ESSS Outline

New models of care at home

Robert Sanders

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Background

Social care continues to face financial, service, quality, and workforce issues. And while care at home appeals as a way of keeping people in their own homes and living independently it is on the whole not doing this well (CRESC, 2016). Despite the promotion of choice, control and independence, the lived experience of home care is often short care assistant visits (15-30 minutes) focused on basic tasks like eating, taking medication or getting dressed.

Home care has no real agreed upon definition, covering a wide range of support services. It is also increasingly a contentious term, with its focus on providing a service at home rather than on maintaining and supporting a wider concept of independent living .

As an overall service, it is critical to the longstanding strategic intention of enabling people to age in place and to deliver care as close as possible to people's homes (King's Fund, 2018). The provision of personal care to people with long-term care needs is the core service provided by most local authorities and covers a wide range of activities, from the basics of helping with household tasks to broader services that cut across health and housing for example. It is often seen (and measured) as an intervention to avoid hospital admission and care.

Time-and-task commissioning remains the dominant approach to home care. While this offers a safe political default for a local authority commissioner and the provider (CRESC, 2016) in recent years attempts have been made to move beyond it. The growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of home care are either not meeting people's needs and / or unsustainable. They can also act as a barrier to developing new models of care. Providers are frustrated with the model. It provides little emphasis on measuring longer-term costs or outcomes, and has been suggested as a contributor to market instability (King's Fund, 2018).

New models

Provision of care in the home needs to take account of the broader context and include community assets, the importance of wellbeing and prevention, and the role played by unpaid carers and other services such as healthcare and housing.

New models of care are needed, but not happening fast enough to meet growing needs. The current system seems to support local innovation rather than widespread improvement, and is often dependent on local leadership, a willingness to change, and the availability of additional funding. There is little evidence of consistent efforts to share learning, scale-up or spread approaches that work well.

There is a desire across the UK to combine new community-based models of health and social care, assistive technologies and remote monitoring, to give people the same quality of support at home as they would in a residential care setting or hospital.

Audit Scotland (2016) argues that NHS boards, councils, and integration authorities, can do more to facilitate change, including focusing funding on community-based models and workforce planning to support new models. There also needs to be a better understanding of local population needs, evaluation of new models, and shared learning. A stronger national approach, alongside local innovation is needed to deliver improvements and instil a learning culture in social care support (Scottish Government, 2021).

The premise of this move away from largely fee-based commissioning, with focus of payment linked to tasks and units of time or processes to be followed, towards one based on outcomes, is that it will enable better quality and more efficient, flexible and person-centred approaches to care (King's Fund, 2018). Outcomes-based and personalised commissioning have the potential to enable providers of all types to innovate and provide care that is flexible and better meets people's needs.

Scottish Care focus group (2019) participants highlighted some foundations for new models of care, including:

- Collaboration and training across teams, sectors and partners
- An emphasis on palliative care
- Respite at Home
- Integration of care home and care at home services
- Step up and step down care
- Rehabilitation and reablement
- More short term care
- Recognition that one size doesn't fit all
- More technology

It's important to note that most new models of care are developments of existing models, and also how interconnected the different areas of care at home are, operating across health, housing, financing, and the workforce. Where things like age-friendly environments have worked (WHO, 2018) it's been through integrated systems, projects and initiatives to prevent loneliness, to adapt homes with technology, to implement tele-assistance and tele-medicine, where good evidence has been collected for scaling up, and where citizens are part of policymaking.

Reduced budgets and increased demand mean local authorities continue to be under pressure to keep costs low, which feeds down to providers. New models of care that provide preventative and personalised care require upfront investment as well as changes to existing funding arrangements.

Recent reports

Audit Scotland's (2016) report identified new local models of care in Scotland which are shifting the balance of care from hospitals to more homely and community-based settings. The aim was to help support new integrated authorities to implement new ways of working, address the challenges facing health and social care services and help increase the pace of change. These approaches included community preventative approaches, enhanced community care models, intermediate care models, and initiatives designed to reduce delayed discharges. It concludes that a lack of national leadership and clear planning is preventing the wider change needed.

SCIE's Rapid Review (2016) looked at the key messages emerging from the evidence on home care and to signpost examples of innovative practice. It summarises the main themes around domiciliary care workforce, person-centred, relationship-based care, outcomes-focused services, specialist services, integrated care, commissioning, and characteristics of the home care market.

Scottish Care's (2017) report looks at the care at home sector's role in delivering preventative care, the changing role of the home care sector - moving away from relationship-based care and the provision of publicly funded care narrowing to those with high level support needs. It considers key principles that should be at the heart of a new sustainable model of home care, and the future development of home care services workforce, commissioning, and prevention in Scotland.

The King's Fund (2018) explored alternatives to traditional 'time-and-task' models of delivering care at home, highlighting a wide range of emerging models of care:

- technology and digital, including assistive technology and in-home monitoring
- coordinated care planning
- new approaches to recruitment in home care, including values-based recruitment
- autonomous team working, including the Buurtzorg model and wellbeing team
- alternative approaches to commissioning, including outcomes-based models
- personalisation, including personal budgets and integrated service funds
- integrated care approaches
- community asset or connections models, including Community Circles
- family-based support
- community living models such as Shared Lives and Homeshare.

The University of Sheffield (2018) explores some of the key issues experienced in home care, including the need to professionalise the care workforce, the opportunities and risks around new models, and the importance of increasing take-up and use of technology. Recommendations for policy, employers and research include a need for Governments to

invest in and improve the status of the home care profession, and help reverse recruitment and retention problems.

The Independent Review of Adult Social Care in Scotland (2021) makes specific recommendations about prioritising improvement programmes for self-directed support, and commissioning and procurement. Examples of improvements include reducing use of institutional / residential care, making better use of adaptations and technology, involving people and their families more in decisions, including wider community support in care, and professionals working better together better across health, social care support and other services such as housing.

Evidence

There are real challenges in finding evidence relating to the impact of non-traditional social care and support generally. This search revealed little in the way of strong empirical research, from Scotland and elsewhere, around new (and existing) models of care at home, which reduces guidance available to policy makers and commissioners.

The lack of evidence around impact, implementation costs, efficiency gains or cash savings, and outcomes for service users was noted by Audit Scotland (2016). Generally, attempts to monitor the impact on local systems, assess the costs, savings, outcomes and sustainability are few. Alongside this learning is not being shared effectively, if at all - particularly timescales, securing funding, costs and resources requirements, staff training and development, impact and outcomes, key success factors, scalability and sustainability.

For newer models it is often too early to assess their impact. Many organisations highlight the lack of time, resource and skills as a barrier to carrying out major change and to properly evaluate new models.

It should also be noted the focus is very much on care at home for older people. There are considerable gaps when it comes to other groups such as younger people, those with mental illness, or with physical disabilities.

Commissioning

Despite the push, progress towards personalisation and outcomes-based commissioning has been slow and inconsistent. There is little evidence (Jasper, 2019) of a shared understanding of either term or how to fully measure them.

Improving care at home is a complex problem, care needs are diverse, and financial pressures transfer down from national policy to local authority budgets and through care firms to the workforce.

It's argued (CRESC, 2016) that with overlapping challenges and differing needs and currently limited options there is a need to move beyond standard reform - i.e. central state and / or market-led initiatives. Current commissioning arrangements constrain the form and focus of services delivered by home care agencies. A response based on social innovation is needed, based on the understanding that there may be no single best way to provide care, and that change needs to be participative and involve new partnerships.

Services focused on time and task can mean providers, commissioners and care workers look at care as units of time - without little focus on individuals, their social needs, and desired outcomes. Sutcliffe's (2021) interviews found home care managers were keen to reform the time and task component, disliking its rigid format and restricted focus that can hinder person-centred care, in terms of length of visit and type of activities delivered (LGiU, 2017). But while outcomes-based commissioning is widely supported in principle, very few fully achieve it.

Hudson (2019) outlines a new model for commissioning and delivery that challenges the current balance of power and the way decisions are made: commissioning small and local, commissioning holistically, commissioning personally, and commissioning ethically.

The King's Fund (2018) highlighted many examples of alternative approaches to commissioning and family based support, but finding examples being widely implemented in practice was more difficult, and the extent to which they could be scaled up was questionable. Most of these approaches are either new or still being piloted and require local authorities to collect and monitor outcomes data. Some commissioners doubted whether providers had sufficient skills or infrastructure to do this.

Discussion from a Local Government Information Unit roundtable (2016) provided examples of more flexible support plans. One council had developed a plan which was less focused on tasks and more focused on support along nine social care domains over a four-week period. The amount of care contact time was fixed across a four-week block, but providers had some discretion in this period to flex support. Outcomes were then assessed retrospectively. Another council was using a similar approach, creating a 'time bank' for care support contact time. This was done within an existing traditional home care contract and they saw it as a step toward outcomes based commissioning.

An example from Norrtalje Sweden (Wales Centre For Public Policy, 2020), saw a public company, an integrated care provider, and an integrated commissioning body created to manage health and social care services for the region. As part of this integrated approach

to health, social care and rehabilitation, home care staff coordinate interventions across the whole pathway of care.

Joint commissioning

The need to broaden the commissioner role and to commission for better outcomes through a collaborative partnership model between home care agencies and commissioners is recognised, taking a more relational approach with providers and other stakeholders. This should include voluntary and community organisations providing social support (Jasper, 2019; Sutcliffe 2021). Davies (2021) found:

- Commissioning involved complex systems and processes, shaped for local context, but frequently changing, suggesting a constant need to reframe arrangements
- Partnership models with providers were mainly transactional, reducing the ability to commission flexible services for personalised outcomes
- Tightly prescribed contracting and working collaboratively with providers are competing and incompatible goals.

The Scottish Government's Independent Review of Adult Social Care in Scotland (2021) calls for social care providers to be supported in developing networks of mutual support, of alliance based commissioning, provider co-operatives, user-led and community-owned organisational models, and social enterprise models. They argue this would help improve quality, flexibility, resilience and responsiveness to people's needs. Reviewing the expertise and skill requirements of social care commissioning to ensure a consistent localised approach for collaborative commissioning processes is also called for by Scottish Care (2021), with involvement from all social care stakeholders in exploring all cost model options.

Enablers

The LGiU (2016) highlight a number of enablers to achieving outcomes based commissioning:

- Better understanding of risk and relaxing outcome attribution
- Trust between local authorities and providers – recognition of the skill of social carers
- A solution to the funding squeeze
- Providers need autonomy and funding
- Openness of information to build trust
- Working out how the NHS works with local government on these issues
- A systems financing overhaul

- Time and resources to think about and implement solutions, rather than fire fighting

Circle (2018) also highlighted the need for suitable ways of regulating and quality assuring new / different models of home care, with frameworks applicable to models like social enterprises. Lack of regulation is limiting their access to the wider market and local authority contracts.

Think Local Act Personal's directory of innovations provides examples of innovative and community-centred models of support that improve people's wellbeing to help commissioners and providers to find out about community-centred approaches that are having a positive impact on people's lives. The examples are all person-centred, work with people's strengths, and are about supporting people to have a life and not a service - helping people stay well and connected with others, supporting people to live well at home, new models of care and support with accommodation, and regaining independence.

Barriers / Issues

Traditional approaches to commissioning are frequently cited as a barrier to spreading innovative models of care (autonomous teams, for example). 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 (King's Fund, 2018b). Initial investment is required to see payoffs later, and these may be in different parts of the system. A lack of trust between commissioners, providers and care workers has been seen as a barrier to commissioning for outcomes. An increase in performance monitoring raises concerns regarding providers' autonomy within this relationship (Davies, 2020).

The LGiU (2016) highlight a number of barriers to achieving outcomes based commissioning, including:

- Lack of trust between commissioners and providers
- Lack of clarity about OBC within social care and across council / health colleagues
- How to attribute outcomes to home care delivery
- A task-focussed culture within social work
- A better understanding (or acceptance) of risk

Think Local Act Personal highlights that it has been a challenge to embed a community first culture throughout social work, commissioning, contracting and procurement generally. Staff speak about the barriers of council procedure and 'the way we do things' attitude. Interviewees saw this changing, with social workers, support planners, and

agencies increasingly seeing the benefits of creative and innovative solutions such as those provided by micro-enterprises.

Integration

Integrated services potentially provide an opportunity to adapt to the preferences of service users, but do present challenges for commissioners.

The King's Fund (2018) found diverse experiences of and opinions about integration, both in terms of commissioning and service delivery. Some local authority commissioners talked about developing a new arrangement with NHS colleagues, either by attempting to establish an integrated community service with input from nurses or seeking a contribution from CCG commissioners for the additional cost of home care agencies carrying out clinical tasks. Three local authorities were working with integrated health and social care teams with a single point of entry into the system for patients and users, and social care and nursing teams working in close collaboration.

There is evidence (Jasper, 2019) of some joint commissioning of home care with NHS commissioners - such as intermediate care services which include home care for older people provided on a short term basis on discharge from hospital. This kind of approach potentially offers the opportunity to design a service around the health and social care needs of older people with complex needs, in a single service, with a greater focus on 'care at home' rather than home care.

Service Users

Service users, carers and families are the voices missing from most of the discussions around new models of care. A tender exercise for Care at Home in Midlothian included volunteer carers assessing all submissions, interviewing and final scoring. However, carers and people who use services generally have little involvement in commissioning or tendering, and there is scope to do more (Audit Scotland, 2016b).

Autonomous team working / neighbourhood care

Buurtzorg

Autonomous team working, including the Netherlands Buurtzorg model - in which small, autonomous, neighbourhood teams of nurses and nurse assistants provide domiciliary and clinical care to help people regain and retain independence and provide

person-centred care - is another outcomes based approach to home care. Key to its success 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 (King's Fund, 2018). A core part of the original model also involves connections to community assets.

The evidence base from the Netherlands shows high satisfaction rates for people supported by the service and staff who work in it. It also has lower costs against typical industry costs, including overheads, reduced demand in the wider health and care system, and lower staff turnover (Helen Sanderson Associates, 2017).

Where it has been adopted in the UK, it has provided good quality of care with positive feedback from staff and clients. But it has required additional investment, as well as more flexible commissioning. Moreover, the benefits of person-centred, preventative care are often long-term and cost savings may be realised in other public services, such as health (Wales Centre For Public Policy, 2020). There are difficulties stemming from cultural and regulatory differences between the Netherlands and the UK. It is unclear whether place-based models inspired by Buurtzorg but limited to a person's social care needs will deliver the same efficiency and benefits. Some other providers of 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 (King's Fund, 2018).

Lalani (2019) found the implementation of a community nursing model based on the Buurtzorg approach in East London had mixed success. Patient experience of the service was positive because of the better access, improved continuity of care and longer appointment times in comparison with traditional community nursing provision. The model also provided important learning for developing service integration in community care, particularly around effective collaborations with other health and social care professionals.

Key observations from a test-and-learn of the Buurtzorg model in West Sussex (King's Fund, 2019) offered 5 key observations around implementing the model, including being able to adapt not implement the model, developing infrastructure for it early, and clarifying the roles and responsibilities of working as a non-hierarchical team.

Neighbourhood care

Leask's (2019) study looked at the implementation of a neighbourhood care model in a Scottish integrated context from the patients perspective. It found care from a self-managing, integrated, health and social care team was highly acceptable to people, with a variety of wellbeing benefits reported. The autonomy of staff to adjust care frequency and duration to patients' needs, alongside active engagement and partnership with support plans, is central to this.

Leask (2019b) also aimed to understand the experiences of working in a self-managing, integrated, health and social care team. Recommendations for future implementation included the collocation of staff, developing frameworks to support clear delineation of tasks and embedded, accessible support structures. Elements of self-management that appeared acceptable included staff rostering, autonomy to adjust care provision, and the ability to provide care continuity to patients.

Collaboration / Multi-disciplinary teams

Scottish Care (2021) puts collaborative assessment, planning and decision making at the centre of social care. Care at home has to be seen as part of a wider context – housing, health, social care, and other coordinated care planning / integrated care support.

The Welsh Government (2018) plans a shift of services to smaller, regional and local centres, with expertise and specialisation shared through hub and spoke models. Within a local area, clusters of GPs, nurses, dentists, community pharmacists, optometrists, physiotherapists, paramedics, and social workers will work alongside other areas of community support as a seamless health and well-being service focussed on prevention and early intervention, including increased use of in-home web based support. These services will support people in making decisions about looking after themselves and staying independent.

The evidence suggests (SCIE (c)) that MDT approaches are associated with improved outcomes for people who use services, including:

- better treatment planning and compliance
- more services provided at home or close to home
- reduction in service utilisation
- greater self-management and better preventative care to stay well
- improved service user experience
- engagement and activation through social prescribing and shared decision-making
- greater continuity of care across different care settings.

Harnett (2020) offers a framework to implement integrated care for older persons in Ireland. There is a growing evidence base supporting effective service responses for older persons, typically including multidisciplinary, community based teams providing services in or near to the older person's home, most notably from smaller regions like Catalonia, Scotland and Singapore.

It should be acknowledged that the wider contributions and involvement can make administration and information management more difficult (LGiU, 2016).

Examples

GP-led Virtual Community Ward teams in Aberdeenshire (Scottish Government, 2021) bring health and social care professionals together to identify, coordinate, organise and deliver services required to support people. The team provides short-term integrated solutions within the community as an alternative to more-resource-intensive community and acute hospital admissions. This approach has reduced hospital admissions, improved multi-disciplinary relationships, with better use of resources, less duplication, and quicker access to interventions.

Enhanced community care (Audit Scotland, 2016) is a multidisciplinary team approach aimed at keeping people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Some models also support quicker discharge from hospital. The Tayside Enhanced Community Support Service enables GPs, with the support of a multidisciplinary team, to lead the assessment of older people with frailty and at risk of unplanned hospital admission, and to respond to any increased need for health and social care support.

All Together Better Sunderland (NHS Confederation, 2016) brought together teams of health and social care professionals, alongside local support organisations. Services are designed to wrap around the person (including family members and carers) and respond quickly to the health and social care needs of people who require help to prevent short term problems from escalating and keep people at home. It showed a reduction in emergency admissions for over 65's, an increase in the number of referrals to the Recovery at Home service, a reduction in the use of community beds, a fall in admissions to residential care, and fewer delayed transfers of care.

East Lothian's service for the integrated care of the elderly offers access to multidisciplinary and multi-agency emergency care at home, or the place people call home, to older people. (Audit Scotland, 2016). The service offers a single point of contact for both people who are at risk of being admitted to hospital, and to actively facilitate the discharge of people from hospital.

A Scottish Care case study (2018) looked at an overnight care at home service through a transfer of budget from the NHS service to the independent sector.

A review from Manchester (CQC, 2017) aimed to understand how older people move through the health and social care system, with a focus on how services work together. It looked at the planning, commissioning and delivery of health and social care services across three key areas: maintaining the wellbeing of a person in their usual place of

residence, care and support when people experience a crisis; and step down services, return to usual place of residence and/or admission to a new place of residence. It found partnership between health and social care services based on a period of time building relationships across the system, including the voluntary and community sector, but joint health and social care working was inconsistent, with different delivery and outcomes across the city. The experiences of people receiving services also varied.There were good preventative initiatives in place, but not enough use of the voluntary and community sector. Areas identified for improvement included, better commissioning and contract monitoring, the need to move to a strengths-based model of home care, and more support for older people with low-level mental health issues.

Primary Care Home

This model is a way of organising care for groups of 30,000 to 50,000 patients, developed by the National Association of Primary Care, and links staff from general practice, community services, hospitals, mental health services, social care, and voluntary organisations to deliver joined-up care.

Evaluation (Nuffield Trust, 2018) found participation in the programme strengthened inter-professional working between GPs and other health professionals, and stimulated new services and ways of working tailored to the needs of different patient groups. Policy-makers should accept that widespread service change takes investment and time to establish, with support from people at all levels and across organisational boundaries.

NAPC (2018) report on case studies of areas across England where primary care and social care are successfully integrating services with local communities benefitting.

House of Care

The Scottish House of Care Approach has been widely used and adopted to encourage and promote GP input to care and support planning conversations routine for people with long-term conditions and support self-management (Scottish Government, 2021). This model allows healthcare to embrace Care and Support Planning and support the self management of people living with multiple long term conditions. It supports and enables people to articulate their own needs and to decide on their own priorities, through a process of joint decision making, goal setting and action planning. Local evaluation and experience suggests it improves public and practitioner satisfaction, develops meaningful person-centred quality improvements, and enhances system transformation (The Alliance).

Matter of Focus' (2020) evaluation of the House of Care model found many places in Scotland where the House of Care approach has been successfully implemented. Local

leadership, the quality of the training and ongoing support to the practices have all been highlighted as factors important to this success. There is also some evidence that this approach can mitigate health inequalities.

Workforce

A general need to elevate the professional status of domiciliary care is identified across the literature. The quality of care depends on the staff who deliver it and improving their status, pay and conditions, and opportunities for progression is vital. The commissioning framework should provide the flexibility to provide person-centred care tailored to the needs of each individual.

Recent events have continued to highlight the instability of the home care market and workforce, with higher turnover and vacancy rates than care industry average (Davies, 2020). Engagement with local providers to identify future demand for services and providing suitable support to meet it is key to understanding and securing capacity.

A Scottish Care focus group (2019) looked at the future role, skillset and responsibilities of home care workers, which would likely need to include:

- Greater self-management in teams
- Autonomous, yet increasingly collaborative ways of working
- Being part of integrated multi-disciplinary teams, with increased blurring of job roles and a wider range of health and care responsibilities
- Leadership of health and social care intervention
- Health education role
- Anticipatory care planning role
- More enhanced clinical skills - especially medication support
- Occupational therapeutic intervention

Integration provides potential for some low-level clinical tasks being built into the work of care workers. Some commissioners (King's Fund, 2018) have seen this as a positive step to ease pressure on nursing staff and meet local integration agendas. But this is assuming practical concerns such as available time and funding (for staff and providers) to do this, in terms of training and in a workplace with high levels of staff turnover.

Sutcliffe (2021) looked at how home care agencies could be supported to deliver personalised home care for people with dementia. Themes and issues identified from home care managers included a focus on the constraints imposed by local authority processes and limitations, taking greater responsibility for assessment and care planning, encouraging outcomes that include wellbeing and social goals, maintaining and

facilitating inclusion of clients in community activities, and developing the skills and status of care workers.

Voluntary Sector

Japan explored using the voluntary sector to fill the shortfall in statutory provision. Hayashi's (2016) interviews with managers from voluntary organisations looks at their experiences. Empirical evidence indicates a limited capacity to deliver this due to differing supply mechanisms between the traditional voluntary – and the new hybrid – organisations. A preparedness to revise interpretations of the earlier models of the voluntary sector are essential. It concludes 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 funding.

Housing

The right home environment can maintain or improve people's physical and mental health, wellbeing and social connections, enable them to carry out day-to-day activities safely and comfortably, and help them to do the things that are important to them. The majority of older people live in mainstream housing, as opposed to specialist housing or residential care, but UK housing stock is often not accessible or adapted to meet people's needs as they get older, with small room sizes, stairs, baths rather than showers and steps outside. Installing aids and adaptations into people's homes, such as grab rails and level access showers, can improve the accessibility and usability of a person's home environment (Centre For Ageing Better, 2017).

Home adaptations

Most evidence comes from outside of the UK (New Zealand and North America), and it shows that home adaptations, particularly minor adaptations, are cost-effective and can improve a range of outcomes for people in later life, including improved performance of everyday activities, improved mental health and preventing falls and injuries, especially when they are done in combination with any necessary repairs, such as improving lighting and removing trip and fall hazards, and are delivered in a timely manner and are in line with people's personal goals. The King's Fund (2018) identified that health, housing and social care commissioners should make specific commitments to improve housing quality, including repairs and adaptations, and put in place preventive strategies to identify and support people at risk.

Improving and adapting homes to support a better quality of life is seen as crucial by the Scottish Government but they admit the process is complex and off-putting (Scottish Government, 2021). Housing adaptations are often an investment rather than a cost, and

clear arrangements should be in place setting out where responsibility sits for paying for and arranging work.

Models

Several new models of care also recognise the links between housing and home care. Innovative approaches are emerging for adults and older people with more complex needs, enabling them to remain in a more homely setting where extra care is provided. Close working between social care, health and housing services is needed. These approaches range from innovation in existing models such as home adaptations to communal living arrangements with shared home care provision and Live In Care.

The Chartered Institute For Housing (CIH, 2018) highlighted schemes that have been developed by housing organisations working in partnership with social care, and health partners. The case studies cover a diverse range of services but a number of overlapping themes contributed to their success, including multi-agency partnership approaches, taking and sharing risks, developing a person-centred approach, use of assets and business commitment to service development, and involvement of local communities. These can be seen across most of the new models of care based around housing.

The SFHA (2021) argue that Scotland's housing sector, working together with health and social care services, can take a preventative approach by reducing the pressure on frontline NHS and community services by delivering more support and interventions at home, building and adapting flexible and connected homes, investing in Technology Enabled Care, and supporting modern sheltered and supported accommodation. They identified the following models and case studies:

- **Step Up Step Down**: provides housing with care for individuals who cannot be at home due to their care and support needs. It helps to prevent unplanned admissions to hospital and facilitates timely discharge from hospital before an individual returns to their own home. A number of housing associations offer very small-scale models, for example, Hanover Housing's Varis Court was developed, managed and funded in collaboration with the NHS, with some homes managed and funded by the NHS.
- **Extra Care Housing**: offers an integrated service model with on site tenancy and housing support and personal care with a local flexible staff team, safety and security and personalised telecare. Evaluations demonstrate benefits in cost-effectiveness and quality of life.
- **Health at Home**: Examples include Near Me and Hospital at Home. Redesign for the future will come from use of data, replacing obsolete systems and infrastructure, alongside personal confidence in using these services. Near Me has been set up by Blackwood for customers across Scotland enabling access to a variety of NHS services remotely. Their digital support system, CleverCogs, enables

customers to keep in contact with loved ones with the family and friends video call feature, which led to an 800% increase in interaction with friends and family during the early months of lockdown.

- **Supported Accommodation**: required where rapid rehousing or Housing First approaches to mainstream housing are not an option for those who have experienced homelessness. This may include small shared living in mainstream social rented tenancies. Homeless Network Scotland is currently carrying out research to explore models for the future.
- **Housing with Support**: Bridging the Gap identifies a number of case studies where people with learning disabilities and/ or complex needs have moved from unsuitable long stay institutional care and out of area placements to housing with support.
- **Community Resource**: Housing with care can act as a 'hub' from which flexible personal care and support services can be delivered to the local community. Communal spaces offer community resources for the wider older population including social events and drop-in services.

Intergenerational Living

In France and Germany, intergenerational housing is put forward as an option by public authorities (Labit, 2016). France mainly favours the student-senior home-sharing model whereas the intergenerational model based on co-housing between older people and families is gaining ground in Germany. Certain conditions are essential for this intergenerational solidarity to be fully effective, particularly voluntary participation and commitment to the project.

Winston Churchill Memorial Trust (2019) reports on a comparative analysis of intergenerational, communal and co-housing models in the Netherlands and Denmark. It identifies the benefits, key factors to success, and makes recommendations for the UK in relation to the under-occupation of homes by older people, combating loneliness, preventing health deterioration among communities and designing healthier built environments.

Homeshare

Homeshare is where someone struggling with housing provides companionship and practical support in exchange for low-cost accommodation. Typically, an older householder with a room to spare will be carefully matched with someone needing low-cost accommodation. Arrangements are overseen by a management company for the protection and assurance of everyone involved (Scottish Government, 2021). Support might include: help with daily living tasks such as shopping, cooking and cleaning; overnight security; engagement with local social activities. Homeshare itself does not provide any element of personal care for the householder.

Results from Martinez' (2020) study indicated that older adults benefitted from the companionship, supplemental income. Navigating boundaries around sharing space and time, and interpersonal relationships were challenging. Agency facilitation was key to supporting a positive experience.

Shared Lives

Shared Lives (Social Finance, 2019; SCIE, 2021; Think Local Act Personal) is a type of care provision for young people or adults who need care and support. It typically has supported people with learning disabilities, mental health problems or other needs that make it harder for them to live on their own. It is growing in popularity for older age groups and is seen as an alternative to supported living or residential care. The schemes match someone who needs care with an approved carer. The carer shares their family and community life, and gives care and support to the person with care needs. The arrangement can be long term live-in, visits for short breaks, and day support. Shared Lives can be a stepping stone for someone to get their own place, a way for people to leave hospital, before returning home, and prevents older people moving into a care home too early.

SCIE (SCIE) lists the potential benefits:

- An additional option through self-directed support
- Another option for respite care
- A step-down support option from hospital or community intermediate care
- Continuity of care in the community
- Combats social isolation
- Supporting older people in the early stages of dementia
- Avoids costly out-of-area placements in residential settings

In the UK the model is currently used in Fife, to support a range of people, particularly those with learning disabilities, but could be extended to offer respite to unpaid carers of frail older people and utilised more extensively across Scotland (Scottish Government, 2021). Thurrock is supporting the growth of the scheme in partnership with the Shared Lives Incubator. The Incubator combines Shared Lives expertise with social investment, supporting the council and provider to deliver and expand Shared Lives care in a way that meets the local context and need (Think Local Act Personal, 2018).

The adult placement model is well established in Northern Ireland (SCIE) but there is little research on the outcomes for older users of Shared Lives (Callaghan, 2017). Current findings suggest that Shared Lives can deliver good outcomes for older people, particularly for overall quality of life - it consistently outperforms all other forms of regulated care in CQC inspections. An independent report by Social Finance showed that Shared Lives costs £26,000 less per year for people with learning disabilities than other

forms of regulated care (£8,000 less for people with mental health problems). Kent University and others have found positive outcomes, and there is a national outcome-measuring tool in use in England (Think Local Act Personal; Helen Sanderson Associates, 2017).

Lessons learned from a recent pilot (Social Finance, 2019):

- Needs are more complex, often requiring carers to have accessible homes
- Local authorities need to devote considerable effort, particularly to referrals
- Reaching a critical mass of placements / carers takes time and long-term resource
- A rigorous and flexible approach needed to respond to challenges and uncertainty
- Investors, providers, and local authorities need to better share risk
- Repayable grant models to support growth may be more appropriate than investment seeking a return

Retirement Communities

Currently, there is no clear definition of Retirement Communities, with at least 10 different terms in use, including 'Assisted Living', 'Extra Care' and 'Retirement Villages'. These models combine housing with a range of care and support services, alongside communal facilities. Evidence shows that Retirement Communities keep people healthy for longer, can reduce and reverse frailty, and provide more effective and cost-efficient delivery of health and care. For example extra care housing in Moray, Scottish Borders and South Lanarkshire combine private housing space with communal facilities, on-site care and dedicated nursing support, enabling people to live alone or with other people of their choosing, in their own home with an onsite team providing 24 hour support (Scottish Government, 2021).

Health Innovation Network (2020) explores a range of alternative 'housing with care' models for older people in Japan and New Zealand which either avoid or delay the need for long term institutional care. These include housing for older people with care services, group homes, small scale multifunctional facilities, welfare housing for people on low income, continuing care retirement communities, naturally occurring retirement communities, and retirement villages. They report around social interaction, connecting with the wider community, safety net, scale, thinking ahead, and includes case studies of the facilities and initiatives visited and identifies the main learning points for the UK. There is some evidence of better outcomes for residents, and many of the facilities are cost-effective and could be replicated in the UK. The recommendations are: improve awareness of housing with care and its role in supporting healthy ageing; increase provision of housing with care services; integrate housing and care facilities for older people with the wider community; commission for outcomes rather than activity; recognise the importance of social interaction and keeping active; provide a clear national policy for funding long term care for older people.

Evans (2020) argues extra care housing offers a model that can support those with dementia to live at home, offering specialist person-centred care as and when it is needed. Key factors include flexible commissioning and staffing, appropriate design of the environment, and suitable location of the scheme within the wider community.

Community / Social connections / Networks

Approaches like Circles of Support, asset-based community development, and local area coordination, again aim to harness the resources of a person's family and community to support them more effectively. This can be underpinned by personalisation, support through direct payments and personal budgets (King's Fund, 2018). There is a great deal of work going on in health and social care to improve community-based care, mainly happening through innovative projects, but arguably a radical transformation of community services is needed. One that makes use of all the assets in the local community, breaks down silos between services and departments, and reduces fragmentation in service delivery (King's Fund, 2018c).

Incentivising community engagement with social care services and building community investment and relationships can help support understanding, development, and innovation to ensure services meet individual and community needs (Scottish Care, 2021). Connecting people to wider community support and resources and cultivating partnerships with local voluntary services, housing associations and other community organisations creates the capacity for self-care and social prescribing, enhances health and wellbeing, and promotes resilience and independence. This can include libraries, parks and leisure centres, voluntary sector programmes and activities, wider community supports, community asset and connections models such as Community Circles (Think Local Act Personal, 2018).

Examples

In Falkirk community-based Living Well centres offer appointments or access to a web portal where people can come in and have a conversation about their wellbeing, and health and social care supports, and access holistic supports, community-based supports and advice to help manage their own health and wellbeing (Scottish Government, 2021).

Thurrock re-commissioned its core home care services with focus on communities. The new framework challenges providers to work on a strengths-based approach to provide home care and identify community resources. The council has retained two areas for the in-house service and is introducing Wellbeing Teams in two neighbourhoods to test and

evaluate the impact of this new way of delivering support to people within their own homes (Think Local Act Personal).

Community Led Support

The Adult Social Care Review in Scotland (2021) makes reference to community led approaches including community engagement, co-production, early intervention and support and the importance of strength-based conversations. Many of the recommendations in the report promote the principles that Community Led Support adheres to (NDTI, 2021). Working across England, Wales and Scotland, Community Led Support programme involves a network of over 30 statutory organisations with responsibility for adult social care working with their partners and communities to design and deliver different ways of working which maximise the strengths and community connections of people locally.

Local Area Coordination

Local Area Coordinators aim to support people with care and support needs to find local solutions. They connect with neighbourhood groups, fire, police, housing and health services, banks and businesses, and with the communities they operate in to help identify people who may benefit from their interventions (Think Local Act Personal, 2018).

Local Area Coordination / Coordinators aims to:

- Provide an accessible point of contact in the local community
- Focus on people's own visions for a good life beyond services or formal support
- Help people build on their own assets and natural supports
- Build relationships with individuals, community members and workers
- Be well-connected, contributing to the local community, linked into the service system
- Support system reform by bringing together all partners

International & national evidence show predictable outcomes & cost impact, including examples from England and Wales. When designed to include the core elements, Local Area Coordination sites see reductions in isolation, visits to GP surgeries and A&E, referrals to Adult Social Care or Mental Health evictions and costs to housing, dependence on formal health & social services, and safeguarding concerns (Helen Sanderson Associates, 2017).

Community Catalysts

The Community Catalyst approach is based on releasing local people's capacity to care, where one coordinator supports a larger group of small, self-organising enterprises. The aim is to reduce costs, while providing flexible and personal care for older people and their families, and creating quality self-employment for local people. The results should be

shorter hospital stays, community connections, and reduced isolation and loneliness (Helen Sanderson Associates, 2017).

An example from Somerset (Community Catalysts, 2017; Helen Sanderson Associates, 2017) highlighted co-design, cost savings, job and community enterprise creation, local care and support for older people, an increase in direct payments. Micro-enterprises supported by
Community Catalysts offer an effective means of provision for self-funders and those with direct payments in rural areas (Wales Centre For Public Policy, 2020).

Community Catalysts undertook a survey of 45 families who have used both a micro-provider and a domiciliary agency. Feedback shows micro-providers are able to deliver good outcomes for people. Community micro-enterprises in rural West Somerset delivered over £134,000 in annual savings. The micro-enterprise model is being regularly used to support the discharge of people from hospital. Social workers are beginning to view micro-provision as one of their everyday tools when responding to the needs of residents (Think Local Act Personal, 2018).

Community Circles

Community Circles is both a charity and an approach, which offers ways of bringing community assets into care, promoting entrepreneurship and engaging people and communities as co-producers of sustainable support. Community Circles are facilitated by volunteers who are recruited, trained and supported by Circle Connectors. They bring together family members, friends, community members and service staff to support individuals. They use person-centred methods and tools to identify the things that are important to people and then plan and act to achieve these things - increasing wellbeing, combating loneliness, building community connections and improving care outcomes.

They are currently mostly used by people with dementia, learning disabilities and mental health needs, as well as older people, but are also being explored with other groups who may benefit - for example, young unemployed people, disabled children and adults, and at-risk families.

The evidence base is limited. A PSSRU report on a sample of Circles for people with learning disabilities showed significant reported increases in social care-related quality of life, in addition to increased community connections, reductions in carer stress and reduced likely costs for people with high support needs (Helen Sanderson Associates, 2017). The Circles were argued to have prevented admission to residential care and potentially reduced the need for mental health services by primary carers (SCIE (b)). Circles have also also reported success in utilising community resources to promote social inclusion and improve wellbeing (Wistow, 2016).

Micro-enterprises

The use of micro-enterprises - small social businesses that provide care and support in diverse ways - is often a crucial part of these community approaches.

New Economics Foundation (2020) report explores the benefits of the micro-enterprises approach to care:

- it creates roles that offer more autonomy and control than a typical care job
- it supports recruitment and retention in social care
- it enables more personalised care
- it grows resilience, creativity and diversity in the social care sector

Evidence (Wales Centre For Public Policy, 2020) suggests that microenterprises can offer more personalised care and strengthen the foundational economy without significantly increasing costs, particularly in rural communities. Many of the innovative approaches that worked best have involved personalised and outcomes-based commissioning, underpinned by a partnership-based relationship between commissioners and providers based on trust. However:

- Successful models in England have often relied on direct payments and self-funders
- Franchise arrangements can enable smaller providers to enter the market but are dependent on local context including the availability of external funding and they may struggle to operate at scale
- The success of local authority trading companies has varied and depends on effective management and the nature of local markets including proportion of self-funders.

A University of Birmingham study (2016) found that many aspects of micro-enterprise provision allowed a more personalised care and support service than larger care providers, particularly within the home. It highlighted three aspects of their approach: autonomy of frontline staff to vary the service being offered, greater continuity of frontline staff compared to large care providers, the high level of accessibility of managers to staff and people using the service.

An example from Thurrock shows fifty two community micro-providers delivering a diverse range of support services for around 300 people, creating 38 jobs and 28 volunteering positions. Internal evaluation showed increased availability and delivery of personalised services (Think Local Act Personal, 2018).

Care co-operatives made up of staff, service users and community members provide a range of health and social care in Quebec (Wales Centre For Public Policy, 2020). These social enterprises are supported by established networks funded by government to provide financial and practical support to existing and new co-operative enterprises. Their success is attributed in part to highly supportive legal and policy environments and well established networks of financial and practical support, which do not currently exist in the UK.

Low levels of direct payment take-up and local authority referrals, alongside the financial fragility of the enterprises have inhibited growth of this approach. Steps local authorities could take to promote models like this include developing a local economic strategy for social care, shifting from a time and task approach to more relational practice, involving people needing support and their families in redirecting investment, and placing a higher priority on collaboration within commissioning, to achieve more personalised care, provider and sector resilience, and better value for money.

Evidence

Generally, there is a lack of evidence of what community solutions are being used, what their impact is, the full scalability of these concepts, the extent to which they can be seen as replacements for traditionally commissioned home care services, or their transferability between services for different service user groups (Audit Scotland, 2016; King's Fund, 2018).

There is also a shortage of evaluation of the outcomes of personalisation and collaboratively designed interventions, whether they lead to improved service satisfaction or better quality of care. There is limited research into the impact and outcomes of micro-enterprises in a health and social care context. Where evidence does exist, conclusive arguments for particular approaches and interventions are difficult to make based on the rigour, validity and generalisability of the methods and findings. Although several reports claim that person-centred, community-led services contribute to equality outcomes, it is not clear where this evidence base is drawn from (Iriss, 2018).

Involving people and families more in decisions

Individuals, carers and families should have a much greater say in their care and be more involved in the relationships between providers and commissioners.

The need to involve people who use services, their families and carers better and earlier in discussions about social care supports is one of the most consistent themes of the recent

Scottish Government (2021) review. The benefits of well-established models such as family-based support are clear, but such models may not be appropriate for all those who need care, and there are also likely to be limits to the number of people willing or able to provide this type of care (Kings Fund 2018).

Evidence (Wales Centre For Public Policy, 2020) shows what people want from care in the home is:

- Joined up care where all the person's needs are met together, underpinned by a focus on wellbeing, independence and communities
- Involvement of people and their carers and family
- Consistent and reliable care
- Good relationships with staff including a caring and compassionate approach
- Staff who are adequately trained and skilled
- Advice and information to enable people to make choices about their care.

Self-Directed Support / Personalisation

The introduction of personal budgets through the Self-directed Support Act should have transformed how services are provided in Scotland, with choice and control resting with the individual rather than the commissioner (Scottish Care, 2019). Many home care providers feel in principle it can support more flexible, person-centred and innovative approaches to care delivery, but in reality is not working for the people they support - due to system barriers, lack of understanding and poor communication. Overall, the introduction of SDS has resulted in little change in the way that social care is delivered (Pearson, 2018). A significant culture change is required, to address risk adversity, fears over loss of control, perspectives on what 'appropriate' resource allocation and use is, and attitudes to older people and their aspirations.

There appears to be very little national evidence being gathered into people's personal experiences of SDS, their perceptions of its impact on their personal outcomes and whether it is helping them have more choice and control over their support (The Alliance, 2017).

There has been considerable scrutiny of SDS in Scotland over the past 4 years. The reviews all recognised the potential of the policy but most partnerships have not fully implemented it. Their findings identify many of the same concerns, including:

- A limit to the availability and extent to which people have choice and control
- Bureaucracy of processes and procedures
- Lack of transparency and recording
- The level of co-production
- Inconsistent knowledge across the workforce

Local authorities were found to largely constrain their social care markets through controlling the choices individuals could make over their care, including the types of activities they could purchase and the types of organisations they could purchase them from. This constraint stems from existing procurement legislation and resistance to change in local authorities (Henderson, 2019). This study also identified challenges, including the private sector "creaming" clients and geographic areas and social enterprises being scapegoated where the local market was failing.

The King's Fund (2018) report commissioners and providers like the concept of Individual Service Funds. These involve establishing a notional amount to meet the needs of each individual service user, which is paid directly to the provider. This can be used to fund a flexible package, negotiated with the service user and their family. For providers this potentially means reduced administration, control of a larger budget, greater strategic planning, and job security for staff.

Austerity, reduced funding, and cutbacks in service provision have limited the impact of personalisation. Uptake and use of personal budgets is inconsistent and under-resourced, but those using them tend to respond positively (King's Fund, 2018) in terms of impact on physical and mental health.

Some care agencies supported self-funding clients only, which managers perceived as providing flexibility to allocate longer visits that could be more closely planned with the client and family (Sutcliffe, 2021).

Person-centred

The '3 conversations' model focuses primarily on people's strengths and community assets. It supports frontline professionals to have three distinct and specific conversations. The first conversation is designed to explore people's needs and connect them to personal, family and community sources of support that may be available. The second, client-led, conversation seeks to assess levels of risk and any crisis contingencies that may be needed, and how to address these.' The third and final conversation focuses on long-term outcomes and planning, built around what a good life looks like to the user, and how best to mobilise the resources needed (including personal budgets), and the personal and community assets available. Initial evidence on the impact of the model suggests a significant reduction in the proportion of contacts that go on to receive long-term packages of care. The model has been shown to deliver savings to the local authority and high levels of satisfaction from people who have contacted teams using the 3 conversations model (SCIE, 2017).

The "Esther" approach from Jönköping County Council, in Sweden, focuses on delivering the best possible outcomes for a fictional older resident. Creating Esther helped

professionals to map a range of care pathways and explore how these could be improved to best meet Esther's needs. A number of areas of Scotland have in recent years tried to take a similar approach (King's Fund; Scottish Government, 2021).

Telecare / Tech / Digital

Social care at home has seen little benefit from advances in technology. Current use of technology exists mainly as home-based adaptations such as handrail fittings, lighting improvements, stair lifts and bathroom adaptations. Simple adaptations can prevent falls and injuries, improve performance of everyday activities, improve mental health and are cost effective.

Nesta's analysis (2014) identified four areas of opportunity for technology to delivery impact in care at home:

- communication tools to reduce isolation, increase connections and social interaction
- platforms or marketplaces that engage support from the community
- tools that build networks of support and enable care management / coordination
- tools that improve integration between individuals, informal and formal care providers

Technology enabled care

Technology Enabled Care in people's homes can support and promote independence, manage risk, and provide assurance. But there are concerns around its use to reduce costs and face to face support. It is suggested (Scottish Government, 2021) that the introduction of technology should be explored and discussed as part of support planning, where the person's needs, rights and preferences should be paramount.

Smart Homes

Some models look at how an individual at home can be better connected to a wider support system, including tools to increase communication, connections and reduce isolation, platforms to engage potential informal carers, care management tools (HomeTouch, Jointly), which build networks of support and enable coordination and care management, and integration tools (Patients Know Best). Sensors can be used to facilitate alert systems and understand a person's level of capability and safety in their own home. The Belong extra care housing scheme in Cheshire, for instance, uses bed pressure sensors, alerting 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 (King's Fund, 2018).

University of Sheffield's (2018b) research looked at best practice in age-friendly and smart homes available in the UK, France and China. It suggested retrofitting solutions for integrated health and social care could support ageing in place. Easy to use, convenient systems that allowed older people a degree of personal control over their environment were given importance. Better lighting, convenient light and temperature control, having good outdoor views and outdoor spaces, alongside aids for memory and orientation were highly rated for both design and technology recommendations. The concept of 'homes for life' or adaptable housing that evolves as people age was well received.

There is a real question about the demand for such technologies, from commissioners of time-and-task services and from service users. Technologies might be best viewed as an enabling tool for care workers and service users where new ways of working have been developed, as a preventive tool, and for supporting informal carers, but not as a replacement for the care workforce (King's Fund, 2018).

Barriers and enablers

There is little to indicate new technologies will make a significant impact on the publicly funded home care market. Integration into working practices and systems, and scalability of new developments remain contentious. It takes time to build a new marketplace and to generate evidence of what works and what does not work. Wider changes to the system are needed, with social entrepreneurs, commissioners and care providers working together (Nesta, 2014; King's Fund, 2018).

NCF (2013) suggest stakeholders - providers, commissioners and government - can act to offer more people the benefits of assistive technology and tackle the barriers to its use:

- explain in the context of outcome-based commissioning and measurement of impact
- take a longer-term approach beyond current fiscal constraints
- embed assistive technology in social care with workforce development and guidance
- clarify the role of technology is to help enable, not to replace caregiving
- ensure new systems meets service needs
- consider the ethical aspect with focus on the best interests of the individual
- review thinking around risk and risk management

Examples

The ADASS (2017) interactive toolkit details results of research into how assistive technology and telecare can support adult social services, including detailed practice examples. Programme examples include:

- The Televida teleassistance service in Barcelona which uses teleassistance to provide targeted support to people before they become more dependent, aiming to postpone and prevent the need for care by offering psychosocial support. The service has significantly delayed unwanted moves into residential care, and reduced emergency calls, ambulance call outs, and A&E attendances.

- Assisted Living Leeds provides a wide range of joined up services to support people with physical, learning and care needs with the aim of:
    - increasing the proportion of people using self-directed support
    - reducing permanent admission to residential and nursing care homes
    - increasing the proportion of older people still at home after discharge from hospital into reablement / rehabilitation services
    - increase the proportion of older people offered reablement service following hospital discharge

- West Sussex County's telecare services install equipment dependent on individual needs, from the Lifeline home unit / pendant, to falls detectors, bed / chair occupancy sensors, temperature sensors, smoke, gas and carbon monoxide detectors.

Data

One of the key problems in moving to outcomes based models is lack of quality information and analysis, about people's changing social care needs, progress toward personal outcome goals or changes to health conditions. Technology could help bridge this information gap. For example, Kingston Council is developing new methods for collecting and analysing information to support integrated care between family members, care providers, the voluntary sector and others, to deliver outcomes with people in their own homes. CoCare is an app and information portal developed in local government with care workers and service users that gathers information to support commissioning based on achievement of personal outcomes, and puts the person needing care at the centre of communication (LGiU, 2017).

References

ADASS (2017) New models of care supported by assistive technology

The Alliance The House of Care Model

The Alliance (2017) Personal experiences of Self-directed Support

Audit Scotland (2016) Changing models of health and social care

Audit Scotland (2016b) Social work in Scotland

Callaghan, L (2017) Older people receiving family-based support in the community: a survey of quality of life among users of 'Shared Lives' in England Health Soc Care Community, 25: 1655-1666

Centre for Ageing Better (2018) Room to improve: The role of home adaptations in improving later life

CIH (2018) Sector showcase: housing and independent living

Circle (2018) Ageing well at home: emergent models of home care provision and the professionalisation of the home care workforce

Community Catalysts (2017) Community micro-providers in Somerset: The impact and outcomes of the Community Catalysts project

CQC (2017) Manchester: local system review report

CRESC (2016) Why We Need Social Innovation In Home Care For Older People

Davies, S (2020) Changes in commissioning home care: an English survey Quality in Ageing and Older Adults, Vol. 21 No. 1, pp. 3-14

Davies, K (2021) The challenges of commissioning home care for older people in England: Commissioners' perspectives Ageing and Society, 41(8), 1858-1877 (paywall)

Evans, SC (2020) Can extra care housing support the changing needs of older people living with dementia? Dementia. 2020;19(5):1492-1508

Harnett, PJ (2020) A 10 Step Framework to Implement Integrated Care for Older Persons Ageing Int 45, 288–304

Hayashi, M. (2016) The Japanese voluntary sector's responses to the increasing unmet demand for home care from an ageing population Ageing and Society, 36(3), 508-533

Health Innovation Network (2020) Alternatives to Long Term Institutional Care for Older People

Helen Sanderson Associates (2017) 6 Innovations in social care

Henderson, F (2019) Social enterprise, social innovation and self-directed care: lessons from Scotland Social Enterprise Journal, Vol. 15 No. 4, pp. 438-456

Hudson, B (2019) Commissioning for change: A new model for commissioning adult social care in England Critical Social Policy. 2019;39(3):413-433 (paywall)

Iriss (2018) Person-centred community-led social support and care: equalities and human rights outcomes

Jasper, R (2019) Commissioning Home Care for Older People: Scoping the Evidence Journal of Long-Term Care, (2019), pp.176–193

The King's Fund Case study 1: Jönköping County Council

The King's Fund (2018) New models of home care

The King's Fund (2018b) Home care in England: Views from commissioners and providers

The King's Fund (2018c) Reimagining community services: making the most of our assets

The King's Fund (2019) A review of the West Suffolk Buurtzorg test-and-learn in 2017-18

Labit, A (2016) Housing and ageing in France and Germany: the intergenerational solution Housing, Care and Support, Vol. 19 No. 2, pp. 45-54

Lalani, M (2019) Transforming community nursing services in the UK; lessons from a participatory evaluation of the implementation of a new community nursing model in East London based on the principles of the Dutch Buurtzorg model BMC Health Services Research 19:945

Leask, CF (2019) Acceptability of delivering an adapted Buurtzorg model in the Scottish care context Public Health Volume 179, February 2020, Pages 111-117

Leask, CF (2019b) Implementation of a neighbourhood care model in a Scottish integrated context - views from patients AIMS Public Health, 2019, 6(2): 143-153

LGiU (2016) Achieving outcomes based commissioning in home care

LGiU (2017) Reviving localism: three challenges

Martinez, L (2020) More Than Just a Room: A Scoping Review of the Impact of Homesharing for Older Adults Innov Aging. 2020;4(2):igaa011

Matter of Focus (2020) From fixer to facilitator: evaluation of the House of Care programme in Scotland

NAPC (2018) Primary care home and social care: working together

NCF (2013) Using assistive technology to support personalisation in social care

NDTI (2021) Community Led Support

NESTA (2014) Who Cares? The Role That Entrepreneurs And Technology Can Play In Improving Informal Care In The UK

New Economics Foundation (2020) Community Micro-enterprise As A Driver Of Local Economic Development In Social Care

NHS Confederation (2016) New models of care and prevention: An integral partnership

Nuffield Trust (2018) Primary Care Home: Evaluating a new model of primary care

Pearson, C (2018) Changing the culture of social care in Scotland: Has a shift to personalization brought about transformative change? Soc Policy Admin. 2018; 52: 662–676

SCIE Shared Lives (Adult Placement) - Models of care and support

SCIE (b) Community Circles

SCIE (c) Multidisciplinary teams

SCIE's (2016) Development of a strategic plan for care and support at home for Social Care Literature review

SCIE (2017) Asset-based places: A model for development

SCIE (2021) Future options for housing and care: Improving housing that facilitates care and support for older people

Scottish Care (2017) Bringing home care: a vision for reforming home care in Scotland

Scottish Care (2018) Focus on Partners for Integration and Improvement

Scottish Care (2019) Bringing Home Care: A Vision for Reforming Home care in Scotland

Scottish Care (2021) Coileanadh

Scottish Government (2021) Independent Review of Adult Social Care in Scotland

SFHA (2021) Housing Scotland: Models of housing with care and support

Social Finance (2019) The Shared Lives Incubator

Sutcliffe, C (2021) Delivering Personalised Home Care for People with Dementia: An Investigation of Care Providers' Roles and Responsibilities Journal of Long-Term Care, (2021), pp.58–69

Think Local Act Personal Community alternative to residential care

Think Local Act Personal (2018) Reimagining Social Care: A Study In Three Places

University of Birmingham (2016) Micro-Enterprises: Small enough to care?

University of Sheffield (2018) Ageing well at home: emergent models of home care provision and the professionalisation of the home care workforce

University of Sheffield (2018b) ODESSA: Optimising care delivery models to support ageing-in-place

Wales Centre For Public Policy (2020) Alternative models of domiciliary care

Welsh Government (2018) A Healthier Wales: our Plan for Health and Social Care

WHO (2018) Healthy settings for older people are healthy settings for all: the experience of Friuli-Venezia Giulia, Italy

Winston Churchill Memorial Trust (2019) Supported independent living: communal and intergenerational living in the Netherlands and Denmark

Wistow, G (2016) Circles of Support and personalization: Exploring the economic case Journal of Intellectual Disabilities 20. 10.1177/1744629516637997

Search Strategy

This summary provides an overview of new models of care at home and the evidence supporting their use.

It was for a Scottish social care audience, widened to include evidence from the other UK nations and comparable countries from around the world. The date range was limited to 2015-present. There were no limits on study design but did have a focus on currency and accessibility. We used a variety of sources and databases in researching this topic, including NHS National Education for Scotland's Knowledge Network, Social Care Institute for Excellence, Google Scholar, ASSIA, CINAHL, ClinicalKey, Cochrane Library, EMBASE, Emerald, Ovid Databases, ProQuest Public Health.

The keywords searched were home care, care at home, domiciliary care, social care models, home care models, social care commissioning, community care models. As the search developed this expanded to include autonomous teams, multi-disciplinary teams, home adaptations, telecare, self-directed support, and personalisation.

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