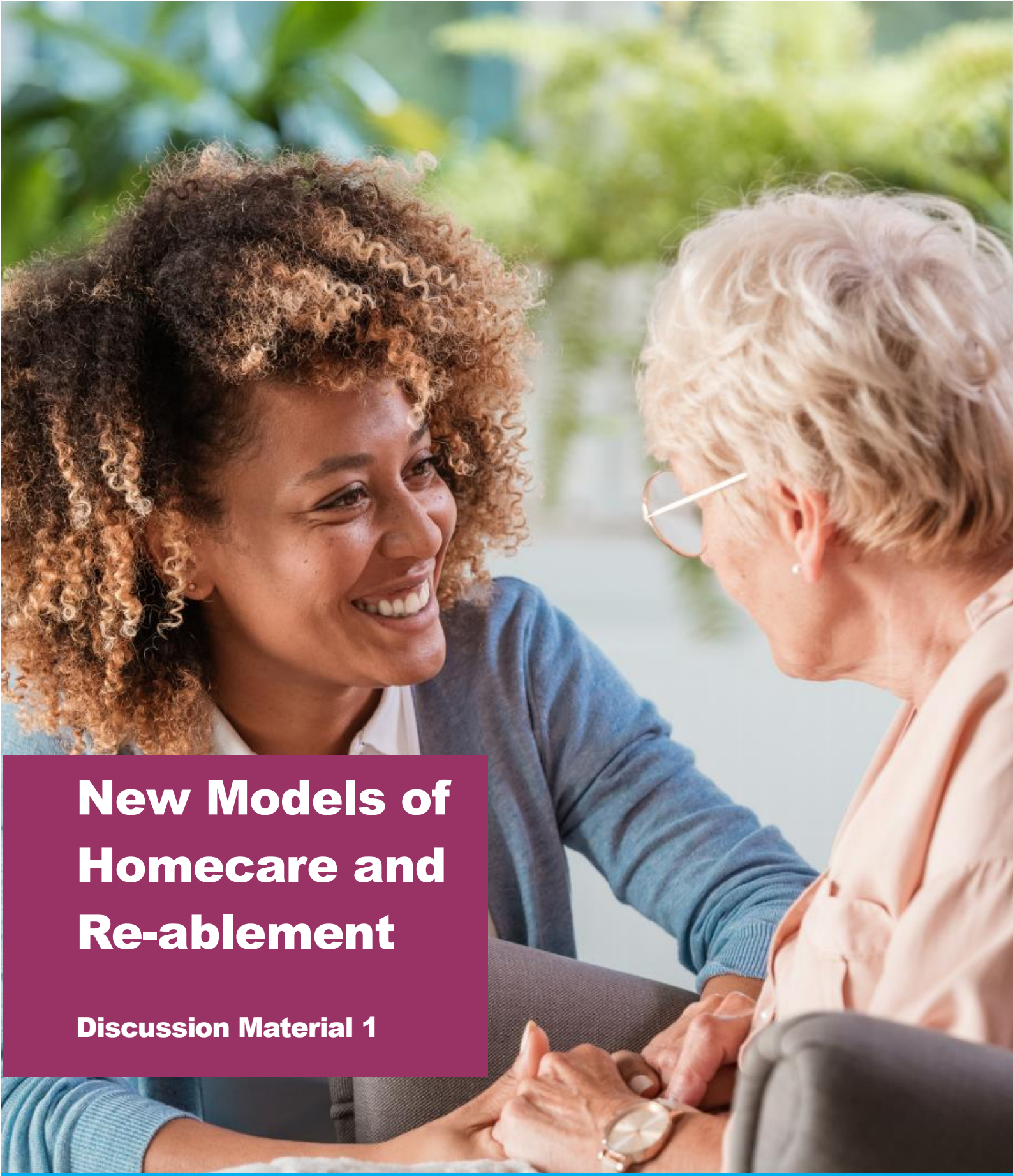

# New Models of Homecare and Re-ablement

## Discussion Material 1

**Prepared by Cate Goodlad and Nick Morgan, August 2025**

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**“Good support isn’t just about ‘services’ – it’s about having a life”.**

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## How you can use the discussion material

Before our first session, we’d like everyone to read this document which summarises the evidence from research, practice and lived experience about new models of homecare and reablement, with a particular focus on care delivery and service models which move away from ‘time and task’ delivery. This is influenced by funding models and commissioning practices, and how care quality is measured, but also has wider links to the job quality of care workers.

The aim of this material is to spark discussions in your local Networks about your experiences and ideas for change. There are questions throughout and at the end for you to discuss in your first Network meeting. The material may also leave you with questions you’d like to ask the IMPACT Networks team, or other Networks across the UK - you can feed these back to your Local Network Coordinator to pass on.

This discussion material:

- Explains what is meant by ‘time and task’ delivery models of care
- Outlines the policy landscape in the four UK nations regarding social care
- Provides some examples of different types of care which are not ‘time and task’ based

As you read this discussion material, you might want to think about:

- Do you have experience with any of the models mentioned here?
- Are there any ideas in this document that you think are interesting and could help to change services?
- What do you think about the challenges identified? Is there anything missing? How might these challenges be overcome?
- Is there anything in this document that you don’t agree with, or that doesn’t match your experience?

# Introduction

This material explores 'new' models of homecare, including re-ablement, across the four UK nations. Homecare is sometimes referred to as 'domiciliary care' or 'care at home'. The term 'new models of homecare' is quite vague, and although many examples are not 'new' it generally refers to homecare work that does not follow a 'time and task' model, which is the dominant way of organising and paying for homecare. More recent UK policy has acknowledged problems with the 'time and task' model and has started to promote a focus on outcomes but has struggled to make much headway (Bennett et al, 2018; Bennett et al 2020; Sanders, 2021). 'Time and task' based care has been criticised for not achieving the best outcomes for people and for not providing job satisfaction to care workers, however the fact that this is still the dominant model of home care suggests that it is not easy to move away from. In this review, we will begin with a brief overview of the care market before looking at some alternative approaches to care.

# What is a 'time and task' model of homecare?

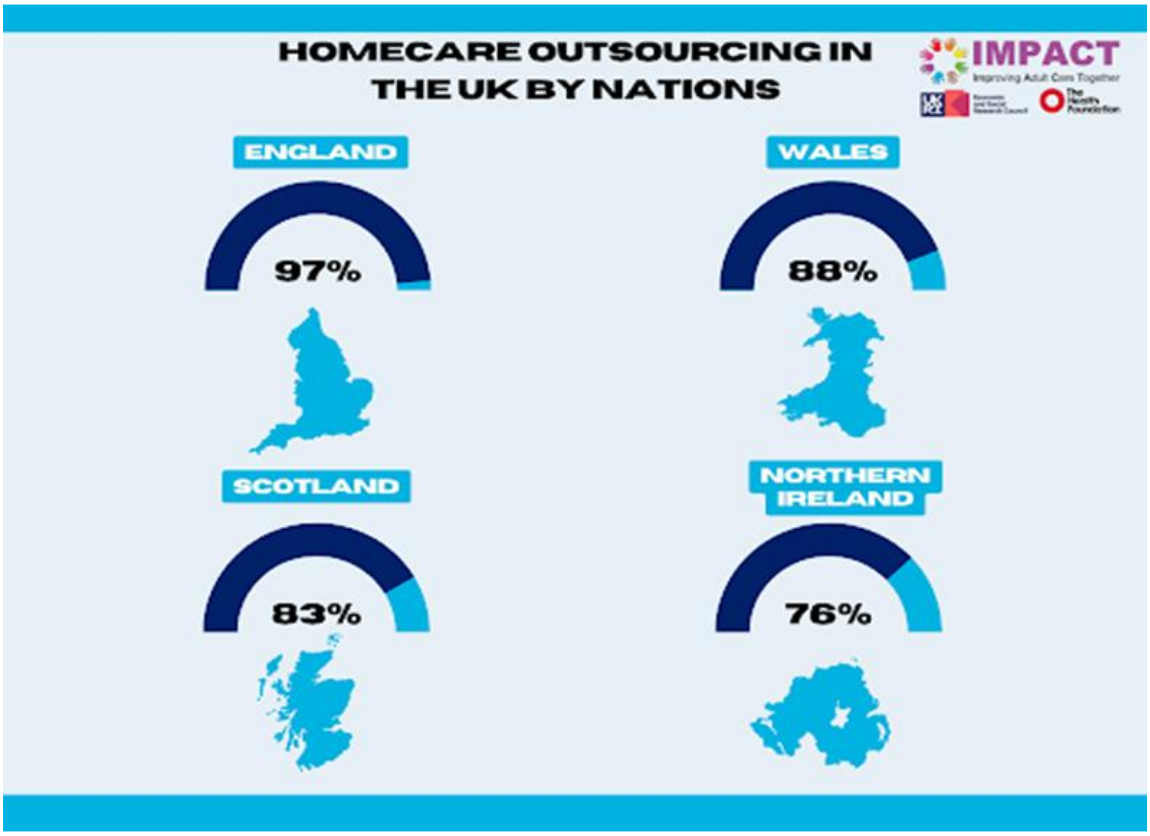
This term refers to a way of paying for and delivering care services in the home, where care provider companies are paid in blocks of time (often 15 minute blocks) to deliver a specific list of care tasks, such as helping someone get washed and dressed, feeding or managing medication. This is the dominant model of commissioning publicly funded care services (Burns, Hamblin, Fisher and Goodlad, 2023). It is an attractive model for commissioning services as it is easy to monitor whether tasks have been completed and to make payment in 15-minute blocks accordingly. Care commissioned on a time and task basis tends to be 'done' to people rather than 'with' people. It does not allow for a more holistic caring approach, which might include reablement or maintaining mobility, and maintaining or increasing social connections which have been shown to be beneficial to people's wellbeing. However, all this has to be seen in the context of increasingly squeezed budgets, a shortage of care workers, and a complex care market.

# The Homecare 'Market' in the UK

The different ways that adult social care is funded across the four nations of the UK has influenced the 'market' for homecare providers and with that, the types of services that are on offer (Needham and Hall, 2022). A 2024 report by the Homecare Association (an independent body which represents homecare providers) provided an overall comparison of the market for homecare across the four nations of the UK.

In England and Wales, support is means-tested, whereas in Scotland people with care needs do not pay for personal care (only additional services like laundry and cleaning), and in Northern Ireland social care is fully funded through the Health Trusts. Local Authorities or Health Trusts in Northern Ireland will either provide care in-house (employing care workers themselves) or outsource the care to independent providers. Some independent providers only provide care to private clients, some work solely on commissioned work for Local Authorities/Health Trusts, and others combine the two. Figure 1 shows the amount of outsourced homecare across the UK nations:

**Figure 1: Percentage of Homecare outsourced across the UK nations**

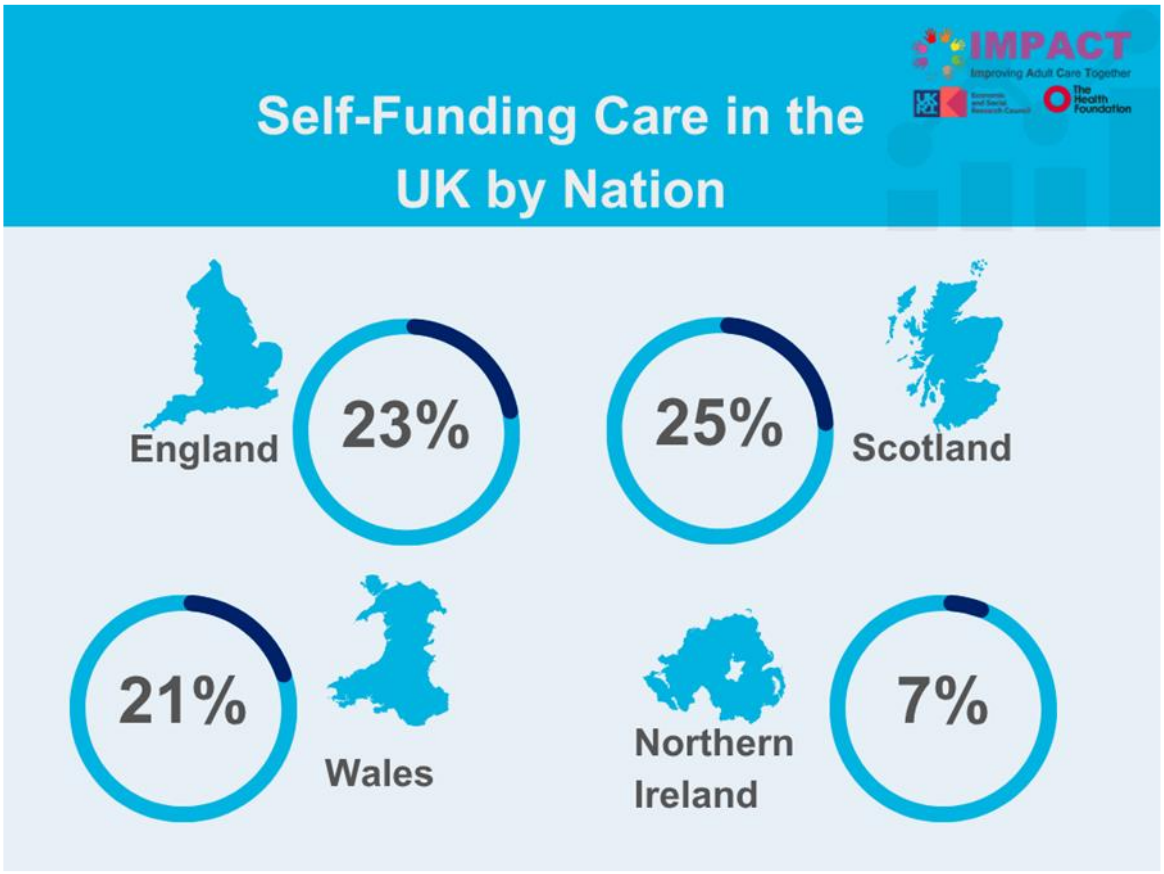



Source: Homecare Association (2024)

Self-funding of care also influences the variety of independent homecare providers and the services they are able to offer. Where there are more private payers, there tends to be a greater variety of providers and choice. In Figure 2 we show the amount of self-funded care in the different UK nations. However, it should be noted there are large area and regional variations (especially in England), for example in Salford only 1% of people

fund their own care, compared to 48.3% in Windsor and Maidenhead (Homecare Association, 2024). The figures for Wales, Scotland and Northern Ireland are estimates based on 2018 figures (the latest available).

**Figure 2: Percentage of people who were self-funders in receipt of community based care in the UK**




Source: Homecare Association (2024)

People who are eligible for public funding can let the Local Authority/Health Trust arrange their care provider (this is called commissioning) or opt to receive the money as a Direct Payment to be able to choose and pay for the care themselves through an independent care provider or hire a personal assistant. However, it is usually younger disabled adults who opt for a Direct Payment - 89% of those receiving Direct Payments in England were below the age of 65 requiring support for a physical or learning disability (Homecare Association, 2024). Direct Payments work less well in areas where there is little choice of provision. In addition, a person receiving care can opt to have their Personal Budget (which is an amount the local authority says is allocated for their funded care) to be paid

as an Individual Service Fund. This means that the money is paid directly to a service provider but the details of this are negotiated between the provider and the person receiving care.

According to the Homecare Association report (2024) private payers (including those in receipt of Direct Payments) are more likely to act like traditional marketplace consumers, choosing services that directly address their needs and expectations on care quality and price. Care providers serving private clients have been shown to better meet quality of life measures and focus on outcomes, but typically will charge more than Local Authority commissioned rates. They are more likely to fulfil their clients' expectations of care through longer visits, consistency of care workers and a focus on establishing relationships and maintaining social connections. These also tend to be small providers (Glasby et al, 2018).

Many care providers would like to create better job quality for frontline care workers, yet policy-led workforce innovation focuses only on education and training at the expense of wider aspects of job quality such as pay, insecurity, work-life balance (Crozier and Atkinson, 2024). Just under half of all homecare workers are on zero-hour contracts in jobs characterised by hard physical work, long hours with few breaks, and minimum wage rates (Skills for Care, 2024). Some workers are still not paid for their travel time between visits or travel expenses. Chronic workforce shortages and high churn within the sector, as care workers move to other providers to find better employment conditions, often means that care providers struggle to maintain a stable workforce, and staff shortages place an increased burden on the care workers that remain in post. Unlike nurses in healthcare, social care workers often say they feel undervalued. It is not surprising therefore that care work jobs are not seen as attractive to many people. Studies have shown that care workers who are allowed more time to care, and have greater autonomy, experience more job satisfaction and this translates directly into the quality of care that is provided (Burns, Hamblin, Fisher and Goodlad, 2023).

All these factors (the market, staff stability, job quality, funding etc) influence the care delivery model, which means that the opportunities for developing new or innovative practice and to move away from 'time and task' based care are challenging. In Northern Ireland, a policy consultation document - the *Power to People* report (Kelly and Kennedy, 2017) - gathered the views of people engaging with and working in social care on how it should be reformed. One of its recommendations was that the adult social care funding model should be reformed by making Direct Payments the norm, so that people are empowered to choose their own care, and that people who are able to contribute to the costs of care should do so in order to free up scarce resources to develop the care sector. The idea being that this would incentivise the 'market' to develop more innovative

practices and give people more choice. The report also proposed greater community involvement and imposing a minimum 'living wage' on care worker wages to improve job quality. However, progress on reform has been hampered by disruption to the Northern Ireland government.

A report for Scotland's Institute for Research in Social Services (IRISS) by Robert Sanders (2021) also supported more community involvement. He suggests that new models which move away from 'time and task' commissioned care are needed but are not happening fast enough, and that 'time and task' focuses too much on short term rather than longer term costs and outcomes, creates market instability and is unsustainable. The solutions offered are increased integration with health care, more support for unpaid carers, and a greater focus on community assets. The report highlights a 2019 *Scottish Care* focus group which suggested the foundations for new models of care include:

- 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

The Sanders report further suggests that there needs to be upfront investment to help implement change as well as reform to the funding model.

## What do people receiving homecare want?

A report by the King's Fund (Bennett et al. 2018) on new models of homecare discussed a range of alternatives to 'time and task' commissioned care. They cite several reports which suggest that there are some common features to what people want from their homecare providers (see box 1.).

**Box 1. Features of good quality home care, from Bennett et al, 2018.**

People using homecare said it should feature:

- **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.

**Question – does this fit with your view of how care should be?**

# What do alternative and new models of care look like?

There are many examples of care providers who are trying to work to the principles of good care outlined above and do not operate on a 'time and task' basis, however they tend to work on a private basis and many charge more for their services than they can receive through public funding, so are rarely commissioned. Some examples of new models of home care have been identified by The King's Fund report (Bennett et al, 2018), and a report for the Welsh government (Bennett et al 2020) which outlined proposals for alternative models of homecare as a focus for developing services. The following sections will look at some of the ways that the move away from 'time and task' commissioned care is being addressed, including outcomes-based commissioning, re-ablement, autonomous team working (e.g. Buurtzorg model/Wellbeing Teams), technology, community assets (e.g. social prescribing, community circles), microenterprises, and family-based support (e.g. Shared Lives, Homeshare).

**Question – do you have experience of any of the models mentioned here?**

## Outcomes-based commissioning

The area of outcomes-based commissioning has been a focus of a previous IMPACT network, Commissioning Differently, but we are including an overview here to provide some context to how changes to the ways that care providers are paid can impact provision. There have been some attempts to move away from 'time and task' commissioning (Bolton, 2012; 2015), and while some progress has been made on this (e.g. Wiltshire, Council, Bournemouth Council, Welsh Local Government Association) the fact that this is not widespread and 'time and task' persists suggests that this is a tricky problem to overcome, particularly in the current funding climate. Franklin et al (2024) have suggested that there needs to be a different cultural approach to implement outcomes focussed commissioning which is not easy to achieve as outcomes can be difficult to measure and therefore apply economic evaluations.

One of the first Councils to adopt an outcomes-based approach was Wiltshire Council which introduced a method of 'payment by results' linked to person-centred outcomes (see box 2.).

**Box 2. Wiltshire County Council's approach to outcomes-based commissioning, based on the evaluation by John Bolton (2015).**

One of the anticipated problems of this change was in the administration of the scheme, so to simplify this the Council divided the county into eight delivery areas and offered care contracts out to tender based on a new 'payment by results' funding model. The 8 contracts were won by 4 providers. Outcomes were decided by care assessors and the customers, then the providers worked with customers to develop a support plan to determine how these outcomes would be achieved. Payment was calculated through a combination of a pre-set fee for each outcome and the level of detail of the support plan. There were no specific rewards for achieving the outcomes, but if providers delivered an outcome earlier than anticipated they were still paid in full. The Council closed their in-house reablement service and transferred staff across to the new providers. The aim was to improve outcomes for customers needing both long and short-term help. About half of the customers needed no further help from the homecare workers after six weeks; a further group needed no further help after six months; some had continuing needs.

The move to outcomes was not without difficulties:

- The biggest change needed was a change of culture to think about outcomes, rather than tasks to be completed. This required training, new paperwork and providers needed time to adjust to the new system.
- All the providers had problems with staff shortages, meaning that sometimes it was easier to be task-focused to ensure everyone's basic needs were met but the outcomes became secondary.
- Communication was important and families and other agencies needed to understand how it was different to traditional homecare services.
- There needed to be a different focus depending on people's different needs, so support plans needed to be flexible and in some cases quite sophisticated:
    - Those requiring short-term reablement were easier to set goals and generally successful.
    - Some with long-term conditions may have needed help to learn to manage their conditions better but were always going to need some help.

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- A further group, such as those with memory loss or dementia, had to focus on living with the condition. Here the aim was to keep them at home for as long as possible and support family carers.
- For some people palliative care was appropriate, and staff needed an understanding of when this was the case and pass the care to appropriate health professionals.

- Outcomes cannot always be delivered by one provider, and it may require a range of providers to work collaboratively to meet people's desired outcomes.

Other councils have adopted their own versions of outcomes-based commissioning (e.g. Bournemouth Council). In 2024 the Welsh Government instigated a push to outcomes-based commissioning by developing a toolkit for commissioners and practitioners in partnership with the Welsh Local Government Association (WLGA, 2024). This is an online collection of documents and tools (which are updated as needed), designed to help people improve services and has been developed through consultation with care providers and service users. They note that while outcomes-based care is more difficult to measure than 'time and task' care, there are benefits in trying to adopt such a system. These include:

- Having greater control that promotes wellbeing
- An improved use of community resources
- A more flexible approach, which can respond more quickly to changing needs, whether that is over time, or week to week
- Improved family engagement and opportunities to shape the service
- Improved use of care and support services enables families to do more social activities with the individual which improves wellbeing
- Improved job satisfaction for care workers
- More accountability for care providers and a better relationship with commissioners
- More positive approach to risk management
- Reduced bureaucracy
- Improved use of resources through focusing services on what matters to the individual.

The WLGA wants to develop these services alongside other outcomes-focussed services such as reablement which we will now turn to in the next section.

## Re-ablement

Although there is no agreed definition of the term re-ablement, there are some common elements which characterise it. Re-ablement is a specific enabling approach that focuses on helping individuals with physical or mental disabilities to adapt to their condition by learning or re-learning daily living skills. Re-ablement emphasises practising activities to promote functional independence, often within a person's home environment (Welsh Government 2022). Delivered primarily within social care, it provides short-term, intensive support to build confidence and maximise autonomy in daily life. Re-ablement services are usually described as person-centred, goal-oriented interventions within the person's home, to help individuals regain or maintain independence in daily activities, particularly following illness, injury or frailty. It aims to reduce the chances of hospital re-admission and reliance on long-term support, and is mostly associated with short-term, intensive support (usually 6-weeks). It differs from a 'time and task' model of care in that it is goal oriented, so there will be a set of agreed aims to work towards. Re-ablement is different from 'traditional' homecare because it is about "doing with" as opposed to "doing for" someone, and is a "risk aware", as opposed to "risk averse" approach (Chen and Beresford, 2023). Re-ablement is sometimes delivered by multidisciplinary teams, so might include health professionals such as physiotherapists or occupational therapists, and it is a collaborative approach working with individuals to help them achieve their self-defined goals. It is also distinct from 'recovery' (helping to regain quality of life and reclaiming aspects lost due to illness, disability, or caring responsibilities) or 'rehabilitation' (focused on addressing health conditions).

There is evidence that the benefits people receive from re-ablement programmes last longer than six months, but often evaluation studies differ between self-reports and professional reports (Beresford et al, 2019a). A further review of re-ablement services (Bennett et al, 2022) suggested that of the eight large-scale studies reviewed, five showed a reduction in ongoing care needs after three months where there was occupational therapist involvement. Functional ability improved in four of the studies at three months, and there was a noted increase in quality of life in three studies at 6-7 months. The authors suggest that professional involvement helped to improve outcomes, and there was a question over the amount of training that care workers had received, so they argue that this needs more research. There were also some questions over bias in the methods and design of some of the studies reviewed.

A study seeking the views of service users, their families and social care professionals (Chen and Beresford, 2023) highlighted several factors which influenced engagement with re-ablement services. These included staff morale, equipment availability,

assessment processes, and social re-ablement needs. The researchers highlighted the complex nature of the reablement process, including the need to establish trusting relationships between those receiving care and re-ablement staff to support success. Staff attitudes to aging were also important as this could either encourage dependency or independence. Staff training was seen as a key element of success.

While re-ablement often has a specific purpose connected with discharge from hospital, there have been suggestions that a reablement approach encouraging activity as part of the homecare package could help people to live well at home for longer and reduce reliance on care. This would also help people to lead more fulfilling lives. There is some evidence (Mulquiny and Oakman, 2022) that supports the view that a re-ablement approach can improve health and wellbeing, but this also highlighted that one of the main difficulties is in developing meaningful outcome goals. Care workers were also more likely to encounter resistance to re-ablement when the person receiving care either did not understand the role of re-ablement or had not been consulted about the re-ablement goals. This emphasised the importance of a supportive approach and working with people receiving care, rather than care being 'done' to people.

While re-ablement goals of increased independence may not be appropriate for some people, such as those with dementia, there is evidence that a re-ablement approach can help people with dementia to manage their condition and remain at home for much longer, but that this also supports unpaid carers (Beresford et al, 2019b).

Box 3: Vale Community Resource Service (VCRS)

Vale Community Resource Service is an integrated team of health, social care, and third-sector professionals based at Barry Hospital, collaborating with services across Cardiff and the Vale of Glamorgan (Cardiff and Vale University Health Board [no date]). Their primary goal is to work with individuals in their own homes to maximise functional independence in daily activities, thereby reducing the need for hospital admissions and long-term social care services (Cardiff and Vale University Health Board [no date]).

The VCRS also provides therapeutic interventions and reablement support following hospital stays to facilitate timely and effective returns home. To achieve this, the initiative works with a multidisciplinary team comprising occupational therapists, social workers, physiotherapists, speech and language therapists, dieticians, nurses, care coordinators, and approximately 45 re-ablement support workers. They offer tailored support for up to six weeks, developing client-centred therapeutic programmes in partnership with individuals to achieve jointly identified goals.

## The Buurtzorg model and Wellbeing Teams

The Buurtzorg model of care was developed in the Netherlands with nurses, and there is good evidence that this improves care outcomes (Hegedus et al. 2022). In the UK, the Wellbeing Teams model operates with care workers based on the principles of Buurtzorg. The basic idea is that a small group of nurses/care workers (usually around 8-10) are responsible for the care of people in a small geographic area or neighbourhood, which reduces travel time, and means that people see the same care workers which allows for good relationships to develop. The nurses/care workers have the authority to risk-assess and decide with the person being cared for and/or their family carers, as to how that care should be delivered to best meet their needs and the desired outcomes of the person. The consistency of nurses/care workers also allows them to notice changes and pick up problems early, such as UTIs, or changes in eating habits, which helps to keep people living well at home through early intervention. The nurses/care workers like the responsibility and have high job satisfaction, and low staff turnover. An example of an independent care provider in England which has adopted a Wellbeing Teams model is BelleVie (see box 4).

### Box 4. BelleVie Care Ltd.

BelleVie Care (https://www.belleviecare.co.uk/) was established with a mission to improve both care and care work. Their model of care is based on autonomous groups of wellbeing workers (they use this term instead of care workers) who work together to support people in a small geographic area taking a person-centred approach. The care is based around the outcomes that the person receiving care (and their family) want to achieve and can include care within the home, such personal care or medication, but also outside the home, such as doing a weekly shop, or visiting a garden centre. Their funding model is quite unique: clients pay a monthly fee based on an expected number of hours of care received, but care delivery is flexible to accommodate changes in needs, and all care visits are at least 30 minutes but often longer. Wellbeing workers are salaried rather than paid per visit, receiving at least the living wage, and are paid for travel expenses. They report high job satisfaction and have a low staff turnover. BelleVie have tried to work with local commissioners to deliver services, but this proved challenging. Technology is an integral part of the care management by the autonomous teams, with communication through an app on their phones. They may capture outcomes by using photos as well as texts, which can be easily communicated between Wellbeing workers and shared with family carers.

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One problem they encountered when starting the business was that readily available care management apps assumed a 'time and task' model of care delivery, prompting BelleVie to develop their own 'Wellbeing Operating Software (Fell, 2023).

## Technology-driven care

As with outcomes-based commissioning, technology in care has been a focus of a previous IMPACT network (Technology for Prevention and Independence) but again we are providing some context here. Technologies are increasingly being used to support care, ranging from widely available products such as Alexa and smart devices, to apps which help unpaid carers stay connected (e.g. Jointly). Some care services are starting to trial using video calls to support care. This could be to replace a short visit such as to remind people about medication. This saves care worker time as visits can be made to numerous people in the same time as a standard care visit for medication. Many care provider companies now use technology to increase office efficiency and phone apps to record care visits and monitor care workers (although as BelleVie Care found, these are usually based around a time and task model of care which don't easily capture outcomes). However, some new companies are using technology as a way to connect people wanting to receive care with self-employed care workers (for example, Care.com, or papool.co.uk). This works by care workers creating a profile of themselves, including their qualifications and experience, which can then be seen by clients seeking care, who can then choose who they would like to interview further based on expressed interest. These are sometimes referred to as 'platform models', or an '*Uber*' model, where people looking for support are 'matched' with self-employed care workers. One such model was included as a case study in research by Hamblin et al (2023) as *Maple Care* company (see box 5 - the name is a pseudonym).

Box 5. 'Maple Care' platform for connecting people needing care and care workers.

Some of the benefits of such models include:

- More choice and control as people wanting care are able to employ care workers directly.
- To make it worthwhile for care workers, care work is usually offered in longer blocks of time, several hours or as live-in care.

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- Longer visits and live-in care can help someone to stay at home for much longer and often works out much cheaper than care home fees.
- Care schedules and outcomes agreed between care workers and the person receiving care (or their family). This might include personal care, shopping, cleaning but also help to socialise, exercise and get out of the house. Due to longer visits, care could be more responsive to needs as they arise and not rushed.
- Consistency of care workers which allows for the development of relationships and continuity of care.
- Care workers have control over their hours and pay rates as they work on a self-employed basis. This is attractive for care workers who like to work in blocks of time, e.g. 2 weeks on, 2 weeks off; or several months at a time, then an extended break.

However, this model is not without problems:

- These are Introductory Platforms, so as care workers are not directly employed, the care provider agencies do not need to be CQC registered. Individual care workers do not require a registration either, so it is the responsibility of those employing the care workers (or their family representative) to do their own checks and references, although most agencies will perform DBS checks, and interview potential care workers.
- Disputes must be managed directly between the care worker and person receiving care (or their family).
- Many care workers do not want the hassle of being self-employed, so it is not attractive for everyone.
- In the case of live-in care, some care workers struggled to get breaks.
- There was the potential for racial bias by not selecting care workers of some ethnic backgrounds, even when they have the right experience and qualifications. This has the effect of care workers reducing their prices to ensure they can get work and it becomes competitive so they are not always able to set their own prices as the model intended.

## Integrated Care

The idea of integration is not new but has seen a renewed focus in the last few years. Following the Health and Care Act (2022) Integrated Care Systems have been formally established in England; the other three nations of the UK already had established integration through regional health boards. Integrating health and care services is not without difficulty, particularly as they receive their funding through different sources (as outlined above) and have different cultures. However, the NHS does have access to sources of funding which are not normally available to social care alone, such as the Better Care Fund, which has been used to develop Social Prescribing (see below). There are numerous other examples across the four nations of different sectors working together to provide services. Integration is not just about health and social care, but partnerships could include local authorities and Clinical Commissioning groups (CCGs) jointly commissioning services, social care and housing developing extra care housing or assisted living services, or health and social care partnerships with voluntary organisations such as befriending services, and more. Economic evaluations of integrated care tend to focus on how budgets are shared or divided across the sectors of health and social care (Mason et al, 2025).

A report by Nuffield Trust (2019) looked at why so many integration projects aimed at reducing hospital admissions didn't produce the results that were expected. Drawing on expert opinion they identified several reasons why this might be happening:

- Poorly designed models which target the wrong population or don't take account of patients' preferences.
- Well designed models which are poorly implemented, especially when they fail to take account of different working cultures and priorities.
- Not giving enough time for changes to bed in or trying to evaluate too quickly.
- Narrow sets of outcomes can be problematic, especially focussing on hospital utilisation.
- Lack of process evaluation makes it difficult to replicate.

They suggest that integrated working projects need to pay attention to:

- The problem being addressed, especially the underlying logic.
- For commissioners to be more realistic in timescales and open to a wider range of methods and approaches to evaluation.
- Focus on collaboration and regular feedback loops to all stakeholders.

## Community Assets[1]

Enhancing people's wellbeing by being more connected to communities and reducing isolation is a common thread across literature around what people want from their homecare. Voluntary, faith and community groups also provide support for unpaid carers who may not be aware of the formal support that is on offer to them. 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 to local solutions, to promote independence and wellbeing. There is some evidence that participating in community activities increases quality adjusted life years (QALY) by up to and reduces care costs, meaning that people live healthier lives for longer (Munford et al, 2020). Similarly, Knapp et al (2015) suggested community development provided a good return on investment at a relatively low cost by reducing care costs and improved wellbeing.

The *Housing Learning and Improvement Network* (Housing LIN) argues that the area in which people live is key to maintaining independence, not just their housing, and introduced the concept of *Continuing Care Neighbourhoods* (Battersby, 2015). Transport, shops, social activities and information services are vital to support wellbeing, and they see the voluntary sector as being important to fill the gaps in home care services by supporting people to access their neighbourhoods.

One model used by *Community Catalysts* (https://www.communitycatalysts.co.uk/) is *Local Area Coordination* which provides a single point of contact for individuals and their families to help people access local support. The main focus here is on local voluntary support, rather than statutory services. This might be achieved through *Community Circles,* which are networks of people who volunteer to help people access local sources of support and maintain or re-establish connections to community groups. A review of a local area coordination in South Wales showed financial benefits in the range of £800,000 to £1.2 million between July 2015 and April 2016 (Roderick et al, 2016).

*Community Catalysts* work to celebrate the strength of people and communities to bring local people together to help other local people. This includes supporting the creation of social care jobs through the development of *Micro-enterprises*. This was found to be particularly popular in rural areas where traditional care providers find it hard to maintain services. The programme employs local 'catalysts' who seek out people who are interested in doing care differently, for example a person who is already caring for relatives or friends but as their care needs increase, the carer may decide to give up work to carry on caring full time. Community Catalysts would then help them to set up a micro-

[1] IMPACT has a range of resources related to ways of working that build on on the strengths of people and communities: https://impact.bham.ac.uk/themes/building-on-strengths-people-communities/

enterprise and support them through coaching and mentoring. Sometimes two or three people might come together to form a micro-enterprise, but these are usually very small companies with fewer than 5 employees, capable of supporting a few local people. Micro-enterprises have been shown to provide high quality personalised care, however micro-businesses in general have a high failure rate (Glasby et al, 2018).

In recent years, there has been increased focus on co-production to develop services, and this lends itself to co-producing community-based services, often where it is felt there is a gap in the market for specialist services or a lack of available options. There are several examples of new community-based care services involving local people in a co-production process, including an example cited by Munoz (2013) in a remote and rural Scottish region. Although this paper is mostly about the co-production process (which is interesting in itself) it discusses some of the difficulties in establishing a new community-based care service which is not time and task focussed. In this area, the NHS and local government had been unsuccessful in securing a private or third sector provider to take on the delivery of care services through the tendering process, so a plan to develop services with the community was developed. The community group wanted to develop a more holistic service to include such things as errands, gardening and maintenance/repairs, and initially focussed on these areas as the 'red tape' and regulation surrounding care was seen as off putting, although eventually a social enterprise was established. The NHS and local government had aims to develop preventative care, produce better outcomes for patients, efficiencies for the public sector and increase working with third sector organisations. The community group had a main focus on job creation, with secondary aims to develop co-produced care. They struggled to recruit to care roles, as many workers previously employed by the local authority did not want to change employers to the new social enterprise, but where there was a reliance on volunteers, rather than job creation, this was seen as exploitation. One of the main issues that the community group found was the reluctance for someone to lead the project, and the development of tensions within the group. Different views on how care should be delivered between the NHS and the community group created more friction. The result was a 'traditional' service delivery model provided by the social enterprise instead of the local authority.

A further example of a new care company which is trying to create better jobs with better care is the Equal Care Co-op which was established in Calderdale (see box 6). This has

been successful in integrating and combining secure employment and volunteers to provide a more holistic service.[2]

### Box 6. Equal Care-Co-op

The Equal Care Co-op (https://www.equalcare.coop/) was founded to provide high quality personalised care alongside good quality care jobs. It operates using a matching system (similar to Maple Care in box 4) for people wanting care to have some choice over the care workers who support them, but the care workers are contracted so there is some guarantee of hours and they are regulated. The independent care workers have a say in what hours they work and their own rate of pay, which is generally well above minimum wage. Employed workers receive the Real Living wage. Care is very localised, based around the villages and towns in the Calder Valley. This is important as this area can be very remote in winter and some parts easily get cut off when there is bad weather. The support is based around Teams, with the person receiving care leading the Team, so it is up to them (or their representative) who is on their Team, but this could include other family members, friends, neighbours, health and social care professionals. The support is negotiated to help people live 'a gloriously ordinary life' based on what is important to them. In addition to paid workers, they have a team of volunteers to help people with such things as doing errands, emotional support, family support, help with appointments, 'life admin' and letters. The volunteers are not involved in regulated activities such as personal care or handling medication.

## Social Prescribing

One area of integrated care which brings together GP surgeries and community assets is Social Prescribing. This was first implemented as a means to reduce GP appointments where it was felt the person may benefit from a greater connection to others in the community to reduce feelings of isolation, help people to manage a long-term condition or support their mental health. The idea is that keeping active helps people to stay independent for longer, reduces isolation and supports mental wellbeing. GPs make a referral to the Social Prescribing teams who then contact the person to discuss what is on offer locally and help them to get involved. This might include building confidence by accompanying them to attend local groups or services such as lunch groups, walking

[2] Another example of co-ops in care is Friends United Together: https://impact.bham.ac.uk/delivery-models/networks/choice-and-control/

groups or volunteering. Social Prescribing is now widespread and there is a growing body of evidence to support it. Evidence suggests that people feel less lonely after taking part in community activities (Foster et al 2021), although a review of 16 studies found some mixed results in relation to improved wellbeing (Pescheny et al, 2019). One of the first areas to pilot and scale this service was Rotherham, which is detailed in Box 7.

### Box 7. Rotherham Social Prescribing Service

The Rotherham Social Prescribing Service was established in 2012 on a 2-year pilot phase, to support people with long-term conditions, and operated by Voluntary Action Rotherham (VAR) on behalf of the clinical commissioning group. It is funded by the NHS through the Better Care Fund. An evaluation of the initial pilot phase (Dayson and Bashir, 2014) showed the potential for cost savings, as in the first 12 months there was a reduction in emergency hospital admissions by 20%, inpatient admissions reduced by 21%, and 21% fewer outpatient appointments. The numbers involved were quite small, but the impact was sufficient for the pilot to be rolled out across the borough and then extended to include people needing mental health support. A more recent evaluation of the service (Damm and Dayson, 2024) showed that the majority of people who engaged with the service reported improved wellbeing, but that emergency hospital admissions remained around the same. An analysis of the data by postcode area was able to show that a quarter of those referred to the service lived in the most deprived areas, and this was helping to address health inequalities by improving wellbeing.

Social prescribing has been evaluated in terms of cost benefits (Kimberlee et al, 2022), with some mixed results, although overall they suggest positive effects. Kimberlee et al (2022) suggest that often the evaluations are conducted after a very short period of time (3 or 6 months) and therefore may not demonstrate longer term gains, although the evidence for social prescribing to support mental ill health appears to be more cost effective.

## Family-based support

Family-based support is an example of a model which has been around for a long time, and even though it has many benefits, it is not suitable for everyone and therefore has been difficult to scale up. The most well-known family-based support is *Shared Lives* where people with disabilities or support needs live with an approved carer and their family (a bit like fostering). This is helpful as a short-term respite service for vulnerable

adults to provide carer breaks, but may be more long term, or as a transition from hospital to home as an alternative to nursing care. Most local authorities operate a scheme like this. There is some evidence to support the Shared Lives programme, with a review by Nesta suggesting that the average net savings from a long-term Shared Lives arrangement for people with learning disabilities averaged £26,000 per person per year, and for those with mental ill health the average was £8,000 per person per year NESTA, (nd).

Another family-based scheme which is less well-known is Homeshare (https://homeshareuk.org/). This is where, typically, an older person living in their own home with a room to spare will be carefully matched with a younger person, who will provide an agreed amount of support in exchange for good quality, affordable accommodation. This allows people to stay living independently in their own home for longer, as well as providing affordable accommodation to the homesharer. An evaluation of a scheme in Leeds (Bagnall, 2020) claimed that support was often two-way, reporting a range of benefits including: companionship, friendship, reduced social isolation and loneliness; feelings of safety; informal support – mainly from the homesharer to the homeowner as expected, but also some support given by the homeowner to the homesharer; intergenerational connections; support/peace of mind for families of homeowners; wider social connections; financial benefits. Homeowners expressed concerns over the homesharer doing too much for them; whereas homesharers were concerned about the health issues of the homeowners. Where matches were successful it was clear that there was mutual care for each other that went beyond the advertised 'selling points' of support and affordable housing. However, take up of the scheme was very small, even after an advertising campaign, with more homesharers interested than homeowners.

## Summary

One question which is often asked is whether new models of care translate to a cost-effective use of public money. Many of the models highlighted here have limited evidence to support cost benefits. However, many of the models here look at reducing social isolation and loneliness and there is some evidence to suggest that programmes focussing on reducing social isolation and loneliness show positive returns on investment. For example, a systematic review of evaluations and interventions to reduce loneliness and social isolation (Engel et al. 2025) examined international studies which included six cost of illness studies, four economic evaluations, and five social return on investment studies. Not all of these studies were related to adult social care. They suggested that most studies reported increased healthcare and 'lost work' costs

associated with loneliness and social isolation, but that evidence for economic and social return on investment evaluations was mixed.

The dominance and persistence of 'time and task' as a care delivery model is an indication of how difficult it is to move away from this way of commissioning care. There are numerous examples of care providers who operate in a more person-centred way, but they tend to be supporting private clients. Numerous reports, from across all four nations, suggest that voluntary and community assets could be utilised more to develop services in the current financial climate, but relying on the goodwill of volunteers can be challenging. Funding is repeatedly identified as a barrier to innovation and implementing change, but also taking an outcomes-based approach to care, it is very hard to define what the outcomes should be. Staff shortages and staff turnover continue to be a problem for the sector, so improving job quality through creating more personalised services may be one way to help.

## Next Steps

Having read the material above, in the first Local Network Meeting, we would like you to discuss:

- Would anyone like to share their experiences of homecare, either as a person who receives support, a carer, or care service provider?

Thinking about this discussion document:

- Do you have experience with any of the models mentioned here?
- Were there any ideas in this document that you thought were interesting and could help to change services?
- What do you think about the challenges identified? Was there anything missing? How might these challenges be overcome?
- Was there anything in this document that you didn't agree with, or that didn't match your experience?

Next steps:

- Are there next steps that you would like to agree as a group? Anything that you would like to discuss?
- At the end of the network process, you will be developing an action plan. Is there anything here that you think could be useful?
- Do you think that there is anyone else that should be involved in your meeting?
- Is there anything that you need from the IMPACT team?

# IMPACT Surveys

Thank you for taking part in our IMPACT Network. We'd like to know a bit more about everyone taking part, and what they hope to achieve. We have two surveys: one is to help us make sure we are being as inclusive as possible and the other is to understand what people hope to accomplish by being part of a Network. The data is anonymous and may be used for evaluation of the Networks and potentially in papers about the Networks. You can complete our IMPACT network surveys by scanning these 'QR codes' with your phone's camera - Open your phone's camera app and point it at the QR code. If you don't see a notification, you might need to enable QR code scanning in your phone's settings.

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