for people with dementia and their carers, one report found that while there were a range of tools available, there was limited evidence of widespread practical application and that individuals re-purposed everyday technologies to their needs (Lorenz et al 2017).

Examples

Home automation and advanced telecare: A home automation package, including a light path that comes on when someone steps out of bed, gas and smoke sensors, fall alert devices, alarms, and 24/7 remote telecare call centre assistance. An evaluation found that it contributed to a reduction in falls, reduction in hospitalisation, reduction in depression, and carer productivity (Carretero 2014).

Scotland National Telecare Development Programme: Launched in 2006, the programme aimed to reduce admissions, speed up discharge, reduce use of care homes, improve quality of life, reduce pressure on carers, extend the range of people assisted by telecare, save money, and support effective procurement. Interventions included movement detectors (with alerts if the person falls or leaves the house), lights that automatically turn on when the person gets out of bed, alarms and sensors (including location sensors, gas detectors and wet bed sensors), reminders to take medicine, carer alerts, and activity monitoring. An evaluation by the University of York using data, service user and carer questionnaire and case studies found that older people reported improved quality of life, maintained or improved health, and felt safer and more independent. All carers involved reported a positive experience. The evaluation also found faster discharge from hospital, reduced hospital admissions, avoided admissions to care homes, and significant cost savings (Carretero 2015).

Kaiser Telehealth (USA): Patients receive video and telephone contact as well as in-person visits in their own home. Video gives patients access to a home health nurse 24 hours a day and has peripheral devices that enable nurses to evaluate cardiopulmonary status and facial expressions, and includes an analogue stethoscope attached to a phone line, as well as digital blood pressure machine, and magnifying lens for close-up viewing. An evaluation (Johnston et al 2000) found a reduction in patient visits and costs with no impact on quality of care (measured by patient compliance with medication, knowledge about their

condition and ability to self-care) or patient satisfaction. Remote visits meant nurse visits could reduce to 5–6 visits per day from 15–20 visits per day.

Co-ordinated care planning

Connecting people

Technology can be used to connect informal and formal care, providing support with co-ordination and care planning. Nesta (Mountain 2014) describes a number of ways that technology can support informal care, including communication tools such as **Breezie** or **Mindings**, which can connect people and reduce isolation. There are also platforms to engage potential informal carers such as **Casserole Club**; tools such as **Jointly** and **OnCare**, which build networks of support, improve logistical efficiency and/or enable co-ordination and care management (for example, by reducing the time care workers use to record visits); and integration tools such as **Patients Know Best**. Community volunteering platforms have been created to match residents with social care needs. These are best understood as part of efforts to tackle social isolation, which can improve long-term outcomes for individuals living in the community, rather than replacing formal care provision.

Carer marketplaces

Examples such as **SuperCarers** and **Care.com** aim to reduce cost and promote consumer choice by linking self-funders directly to individual care workers. Care.com is in part funded by Google Capital and also operates across childcare, petcare and cleaning, among other sectors. They may offer greater choice and cheaper service provision. However, these are introductory platforms that do not provide services directly and are not CQC registered.

Examples

Intelligent system for independent living and self-care of seniors with cognitive problems or mild dementia (ISISEMD): Funded by the European Commission from 2009 to 2011 and piloted in Denmark, Belfast, Greece and Finland, the programme aimed to help older people with mild cognitive impairment and dementia to be more independent and safe at home, support formal carers to work remotely, and allow informal carers to support their relatives. It provided a platform with integrated components, including:

- Carebox, where a touch screen displays reminders and messages to enforce daily routine and carers can request a confirmation; it also provides a memory lane function with personal picture slideshow and brain games that can be chosen remotely by carers

- Video call service, mainly initiated by the caregiver, with the screen making a noise like a traditional phone

Outdoor safety with the Lommy GPS device, allowing carers to see the position of the person remotely. Also has an alarm button that sends a text with the person's location. Includes services for the informal carer to support remotely (eg, setting temperature, controlling ovens, night movement detectors or distance parameters for alarms).

An evaluation found that users benefited from more independent living, including going out more often and calling less on informal carers. For informal carers, the approach provided potential to save time and money on travel, more freedom for their personal life, reassurance and peace of mind, as well as reduced stress (Carretero 2015).

Vida is a home care provider that focuses on quality of care, training and workforce. It has developed an end-to-end technology platform and aims to provide a blueprint of how providers should train, educate and upskill carers using technology and tools, to provide a more efficient way of delivering care. Key to the approach is that it enables new ways of working and delivering care. Technology platforms enable effective communication between all paid and unpaid carers, as well as assisting with logistics, monitoring and tracking of care, and include rota allocation and digitised care plans. The platform enables collection of outcomes data and progress towards care plans.

Cera uses technology including digital care records, automated operations and an artificial intelligence engine. The technology enables communication (for example, through a decision support platform) and facilitates handover between care workers and other professionals and family members.

Recruitment and retention

Recruiting and retaining care workers is a significant challenge facing home care providers. Issues include poor pay, isolated working conditions, lack of job stability (for example, with zero-hours contracts) and lack of progression. Care is often considered a low-paid, low-esteem role and innovative approaches recognise the need to improve terms and conditions for care workers and ensure that caring is an attractive career option. Skills for Care (Skills for Care 2017a) estimates that the average pay for a care worker in 2016 was £7.97 per hour, that there was a turnover rate of 32.5 per cent and a vacancy rate of 9.2 per cent. Issues with recruitment and retention impact on continuity for service users, while engagement and wellbeing of staff is directly related to user experience (Maben 2013).

Efforts to reduce turnover of care workers have led some home care providers to adopt innovative approaches to recruitment, aiming to maximise retention by more careful approaches to recruiting the right people. Values-based recruitment considers the extent to which candidates demonstrate values linked to caring roles such as compassion, alongside candidates' skills-based experience. An evaluation of values-based recruitment carried out by Consilium with Skills for Care found that staff performed better and had a lower turnover rate, and that it enabled employers to identify staff with attributes such as empathy, which could not be taught or learnt (Consilium 2016). A University of Birmingham evaluation of values-based recruitment is forthcoming.

Other approaches look to improve terms and conditions for care workers, including addressing issues of training, stability, pay and autonomy. Reducing hierarchy in teams has enabled organisations like Cera and Vida in the UK to offer training and attractive rates of pay to make a career in care more attractive, although that may come with altered conditions such as sick leave. European countries (including Germany, Austria and Denmark) have reformed educational qualifications and training of home care workers to improve the profession's image and encourage recruitment to the sector (Rostgaard *et al* 2011). Reform programmes in Denmark, which focused on a more rehabilitative approach to home care, have also been highlighted as having improved the status of care work, whereby carers are seen as coaches undertaking more positive, motivational work that is distanced from the 'dirty work of homecare' (Meldgaard Hansen 2016). New approaches to the organisation and delivery of care, such as autonomous teams (see 'Autonomous team working'), aim to improve working conditions for care workers, including regular team meetings to avoid isolated working conditions, and more training and flexibility to work autonomously and flexibly to meet the person's needs.

Interviewees outlined the importance of valuing staff contribution and the impact that has on service users:

Don't treat them like a commodity because they're doing something very tough and very hard. They're not cleaners. And if you don't give them the right skills and training and remunerate them well enough, they're not going to do a very good job.

So, we take our care workers' wellbeing extremely seriously and we try to do what we can to ensure that they are satisfied, which in turn is why we have a very high satisfaction rate from them... But that workforce support above and beyond technology is also extremely important and I think it's completely overlooked by a lot of care providers.

One interviewee suggested a national campaign to make care work more appealing:

I think there needs to be a national effort to identify and encourage people to become care workers and also to have a national mandatory qualification system around that.

Examples

Cooperative Home Care Associates in the Bronx, USA, provides a minimum number of hours' work per week, free training and peer mentors, and workers are able to buy shares in the company and have the right to serve on the board of directors. The company reports good staff experience and low turnover rates compared to the industry average (Rieder *et al* 2012).

Values-based recruitment aims to attract and select candidates based on their values and behaviours – for example, compassion – in order to ensure high-quality care. Approaches range from assessing what is included in pre-application information to weighting values alongside (or above) qualifications and experience. Skills for Care has developed a set of tools and workshops for values-based recruitment, including a checklist for organisations considering adopting the approach (Skills for Care n.d.).

St Monica's Trust in Bristol engaged with service users to identify what was important to them, such as patience and listening skills, to inform their recruitment approach (Blood *et al* 2012).

Autonomous team working

Central to improving care workers' experience and providing person-centred care based on continuity and building relationships are new approaches to organising care workers and the delivery of care. There is good evidence surrounding the Netherlands-based Buurtzorg approach to care (described in more detail *below*) but there is less evidence for adaptations in the UK and there are likely to be some important cultural and contextual factors that will impact its transferability. Importantly, health and social care needs are met together in the Buurtzorg approach, and it is unclear whether adaptations that involve delivering social care alone can achieve the same outcomes. In addition, the Buurtzorg approach is nurse-led, and implementing this in the UK would be challenging for a number of reasons, including nurse shortages, different payment systems and the need for initial investment.

New organisational models focus on team working to provide flexible and relationship-based care, which leads to improved working environments for care

workers, as well as efficiencies in travel and overheads. They move away from an isolated and fragmented, task-oriented approach towards a focus on team working, autonomy for care workers, as well as relationship-based and person-centred care for service users. New approaches to care workers' roles are linked to organisational models and approaches to care.

Key elements often include:

- geographically or 'neighbourhood' based working – to enable continuity and relationship-based care as well as efficiencies from reduced travelling time
- small, autonomous or self-managed teams – to enable flexibility in meeting care needs as well as improved flexibility and control for care workers over their hours and greater job satisfaction
- case management approach – to provide proactive and flexible care
- involvement of community and NHS partners – to meet all of a person's needs together
- training and development for care workers – to improve recruitment and retention, provide greater job satisfaction and improve quality of care.

Many of the place-based team approaches are inspired by the Buurtzorg model developed in the Netherlands, for which there is good evidence of positive staff and user experience, as well as financial savings. When compared to the industry average, the Buurtzorg approach used less of the authorised/prescribed hours of care (40 per cent compared to 70 per cent) and delivered fewer hours of home care per service user (an average of 108 hours compared to the industry average of 168 hours) (Grey et al 2015; Laloux 2014). With fewer hours of care and service users recovering faster, as well as fewer overheads and back-office administrative costs, Buurtzorg offers financial savings compared to traditional models (up to 50 per cent) and reported more than 200 million euros in revenue in 2013 (Kreitzer et al 2015; Monsen and de Blok 2013). Buurtzorg reports high employee engagement and satisfaction scores as well as low employee turnover (Kreitzer et al 2015; Nandram 2015). The model also has high client satisfaction, with rates 30 per cent above the national average, and it has been rated the highest for client satisfaction in an index of 308 home care organisations (Alders 2015; Monsen and de Blok 2013; European Commission 2015).

There is less evidence for adaptations of the model in a UK setting, though there are several examples of new approaches to home care inspired by Buurtzorg and some evidence of positive results. Self-reported outcomes for the approach adopted in Monmouthshire, for example (outlined in more detail *below*), include

improved staff morale and job satisfaction, as well as low staff sickness rates (SCIE 2014).

Our interviews outlined further potential benefits, as well as important contextual factors, such as the importance of building relationships in the context of personal care:

I was having to change her, wash her. But they weren't doing it because she was very resistant to them, because obviously they weren't building a relationship or a rapport with her... Which I think is fundamental – building someone's trust when they're doing something like personal care. It's all about dignity and respect and that was one thing that was lacking.

Interviewees described autonomous team working as enabling greater flexibility in meeting care needs and using resources, including drawing on community assets to meet an individual's needs in the round.

... if we got flexibility in how we use the time, what we might be saying is 'on a Tuesday, let's go to the local store, let's buy enough food for you and your neighbour, let's cook for your neighbour and have your neighbour around' and what we might be able to do is say in the next week, the neighbour does the same, and the savings as it were in terms of that half-hour or 45 minutes or whatever means two things: one is, you know, once a month we can go to the garden centre and have lunch because you're hugely passionate about gardening and you never get to garden centres any more, and we can support you to go and have your lunch at the luncheon club at the faith community that really matters to you...

The cultural context was raised as a potential barrier to the application of a Buurtzorg-type approach in a UK setting. CQC requirements for a registered manager (opposed to the Buurtzorg approach of no hierarchy), as well as practices such as electronic monitoring or the culture of commissioning on 15- or 30-minute units of time, were cited as an unhelpful cultural backdrop to creating an autonomous, flexible approach for workers or care delivery. Some providers described difficulty moving commissioners away from traditional, time-and-task approaches and the need to challenge ways of working to enable flexibility and new approaches:

And we're starting to challenge it a bit more, so I feel like for me, one of the biggest challenges is actually being able to challenge other people to

say, 'hold on a minute, this is safe, this is what this person wants; why can't we do it?'

Some providers described developing new or separate policies and processes on human resources (HR) and finance to implement new ways of working and avoid bureaucracy or a culture of risk aversion.

A case management and proactive approach to care was highlighted as creating a focus on promoting independence, in comparison to the time-and-task focus, which can incentivise dependence, in that if a person needs more support, a provider will receive more income:

So traditionally, dom care makes people dependent on the care, and we like to... we celebrate when people cut their care down, because that means that they are becoming more independent again.

Personal budgets, direct payments and individual service funds (ISFs) were described as a way of getting around the bureaucratic and inflexible nature of commissioning to enable providers to adopt more flexible and person-centred approaches (see 'Alternative commissioning'):

... and let them decide between Mrs Smith and the provider what's achievable and what's needed.

Key to the success of the Buurtzorg model is the integration of health and social care to provide a holistic, person-centred approach where one professional meets all of a person's needs. Investing nursing time upfront saves on care needs and time required later, as well as savings from fewer professionals making visits and lower back-office costs. It is unclear whether models inspired by the Buurtzorg approach but limited to a person's social care needs will deliver the same efficiency and experience benefits. At the least, initial investment is required to see pay-offs later, and these may be in different parts of the system.

Introducing new ways of working requires initial investment. Some providers of social care place-based team approaches in the UK described difficulty competing for local authority contracts, leading to reliance on self-funders and spot-purchased or short-notice arrangements. In order to make the best use of resources, providers were increasingly drawing on community assets (such as befrienders) to meet holistic needs of service users.

Examples

Buurtzorg, Netherlands: The Buurtzorg 'neighbourhood care' model in the Netherlands was introduced in 2006 and is based on 'humanity over bureaucracy' (Kreitzer et al 2015). This mantra enables staff to work autonomously and to be creative, as well as utilise and develop their skills. Self-directed teams of up to 12 nurses provide personal and clinical care for 50–60 patients, delivering holistic care instead of tasks being divided between several providers, care workers and clinical workers. Teams are small and geographically based so that service users see a maximum of three or four people and care is delivered on principles of reablement, maximising independence and supporting self-care. Care is relationship based and not limited to providing for a person's physical needs. Buurtzorg has a simplified payment system with a set rate for each visit, regardless of duration, and has low overhead and back-office costs as a result of its non-hierarchical structure.

Wellbeing teams: Self-managed teams that focus on person-centred care and supporting people in their communities, inspired by the Buurtzorg approach. Care is based on a support sequence co-designed with the person to deliver their priorities. This sequence is repeated every six months to ensure that people are able to live well at home and are connected to their community. It involves moving through the following steps:

- self-care – a health coaching approach focused on what can be done to make the individual feel more confident in how they are managing their care at home
- digital or assistive technology – this may include remote sensors or facilitating Skype calls with family members who do not live nearby
- community – this may include lunch clubs or falls clinics
- wellbeing teams are the final step in the sequence.

Wellbeing teams are small, self-managed and neighbourhood-based. Individuals choose their own team using video introductions and one-page profiles, with a guarantee of no more than four people. They design an ideal week for the person, where visits have an indicative time related to what they are trying to achieve in that visit. Reduced travel time and lack of hierarchy provides low back-office costs. Wellbeing teams work closely with Community Circles (see 'Community assets and connecting') to provide support beyond formal services. Wellbeing teams are being developed in a range of formats, including with local authorities incorporating reablement teams, or teams that are based in GP surgeries.

Love2Care Devon: Provides relationship-based and person-centred care by small, local teams. Teams do not work on a 'time-and-task' basis but are able to develop flexible care plans according to changing needs of service users. Care plans evolve as knowledge of the service user develops, to include greater flexibility, routine and detail.

Small, self-managed teams work in specified geographical areas and create rotas themselves. This enables staff to feel secure, knowing where they are going and what they are doing, with set routines with service users they know. Teams communicate and remain connected through apps and weekly meetings, ensuring that staff feel connected to their colleagues. Service users see a maximum of four people to ensure continuity, which enables small changes to be picked up. Care is relationship based; giving people the time they need is a priority because relationships take time to build.

Care staff are called wellbeing workers. Training and development is discussed at weekly team meetings and there is an aim to develop specialist knowledge within each team member – for example, to become a dementia 'trainee trainer' or champion. Values-based recruitment and ongoing mentoring is used to ensure that staff have what they need to care for individuals in a person-centred way. Decisions about recruitment are made involving wellbeing workers and service users, who continue to be involved in mentoring.

Service users are connected to resources and groups in the local community, including support groups and condition-specific organisations, to connect people to their hobbies and interests, to give people the confidence to try new things and support them to access community assets and prevent social isolation.

Place-based teams, Monmouthshire: Autonomous, place-based teams work around a group of service users in set geographical areas. Staff are able to get to know service users, and packages of care are altered through joint reviews with social workers, physiotherapists and occupational therapists to provide a seamless approach. Working in limited geographical areas prevents time being spent travelling between service users.

Care is relationship based and focused on being flexible to the needs of people being supported on a daily basis, rather than packages of care or time. Moving away from task-and-time has included removing exact times from rotas and replacing them with calls in the 'afternoon' or 'evening', with more detail decided upon based on dialogue between staff and service users.

Teams work autonomously to meet service users' needs; they have regular team meetings and manage a budget. Regular team meetings ensure that information

is shared. Information being held by teams means that information about service users is not held by any one individual.

Staff are encouraged to be professional practitioners, making links with whoever is necessary to support care for their service users. This helps staff feel valued and more engaged. A framework is used for staff competencies, to focus on the desired skills. There are no zero-hours contracts; instead, staff have a contracted number of hours with set working patterns established within teams. Ensuring that staff have flexibility and autonomy and are empowered to meet the needs of service users is considered key to good-quality care.

Alternative commissioning

New approaches to commissioning enable more flexible, person-centred approaches to care and improved working conditions for carers; they also incentivise better outcomes for individuals, based on providers and commissioners working together. Approaches range from large-scale outcomes-based contracts or commissioning an overarching provider to manage the process of assessing and arranging care, to enabling greater choice and flexibility for individuals through ISFs, direct payments and integrated personal budgets (see 'Personalisation'). Inflexible and risk-averse approaches to commissioning were raised by several innovative providers as a barrier:

... there isn't as much national endorsement and permission around working with innovative providers, which again means that if they want to be risk averse then going with an innovative provider is probably not going to be suitable, and if it is even slightly risky because it's doing something different even if it is well validated, again, local authorities will not be really encouraged to do that or will not feel happy to do so.

Outcomes-based commissioning

Outcomes-based commissioning removes the focus of payment from tasks and units of time or processes to be followed towards outcomes to be expected (Billings and de Weger 2015). The premise is that this approach will enable more flexible and person-centred approaches to care, better-quality and more efficient care. One of the most commonly cited examples of outcomes-based commissioning is the large-scale approach adopted in **Wiltshire** (described *below*), but approaches can vary from additional financial incentives incorporated into existing contracts, to introducing outcome measures for individual contracts or a complete overhaul of payment mechanisms (Bolton 2016).

Though there is a general consensus that outcomes-based commissioning would enable person-centred care and be a positive step for home care, there is limited evidence about impact of these approaches to date (Billings and de Weger 2015; Bolton 2016; Smith et al 2017).

Outcomes-based approaches are considered an enabler for shifting to more person-centred care for service users, enabling greater control and flexibility for providers to meet the needs of service users in a responsive way. As well as improving the experience for service users, interviewees described how new ways of working enabled by more flexible approaches to commissioning led to greater job satisfaction:

People are saying that actually I have worked for how many years in a system that doesn't offer what people need, you know. Especially around home care, people are saying, 'well, actually, I want to stay in a time that works for me and it works for the client and I want to have that flexibility to be able to support them in anything that they might want to do to get a good life. And actually, as long as I have got some systems in place, then I should be allowed to offer that really, really flexible, really person-centred service'.

Outcomes-based payment mechanisms may increase security for providers, enabling them to invest in their staff and quality improvement (Bolton 2012), providing better working arrangements for staff, including training and stability that can lead to improved staff and job satisfaction (Hughes *et al* 2013) – for example, if new approaches to payment enable providers to employ staff as salaried rather than on zero-hours contracts.

The shift of power from commissioners to providers may also improve relationships. Strategic approaches, such as the Wiltshire example, mean that commissioners are managing far fewer contracts, which makes maintaining constructive and positive working relationships with those contract-holders easier as a result.

The concept of outcomes-based commissioning has been present in policy rhetoric for a long time but much of care continues to be commissioned on a 'time-and-task' basis. In its report on outcomes-based commissioning, the LGiU identifies key barriers as lack of trust between providers and commissioners, lack of trust in home care workers, and continued cultural focus on task-and-time (Koehler 2016). The survey found that while most councils see outcomes-based commissioning as ideal, just 11 per cent use it in full.

Moving to outcomes-based commissioning requires investment and time to realise benefits as well as new ways of working (Bolton 2015). The onus is on providers to take financial risk and this may be less attractive for some providers. One of the barriers to implementing outcomes-based commissioning is that outcomes are difficult to measure, which means that providing assurance for commissioners is more complex. Technology and digital approaches to care management may enable a more outcomes-focused approach to care – for example, with programmes that enable capturing of data about individuals (see ‘Co-ordinated care planning’). Conversely, existing technical approaches such as electronic call monitoring, which may be used to provide assurance based on time, act as a barrier to adopting new cultures of trust and relationships that enable outcomes-based approaches (Koehler 2016). Outcomes should be measured against progress towards personal goals.

One potential challenge with outcomes-based approaches is that they could lead providers to cherry-pick individuals who will provide good outcomes (Bolton and Mellors 2016). This is linked to complexities of measuring outcomes and linking payment to results. Outcomes-based contracts themselves will not hold providers to account for achieving improved outcomes for service users, and ongoing constructive relationships between providers and commissioners will be required.

Integrator models

Some new approaches seek to address fragmentation by commissioning an organisation to provide or oversee all elements of assessment and provision in a geographical area. Commissioning through an ‘integrator’ may have benefits for ease of access to information and advice, enabling people to make informed choices about their care and providing a way for individuals to access information about what is available and to compare quality and costs of services with the support and advice of a broker. This model also brings together a number of providers, potentially producing a more coherent network that could prevent fragmentation and promote working together as well as a collective voice in negotiations with the local authority. Some argue that the model will support smaller providers in competing with larger providers as the ‘integrator’ is able to sub-contract to those smaller providers. However, it is unclear whether this happens in practice, as the integrator will likely face the same difficulties as local authority commissioners. An integrator model does not necessarily address the availability or quality of services for users. And there is no way to determine changes in unmet need or satisfaction of those who have not accessed the service. It may provide an opportunity to provide care that is more joined up – for example, across health and social care (Addicott 2014).

Examples

Outcomes-based commissioning in Wiltshire: Wiltshire is an example of a large-scale change in commissioning approach, which involved reducing 90 individual contracts worth £14 million to eight outcomes-based contracts with four providers worth £11 million (Smith et al 2017; LGA 2014). In their model, an assessment is undertaken by customer care co-ordinators, followed by a care plan and linked to a payment based on a desired outcome as opposed to units of time. Providers face penalties if outcomes are not achieved at the payment set, and are able to keep any additional money if they underspend, which acts as a strong incentive. The model focuses on utilising community capacity to support people and requires that workforce be salaried. The outcomes-based commissioning model in Wiltshire is based on extending a reablement approach to care beyond the 6-week period. It prioritises maximising independence and promotes improvement for individuals. This requires a different way of working, which may be difficult for some staff such as those undertaking assessments or providing care, who are used to traditional approaches to care. However, this may also produce greater job satisfaction and stability for workers (Bolton 2012). With the outcomes-based commissioning model in Wiltshire, more people than expected decided to stay with their current provider through direct payments, which meant it took longer to transfer from the old system to the new (Bolton 2012).

Kotitori model in Finland: In Finland, the **Kotitori model** involves the city contracting with a private provider that provides a 'one-stop shop' or 'integrator'. Case managers work with a range of public, private and third sector organisations to provide personalised help for each individual, in place of standard packages of care (Tynkkynen 2012). Self-reported evaluation measures show high customer satisfaction results, and though the costs of case management were higher, overall costs per customer over the age of 75 were lower than for individuals in the city system. Individuals in the Kotitori system had 14 per cent fewer visits to emergency care, 15 per cent less inpatient care, 30 per cent less consultations with specialists and 29 per cent less moves to institutional care compared to individuals in the city system (Lillrank 2016). The Kotitori model has been implemented in an urban area where clients are likely to have more purchasing power, and there are likely to be more providers than in rural areas. The model is most suited to a market that has a large number of diverse providers (OECD 2012).

Gesundes Kinzigital model, Germany: Gesundes Kinzigital was established in 2006 as an integrated care management company. It holds long-term contracts with funders and operates on a membership model, with Gesundes Kinzigital holding virtual accountability for the budget for the population group and

negotiating a range of contracts with local providers. The approach includes a focus on prevention (including healthy lifestyles), a patient-centred approach (including individual treatment plans and a named health care professional chosen by the patient who provides continuity of care), and an integrated IT system. The approach has led to cost savings of 7 per cent and reduced emergency hospital admissions (equating to €4.6 million in 2012), as well as improved health outcomes and patient experience (NHS England 2016).

Devon Cares: Northern Devon Healthcare NHS Trust runs **Devon Cares**, working with local domiciliary care providers to organise care. The trust was awarded the five-year contract in April 2016 and has reported reductions in the number of unfilled care packages: 70 per cent of packages are filled within 1.5 hours of referral, and 97 per cent within four hours. Devon Cares works with more than 30 providers to fill packages of care. Other reported benefits include improved staff retention rates and a small reduction in delayed transfers of care (Nursing Time 2017). The approach has resulted in some local providers being excluded from the list of subcontracted providers, with some unhappy about the fees that go to the overarching organisation as part of the model.

Personalisation

As well as large-scale outcomes-based commissioning, there is a move to a more personalised approach that promotes individual choice and a healthy market in which people can exercise choice. Direct payments, personal budgets and ISFs are all means to increase personal choice and control over care arrangements. **Direct payments and personal budgets** are more established, particularly for adults with learning disabilities, and provide individuals with a budget (approved by an assessor) to purchase services of their choice from a provider of their choice. Personal budgets are notional budgets managed by the local authority; direct payments are budgets transferred to individuals, either in the form of pre-paid cards or cash direct into their bank accounts.

An evaluation of individual budgets carried out in 2008 (Glendinning et al 2008) found that they were positively received by users. Benefits varied by user group, highlighting that individual budgets work well for working-age people with disabilities, though there were mixed findings for people with learning disabilities; it also highlighted challenges for older people, including that 'a potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control'. Challenges highlighted by the evaluation included whether economies of scale (or purchasing power) as found in large contracts could be achieved or sustained by individual budget purchases, and indeed how changes would impact on the wider care market. For example, if greater use of individual

budgets increased demand for personal assistants, would their prices increase? Personal budgets rely on individuals having choice; there may be instances (for example, in rural areas) where choice is limited, so personal budgets may work less well.

A more recent national survey of personal budget holders (Hatton and Waters 2013) found that 70 per cent reported a positive impact in terms of getting the support they needed, being supported with dignity and being as independent as they wanted to be. Over 60 per cent reported a positive impact on physical health, mental wellbeing, and control over support. The survey found that personal budgets were less likely to make a difference for older people in terms of mental wellbeing, control over important things in life, and relationships with paid supporters. Importantly, support for planning was associated with better outcomes, particularly for older people.

Individual service funds (ISFs) are similar but far less established. They involve an agreed amount of money going directly to a provider to provide care for an individual, giving providers flexibility in how they meet the person's needs. ISFs have been described as a 'middle option' to direct payments, suitable for individuals who want the flexibility but not the responsibility. They are 'an internal system of accounting within a service provider that makes the personal budget transparent to the individual or family. This helps to provide flexible support by making the organisation accountable to the person' (TLAP 2014). One interviewee outlined the potential benefits of ISFs:

So I wonder whether in the future, part of what we need to do to establish a different kind of home care is to enable consumers, to enable citizens to say 'I know it's my right to have an individual budget, I want it as an individual service fund, I'm off now to choose my provider of choice'.

Moving beyond social care, some approaches aim to bring together a person's health and social care needs into one budget, enabling even greater flexibility in how care is arranged. **Integrated personal budgets** involve health and social care commissioners working together to provide a pot of money for individuals to use for their care. A notional budget, funded jointly by social care and health services, is managed by individuals to enable new ways of working. Integrated budgets may offer an opportunity to address inefficient and fragmented approaches to meeting needs, bringing together funding sources for community health services, social services and benefits with a simplified single point of access. While personal budgets are established in social care, they are less established in health services, which may present challenges in implementing this approach, and it highlights the need for new ways of working alongside innovative financial approaches.

Integrated personal commissioning aims to 'enable people, with help from carers and families, to combine the resources available to them in order to control their care', including health and social care, as well as the voluntary sector (Agur *et al* 2017). An evaluation by the University of York is due to be completed in April 2019. Its interim report highlighted the need for good relationships between agencies, including governance and ways of working to support joint working such as multidisciplinary teams and co-location (to enable teams to work on caseloads together). Sites that were led by or used external organisations had made more progress in delivering the work, with leadership from the clinical commissioning group (CCG) and local authority for long-term change. Linked datasets between health and social care enabled cohort identification and costing of packages where it was in place. Where it was not, developing linked datasets and implementing integrated personal commissioning without them was a major challenge. Starting with a defined area was considered beneficial.

Personalised commissioning relies on individuals being able to exercise their choice. In some instances, commissioners have taken steps to ensure that individuals have a market of providers to choose from. In Somerset, the local authority worked with **Community Catalysts** to support and encourage local microenterprises (see 'Community assets and connections'). Local authorities are responsible for ensuring that there is a market in which individuals can exercise their choice, and microenterprises may suit some service users and some care workers. They may be able to offer more personalised and relationship-based care, as well as autonomy for staff. They may also be able to innovate – for example, providing specific care for minority groups. Microenterprises have been found to be 'more flexible than larger providers in the way in which care in the home was delivered' and cost-neutral (Needham *et al* 2015).

The role of support, advice and information in enabling individuals to exercise choice will be key, whether they are using personal budgets to exercise choice with local authority funded care or funding their own care. The Care Act recognises the need for information and advice for all those in need of support, including those who fund their own care. Information and advice is often raised as a concern for those accessing home care services (Healthwatch 2017; CQC 2013). In the **Wiltshire** outcomes-based commissioning example (see 'Alternative commissioning'), assessment services and advice are available for all including self-funders. Other studies have highlighted the role that local authorities can play in assessing housing needs (Battersby 2016). There are several examples of **websites and databases** listing local services, with common challenges of keeping databases up to date in a market that has high churn. In **Germany**, a website provides a single point of access and information for residents about their care options.

Examples

Inclusion Glasgow provides individually tailored and creative support to people of all ages, working in partnership with families and enabled by ISFs. People are supported to use their budgets creatively to meet agreed outcomes and may even be supported to leave the organisation and become employers in their own right. An evaluation found significant improvement in quality of life and outcomes, with support costs reduced by 44 per cent over five years. The evaluation suggests that commissioners 'need to free up services to manage individual budgets on behalf of individuals and families. This is legally and technically very easy, and it opens the door to a whole range of innovations' (Animate 2014).

The **Somerset Microenterprise Project** provides support for those interested in setting up a microenterprise, aiming to ensure a healthy local market.

Integrated care approaches

Working with services beyond social care such as district nursing, occupational therapy, housing and other public services offers an opportunity to maximise assets and ensure that people's experiences of care are co-ordinated and person-centred (Charles et al 2018).

Integrated health and social care community-based teams

Integrated community teams bring together community health, social care and other professionals. They exist in many forms: some use stratification and case management approaches aimed at specific populations, others are based on principles of placed-based teams, as described in the Buurtzorg example (see 'Autonomous team working'), while others still are aligned with GP practices (Burgess 2012). Key elements include shared assessments and care planning, which have the potential to reduce duplication and improve co-ordination of care. There is potential for alternative approaches to workforce and traditional roles – for example, having more generalist or flexible roles. Some approaches are commissioned jointly by the local authority and the CCG. The important elements are that working together enables care that is focused on meeting all of a person's needs:

We're not just saying, we've come in, washed and dressed this person and gone out of the house; we're looking at that person every time as an individual and the bigger picture, making sure that their care needs are met, but also things that need addressing in their home.

If they're able to deliver outcomes for people in a really flexible service that's person-centred, well, that's what everybody wants.

A Cochrane review found promising evidence for case management approaches to home support for people with dementia, including potential for reduction in admissions to residential or nursing homes, reduced carer burden, and reduced overall health costs (Reilly et al 2015).

Integrated health and social care teams in Torbay serve between 25,000 and 40,000 older people. Ward-based health and social care co-ordinators are the key point of contact for referrals. Their outcomes include low emergency admissions and low delayed transfers of care (Sonola et al 2013). In Catalonia, the Social and Health Care and Interaction Plan (**PIAISS**), by a local integrated care board, defines health and social care priorities and has developed a number of initiatives, including a more co-ordinated approach to home care which involves 'streamlining and coordination of home assistance and care services provided by the two systems' (health and social care), and introduces time-limited home help service and post-discharge home rehabilitation as alternatives to extended hospital stays. The approach has led to reduced hospital admissions, fewer accident and emergency (A&E) visits, reduced medication costs and faster responses (European Social Network 2017). Germany developed a network of **local care management services**, which aim to use case management tools, enable service co-ordination, and provide and monitor customised home care packages (The Danish National Centre for Social Research 2011).

Housing

A number of new models of care recognise the links between housing and home care. As outlined by the Housing Partnership United Kingdom (2012), 'The once distinct boundaries between housing arrangement, domiciliary care and handyman services are potentially so blurred as to be counterproductive'. Approaches range from adapting a person's home (for example, through adding a stairlift or light sensors) to communal living arrangements with shared home care provision. Team approaches that include handypersons to improve housing, such as CAPABLE (described in more detail *below*), work with social care to meet a person's environmental needs and prevent deterioration.

Home adaptations range from minor adaptations that cost less than £1,000 (such as hand rails and lighting improvements) and major adaptations that cost between £1,000 and £10,000 (such as stairlifts and bathroom adaptations). A systematic review of the evidence (Centre for Ageing Better 2017) found that minor adaptations prevent falls and injuries, improve performance of everyday activities, improve mental health and are cost effective. The evidence is less clear for major adaptations but suggests that they can support people to achieve outcomes in some circumstances. Individuals, their family and carers should be involved in the decision-making process regarding housing adaptations, focusing

on individual goals and what the person wants to achieve. People may be resistant to adapting their homes until a point of crisis, and delays in installing adaptations can reduce their effectiveness.

Public services, voluntary sector and others

Beyond social care, housing and health, there are a range of innovative approaches working with the voluntary sector and other public services in ways that support people and link them to their communities. While support from the voluntary sector and other public services cannot replace statutory home care services, the additional support and connections can meet needs that go beyond the physical, which are important in prevention and maintenance of wellbeing.

Working with voluntary sector organisations can connect people with neighbours, befriending services, and a range of innovative approaches to provide support beyond a person's physical needs. The Royal Voluntary Service's **Good Neighbours** initiative aims to help people stay independent through friendly, social contact. The service works with local GPs to identify older people most at risk of hospital admission, and volunteers provide practical help ranging from changing a light bulb to picking up a prescription.

Other examples highlight the role that other public services can play and the benefits of working with them. Jersey Post are piloting a **Call & Check** service, where postal workers provide a regular visit to those who would benefit from extra help and support, having a brief conversation to check how the person is and working with the person's contacts to relay messages or requests to the appropriate authority as needed.

Fire and rescue services have partnered with Age UK, the Alzheimer's Society and NHS services to provide **safe and well visits**, including visiting vulnerable people who are not engaging with services, addressing safety hazards in people's homes, and informing people about (and making referrals to) other services (Charles et al 2018).

Examples

In **Lidköping, Sweden, integrated home care teams** provide person-centred integrated care for frail older people (European Social Network 2017). Home care teams include home helpers, occupational therapists, physiotherapists and nurses who work closely with a separate mobile palliative care team. A municipal home care nurse co-ordinates care. In the **Norrtälje model, in Sweden**, the local public bodies responsible for health and social care formed a joint committee that owns and directs a public company which is responsible for purchasing and delivering care for the whole population (Wodchis et al 2015). A

local evaluation of Sweden's integrated home care teams carried out by a consultant company in 2010 found that the increased costs of home care were counterbalanced by less use of residential care; it also found that, for individuals served by the integrated home care team, there was a 92 per cent reduction in number of days at hospital and 80 per cent reduction in number of visits to the emergency ward (European Social Network 2017).

The **Encompass multispecialty community provider (MCP) in Kent** has established five multidisciplinary community teams made up of GPs, community nurses, pharmacists, social prescribers, social care workers, and health and social care co-ordinators who manage caseloads of individuals identified as being at high risk of hospital admission. A database provides details of local voluntary and community services. Community networks made up of service users, patients and frontline staff from health, social care and local voluntary services co-designed the care model.

Community Aging in Place, Advancing Better Living for Elders

(CAPABLE): CAPABLE supports low-income older people in the United States who have difficulties with one or two activities of daily living (ADLs) (Szanton et al 2011). Occupational therapy, nursing and 'handyman' visits are co-ordinated to work towards functional goals identified as important by the service user. Key elements include motivational interviewing and person-centred care; the intervention is structured around assessment, education and interactive problem-solving customised to each individual's goals. Occupational therapists carry out interviews to identify problem areas, followed by observations of the person carrying out tasks identified as difficult, assessing the environment, and discussing potential modifications and assistive devices. Nurses visit the person to work on functional goals and help the participant identify any issues with pain, medication management, mental health and communication with primary care. Civic works 'handymen' visit the person's home to identify and install any necessary equipment such as railings on stairwells, fixing flooring, installing doorbells and supplying non-slip bath mats. Occupational therapists and nurses are co-located and hold bi-weekly meetings to discuss cases.

Key to the approach is that it is not just person-centred, but person-directed. It is also based on investing health care money in the home environment, recognising that this will have an impact on health care in turn. The model is designed to be integrated as a referral from primary care, health providers or social care. During a five-month period of receiving support from the CAPABLE model, the number of ADLs individuals reported having difficulty with fell by almost 50 per cent, and the number who reported having no difficulty in self-care increased by 50 per cent. At the five-month reassessment point, more than double reported having no difficulty performing their usual activities and

depressive symptoms were also significantly reduced. Individuals were less likely to be hospitalised during the intervention than in the year before (Szanton *et al* 2015). A prospective randomised controlled pilot trial found that the intervention group improved on all outcomes (difficulty in performing ADLs, health-related quality of life and falls efficacy) (Szanton *et al* 2011).

Mountain Empire's Program of All-inclusive Care for the Elderly (PACE)

in the United States offers health and social care in community centres and people's homes. Serving mostly women with multiple long-term conditions, the approach is based on 'aging in place' and co-ordinating care from an interdisciplinary team. Day centres provide rehabilitative and psychotherapy services, as well as socialisation, food, games and exercise, and laundry and bathing for some. At home, interdisciplinary care teams develop individual care plans, based on a review of the person's home and support networks, with assessments repeated twice a year. Each team is responsible for 150 older people and includes two primary care providers, nurses, occupational and physical therapists, dieticians, social workers, personal care attendants and drivers. Daily briefings enable team members to review problems and adjust care plans as needed. The PACE approach has been found to improve quality of care, including lower mortality rates, better management of pain and reduced hospitalisations and 93 per cent of individuals would recommend the programme to a friend or relative (Ghosh *et al.* 2014). It may be particularly suited to rural populations.

Age UK's co-ordinators were established as part of Cornwall's personalised integrated care programme (Age UK 2016). The programme involved Age UK, local GPs, community teams and social services identifying older people with multiple long-term conditions most at risk of unplanned hospital admission. The role of the co-ordinator was to undertake a series of structured conversations with individuals to understand their personal goals and circumstances, using that to work with other services to develop an individually tailored plan. Co-ordinators continue to work with those individuals for three months of intensive support, including volunteers, health, social care and community groups. The pilot of Age UK's personalised integrated care programme in 2012 found an 8 per cent reduction in social care costs and a 26 per cent reduction in emergency hospital admissions. Since then, pilots in Kent, Surrey and Sussex have also demonstrated improvements in wellbeing and reduced hospital use. Nuffield Trust is carrying out an evaluation that is due to be published in the summer of 2018.

Community assets and connecting

Being connected to communities and enhancing a person's wellbeing overall is a common theme in literature about what people want from their home care. Individuals' needs and how they are met go beyond what paid care workers provide, and include care and support from friends and family, support to get involved in the community, voluntary sector services and more. New approaches to home care should move from a narrow focus on eligibility to a broad focus on the personal, the family and the community (Bolton and Mellors 2016; Charles et al 2018).

Supporting informal care

Many individuals receiving formal home care will rely on a range of people, including friends, family and neighbours (informal caregivers) alongside caregivers employed by home care providers (formal caregivers). Recognising and co-ordinating this care, and enabling both to communicate and work together, can avoid duplication of tasks, provide support for informal carers and provide more joined-up care for individuals. Technology can also strengthen communication and co-ordination of care between informal and formal caregivers and reduce duplication of tasks – for example, with care plan apps that can help communication and care planning, as well as provide reassurance for informal carers (see 'Co-ordinated care planning').

In the Netherlands, the range of support networks individuals will be receiving care from is recognised and home care providers are required to **strengthen links with informal carers**. What is most helpful may depend on the type of support network the individual has, including whether their network is small or large and whether it is made up of mostly formal or informal caregivers (or a mix of both). It may range from supporting spousal caregivers to mobilising more helpers from the individual's personal network, or for larger networks it may be explicit organisations and nominated individuals to co-ordinate care (Broese van Groenou et al 2016).

Informal caregivers may be unknown to services and may not be forthcoming in accessing support or help. GPs and other health care professionals may be well placed to identify and signpost informal caregivers to support that is available.

Interviewees highlighted the importance and value of working with informal carers:

... I think for a long time we've so many services and so many different organisations and people with fancy job titles that when we... I think when we think about the need for services it's almost as if the family role has come to an end because it's time for the professionals to get involved... They're the experts in the person's life, not the professionals.

Paid care leave for informal care-givers such as family members is offered in many countries (Colombo et al 2011) including Belgium, which offers up to 12 months of publicly paid leave for carers; Japan offers up to 93 days with 40 per cent of salary paid, and in Norway, full salary is paid for carers' leave. Denmark reimburses 82 per cent to employers who pay full wages during care leave. These only apply to carers who are employed, many of which are not. Another approach, as taken in Finland, is **direct remuneration** from local authorities to informal caregivers of an amount similar to what formal carers would be paid. In Germany, cash benefits are paid to family carers at 50 per cent lower than the cost of home care agencies and take-up is high. In the UK, direct payments and personal budgets can be used to pay informal caregivers, though in practice few people do this (Colombo et al 2011).

Targeting financial remuneration to informal caregivers is complex, and trade-offs often have to be made between providing tokenistic remuneration to a broad range of carers or more substantial financial support for a narrower group. Complexities include assessing who is eligible, who is the primary caregiver, and how assessments are made and circumstances monitored. There may also be impacts on the quality of care the individual is receiving and impacts on the private market – for example, if payments for informal carers lead to a 'grey market' of individuals paying non-family members to provide care that is low quality or trapping family members in a caregiving role.

Supporting informal carers can also include respite care, counselling and training services. Sweden has an **integrated respite and support system** for carers, which includes counselling, training and respite care free of charge. Respite care ranges from in-home care, 24-hour 'instant relief' services, and weekend breaks. Other countries such as France and Germany have **information centres** that can provide advice and signposting for financial, physical, emotional and social aspects of caring, and can connect caregivers to formal carers and statutory services for advice about the individual's condition or care needs. In Bremen, Germany, **social services centres** are partly funded by communities and voluntary sector organisations but also receive grants from local authorities.

The economic value of care provided by friends, family and neighbours far exceeds expenditure on formal care and is often preferred by individuals. The Organisation for Economic Co-operation and Development (OECD) (Colombo et al

2011) describes support for this type of care as a 'win-win-win approach: for the care recipient; for the carers; and for public systems'. It concludes that cash benefits can provide compensation and recognition for carers but that they should be seen as an element of a care plan, alongside training for the informal caregiver, work reconciliation measures (such as flexible working arrangements) and other forms of support (such as respite care and counselling).

Connecting to communities

There are a range of models that exist to connect people to their communities and local voluntary sector support. **Community-led support**, described as local partnerships focused on collaborating to support people to live fulfilled lives, is based on principles of information and access about diverse local solutions, promoting independence and wellbeing, providing holistic and seamless support, empowering staff and improving use of local resources. An evaluation of a range of interpretations of community-led support found examples of improved experiences and outcomes for local people, reduced waiting times between first contact and accessing support, more referrals resolved at first point of contact, reduced cost, improved staff morale and satisfaction (including examples of improved retention and absence rates) and potential savings (Bown et al 2017). Housing LIN (Battersby 2015) introduced the concept of Continuing Care Neighbourhoods, moving from a system where older people live in isolation with brief home care visits offering minimal levels of support, to a co-ordinated approach from health and care providers, voluntary organisations, community groups and other public services.

Local area co-ordination began in Australia to support people with learning disabilities and has since been adopted in a range of countries and for a range of service users. It operates as a single point of contact and builds relationships with individuals, families and communities to develop networks of stakeholders, enabling co-ordinators or 'community navigators' to draw support from the community to enable individuals to maximise their independence and connections to their communities. The approach moves the focus to local relationships and assistance rather than use of statutory services. It aims to add value to existing support services not replace them, recognising that people's needs often go beyond the physical:

... when you dig deep into people's anxiety and need, there is a lot of, 'this happens because of', or 'this is my fear because of'...

[our purpose is] to do whatever it takes to enable you to live well at home, and be part of your community.

... it's not really a service, it's just a way of supporting you to think about the things that really matter in your life.

An evaluation of local area co-ordination and **local community co-ordination in Swansea and Neath Port Talbot** demonstrated financial benefits in the range of £800,000 to £1.2 million between July 2015 and April 2016, representing a benefit/cost ratio of between 2:1 and 3:1 (Roderick et al 2016). Highlighted as key to success of local area co-ordination in Wales, were agile and dedicated leadership, co-produced recruitment of co-ordinators, senior-level support and a high level of autonomy from local authorities.

In Japan, local authorities outsourced care to not-for-profit '**welfare councils**', which demonstrated savings compared to in-house provision. Later, these developed into 'welfare corporations' funded by membership fees, services charges and public subsidies. Key to these organisations is a mutual help ethos where local residents are recruited as paid volunteers or can receive time credits redeemable for other relatives or for use later in life. In more rural areas, citizen-led voluntary groups and co-operatives were formed, which operate on the basis of mutual help and paid volunteers. A review of the approach found that 'the best strategy to unlock the voluntary sector's full potential to deliver supplementary home care is a multi-platformed approach, with adequate public purse funding, which pragmatically maximises resources' (Hayashi 2015).

Examples

Community circles informally co-ordinate support from friends, family and neighbours. They can put people in touch with things that may have a huge impact on their wellbeing but are not part of funded services – for example, putting them back in touch with a bowling club or a faith community to prevent loneliness. They go beyond signposting, supporting the person to maximise independence and involvement and to work towards their goals. They can also link into formal care (for example, each wellbeing team, as described earlier in this report, has a community circle connector). The wellbeing worker and the community circle connector go out together to hold initial conversations and work together to meet the person's needs in the round. A review of evidence for circles of support (Wistow et al 2016) found circle members reported that they 'produced major social, psychological and practical outcomes for the individual and their family'.

Living Well is a programme initiated in Cornwall that aims to move towards more proactive, long-term and planned approaches to care. The focus is on meeting a person's whole life needs proactively, not reacting to an episode of ill health and subsequent cycle of dependency. A matched cohort evaluation of 100

users of the programme over a year by Cell Consulting found a 20 per cent improvement in wellbeing, 41 per cent reduction in acute hospital costs, 8 per cent reduction in social care costs, 28 per cent reduction in community hospital inpatient activity and 20 per cent reduction in community hospital length of stay (NHS England 2016). A more in-depth evaluation covering 1,000 users is under way with the South West Academic Health Science Network.

Careview is an app in use in Leeds, which identifies households where there are signs of isolation, such as rubbish not being collected, and public-facing professionals (such as police community support officers, traffic wardens and post office staff) can mark these to alert agencies that there may be cause for concern (Voluntary Organisations Disability Group 2017).

Social prescribing enables GPs to refer patients to voluntary and community services. The **Rotherham social prescribing service** has a team of voluntary and community sector advisers who receive referrals from GPs, assess the individual's needs and refer onto support in the voluntary and community sector. It is funded through the Better Care Fund and administers a grant funding pot to commission additional services or activities from the voluntary and community sector. An evaluation (Dayson et al 2016) found that service users had fewer non-elective inpatient admissions and A&E attendances in the year after their referral to social prescribing compared to the year before. A&E attendances reduced by 17 per cent, while non-elective inpatient spells reduced by 11 per cent; these figures were more stark when service users over the age of 80 were excluded from the analysis. The evaluation also found improvements in wellbeing and self-management. After three to four months, 82 per cent of service users had experienced positive change in at least one outcome area. Social prescribing was particularly effective at reducing social isolation and loneliness for service users with long-term conditions. It is estimated that the total NHS costs avoided between 2012 and 2015 were more than £500,000.

Family-based support and communal living

Shared Lives and Homeshare

Shared Lives, and similar programmes in Europe and the United States, are well established, particularly for people with learning disabilities. Individuals are matched with carers who are paid a modest amount and share their lives and their homes with the person. Arrangements vary but can include full-time live-in arrangements, short breaks and respite, or day care. Matching is a key element of the approach, with time invested to ensure a mutually beneficial relationship and compatibility in terms of skills, interests and the home environment, with assessments and visits taking place before a match is made (Brookes and

Callaghan 2013). Service users are invited to become part of carers' lives, including their families, social networks and neighbourhoods.

I think the commitment of having somebody live with part of your family and be a part of your family is something that people don't really take on lightly. So, you know, people's values and people's commitment to the people they work with is really extraordinary. It's not just a job. You know, it is a job, people get paid for it, but it is having somebody in your home with you and I think that's just a really... It just shines through with the kind of the people that we support and the people that offer the support. The relationships are just built on a... such a nice level of how they benefit one another's lives really rather than just, 'oh, I'm coming in to a residential home to do a night shift or an early shift', and it's different staff all the time. It's really lovely.

Shared Lives approaches enable greater flexibility about care. As well as continuity and relationship-based care, the approach can encourage social interaction, inclusion and integration into communities and promotes continued development of life skills (Brookes and Callaghan 2013). There is strong evidence for Shared Lives approaches, in terms of cost savings (Todd et al 2013), service user experience (Brookes et al 2016) and quality of life outcomes (Callaghan et al 2017). The approach is more established for people with learning disabilities, and evidence often compares the approach to residential settings. A high proportion (95 per cent) of Shared Lives schemes have been rated as good or excellent by the CQC – the highest proportion of all regulated social care service types (Brookes and Callaghan 2013). In a survey of 500 Shared Lives users, 34 per cent had made five or more new friends, 32 per cent had made two to four new friends, and 30 per cent had made one new friend; 35 per cent had learned a household task and 30 per cent had taken their first ever holiday in the UK (Todd et al 2013). In a more recent survey, older people reported that they 'valued the increased opportunities for social contact and getting involved in activities, many describing their Shared Lives carer as a friend or source of company and the value of feeling "part of a family"' (Callaghan et al 2017). Homeowners have reported that having someone stay with them made them feel safer and that the opportunity to learn from each other was a valuable experience (Allen et al 2014).

As interest grows for expanding Shared Lives with older people, there are some specific contextual factors to consider. Older people are more likely to require care on an urgent basis – for example, as a result of rapid deterioration, whereas people with learning disabilities are likely to have longstanding social care involvement in their life (Brookes and Callaghan 2013). The same study argues that further work is required to raise awareness of Shared Lives

schemes, as recruiting sufficient carers can be a constraint. Despite evidence of the benefits of Shared Lives and Homeshare schemes, they remain a small part of social care provision. Reasons for this include: lack of upfront investment, difficulty with recruitment of carers, lack of awareness, and short-term matches.

Novus Homeshare is a similar programme that brings together people who need help to live independently with (often younger) people who provide companionship and help in exchange for an affordable place to live. Householders range from 70 to 90 years old, and the average age of a homesharer is 27.

Although there is limited evidence to date about impacts of Homeshare, the schemes could prove mutually beneficial: they are able to provide companionship, prevent loneliness, bring financial benefits in the form of affordable housing for the homesharer and low-cost support for the homeowner, and enable someone to live independently in their own home for longer. They have the potential to strengthen local communities and bring people of different ages, cultures and social backgrounds together. However, success and longevity is reliant on the matching process, and alleviating apprehension among homeowners to join the scheme (Allen et al 2014; Shared Lives Plus 2017). Suggestions for increasing uptake of Homeshare schemes include use of personal budgets, wider and targeted promotion, and the need to ensure that homesharers do not suffer loss of benefits (eg, single occupancy council tax discount).

Communal living

Communal living arrangements can provide a means for people to continue living independently as an alternative to home care or residential nursing homes, enabling individuals to make collective arrangements for care and support needs. **The Green House Project** in the United States was developed as an alternative to nursing homes. The approach provides support for a small number of people (10–12) to live in a real home environment with a low staff ratio, freedom to set their own daily routines, and common areas with a family-like atmosphere. Staff are certified nurse assistants who also plan activities for residents and prepare food. Staff have autonomy and work in teams. The approach is based on principles of person-centred care and empowered teams, with a coaching approach to leadership. Evidence of impact includes better service user experience, better quality of life and lower rates of hospitalisation when compared with older people in traditional residential settings (Kane and Cutler 2008). In the UK, **Evermore** provides a family-style environment in households of between 10 and 12 older people. Each person has an apartment with a communal space. Residents are called 'villagers' and have their domestic

and catering needs met, and are able to buy care packages as needed. The approach is designed to cater for residents for the remainder of their lives, even if they require constant care.

Examples

Vernon Gardens, Brighton, is a block of 10 self-contained extra care flats. The local authority involved prospective tenants, as well as their families, social workers and carers, in the development of the flats. Residents chose to commission care using a block contract for their 'rise-and-retire' service and night cover, using personal budgets for everything else (Hortop and Day 2012).

3 Discussion

This report aimed to highlight innovative approaches to home care that offer potential to improve quality and respond to challenges in the home care market. The challenges – and therefore the solutions – vary, and include (but are not limited to) local factors such as rurality, the state of the local provider market, historical approaches to commissioning, and workforce availability. However, some common themes emerged from the evidence we looked at, both in terms of challenges and key priorities for new models.

Common challenges

Resources

Innovative models require investment upfront, but there is often a lack of clarity about to whom savings are likely to accrue and when. The cost of commissioning home care has been effectively driven down over recent years and in many areas it is a low-priced market in which innovative models are unlikely to be able to compete on the basis of price per hour of care. The question is whether making further cost savings on this basis in the home care market is realistic, and indeed whether it is desirable. Investment in new approaches should be considered in the context of health and care, and as part of a wider shift to preventive and community-based care.

Time-and-task commissioning

The nature of commissioning was raised consistently as a barrier to adopting and implementing innovative approaches. Commissioning on the basis of blocks of time and specific tasks was highlighted as preventing providers from being able to think differently about how workforce is recruited, trained and employed, as well as their ability to provide person-centred care that is flexible and focuses on promoting independence. Innovative providers described some commissioners as being risk averse. This approach to commissioning has also meant that outcomes have not traditionally been recorded for home care service users, making it difficult to establish impact or move towards models of care that are incentivised and focused on improving outcomes for service users.

Health and social care

Many innovative providers referred to the challenges that arise from having health and social care needs assessed and met by different systems. Where innovative providers were trying to meet individuals' health and social care needs together, they faced challenges in working across organisations that

differed in terms of culture, pay rates for staff, bureaucratic processes, information governance and approaches to commissioning.

Priorities for innovative approaches

Workforce

Recruiting and retaining care workers was a priority for providers. Making care an attractive career option and providing a better working environment was not limited to better pay and terms and conditions, but was linked to more satisfying working arrangements and organisational models. This includes (for example) less isolated working conditions, additional responsibilities and training, and ability to be flexible to the needs of service users, to work autonomously and make decisions.

Person-centred approach

Innovative providers described moving away from a transactional approach to care towards building trust and relationships between service users and those who provide personal and intimate care. This ranged from service users choosing their teams of carers, to working in small geographically based teams. Flexibility to meet a person's needs according to their changing priorities and circumstances, as well as going beyond physical needs, was important.

Proactive and preventive approach

Underlying many of the innovative approaches to home care was moving towards a model of care focused on the principle of proactive and preventive care, and away from reactive, fragmented and episodic home care. This includes meeting all of a person's needs together, from health and social care to social and general wellbeing.

Informal caregivers and community assets

A person's network of informal caregivers should be recognised and involved as a key part of an individual's care team. Supporting informal caregivers should be a priority for policy-makers. Community assets range from voluntary sector organisations providing befriending support, to alternative approaches to care, and incorporating these into care teams enables a focus on wellbeing and independence.

Technology as an enabler

Providers and commissioners we spoke to were clear that technology should not be seen as a solution in itself, but as an enabler for new ways of working and approaches to providing care. Technology has the potential to provide

reassurance for informal carers, to aid communication between members of a care team and as part of new ways of organising and working.

Commissioning

Traditional approaches to commissioning and payment mechanisms that enable flexibility and new ways of working – ranging from large-scale outcomes-based approaches to ISFs – were raised by innovative providers as necessary tools to enable adoption of new ways of working. New approaches to commissioning were considered necessary to provide different working arrangements for carers and to incentivise an approach focused on outcomes for service users.

Home care should be considered as part of a wider move towards preventive, population-based approaches to health and social care that make the most of community assets (Humphries et al 2016; Maybin et al 2016; Charles et al 2018). The approaches outlined here offer potential to change the way that home care is delivered and the quality of care experienced by service users, focusing on a move towards integrated, person-centred care where care workers operate in teams, and informal carers are supported and considered as part of the care team.

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