Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

# Alternative models of domiciliary care

**Laura Bennett, Megan Park & Steve Martin**
Wales Centre for Public Policy
December 2020

# Our Mission

The Wales Centre for Public Policy helps to improve policy making and public services by supporting ministers and public service leaders to access and apply rigorous independent evidence about what works. It works in partnership with leading researchers and policy experts to synthesise and mobilise existing evidence and identify gaps where there is a need to generate new knowledge.

The Centre is independent of government but works closely with policy makers and practitioners to develop fresh thinking about how to address strategic challenges in health and social care, education, housing, the economy and other devolved responsibilities. It:

- Supports Welsh Government Ministers to identify, access and use authoritative evidence and independent expertise that can help inform and improve policy;
- Works with public services to access, generate, evaluate and apply evidence about what works in addressing key economic and societal challenges; and
- Draws on its work with Ministers and public services, to advance understanding of how evidence can inform and improve policy making and public services and contribute to theories of policy making and implementation.

Through secondments, PhD placements and its Research Apprenticeship programme, the Centre also helps to build capacity among researchers to engage in policy relevant research which has impact.

For further information please visit our website at [www.wcpp.org.uk](http://www.wcpp.org.uk)

## Core Funders

**Cardiff University** was founded in 1883. Located in a thriving capital city, Cardiff is an ambitious and innovative university, which is intent on building strong international relationships while demonstrating its commitment to Wales.

**Economic and Social Research Council (ESRC)** is part of UK Research and Innovation, a new organisation that brings together the UK's seven research councils, Innovate UK and Research England to maximise the contribution of each council and create the best environment for research and innovation to flourish.

**Welsh Government** is the devolved government of Wales, responsible for key areas of public life, including health, education, local government, and the environment.

# Contents

# Summary


- This report brings together evidence about a range of models of domiciliary care from the UK and internationally.
- It focuses on microenterprises, franchises, local authority trading companies and alternative approaches to commissioning in the UK, Netherlands, Sweden and Quebec.
- Longstanding challenges facing domiciliary care in Wales - funding and market fragility, commissioning and workforce stability - are found in other countries. All models of care have to tackle these and experts emphasised that increasing the role of public and voluntary providers will not of itself resolve them.
- Evidence from Somerset shows that micro-enterprises supported by Community Catalysts offer an effective means of provision for self-funders and those with direct payments in rural areas, which is aligned with the Welsh Government's ambitions for the foundational economy.
- Franchise arrangements can enable smaller providers to enter the market by providing practical and financial support and access to training. But most franchisees are small providers and implementing this model at scale is challenging.
- Local Authority Trading Companies aim to improve efficiency whilst retaining public sector control over services. However, their success depends on effective management and local context, and some have run into financial difficulties.
- Personalised and outcomes-based commissioning enable more flexible and innovative care, and the success of innovative models in the UK often relies on direct payments.
- The Buurtzorg model developed in the Netherlands provides high quality care without increasing costs. Examples of domiciliary care inspired by this approach in the UK offer a way to improve the quality of care but require extra investment.
- The Norrtaeljje model in Sweden integrates purchaser and provider in ways that enable prevention and more joined-up health and social care. It covers a wide range of services but has homecare at the centre.
- Care co-operatives in Quebec have benefitted from a highly supportive legal and policy environment alongside established networks of financial and practical support. Without this level of support, co-operatives in the UK may struggle to provide care at scale.

# Introduction

Welsh Government ministers asked the Wales Centre for Public Policy to consider alternative models for domiciliary care in Wales, drawing on models and evidence from international examples as well as England and Scotland.

Domiciliary care providers and markets are facing a range of challenges as a result of changing population demographics and funding pressures, which produce market fragility and workforce shortages. Alternative models of domiciliary care are being explored in Wales and elsewhere as possible responses to these challenges. The Coronavirus pandemic has placed additional pressure on social care, amplifying these existing challenges and leading to new ones including the additional costs of personal protective equipment (PPE) and other measures to prevent transmission of the virus. On the plus side, it has opened up the possibility of accelerating the introduction of new ways of working, presenting an opportunity for disruptive change.

The first section of this report brings together findings from a series of interviews that we conducted with policymakers, managers, and researchers with expert knowledge of domiciliary care in Wales, as well as some key themes identified from UK and international models of domiciliary care. It outlines what is known about the current state of domiciliary care provision in Wales and the key issues that need to be addressed. The second section examines approaches elsewhere that may offer valuable insights for Wales, bringing together existing evidence and new evidence that we have gathered through conversations with experts in England, Scotland, the Netherlands, Sweden and Quebec.

# Domiciliary care in Wales

Domiciliary care is the term used to describe social care provided in people's homes to help with daily tasks, managing medications, help to mobilise, personal care such as help with washing, and some clinical care such as catheter management and PEG feeding. It may also include reablement services which aim to maximise a person's independence, for example following a hospital stay. Domiciliary care is central to realising the ambitions set out in A Healthier Wales for a focus on preventative, person-centred, community-based care with greater joined-up working between health and social care (Welsh Government, 2018a).

Local authorities are responsible for assessing a person's needs and arranging care and use national eligibility criteria to assess entitlement to care. The amount a person pays towards their care is determined by a means test. In Wales, regardless of a person's savings or income, there is a maximum weekly charge. The majority of domiciliary care in Wales is provided by the private sector, with some more specialist and complex care delivered by local authorities and a small proportion provided by the not for profit sector, though this varies between local authorities.

Analysis by Wales Fiscal Analysis (2020) found that local authority spending on care for older adults in Wales for 2018-19 was £837.2 million and that planning for future needs should take into account projected growth in numbers of older people with complex care needs and evidence that people are increasingly choosing care at home. Many people rely on family and friends for some or all of the care which they need in the home. There are an estimated 370,230 unpaid carers in Wales contributing care worth £8.1 billion per year. This is the highest figure among all UK countries and is expected to rise to over half a million by 2037.

The Social Services and Well-being (Wales) Act 2014 requires local authorities to promote social enterprises, co-operatives, user-led services, and the third sector. Some of these organisations have developed in Wales, but there are few instances where social value domiciliary care providers are operating at scale. Care and health services are examples of the Foundational Economy, and as such part of the Welsh Government's ambitions to shift toward a focus on place and resilient communities including jobs closer to home and moving away from reliance on large multinational companies. The Welsh Government is committed to 'rebalancing' the domiciliary care market (Standing up for Wales: Welsh Labour Manifesto 2019). Interpretations of 'rebalancing' range from encouraging more third sector and co-operative provision to bringing all care back 'in-house', but many of the experts who we spoke with expressed concerns about the latter.

Rebalancing may provide an opportunity for more strategic and joint commissioning. However, experts who we spoke with believed there were significant risks and were concerned that rebalancing could exacerbate market fragility, for example if private sector providers choose to exit the market, reduce choice for service users and decrease capacity to respond to fluctuations in demand, the importance of which has been highlighted during the Coronavirus pandemic. Moreover, they believed that rebalancing will not necessarily improve pay and conditions for care workers unless funding is increased.

There was agreement among the experts that the current market is unsustainable. However, they believed that there is no correlation between ownership and the quality of care or social value that an organisation provides. There are good (and bad) providers in all sectors. The important thing that governments can do is to create the conditions which encourage a culture and leadership which is centred on the provision of high-quality care and improved working conditions; and that social value is generated by providers from the private, public and voluntary sectors through investment in staff and co-production with clients and communities.

# Challenges and priorities for alternative models

For these reasons, any attempt to rebalance the domiciliary care market must be considered in the context of wider challenges facing the sector and should focus on increasing funding and reducing market fragility, improving commissioning, and improving pay and conditions for the workforce.

## Funding and market fragility

There has long been recognition that addressing the funding of social care is a priority (Boyce, 2017). The Coronavirus pandemic has further highlighted the funding pressures in social care, and the Welsh Government has made extra funding available for the sector to help with the increased costs of responding, including PPE and staffing costs.

Much of domiciliary care is commissioned via a tendering process and on a 'time and task' basis, meaning that providers are paid an hourly rate for undertaking specific tasks. In Wales, the average hourly price paid for domiciliary care was £16.78 in 2018 ranging from £14.68 in Merthyr Tydfil to £20.08 in Carmarthenshire. UKHCA's recommended minimum price for homecare in 2018 was £18.01 per hour (UKHCA, 2018). Squeezed budgets and increasing demand mean local authorities have faced pressure to keep costs low. This has, in turn, placed financial pressure on providers, who are facing increased costs - for example, the increases to the living wage. Any move towards increased 'in-house' provision is likely to increase costs, reflecting more favourable terms and conditions for workers and the additional management resources that would be required.

A review of domiciliary care in Wales concluded that the market is fragile and lacks capacity (Care and Social Services Inspectorate Wales, 2016). Providers exiting the market remains a concern. In January 2020, the Mears Group, a large independent provider announced its exit from the UK domiciliary care market citing plans to focus on higher-return markets in supported housing and housing for asylum seekers (Home Care Insight, 2020a). Wales is less dependent than England on very large providers and this may mean it is more resilient. However, smaller organisations and not-for-profits also face challenges including struggling to compete financially whilst meeting their quality standards and providing fair wages for staff. Smaller providers may have fewer resources to invest in innovation such as technology and may lack the skills and resources to compete with larger providers in tendering exercises.

## Commissioning

The review also found wide variations in approaches to commissioning across Wales (Care and Social Services Inspectorate Wales, 2016). The continued use of 'time and task' commissioning has been described by some as leading to the commodification of care, driving down costs and removing flexibility to meet people's needs and provide person-centred and relationship-based care (Kings Fund, 2018). The established 'time and task'

approach to commissioning can result in rushed visits and a lack of flexibility to respond to a person's needs (Care and Social Services Inspectorate Wales, 2016). The experts who we interviewed also believed that it encourages over-prescribing because providers lack incentives to promote independence and are unable to adjust care packages as clients' needs change over time. Commissioning was often described as a barrier for developing alternative models of care.

The role of commissioners in shaping domiciliary care is key and extends beyond procurement, through continued relationships, collaboration, and monitoring. There are well established approaches to commissioning which give individuals greater choice, flexibility, and control over their care including outcomes-based commissioning and personalisation through direct payments, personal budgets or individual service funds (where an agreed amount of money goes directly to a provider). Direct payments are available in Wales (whilst personal budgets are not), however, uptake has been much lower in Wales than in England and has increased at a slower pace (Senedd Research, 2015). Integrated personal budgets also offer an opportunity to bring together a person's health and social care needs. Alternative approaches to commissioning have the potential to enable providers to organise care differently and prioritise autonomy and flexibility, as well as incorporate community assets and principles of social value.

Commissioning was consistently highlighted by the experts as an essential element in developing alternative models of domiciliary care. The limitations of traditional approaches to commissioning are well established in the literature (Kings Fund 2018). Experts described the challenges of implementing models of care that are able to improve workforce terms and conditions, provide flexible person centred care and incentivise a focus on independence, prevention and reablement within current commissioning practices.

They also warned against setting expectations to demonstrate cost savings or impacts in unrealistic time frames. Improving quality of care and sustainability of the market requires investment and benefits are likely to be realised in different parts of the system. Cultural changes in commissioning, including supporting and enabling providers of all types to innovate and provide care that is flexible and better meets people's needs, were described as key, including incentivising care that is preventative and person-centred.

## Workforce

Workforce remains a fundamental challenge for domiciliary care in Wales, both in terms of recruitment and retention of staff. 32% of staff working for commissioned domiciliary care providers in Wales left during 2018 compared to 15% employed by day and other care providers (Social Care Wales, 2018). Lack of continuity and unreliable visits are major factors in poor experience of care (Care and Social Services Inspectorate Wales, 2016). Domiciliary care is a low wage sector, with many staff paid below the real Living Wage and a high prevalence of zero-hours contracts.

Responses to a consultation on the domiciliary care workforce in Wales highlighted low wages, work pressures, unsociable hours and poor terms and conditions as contributing to

difficulties in recruiting and retaining domiciliary care staff (Welsh Government, 2016). Since April 2018, providers have been required to give workers a choice of contract arrangement after three months of employment including an alternative to a zero-hours contract (Welsh Government, 2018b). Recruiting and retaining adequate staffing to provide domiciliary care remains a key challenge for capacity and quality in the sector. Much of domiciliary care is relationship-based and the workforce has an important impact on the way care is experienced. And, as noted above, many people in Wales depend on unpaid carers who are themselves subject to poor wellbeing, and high levels of stress and anxiety (Carers Wales, 2019).

The Resolution Foundation (2015) estimates some of the costs of increasing pay for care workers would be offset by decreased benefits and increased tax revenue and would improve staff retention and absenteeism, though the savings in benefits payments and increases in tax receipts would largely accrue to the UK Government rather than the Welsh Government. Improving working conditions for domiciliary care workers will be a key priority for developing new models, including providing training, improving pay and conditions, and offering career development.  Ensuring that domiciliary care workers have adequate employment security, pay and conditions of work is also crucial to the achievement of the Welsh Government's fair work agenda and links closely to work on the Foundational Economy. The Welsh Government has also committed to establishing a Social Care Fair Work Forum to consider further steps to achieving fair work in the sector.

Domiciliary care is relationship based and investment in workforce is essential to provide fair pay, better conditions, training, and career development. Freedom and flexibility to enable staff to provide person-centred care and explore new ways of working is key, for example in developing new roles. Wellbeing and engagement of staff is a key indicator of user experience (Sizmur and Raleigh, 2018).

## Reimagining homecare

Many of the experts described a need to reimagine domiciliary care as part of wider community services to better meet people's needs and that looking at what is traditionally described as domiciliary care in isolation does not reflect the approach to care that we should aspire to. They emphasised the need for a clear vision. Some talked about the need for a clearer strategy and policy from national governments, others said it is important to be clear about the purpose of implementing changes locally. They agreed that it was important to examine what people's needs are and how the system as a whole can best meet those needs.

Experts often cited need for more joined up health and social care where social care is an equal partner, a need to redesign roles and workforce terms and conditions, need to incorporate new technologies, changes to commissioning and a need for greater focus on prevention, maximising independence and community assets.

The unique circumstances of the Coronavirus pandemic were described as having led to the rapid introduction of new ways of working which should be harnessed as an opportunity to develop new approaches. Experts interviewed described how a culture of trust and shared responsibility had emerged between providers and commissioners in responding to the pandemic, and rapid responses to changing circumstances were enabled by greater flexibility, autonomy and permission as well as reduced bureaucracy.

Many of the examples described throughout this report incorporate community assets and resources, including asset or strengths-based assessment of needs. Cultural changes will be necessary to implement this approach in Wales, as well as a need for assessors to have a good knowledge of local community assets.

There was agreement amongst the experts that the lens for improving care for people in their homes needed to be widened to incorporate informal carers, community assets, the NHS, and a wider focus on wellbeing and prevention. Some argued that all aspects of domiciliary care should reflect this, others felt that this was more applicable to intermediate care and reablement and that longer-term social care needs could be delivered effectively without wider support. This approach should also be developed in conjunction with carers' assessments to avoid negative impacts and additional burden on informal carers.

## No one universal model

Many of the experts emphasised that there is no one best model for domiciliary care. Some argued for a mixed economy of providers, others described different types of care and local contexts requiring different approaches. Some experts described the need to differentiate between types of care - for example long term social care needs compared with intermediate and reablement services, which may benefit from different approaches. Others felt the principles of integrated models with greater focus on community assets and person-centred care should be central to all types of care provision.

# UK Practice

Many of the same challenges facing domiciliary care in Wales are also being experienced in England and Scotland. These include a fragile domiciliary care market and workforce challenges. However, there are some important differences (Nuffield Trust, 2020) in the make up of domiciliary care markets across the UK which it is important to take into account when assessing whether practice elsewhere might be adopted in Wales.

England has a higher number of privately owned providers and a higher proportion of self-funders. There is high turnover in providers and cross-subsidisation of self funded and local authority funded provision. The Care Quality Commission has a market oversight function to monitor financial performance of large providers and raise concerns about potential failures

to local authorities. Scotland faces similar challenges with the instability of the market. The voluntary sector provides the majority of domiciliary care services and employs most of the domiciliary care workforce. There are fewer self-funders in Scotland and Wales than in England.

We spoke to a wide range of experts with in-depth knowledge of provision in England and Scotland - including researchers, local government organisations, and Directors of Adult Social Care - and we asked them in particular about insights that Wales might draw from experience of social enterprises and franchises, local authority trading companies, and other innovative approaches to domiciliary care.

## Microenterprises

As noted above, the Social Services and Wellbeing (Wales) Act 2014 places a duty on local authorities in Wales to promote social enterprises, co-operatives, user-led services and the third sector. Micro-enterprises are very small services that may be made up of just one or two people providing care services or employ up to five full-time staff. They may be set up as social enterprises or charities and others are set up as limited companies.

The potential benefits of social enterprises are described as innovation, choice, greater staff ownership and lower turnover, improved partnership working and reinvestment of profit. However, challenges include the potential lack of management capacity to run a business as well as delivering care, lack of organisational support and leadership, complexities of competing in a cost driven market and demonstrating benefits (Millar et al, 2012).

An ESRC funded evaluation of micro-enterprises in social care in England (Needham et al, 2015) found that operating at a smaller scale enabled more personalised care, particularly for home care, and was enabled by autonomy and continuity of frontline staff, allowing flexibility in how care is delivered, as well as the accessibility of managers to staff and people using services. People using micro-enterprises were more likely to report that their provider helped them do the things they value and enjoy.  The evaluation found larger providers, however, were able to offer economies of scale to offer wider choices of day activities. Overall, the evaluation concludes that micro-enterprises offer more personalised and valued care without a trade-off between price and quality. Key enablers include flexible payment options such as direct payments, commissioning that enables micro-enterprises to join preferred provider lists, ensuring social workers are aware of available micro-enterprises, proportional regulation, and dedicated start-up support.

Many of the experts referred to **Somerset** as an innovative local authority with a strong focus on prevention and community assets which could be particularly relevant to rural areas with large older populations.

Somerset's work to improve the local care market included developing better relationships with local providers and establishing micro-enterprises, initially with the help of Community Catalysts who provided start-up support with business skills. The 575 micro-providers in the area support almost half of those who receive care and support in the community. In Somerset, the development of microenterprises is part of a strengths-based approach, focused on maintaining and regaining independence, community assets, outcomes, and reducing admissions to residential care for older people. The development of microenterprises was initiated as part of work towards greater personalisation and choice in social care. The majority (approximately 90%) of social care providers are locally based, with only one large national provider.

A Contact Centre aims to find community-based solutions and where possible avoid referral for a formal social work assessment. Community Connectors act as local or village-based agents with knowledge of local community assets and support. They initiate community-based meeting points and community cafes and also regularly sit in on hospital discharge meetings. The approach in Somerset aims to avoid reliance on formal services wherever possible, first connecting people to community assets and informal services.

The approach is to offer personal budgets or direct payments first. Many of the people who use micro-enterprises are self-funders or those with direct payments. As they are not regulated, the local authority cannot commission from them directly and so it is done through direct payments or personal budgets. For those who do not wish to use a personal budget or direct payment, Somerset has an open approach to commissioning formal domiciliary care services (rather than few preferred providers or block contracts) to enable a variety of providers to operate in the market and prevent reliance on a limited number of large providers. Intermediate and reablement services are delivered through an integrated model where health and social care work together and providers have been trained by health colleagues to reduce reliance on specialists. Somerset are exploring innovative ways of commissioning in partnership with providers with ambitions to provide better working conditions (for example permanent contracts) and aligned incentive for reablement and promoting independence.

Somerset County Council has transitioned from an £8 million overspend on adult social care in 2015/16 to a £1.5 million underspend in 2017. It reports it has reduced its delayed discharges from hospital by 75% between 2016 and 2018. During this time outcomes for older people have improved as well as performance in reducing delays from hospital (Bolton, 2019). After its first year of service, 60% of contacts are resolved by the Contact Centre. Somerset reports that the development of micro-enterprises has been a positive development, particularly in terms of capacity in rural areas which are less attractive to larger care providers as a result of additional costs associated with providing care in rural areas. It has also been a positive contribution to the economy in Somerset, providing jobs for local people. This illustrates the potential for supporting development of microenterprises to

support ambitions of the foundational economy in Wales. The development of micro-enterprises has led to some challenge from more traditional care providers who have expressed concern about the lack of registration requirements and the monitoring of micro-enterprises and whilst improved, capacity issues in the provision of care remain.

**Community Catalysts** work in local areas across the UK including in **Pembrokeshire, Swansea and Powys** and the Foundational Economy Challenge Fund has awarded money to initiatives in Flintshire and Swansea to develop micro-enterprises. Micro-enterprises may be particularly relevant for rural settings, where the market is less attractive for larger providers due to the additional expense of providing care in those areas, as well as their potential for contribution to the local economy. Whilst there is strong evidence for the benefits of micro-enterprises, there has not been a formal evaluation of the approach in Somerset.

## Franchises

As part of a national review of domiciliary care in Wales in 2016, Care and Social Services Inspectorate Wales recommended development of a Welsh-branded domiciliary care franchise either by setting up a social interest enterprise or partnering with an existing independent or third sector provider, to support small and new domiciliary care businesses in Wales (CSSIW, 2016). Under a franchise model, small and new domiciliary care agencies use the branding of an established franchiser. The agency benefits from the franchiser's support and operating under a known and trusted brand and in return, the franchiser receives a percentage of the agency's revenue. The infrastructure of franchises may also provide opportunities for access to better training for care workers, for example where the franchiser provides training.

There are a wide range of potential organisational formats including commercial, subsidised or non-profit social franchises. Social franchises operate in a similar way to commercial franchises, using an existing structure and brand name to support replicating or scaling of proven models through contractual partnerships. In social franchises profits are reinvested.

**Care and Share Associates** (CASA) is a social franchise that was established in 2004 based on Sunderland's Home Care Associates model. One of the challenges of establishing social franchises is availability of funds for investment. CASA received European funding when it was initially established and since moved to a self-financed model, receiving a 4.2% royalty fee when a new franchise company breaks even (Zióïkowska, 2018). CASA provides a range of back-office support to franchisees, including support with business aspects such as registering with regulatory bodies, developing business plans, HR processes, help with accessing approved provider lists, start-up funding and training for staff. In 2018, CASA had 850 employees providing 18,000 hours of care per week. CASA ran as a social franchise model until 2014 when it became an employee-owned social enterprise and became Be Caring in 2019. Be Caring is the UK's largest employee-owned social care provider.

**Caremark** is a national franchise operating in the UK. The franchise provides specialist training to franchisee staff such as a Virtual Dementia Tour, to help staff to better understand the experience of living with dementia. They have also rolled out the PatchCare system whereby Assistants are responsible for an area of no more than 10 clients and can operate responsively to client needs. This approach has given workers greater security with fixed-term contracts and regular hours. However, they have shifted toward a greater proportion of private (or self-funded) work in recent years as smaller franchisees seek the greater financial security provided by the self-funded market (Home Care Insight, 2020b).

Both of these examples demonstrate challenges faced by franchise models. Franchises are dependent on relationships between franchiser and franchisee and important contextual factors such as shared values are important in implementation (Zióïkowska, 2018). Franchise arrangements may facilitate entry to the market for smaller providers by providing practical and financial support, as well as improving access to training and knowledge to develop quality of care. However, franchisees are often small providers who can face financial challenges as well as challenges of replicating a model in a different setting (UKHCA, 2020). There is little evidence or formal evaluation available on the impact of franchise models.

There are some similarities in the approaches of microenterprise development and franchises described above. Community Catalysts provided back-office support around contracting, regulation and training for the development of microenterprises in a similar way a franchiser would without some of the formal organisational arrangements of franchises.

The national review of domiciliary care in Wales CSSIW (2016) surveyed domiciliary care providers in Wales and found that 7% of responding providers were already run on a franchise model. These providers said that working with franchisers enabled them to set up a new agency more safely and with greater support but that franchisers tended to lack awareness of the regulatory context of Wales. Experts we spoke to described several examples of innovative franchises operating in Wales including:

- **Home Instead** is a large-scale franchise company operating internationally with over 215 franchises in the UK (including in Wales). The company has implemented technology-based innovations such as a sensor technology service that gives carers insight into clients' activity levels and flags potential health issues (Home Care Insight, 2020c).
- **Bluebird Care** was established as a small family business and has achieved significant growth through a franchising model. Bluebird Care is now one of the largest private providers of domiciliary care in the UK with over 200 franchisees, including several in South Wales (Franchise Direct, 2020).

- **Solva Care** in Pembrokeshire is a small scale social franchise based on a community assets approach. Domiciliary care provision is supported by over 30 trained volunteers who deliver practical support and organise social events (Solva Care, Undated).

## Local Authority Trading Companies

Welsh Government has made a commitment to 'rebalance' the domiciliary care market (Standing up for Wales: Welsh Labour Manifesto 2019), moving away from care being provided in the interests of profit for large private providers and moving to more services being provided in-house or for social value. Local Authority Trading Companies (LATCs) allow a local authority to trade services for profit or to provide statutory services on a not-for-profit basis alongside privately funded work. Any profits made by a LATC can be reinvested into the local authority, providing an additional source of income.

LATCs may be pursued as a means to make cost savings or to give local authorities greater control over quality of care, as well as enable their role to step in as a provider of last resort. Setting up a LATC can be viewed as a means to introduce greater strategic and commercial thinking into the governance of provision, for example, through the creation of a commercially-minded board. LATCs have been presented as reducing some of the risks associated with outsourcing, such as long term and inflexible contracts, a focus on short-term profitability, and high staff turnover (Grant Thompson, 2018). The LATC model potentially enables local authorities to retain greater strategic control over services in their role as shareholders but decisions may be made more quickly through broad approval when compared to seeking cabinet approval. In addition, LATCs can generate an additional source of revenue from privately funded work (although this may affect the application of the Teckal exemption).

**Essex Cares** was the first adult social care LATC in England, launched in 2009 and provided home care, day centres, and reablement services. After launching the LATC reported a range of positive outcomes including the improved motivation and morale of staff, more adaptable and responsive services, and savings of around 10% of the contract value (Walsh, 2009). The model was initially financially successful recording a £3.5 million profit in 2010-11. However, profits dropped the next financial year to £1.5 million and the organisation was later restructured (Grant Thornton, 2018).

**Chelsea Care** was established in 2008 and went into liquidation in May 2011. A report from the council's Scrutiny Committee details fundamental problems with the LATC's business case (Royal Borough of Kensington and Chelsea, 2011). Profit forecasts were heavily reliant on the growth of a high-paying private client base. In practice, the rate of private clients signing up for services was much lower than expected and they were unable to charge high rates due to market competition.

These examples illustrate some of the challenges the LATC model raises including encountered financial difficulties. Transfers of staff are likely to be subject to the Transfer of Undertakings (Protection of Employment) Regulations 2006 which preserve the terms and

conditions of existing staff although do not apply to new starters. Moving provision from in-house services to an LATC could create tension between the local authority and staff and could be viewed as an opportunity for cost reductions by providing less generous terms and conditions for staff (Unison, 2013).

Like other companies, LATCs are subject to VAT, corporation tax and are subject to state aid rules. Some LATCs, however, may be covered by the 'Teckal exemption', which exempts public sector bodies from the requirement to put in place a competitive tendering process for contracts above a certain value. This exemption applies if the contract is awarded to a subsidiary body which only provides services to the local authority or authorities that control it (ibid). Understanding whether the Teckal exemption will apply is an important consideration for local authorities establishing trading companies and a failure to understand the regulations and their implications could undermine the business plan (Unison, 2013). LATCs are governed by company law and must be run according to the best interests of shareholders. Shareholders could include the local authority and a councillor could be appointed as company director, however, they must act in the best interests of the LATC which may give rise to a potential conflict of interest (Sandford, 2018).

In some cases, LATCs have been set up with the intention of later moving to a social enterprise, mutual or co-operative model of delivery (Walsh, 2009). If a trading company is transferred to another model, the company may no longer be covered by the Teckal exemption, requiring the award of large contracts through a competitive tendering process. This could mean that a new co-operative body or social enterprise cannot be straightforwardly awarded a contract for services previously provided by the LATC (Unison, 2013).

However, LATCs continue to provide domiciliary care in a number of local authorities. **Optails is an LATC owned by Wokingham and Windsor and Maidenhead** employing 700 staff and providing home care.

**Tricuro Care and Support** is a joint LATC which was established in 2015 and is owned by **Dorset Council and Bournemouth, Christchurch and Poole council**. It is governed by an Executive Shareholder Group made up of elected councillors. It has a turnover of £40m (£160k profit in 18/19), employs 1400 staff and provides support to 6000 clients each year. Its annual report for 2018/19 reports 98% of clients are happy with the services, all of its services are rated 'good' by the Care Quality Commission and the organisation was awarded 'Care Provider of the Year'. The large majority of its income comes from the local councils (just 4% from fees and charges). Additional income from selling services to self-funders, the NHS and other local organisations has created £1.4m additional income that has enabled Tricuro to invest in technology and innovation, which they call 'profit for purpose' enabling reinvestment that positively impacts services for local communities and enables the company to extend its reach to those who may not meet local authority eligibility criteria with the aim of maximising independence and wellbeing (Tricuro, 2019). However, a report by Unison (2017) for Dorset Council outlined a number of challenges facing Tricuro including criticism about cuts to terms and conditions for staff.

The success of LATCs in meeting their aims is likely dependent on a wide range of factors including how they are set up and managed by local authorities. Conducting an appraisal of the appropriate delivery model and the development of a business case alongside a robust consultation is key to ensuring that an LATC is viable and meets the objectives of the local authority. The knock-on effects on other services provided by the local authority should also be considered carefully. Developing a profitable LATC is also likely to be a long-term project with profits unlikely in the first three years and growth taken in incremental phases (Grant Thornton, 2018).

Although there are a number of long-standing LATCs providing home care in the UK, there are also examples of LATCs being restructured or going into liquidation. Setting up a LATC requires careful consideration and risk management on the part of local authorities and the evidence for the benefits of LATC is limited. LATCs that have been established in England have largely aimed to deliver cost savings, income generation and respond to the personalisation agenda rather than to facilitate social value. LATCs in England have not always contributed to market stability, with some having required restructuring to survive or gone into liquidation. Experts we spoke to described LATCs as a 'cosmetic exercise' and felt that the aims of some local authorities when setting up a LATC could be achieved through cultural or leadership change in terms of relationships with external providers and in-house provision.

## Commissioning

The limitations of traditional approaches to commissioning and the challenges it presents to developing innovative models of domiciliary care are well-established (Kings Fund, 2018). Rhetoric and policy ambitions for moving toward outcomes-based commissioning has been present for some time but much of domiciliary care continues to be commissioned on a time and task basis. Outcomes-based commissioning can consist of large-scale changes to the way care is commissioned across a locality or the inclusion of financial incentives based on outcomes in contracts. Outcomes can refer to individuals for example improved mobility for a service user or be interpreted more broadly to include wider community assets and social value outcomes for communities (Harlock, 2014). Whilst evidence about the impact of outcomes-based approaches is limited, they have the potential to enable providers to meet care needs more flexibly and improve working conditions for staff (Bolton and Mellors, 2016). Key barriers may include lack of trust between providers and commissioners. Many of the experts we spoke to described greater trust and flexibility for providers as a key enabler of innovative approaches to domiciliary care.

Many of the innovative models we have described were enabled by the flexibility of direct payments and personal budgets (including development of micro-enterprises in Somerset and Wellbeing Teams). Personal budgets are managed by local authorities and direct payments are where budgets are transferred to individuals. User experience is generally positive, enabling greater independence, choice and control over their care (Hatton and Waters 2013). They work particularly well for working age people with disabilities but some groups may require support for managing their budgets and they may work less well in areas

with less choice. They also provide a mechanism by which providers have to tailor their services to individuals needs and a key enabler is support, information and advice to enable individuals to take control and make informed choices (IPC 2016). Potential challenges of individual budgets include lack of economies of scale, and potential impacts on the market (Glendinning et al, 2008). Direct payments and personal budgets are well established in the UK. Direct payments are available in Wales (personal budgets are not) although take up is lower in Wales (Senedd Research, 2015).

There are a number of ways in which local authorities enable and support increased personalised commissioning which are important to support its uptake. **Calderdale** conducted an engagement exercise to develop home care services which involved talking to people about their experiences of using home care services to understand what is needed in the market. The findings showed that priorities for individuals were quality issues such as continuity of workers not who the provider was. The exercise led to development of Individual Service Funds to enable personalised contracting and flexible support for those who do not want the responsibility of direct payments and take up was high (IPC 2016). Salvere is a social enterprise in **Lancashire** that has been commissioned by the local authority as a brokerage service providing information to people about services available, as well as information and advice about direct payments to support people to manage their own support flexibly (IPC 2016).

Individual Service Funds were described by experts as enabling providers to deliver care more flexibly. A budget is agreed for an individual's care and paid directly to a provider which can be chosen by the individual, and underpinned by a flexible, outcome focused contract with the local authority (IPC 2016). Organisations are accountable to the person receiving care, who has oversight of how their Individual Service Fund is being spent. The experts we spoke to discussed the potential of individual service funds to enable flexibility in how care is delivered and incentivising a focus on promoting independence and reablement.

**Devon** started a pilot of Individual Service Funds in May 2018 based on an outcomes-based assessment and support plan developed by the provider with the individual and their 'circle of support'. Contracts are then developed between provider, service user and commissioner in a similar way as for a direct payment. The provider acts as a third party manager of funds and is accountable for outcomes. An evaluation of the pilot (IPC, 2019) found that for the majority of individuals the ISF had improved flexibility of provision and quality of life, enabled providers to plan care and support more flexibly and creatively, enable better integration and connection to communities, and demonstrated potential for efficiencies. It was too early to understand financial impact but where ISFs had been in place for over a year, there were projected underspends.

Many of the experts and innovators described a need for cultural changes in commissioning to enable a partnership based relationship between commissioners and providers based on trust; and enabling providers' flexibility to innovate and meet people's needs. Many discussed ways in which responding to the Coronavirus pandemic had accelerated development of these types of relationships based on necessity and the benefits of doing so, describing providers as more able to respond quickly to changing circumstances and need.

In **Torbay**, a Living Well@Home approach is based on integrated care and support focused on outcomes and enablement. Homecare providers were involved in the redesign of the specification and performance indicators. Care Collaborative Meetings bring together a range of local stakeholders including providers and commissioners encouraging a culture of partnership.

# International practice

Ensuring a stable and diverse domiciliary care market that provides good quality of care, as well as addresses challenges of market fragility and workforce shortages, are a concern for many countries. Work from The King's Fund (2018) explored innovation in approaches to delivering home care and found that while some alternative models of provision are developing, there are few examples where these have been effectively scaled up. Some of the examples highlighted in that work are described below:

- In Finland's Kotitori model, the city contracts with a private provider which acts as an integrator co-ordinating personalised care from a range of providers (including public, private and not-for-profit).
- In Germany, information centres and a single point of access website provide advice about care options and cash payments are available for the person needing care to pay a family member. Although this is worth half the value of direct provision of care, uptake is high.
- In the Kinzigtal region, a care management company is integrated with health care and operates a membership model, negotiating with local providers on the behalf of enrolled residents.
- Denmark has reformed training and education of domiciliary care workers and reimburses employers who offer paid care leave.
- In Japan, care is outsourced to not-for-profit welfare councils, which have adapted to become 'welfare corporations' funded by membership fees, public subsidies and service charges. In rural areas, the model was adapted to incorporate mutual help, paid volunteers and co-operatives.

Here we analyse three examples in greater depth:

- The Netherlands – Buurtzorg
- Sweden – Norrtalje
- Quebec – cooperatives

We provide a brief overview of each approach, its objectives and context, and its potential relevance to Wales together with a summary of any evidence about their effectiveness.

# The Netherlands - Buurtzorg

The Buurtzorg model originated in the Netherlands and involves small autonomous teams that are neighbourhood based and provide a range of care in people's homes. Teams are made up of nurses and nurse assistants who provide services that would traditionally be delivered by domiciliary care as well as clinical care, for older people and people with long term conditions.

The model provides holistic, long-term care at home and aims to reduce bureaucracy to prioritise time spent on direct care. Key elements include:

- Teams work with individuals and their existing support networks to provide care focused on continuity, flexibility, and enabling independence.
- An integrated needs assessment is carried out which incorporates informal support networks and community assets.
- Teams are self-managed and non-hierarchical, with administrative support provided by a small back office and developmental support from coaches, keeping administrative costs very low.

There are many examples of the Buurtzorg model being adapted and implemented in various contexts in Wales and the rest of the UK, including for domiciliary care, which are discussed in more detail below.

## Objectives/context

The Buurtzorg model in the Netherlands was developed by a nurse in the context of rising costs and a disillusioned workforce and aimed to empower frontline workers, provide better continuity and quality of care that was more user centred and integrated with families and neighbourhood assets (Centre for Public Impact, 2018).

In the Netherlands, there is a universal mandated social care insurance scheme which was introduced in 1968. It is administered by private insurance companies and paid for via income-related premium deducted from wages and an employer contribution paid for via payroll taxes (Kings Fund, 2014). The extent of care provided is determined by a needs assessment. Individuals are also able to pay out of pocket for additional care. Direct budgets are available for individuals with social care needs and can be used to pay relatives.

## Evidence base

Evaluations of the original Buurtzorg suggest impressive performance related to efficiency and user satisfaction. Evidence is less clear for adaptations of the model in different settings including the UK. However, there are examples of domiciliary care models that are inspired by the Buurtzorg model that have been received well by staff and people using services.

The original Buurtzorg model performs well in terms of efficiency and a number of outcomes including fewer home care hours being required, high staff satisfaction and low turnover (Gray et al, 2015), reduced amount of time requiring care, fewer emergency admissions and high client satisfaction (Monsen and de Blok, 2013). The nurse led model prevents multiple visits being required and enables reduced management costs. Overheads are kept low by minimising bureaucracy and administrative staff; and costs have been shown to be lower for Buurtzorg (Gray et al, 2015). In 2016, there were 850 Buurtzorg teams across the Netherlands with 10,000 nursing staff and just 45 central office staff (de Blok, 2016).

At face value the evidence for the Buurtzorg model is very positive in terms of quality of care and affordability and this is one of the reasons the approach has received so much interest, for example the RSA recent report on the potential for self-managed teams in social care (Hannan, 2020). However, questions have been raised about the affordability of the approach in practice.

## Implementation in the UK

There are many examples of Buurtzorg inspired approaches to domiciliary care (as well as community nursing) being implemented in the UK. They are often referred to as neighbourhood care or self-managing teams.

**Cornerstone, Scotland**

Cornerstone is one of 12 'Neighbourhood Care' test sites being developed across Scotland alongside the Scottish government. Cornerstone has received funding from the Carnegie UK Trust, National Lottery, and the Scottish Government.

Cornerstone is one of the largest social care organisations in Scotland providing care and support to adults, young people and children with disabilities and other needs. Inspired by the Buurtzorg model, the organisation has developed Local Care and Support Teams (LCAST), with the aim of developing a local structure where care workers have devolved autonomy and accountability. LCASTs consist of nine elements: business systems, community decisions, cornerstone charitable foundation, cutting edge technology, strong partnerships, trust and empowerment, neighbourhood care and support, trust and empowerment, and inspiring others to change through stories.

Some key elements for implementing the approach included working with Scotland's Health and Social Care Partnerships to test alternative and flexible approaches to commissioning that are not risk-averse and are based on greater trust in the commissioner/provider relationship (Hannan, 2019). A number of alternative approaches to commissioning are being trialled in different areas including self-directed support (where an individual has control of their budget), outcome-based commissioning (where care is no longer commissioned based on hours of care but on evidence of agreed outcomes), and block funding (where payments are made to the provider quarterly, subject to reporting on workforce, quality and productivity indicators).

It was found that it was important to ensure that staff feel adequately valued and supported in the transition from traditional roles and hierarchies. As a result, Cornerstone introduced a mentor role to provide leadership and guidance, inadvertently introducing layers of management.

An independent evaluation by the University of Strathclyde (2019) found reduced overall spend on recruitment, reduced mandatory training costs, better staff retention, improved lost time rate, less reliance on agency staff, and better staff engagement. A report by Health Improvement Scotland (2019), which was commissioned by the Scottish Government to support the development of the neighbourhood care pilots, outlines a number of key learnings. Staff and the people they support valued the principles of the model, particularly that it enables holistic and person-centred care. Key elements for success included multidisciplinary team huddles which reduced duplication and enabled flexible and personalised care for people with complex needs, relationship-based care, and linking people to community resources. Key challenges included the complexities of transitioning from traditional roles and teams to self-organising teams, lack of supportive systems, and workforce sustainability. Wider contextual priorities included collaborative commissioning, availability of community resources, and integration of community health and social care services at the point of care.

**Wellbeing Teams**

Wellbeing Teams was founded in 2016 and is a domiciliary care provider that operates in locations across the UK including Wigan, Oxfordshire and Thurrock. It applies the principles of Buurtzorg, including self-managed teams and neighbourhood-based care that is focused on flexibility, community assets, relationship-based care and autonomy. Care is provided by small, neighbourhood-based teams with a focus on staff who have autonomy and trust to build relationships with people they support and to provide care flexibly to meet the person's preferences. Wellbeing Teams work with a focus on supporting people to regain independence and connecting people with community assets. It has a strong focus on improving working conditions for staff who are salaried for shift work, and not paid only on the basis of contact time. The approach to recruitment focuses on values over experience and technology is used in innovative ways to support staff and people.

Wellbeing Teams are founded on the principles that traditional domiciliary care services and/or tasks do not support an aspirational model of care and that they should be commissioned within a broader service offer. The Wellbeing Teams approach has required tailoring to each local context including working with local commissioners.

However, this approach requires investment and new approaches to commissioning – it is not sustainable to deliver this kind of service for the traditional hourly rate cost. One of the ways local authorities who have adopted Wellbeing Teams have overcome this is to rethink the scope of domiciliary care, for example having district nurses train care workers to carry out some simple tasks such as administering an injection or incorporating elements of social prescribing as part of Wellbeing Teams. In Burnley, Wellbeing Teams and Calico Group are exploring helping people with personal health budgets.

Wellbeing Teams has been rated Outstanding by the Care Quality Commission in England and has won several awards including the Guardian Public Services Award. They report significantly lower staff churn than traditional domiciliary care providers. Wellbeing Teams was highlighted to us by several experts as an example of an alternative approach to domiciliary care that offered high quality, person-centred care. However, there is no formal evaluation available currently.

**Thurrock, England**

Thurrock has developed a 'Local Area Co-ordination' model for social care where a team of workers develop knowledge of a neighbourhood (Bolton, 2019). Local area co-ordinators help connect people to community assets based on a 'strengths-based' assessment and reduce the risk of people becoming dependent on formal domiciliary care services. This has resulted in lower than predicted numbers of people requiring formal care. Delaying services has meant that those entering formal services have more complex and therefore more expensive needs.

The local voluntary sector has formal partnerships with the local authority and has led to growth in the number of micro-enterprises operating in Thurrock, often through personal budgets enabling choice and market capacity. There have been three provider failures in Thurrock and so there is an ambition not to be overly reliant on a single approach. Different commissioning options alongside the development of micro-enterprises are being developed in response, including direct payments, individual service funds, and traditional procurement. There are also two locality based 'Wellbeing Teams' who work alongside networks of health professionals and have ambitions for building further links with the NHS. They recognise that wider system change is required for changes to care.

Some important learning from Thurrock includes the need for time when implementing new approaches (they report an eight-year period of change), clarity about purpose and a clear direction for staff, as well as staff ownership and freedom. Thurrock has achieved one of the lowest levels of spending on adult social care.

**West Suffolk, England**

In West Suffolk, NHS and local government colleagues have been working together to support a pilot of the Buurtzorg model. They have employed a team of four nurses and two assistant practitioners and transferred the community nursing caseload, as well as set up referrals from GPs. Referral criteria were flexible but individuals needed to have a health need. In their review of the approach, The King's Fund identified the following key learning (Maybin et al, 2019):

- The model is unlikely to look the same in a local context - focus on aims and what aspects of the model will support those aims
- Requires infrastructure to support new ways of working such as IT systems, referral criteria – develop these early on

- Support development of non-hierarchical culture in the team – new ways of working require time and support
- Clarify roles and responsibilities – do not assume a shared understanding
- Protect new ways of working from system pressures to demonstrate impact – new ways of working take time

## Relevance to Wales

The original Buurtzorg model was developed by a not-for-profit social enterprise and is focused on providing person-centred care that is joined up and focuses on promoting independence and working with community assets. There are some models of care in the home in Wales that draw on it.

In 2018, the Welsh Government pledged £1.2m towards a pilot of Buurtzorg inspired Neighbourhood Nursing for community nursing teams in three areas; Aneurin Bevan University Health Board, Powys Teaching Health Board, Cwm Taf Health Board (Cwm Taf University Health Board, 2018).

In Monmouthshire, the council has adopted many of the elements of Buurtzorg self-managing teams to its domiciliary care services (RSA, 2019). In 2014, it piloted the Raglan project which was based on flexibility, autonomy for staff, salaried care workers, and relationship-based domiciliary care. An in-house evaluation (Richings, 2014) found that the project was well received by staff and service users and highlighted the right people and the right culture as key to the success of the project, achieved by giving staff the autonomy and flexibility to enable more compassionate, relationship-based care and improved engagement and motivation. The evaluation was less clear about the cost implications, and highlighted the complexity of measuring outcomes, but concluded the model was likely able to provide better outcomes for the same cost. In addition, it is unclear the extent to which the Raglan model would be transferrable to other local authorities in Wales, including those with very different socio-economic demographics and fewer self-funders.

## Summary

The evidence about the original version of Buurtzorg in the Netherlands is promising and has been highlighted as an example of good practice with the potential to improve quality without increasing costs. There is less evidence about the effectiveness of Buurtzorg inspired approaches that exist in the UK, particularly for those that focus solely on domiciliary care. Overall, evaluations suggest that the approach provides good quality care with positive feedback from staff and people using services but that it requires investment. Commissioning and funding are commonly cited as barriers to implementing a Buurtzorg inspired approach and examples in the UK often rely on direct payments or personal budgets as a means of commissioning. In some cases it may be unable to compete with traditional local authority funded care and instead caters to the self-fund market. Experts who we spoke to described the complexities of demonstrating impact of the preventative approach of these models of

care and the need for cultural change in commissioning practices, enabling greater trust, flexibility and autonomy as well as changes to the way impact is measured.

# Sweden - Norrtalje

In the Norrtalje model, a public company was created to manage health and care services. As part of the approach, two organisations were created: the TioHundra Care Company which is a large integrated care provider and the TioHundra Administration which is a local commissioning body with integrated responsibility for health and social care (Sjogren and Ahblom, 2012). The integrated administration collects payments from different sources and makes payments to providers, has responsibility for health and social care of the population and is owned and steered by a joint political governing committee made up of representatives from the county and the municipality. All providers in the area are required to act within an integrated chain of home care services, health care and rehabilitation (Back and Calltorp, 2015). A person can choose a private provider and needs defined by their care manager are still publicly funded but individuals are able to buy extra services at a reduced price.

The model was implemented across four phases between 2006-2012. The planning and preparation phase involved public meetings where plans were presented to the public for the new model and negotiations held with trade unions. In 2006, the 'macro-structure' was established for revenue collection and fund pooling. The committee and administration were split from the public company, forming roles as purchaser and provider. Employment contracts were transferred to the new organisation.

Between 2007 and 2009, the structure for micro-integration was implemented. Patients and clients were defined into three groups; 0-18, 18-64, above 65 with different reporting data required for each group and new financial systems were developed. Whilst the model covers the whole population of the region, there are specific programmes for older people aimed at providing integrated care with a focus on prevention and promoting independence and good quality of life, as well as improving care pathways and coordination between health and social care.

As part of this, an IVOP or integrated provision of health, social care and rehabilitation for older people at home or in residential care, aims to prevent emergency hospital admissions. It brings together home care with district nurses, primary care, paramedics and rehabilitation. Home care staff identify people with increasing needs and communicate with district nurses who can provide extra services. Each older person has a care coordinator, who is often a home care worker, who coordinates interventions for their care pathway across homecare, rehabilitation and other healthcare services. A care manager has a delegated right to make decisions about older people in need of home care, in line with the national Social Service Act of 1982.

## Objectives/context

Sweden has an ageing population, financial pressures, and concerns about the quality of care including in the coordination between different health and social care providers. Social care in Sweden is funded by municipal taxes and government grants. Individuals can apply for municipality funded home care subject to an assessment of need. Municipalities decide their own rates for home care and there is a maximum monthly charge. The number of private providers of social care has been rising and some concerns have been raised about prioritisation of profit over standards of care.

Norrtaelje is a municipality of Stockholm that is rural and has a higher proportion of older people than average in Sweden. The local hospital was facing closure as a result of financial challenges which was an important driver of change. Sweden has a complex management system where different facets of care are funded and managed by different levels of government and there was a need to provide better coordination between health and social care for older people with complex needs.

## Evidence

Evaluations show stable or decreased costs and improved quality for older people with home care, where the model helped provide more integrated care and enabled resources to be pooled and redistributed and reduced the proportion of adults in nursing homes (Andersson Back and Calltorp, 2015). They have also found that the model supported access to specialists for people with complex needs enabling continuity of care. Both elements of integration (macro and micro) were necessary to enable change.

The Norrtaelje model is distinct from other approaches focused on integration in that it aims to integrate both the purchaser and provider aspects of care, incorporating responsibility for health and social care of a whole population (Sjogren and Ahblom, 2012). This has enabled the development of comprehensive contracts and performance monitoring across authorities responsible for health and social care and in turn enabled pooling of resources and ownership of joint problems.

Some important elements highlighted in evaluations of the Norrtaelje model include the importance of local context: the threat of closure of Norrtaelje hospital provided the impetus for change and motivation for collaboration and because Norrtaelje is a smaller community existing relationships between professionals from different fields and with citizens aided reform. This also meant there were limited providers operating in the area. In 2010, the Swedish Act on System of Choice in the Public Sector legislated for individuals to choose their primary care and home care providers. This complicated the implementation of Norrtaelje as new actors entered the market and integration had to take place across organisational boundaries (Sjogren and Ahblom, 2012).

The Norrtaelje model was initially a pilot and has recently made permanent. Further evaluation work is underway.

## Implementation in the UK

We have not been able to find direct examples or iterations of the approach being implemented in the UK. Some areas have looked to the model for inspiration when developing integrated neighbourhood teams, for example in Worcestershire, local leaders visited Norrtaeljje and Buurtzorg when developing integrated neighbourhood teams. There are also some similarities in examples of local authority trading companies such as Tricuro in Dorset (as described above).

## Relevance to Wales

The integrated purchaser enabled a focus on prevention and more joined-up health and social care for individuals. The approach extends far beyond domiciliary care services but homecare is at the centre of the approach, with a focus on 'home first'.

## Summary

Evaluations show promising efficiencies created by the Norrtaelje model, which in contrast to the Buurtzorg approach was led by changes to macro-structures to enable closer working between health and social care. However, as far as we know, it has not yet been tried in the UK and it would represent a significant shift beyond current models of domiciliary care.

# Quebec – Co-operatives

Cooperatives are well established in Quebec and co-operative enterprises are common across many sectors including social care. Multi-stakeholder or social solidarity co-operatives for health and social care were established in 1996, involving staff, service users and community members in their ownership structures. A network of 103 social enterprises (a mixture of co-operatives and non-profit associations) were created covering every region of Quebec (Girard and Restakis, 2012).

Care co-operatives in Quebec are supported by established networks providing access to financial and practical support. Each region of Quebec has a Regional Development Co-operative funded by the Quebec government to support and foster new co-operative enterprises in the region. These organisations are co-operatives themselves and had 1200 members and 60 paid staff in 2012 (Girard and Restakis, 2012). Although the majority of income is generated from service user fees, between 15-20% of funding is provided by provincial government grants (Girard and Restakis, 2012). The Regional Development Co-operatives also enable care co-operatives to access social finance provided by credit unions (Conaty, 2014). Agreements are in place with trade unions about salaries.

## Objectives/context

Before the development of home care co-operatives in Quebec, home care was provided by a mix of voluntary and private sector organisations with a few emerging co-operatives. There were concerns around unmet need within the population and undeclared work or

moonlighting in the sector. The French language context was important in the formation of co-operatives in Quebec, as they were a way for the local Francophone population to develop provision outside of the larger providers controlled by English-speakers (Girard and Restakis, 2012). One of the aims of the model was job creation and benefits to the community, particularly for women.

The approach was inspired by the Italian model of social co-operatives which similarly include a range of stakeholders as owners including service users and their families. Although most co-operatives are small, they are supported by a system of co-operative consortia (or federation) offering back-office services such as training and support with contracting. Each successful co-operative commits to incubating at least one new social co-operative and all co-operatives contribute 3% of their net profits to mutual funds (Conaty, 2014).

## Evidence

Proponents of the multi-stakeholder co-operative model have argued that it brings about the following benefits:

- Greater service user control;
- Opportunities for service users to become more involved in their communities;
- Improvements to the status, terms and conditions and pay of care workers;
- Improved quality and coverage of services;
- Good governance safeguards.

Co-operatives in Quebec seem to have fared better than other non-profit or social enterprise models and have been able to expand their services to residential accommodation (Girard and Restakis, 2012). More recently, as demands on services increase, questions are being raised about additional funding so that they can provide services such as working with co-ops in health, housing, and transport to better meet member's needs (Girard and Restakis, 2012).

Co-operative models of delivery can be challenging for a number of reasons. In a multi-stakeholder model, tensions can arise around the competing interests of stakeholder groups and trade-offs will need to be made, such as between staff pay and the cost of services. Moving to a co-operative model of delivery can also present a challenging cultural change for staff and leaders familiar with a more hierarchical model of management (Conaty, 2014, Girard and Restakis, 2012). Care workers may also need support to develop business skills to help them manage the enterprises alongside their co-workers (Girard and Restakis (2012).

The proliferation of care co-operatives in Quebec and Italy, reflects a large-scale mobilisation of resources to finance and support emerging enterprises alongside a supporting legal and political climate. In both cases, the development of a large number of co-operatives took place over a number of years and was facilitated by established networks such as the Regional Development Co-operatives in Quebec and co-operative consortia in Italy. These

structures provide a wide range of support, including facilitating access to funding from the public sector, co-operative banks, and other social investors. The availability of additional sources of funding, particularly during the early stages of establishing a co-operative is key to ensuring the purported benefits of co-operative provision such as high staff pay and higher quality are realised. These structures also provide extensive peer-to-peer support for new co-operative enterprises. In Italy a range of policy levers have been used to facilitate the emergence of co-operatives including a lower rate of corporation tax, lower VAT, and tax relief on donations (Conaty, 2014).

## Implementation in the UK

Co-operatives have been extensively developed in Quebec, Italy and elsewhere in Europe but there are far fewer examples in the UK. These are mainly small scale and have faced challenges in securing financial support and developing relationships with local authorities to become listed as an approved provider. Some co-operatives rely on voluntary support from directors and other volunteers and in-kind support from local authorities (such as access to training). Conaty (2014) proposes strategic involvement of volunteers and making use of digital technology (such as quick accounting software) to increase the financial sustainability of co-operative provision.

Fisher et al. (2010) provide examples of small-scale co-operatives in England and the challenges they have faced. **Sunshine Care in Rochdale** (a worker co-operative) was established in 2008 by local authority workers who wanted greater control over the service they provided and better pay and conditions. The co-operative is very small scale (two employees in 2010) and faced challenges in building relationships with the local authority as people move out of roles.

Co-operatives with an independent source of income from more affluent, private clients have had more success in increasing their scale. **Caring Support in Croydon** is a multi-stakeholder co-operative established by care workers and service users. The co-operative was founded by a couple using direct payments but who found it difficult to manage their responsibilities as employers and had concerns around the training and pay of staff (Roulstone and Hwang, 2013). Provision is based on a cluster model focusing on small geographic locations, ensuring that carers are local to service users and reducing travel costs. The co-operative is aided by the fact it covers an affluent area, leading to increased revenue (Fisher et al., 2010).

Partnership working with the public sector and trade unions has been highlighted as a factor in the success of co-operatives. Care co-operatives are also likely to need support from local authorities to enter the market through access to provider lists and in-kind support such as access to training. Partnership work with local authorities, housing associations, and the private sector has proved to be a successful approach to encourage the entry of new co-operative providers of housing (Conaty, 2014).

## Relevance to Wales

In Wales, the cooperative model has been of interest for some time and there are a range of organisations involved in promoting the co-operative model and providing practical support to emerging enterprises. These include the Wales Co-operative Centre and the Co-production Network Wales. There are a small number of examples of co-operative provision of care in Wales. **Cartrefi Cymru** provides home care for adults with learning difficulties and physical disabilities. In 2016, they became a multi-stakeholder co-operative with staff, service users and community supports becoming members. Other care organisations have been established which use co-operative principles such as **Dewis Centre for Independent Living** operates in Rhondda Cynon Taf, MerthyrTydfil, Vale of Glamorgan and Cardiff. It is a non-profit company controlled by a majority of disabled people which provides support for direct payment users and training for their personal assistants. Edwards (2015) reports that many trade unions operating in Wales are wary of the model, with concerns around terms and conditions, trade union recognition and pensions.

## Summary

Financial sustainability and scalability are key concerns for the development of co-operative care provision. While there are a number of examples of co-operatives providing social care in the UK, co-operative provision is on a much smaller scale than regions such as Quebec. Care co-operatives in Quebec have benefitted from a highly supportive legal and policy environment alongside established networks of financial and practical support. Co-operatives in the UK have often struggled to expand and partnership working with local government and other commissioning bodies play an important role in their success. A wide range of policy levers have been used to encourage the development of co-operatives internationally.

# Conclusions

This report describes a wide range of alternative approaches to domiciliary care which have been developed in the UK and beyond. Some involve changes to organisational structures, others make changes to improve service quality through alternative approaches to commissioning.

There is evidence that **micro-enterprises have the potential to offer more personalised care that people value without a trade-off between price and quality**. The example of Somerset illustrates their potential, particularly for rural communities, to improve supply of care and to contribute to local economies, providing jobs for local people. Development of micro-enterprises in Somerset required investment and support from local government and was reliant on use of direct payments. This model aligns with ambitions in Wales to rebalance the care market away from large for profit providers and is aligned with the Welsh Government's aim of supporting the Foundational Economy in order to boost local economies and provide better jobs closer to home. This approach may offer some of the benefits of the franchising model in terms of support for start-ups without the formal structures and challenges of the franchising approach. However, the level of take up is likely to depend on local context.

There is evidence that, like micro-enterprise models, **franchise arrangements can enable smaller providers to enter the market by providing practical and financial support and access to training and knowledge to develop quality of care**. However, franchisees are often small providers that face financial challenges and therefore challenges with stability. Franchises that have developed and scaled effectively are likely to have secured alternative sources of funding such as from private self-funded clients. The success of new franchises is therefore dependent on contextual factors such as local demand for private domiciliary care or the availability of external funding and support. In the context of Wales, where self-funding is less common, external support may be required to get new franchises off the ground and ensure their financial sustainability.

Many local authorities in the UK have considered creating Local Authority Trading Companies to provide home care, mainly in response to financial pressures and the personalisation agenda. The success of this model has varied and has depended on the nature of local markets including numbers of self-funders. Some LATCs have been restructured or gone into liquidation and therefore not increased market stability. Unions have also raised concerns about their potential impact on staff pay, terms and conditions. **Setting up a successful LATC therefore requires careful consideration of the local market and effective risk management on the part of local authorities.** Experts who we spoke to felt that local authorities could potentially achieve the same aims while keeping provision in-house through more effective leadership and management.

**Innovative commissioning that includes more personalised and outcomes-based approaches offer potential to improve the quality of services for users**. They can encourage and enable new ways of working that better reflect people's needs but they require trust between commissioners and providers to free up more flexible, person-centred care in the home, as opposed to time and task based models of contracting. Many of the innovative approaches to domiciliary care described in this report relied on alternative approaches to commissioning such as direct payments and personal budgets. Personal budgets are not currently available in Wales and uptake of direct payments is lower than in England. Some individuals may require support to manage their direct payment or personal budget and alternatives such as individual service funds where payments go directly to providers offer an alternative for individuals who do not want the responsibility of managing their budget. Organisations such as the Dewis Centre for Independent Living can also provide support to people with their direct payments. Many experts spoke about the potential of individual service funds and integrated personal budgets to enable better quality care.

Buurtzorg is a well-established and often cited example of what good care looks like. In its original format in the Netherlands the model relies on integration of health and social care as well as flattened hierarchy to achieve its impressive outcomes efficiently. Adaptations of the model in the UK that focus on domiciliary care provide more person-centred care. However, they are often unable to compete with the hourly rates for care commissioned on a time and task basis and are therefore reliant on self-funders or those with direct payments. **Approaches inspired by the Buurtzorg model require investment and a recognition that the benefits of investing in models that provide more person-centred and preventative care are often long term and cost savings may be realised in other public services**, such as health.

**Sweden's Norrtaelje model provides an example of a system wide reimagining of domiciliary care and its potential as a central role in an integrated health and care system**. Many of the experts we spoke to argued that it was important to aspire to a future model where domiciliary care is part of a place-based or population-based system of care that is focused on a preventative and home first approach. However, this represents a significant shift beyond current approaches to care in Wales and is still in relatively early stages of development.

There is a strong interest in co-operative models of care provision in Wales and the promotion of co-operative enterprises (alongside user-led services, social enterprises and the third sector) is required by the Social-Services and Well-being (Wales) Act 2014. However, co-operative provision in the UK is currently small scale and many co-operatives have struggled to expand and achieve financial sustainability. Other regions including Quebec and Northern Italy have developed care co-operatives to a much larger scale. **The experience of regions in which co-operatives operate at scale shows that they require a range of support measures in order to do so.** These include a supportive legal and

policy environment, established networks of financial and practical support, partnership working with local trade unions and tax relief measures. It is important to note that in these regions, co-operatives are not solely reliant on service user fees and can access government grants and social investment through credit unions and mutual funds. In order for co-operatives to operate at scale in Wales, it would be necessary to replicate these conditions and this requires investment as well as changes in the legal and policy frameworks.

**The fundamental and longstanding challenges facing the provision of domiciliary care in Wales - funding, workforce shortages, market fragility and current approaches to commissioning - are found elsewhere and will need to be addressed whatever model or models of care are adopted in the future**. There is no single or straightforward solution. But the evidence and experience outlined in the report demonstrates that **there are practical examples and experience – in Wales and further afield – that we can draw on to develop higher quality, more person-centred care in the home.**

# References


ADSS Cymru. (2019). **Report on Innovative Care Delivery Models in the Community**. Retrieved from: **https://www.adss.cymru/en/blog/post/innovative-care-delivery-models**

Andersson Back, M and Calltorp, J. (2015). **The Norrtaelje model: a unique model for integrated health and social care in Sweden**. Retrieved from: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628508/#r9**

Bolton, J. (2019). **New Developments in Adult Social Care**. Retrieved from: **https://ipc.brookes.ac.uk/publications/pdf/New_Developments_in_Adult_Social_Care.pdf**

Bolton, J. and Mellors M. (2016). **Two discussion papers on domiciliary care commissioning and procurement. Oxford Brookes University**. Retrieved from: **https://ipc.brookes.ac.uk/publications/IPC%20Two%20discussion%20papers%20on%20domiciliary%20care%20in%20Wales%20-%20August%202016_Final.pdf**

Boyce, S. (2017). **Paying for adult social care in Wales: Debate and Reform. National Assembly for Wales**. Retrieved from: **https://senedd.wales/Research%20Documents/17-009/17-009-Web-English.pdf**

Care and Social Services Inspectorate Wales. (2016). **'Above and Beyond' – National Review of Domiciliary Care in Wales**. Retrieved from: **https://careinspectorate.wales/sites/default/files/2018-03/161027aboveandbeyonden.pdf**

Carers Wales. (2019). **Press Release: Wales' unpaid carers suffering anxiety and stress**. Retrieved from: **https://www.carersuk.org/wales/news-campaigns/news/press-release-wales-unpaid-carers-suffering-anxiety-and-stress**

Centre for Public Impact. (2018). **Buurtzorg: revolutionising home care in the Netherlands**. Retrieved from: **https://www.centreforpublicimpact.org/case-study/buurtzorg-revolutionising-home-care-netherlands/?utm_source=Centre+for+Public+Impact&utm_campaign=bb6b21b0ba-EMAIL_CAMPAIGN_2018_11_20_11_51&utm_medium=email&utm_term=0_3b8694e112-bb6b21b0ba-220989717**

Conaty, P. (2014). **Social Co-operatives: A Democratic Co-production Agenda for Care Services in the UK**. Retrieved from: **https://www.uk.coop/sites/default/files/uploads/attachments/social_co-operatives_report1_0.pdf**

Consilium. (2016). **Study into the impact of a values based approach to recruitment and retention. Skills for Care**. Retrieved from: **https://www.skillsforcare.org.uk/Documents/NMDS-SC-and-intelligence/Research-evidence/Values-based-recruitment-Final-evaluation-report.pdf**

Cwm Taf University Health Board. (2018). **Neighbourhood Nursing Pilot Launch Event.** Retrieved from: **https://cwmtafmorgannwg.wales/launch-of-neighbourhood-nursing-pilot/**

De Blok, J. (2016). **Buurtzorg – could it work in England?** Retrieved from: **https://www.kingsfund.org.uk/audio-video/jos-de-blok-buurtzorg-could-it-work-in-england**

Edwards, K. (2015). **Is the Feeling Mutual? New Ways of Designing and Delivering Public Services in Wales.** Retrieved from: **https://www.audit.wales/sites/default/files/seminar_documents/Is-the-feeling-mutual-Keith_Edwards.pdf**.

Fisher, J., Rayner, M. and Baines, S. (2010). **Personalisation of social care and health: A co-operative solution**. Co-operatives UK. Retrieved from: **http://e-space.mmu.ac.uk/205274/1/Personalisation%20of%20social%20care%20and%20health%20-%20a%20cooperative%20solution.pdf.**

Franchise Direct. (2020). **Bluebird Care**. Retrieved from: **https://www.franchisedirect.co.uk/directory/bluebirdcare/1642/**

Girard, J. and Restakis, J. (2012). **Co-operative models of care for older people: The Quebec experience**. Retrieved from: **http://library.uniteddiversity.coop/Cooperatives/Co-operative_models_of_care_for_older_people-The_Quebec_experience.pdf**

Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M., Wilberforce, M. (2008). **Evaluation of the individual budgets pilot programme: final report**. Retrieved from: **https://www.york.ac.uk/inst/spru/pubs/pdf/IBSEN.pdf**

Grant Thornton. (2015). **Spreading their wings: Building a successful Local Authority Trading Company.** Retrieved from: **https://www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/publication/2015/spreading-their-wings-building-a-successful-local-authority-trading-company.pdf**

Grant Thornton. (2018). **In good company: Latest trends in local authority trading companies**. Retrieved from: **https://www.grantthornton.co.uk/globalassets/1.-member-firms/united-kingdom/pdf/search/in-good-company-2018.pdf**

Gray, B., Sarnak, D. and Burgers, J (2015). **Home Care by Self-governing nursing teams**. Retrieved from: **https://www.commonwealthfund.org/publications/case-study/2015/may/home-care-self-governing-nursing-teams-netherlands-buurtzorg-model**

Guzman-Castillo, M. Ahmadi-Abhari, S., Bandosz, P., Capewell, S., Steptoe, A., Singh-Manoux, A., Kivimaki, M., Shipley, M., Brunner, E. and O'Flaherty, M. (2017). **Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study**. Retrieved from: **https://pubmed.ncbi.nlm.nih.gov/28736759/**

Hannan, R. (2019). **Radical home care – how self-management could save social care**. Retrieved from: **https://www.thersa.org/discover/publications-and-articles/reports/social-care-radical**

Harlock, J. (2014). **From outcomes-based commissioning to social value? Implications for performance managing the third sector**. Retrieved from: **https://www.researchgate.net/publication/303020352_From_outcomes-based_commissioning_to_social_value_Implications_for_performance_managing_the_third_sector_Third_Sector_Research_Centre_Working_Paper_123**

Hatton, C. and Waters, J. (2013). **The National Personal Budget Survey: Summary of Main Findings**. Retrieved from: **http://www.mertonmencap.org.uk/pdfs/NPB_survey_report_summary.pdf**

Health Improvement Scotland. (2019). **Learning from neighbourhood care test sites in Scotland**. Retrieved from: **https://ihub.scot/media/6937/20191205-neighbourhood-care-eval-eevit-v014final.pdf**

Home Care Insight (2020a). **Mears Group to exit domiciliary care operations.** Retrieved from: **https://www.homecareinsight.co.uk/breaking-news-mears-group-to-exit-domiciliary-care-operations/**

Home Care Insight. (2020b). **The Big Interview: Caremark managing director David Glover.** Retrieved from: **https://www.homecareinsight.co.uk/the-big-interview-caremark-managing-director-david-glover/**

Home Care Insight. (2020c). **Innovation and technology high on the agenda for Home Instead**. Retrieved from: **https://www.homecareinsight.co.uk/innovation-and-technology-high-on-the-agenda-for-home-instead/**

Institute of Public Care. (2016). **Market Shaping Review: Market Shaping to Support Individual Purchasing of Care.** Retrieved from: **https://ipc.brookes.ac.uk/docs/market-shaping/Market%20shaping%20to%20support%20individual%20purchasing%20of%20care.pdf**

Institute of Public Care. (2019). **Devon County Council, Adult Care &Health Commissioning: Individual Service Funds in Devon – pilot evaluation report**. Retrieved from: **https://www.skillsforcare.org.uk/Documents/Events/ISF-events/IPC-DCC-Individual-Service-Funds-evaluation-report.pdf**

Kings Fund. (2014). **A new settlement for health and social care**. Retrieved from: **https://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care**

Kings Fund. (2018). **New models of homecare**. Retrieved from: **https://www.kingsfund.org.uk/publications/new-models-home-care**

Kings Fund. (2018). **Home care in England: views from commissioners and providers.** Retrieved from: **https://www.kingsfund.org.uk/publications/home-care-england**

Maybin, J., Honeyman, M., Williams, E. and Perks-Baker, S. (2019). **A review of the West Suffolk Buurtzorg test-and-learn in 2017-18**. Retrieved from: **https://www.kingsfund.org.uk/sites/default/files/2020-03/Review-West-Suffolk-Buurtzorg-test-learn-2019.pdf**

Millar, R., Hall, K. and Miller, R. (2012). **Increasing the Role of Social Business Models in Health and Social Care: An Evidence Review.** Retrieved from: **http://ppiw.org.uk/files/2016/06/Social-Business-Models-in-health-and-social-care.pdf**

Monson, K and de Blok, J (2013). **Buurtzorg: Nurse-led community care**. Retrieved from: **https://pubmed.ncbi.nlm.nih.gov/24400466/**

Needham, C., Allen, K., Hall, K., McKay, S., Glasby, J., Carr, S., Littlechild, R., Tanner, D. and the Micro-Enterprise Project Co-Researchers (2015). **Micro-Enterprises: Small enough to care?** Retrieved from: **https://www.birmingham.ac.uk/research/activity/micro-enterprises/index.aspx**

Nuffield Trust. (2020). **What does the provider market look like across the four countries?** Retrieved from: **https://www.nuffieldtrust.org.uk/news-item/what-does-the-provider-market-look-like-across-the-four-nations**

Resolution Foundation. (2015). **As if we cared: The costs and benefits of a living wage for social care workers**. Retrieved from: **https://www.resolutionfoundation.org/app/uploads/2015/03/As-if-we-cared.pdf**

Richings, C. (2014). **Raglan: A new approach to service delivery in domiciliary care**. Retrieved from: **https://www.monmouthshire.gov.uk/app/uploads/2016/06/Raglan-Evaluation.pdf**

Rostgaard, T., Glendinning, C., Gori, C., Kroger, T., Osterie, A., Szebehely, M., Theobald, H., Timonen, V., Vabo, M. (2011**). Living independently at home: reforms in homecare in 9 European countries**. Retrieved:

**https://pure.york.ac.uk/portal/en/publications/livindhome-living-independently-at-home-reforms-in-home-care-in-9-european-countries(13d153af-71c7-425d-b179-fdcd0e60b7a1)/export.html**

Roulstone, A. and Hwang, S. (2013). **Co-operation and Co-operatives in the Development of Direct Payment Schemes in Wales.** Retrieved from: **http://nrl.northumbria.ac.uk/id/eprint/16785/1/direct-payments-report-eng.pdf**

Sandford, M. (2019) **Local government: alternative models of service delivery**. House of Commons Library. Retrieved from: **https://commonslibrary.parliament.uk/research-briefings/sn05950/**

Senedd Research. (2015). **Briefing Paper – Provision of direct payments for adults by Welsh local authorities**. Retrieved from: **https://business.senedd.wales/documents/s49695/Paper%20to%20note%205%20Annex%20A.pdf**

Sizmur, S. and Raleigh, V. (2018). **The risks to care quality and staff wellbeing of an NHS system under pressure**. Retrieved from: **https://www.picker.org/wp-content/uploads/2014/12/Risks-to-care-quality-and-staff-wellbeing-VR-SS-v8-Final.pdf**

Sjogren, E. and Ahblom, P. (2012). **Report on the TioHundra Project: Tools for Realizing Integration.** Retrieved from: **http://leadinghealthcare.se/wordpress/wp-content/uploads/2016/03/Summary-of-TioHundra_LHC_20130129.pdf**

Social Care Wales. (2018). **Workforce profile 2018: Commissioned Care Provider Services.** Retrieved from: **https://socialcare.wales/cms_assets/file-uploads/SCWWDP_commissioned-services_2018_eng_Final.pdf**

Solva Care. (Undated). **The Solva Care Toolkit**. Retrieved from: **https://www.solvacare.co.uk/chapter-1/.**

Tricuro. (2019). **Annual Review 2018/19**. Retrieved from: **https://www.tricuro.co.uk/wp-content/uploads/2019/10/FINAL-Tricuro-Annual-Report-2018-19.pdf**

UKHCA. (2018). **The homecare deficit 2018**. Retrieved from: **https://www.ukhca.co.uk/downloads.aspx?ID=589**

UKHCA. (2020). **Homecare in the time of coronavirus.** Retrieved from: **https://ukhcablog.com/blog/homecare-in-the-time-of-coronavirus/**

Unison Local Government. (2013). **Branch guide to local authority trading companies**. Retrieved from: **https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue212753.pdf**

Unison. (2017). **A Report on Tricuro for Dorset County Council Cabinet from UNISON**. Retrieved from: **https://southwest.unison.org.uk/content/uploads/sites/4/2017/03/Report-to-Dorset-Cabinet-April-2017-2.pdf**

University of Strathclyde. (2019). **Redesigning Work in Social Care: An evaluation of a Franchise Model and the use of Self-Organising Teams in social care delivery in Scotland.** Retrieved from: **http://openteams.co.uk/wp-content/uploads/2019/10/One_Year_on_Report_2018-1.pdf**

Wales Fiscal Analysis. (2020). **The future of care in Wales: Resourcing social care for older adults**. Retrieved from: **https://www.cardiff.ac.uk/wales-governance-centre/publications/finance**

Walsh, M. (2009). **Essex Cares: The birth of a groundbreaking local authority trading company.** Retrieved from: **http://www.careandhealthsolutions.co.uk/wp-content/uploads/2010/04/pp113-20.pdf**

Welsh Government. (2016). **Consultation – summary of response. Domiciliary Care Workforce: Improving the recruitment and retention of Domiciliary Care Workers in Wales**. Retrieved from: **https://gov.wales/sites/default/files/consultations/2018-01/161117domiciliary-consultation-responsesen.pdf**

Welsh Government. (2018a). **A Healthier Wales: Our Plan for Health and Social Care.** Retrieved from: **https://gov.wales/healthier-wales-long-term-plan-health-and-social-care**

Welsh Government. (2018b). **New requirements to ensure care workers are treated fairly come into force**. Retrieved from: **https://gov.wales/new-requirements-ensure-care-workers-are-treated-fairly-come-force-0**

Welsh Labour. (2019). **Standing up for Wales: Welsh Labour Manifesto.** Retrieved from: **https://labourlist.org/2019/11/welsh-labour-manifesto-standing-up-for-wales/**

Zióïkowska, M. (2018). **Social enterprise scaling up strategy – franchise development**. Retrieved from: **https://cor.sgh.waw.pl/bitstream/handle/20.500.12182/845/3social%20enterprise_2018H.pdf?sequence=2&isAllowed=y**

## Author Details

**Laura Bennett** is a Research Associate at the Wales Centre for Public Policy.

**Megan Park** is a Research Apprentice at the Wales Centre for Public Policy.

**Professor Steve Martin** is the Director of Wales Centre for Public Policy.

For further information please contact:
**WCPP Lead**
Wales Centre for Public Policy
+44 (0) 29 2087 5345
**info@wcpp.org.uk**



Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru