Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Report summary
December 2020

Alternative models of domiciliary care

Policy context

Domiciliary care faces a combination of growing demand and continued financial pressure. This makes it difficult to recruit and retain staff and means that the market continues to be fragile. The Coronavirus pandemic has amplified these challenges, but could also give added impetus to efforts to find new and better ways to provide high quality, person-centred care in the home.

We were asked by the First Minister to review selected examples of alternative models of domiciliary care provision, that have been developed elsewhere in the UK and in other countries, which may offer valuable insights for Wales. This briefing paper summarises our findings.

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Domiciliary care in Wales

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 not-for-profit organisations. 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, and the Welsh Government is committed to 'rebalancing the market'. Interpretations of what this means in practice range from encouraging more third sector providers to bringing all care back 'in-house' to local authorities. Experts who we spoke with agreed that the current market is unsustainable but emphasised that ownership is not the key issue. There are examples of good and less good care in both the public and private sector and what matters is leadership and a culture which focuses on the provision of high-quality care and improved working conditions, regardless of type of provider.

UK practice

Evidence about the operation and effectiveness of social enterprises and franchises, local authority trading companies and other innovative approaches to domiciliary care that have been developed in England and Scotland suggests that:

- Microenterprises can offer more personalised care and strengthen the foundational economy without significantly increasing costs. They may be particularly effective in rural communities. However, successful models in England have often relied on direct payments and self-funders.
- Franchise arrangements can enable smaller providers to enter the market by providing practical and financial support. However, their success is dependent on local context including the availability of

external funding and they may struggle to operate at scale.

- The success of local authority trading companies has varied and depends on effective management and the nature of local markets including proportion of self-funders. Experts who we spoke to cautioned that several trading companies have run into financial difficulties because of ineffective leadership and management.
- Many of the innovative approaches that worked best have involved personalised and outcomes-based commissioning, underpinned by a partnership-based relationship between commissioners and providers based on trust.

International practice

Ensuring a stable and diverse domiciliary care market that provides good quality care is a challenge which is common to many other countries. We explored three models of provision in other countries:

- The Buurtzorg model originated in the Netherlands and involves small, autonomous and neighbourhood-based teams of nurses and nurse assistants providing domiciliary care as well as clinical care. It is often cited as a way to improve quality without increasing costs. Where it has been adopted in the UK, it has provided good quality of care with positive feedback from staff and clients. But it has required additional investment, as well as more flexible commissioning. Moreover, the benefits of person-centred, preventative care are often long-term and cost savings may be realised in other public services, such as health.
- In Norrtalje Sweden, a public company was created to manage health and care services for the region. An integrated care provider and an integrated commissioning body were created with responsibility for health and social care. As part of this integrated approach to health, social care and rehabilitation, home care staff coordinate interventions across the whole pathway of care. The approach provides an example of a reimagining of the whole health and social care system which places domiciliary care at its heart.
- In Quebec, care co-operatives made up of staff, service users and community members provide a range of health and social care. These social enterprises are supported by established networks funded by government to provide financial and practical support to existing and new co-operative enterprises. Co-operatives were developed in part to provide the Francophone population with an alternative to English-speaking larger providers. Their success is attributed in part to highly supportive legal and policy environments and well established networks of financial and practical support, which do not currently exist in the UK.

Key lessons

Evidence shows what people want from care in the home is:

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

The evidence from models that we have reviewed shows that there is no simple 'one-size-fits all' solution. But there are some important guiding principles:

- Provision of care in the home needs to go beyond what has traditionally been described as domiciliary care and take account of the broader context including community assets, the importance of wellbeing and prevention, and the role played by unpaid carers and other services such as healthcare and housing.
- Domiciliary care is relationship based. The quality of care depends on the staff who deliver it and improving their status, pay and conditions, and opportunities for progression is vital. It is also important that they operate within a commissioning framework that gives them the freedom and flexibility to provide person-centred care tailored to the needs of each individual.
- This means giving individuals and their families a greater say and developing trust-based relationships between providers and commissioners.
- Current 'time and task' approaches to commissioning can act as a barrier to developing new models of care. Outcomes-based and personalised commissioning have the potential to enable providers of all types to innovate and provide care that is flexible and better meets people's needs.
- Squeezed budgets and increasing demand mean local authorities face pressure to keep costs low, in turn placing financial pressure on providers. Implementing new models that provide preventative and personalised care will require upfront investment as well as changes to existing funding arrangements including further integration of health and social care funding.

Find out more

For the full report see Bennett, L., Park, M. & Martin, S.J. (2020). **Alternative models of domiciliary care.** Cardiff: Wales Centre for Public Policy

About the Wales Centre for Public Policy

Here at the Centre, we collaborate with leading policy experts to provide ministers, the civil service and Welsh public services with high quality evidence and independent advice that helps them to improve policy decisions and outcomes.

Funded by the Economic and Social Research Council and Welsh Government, the Centre is based at Cardiff University and is a member of the UK's What Works Network.

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