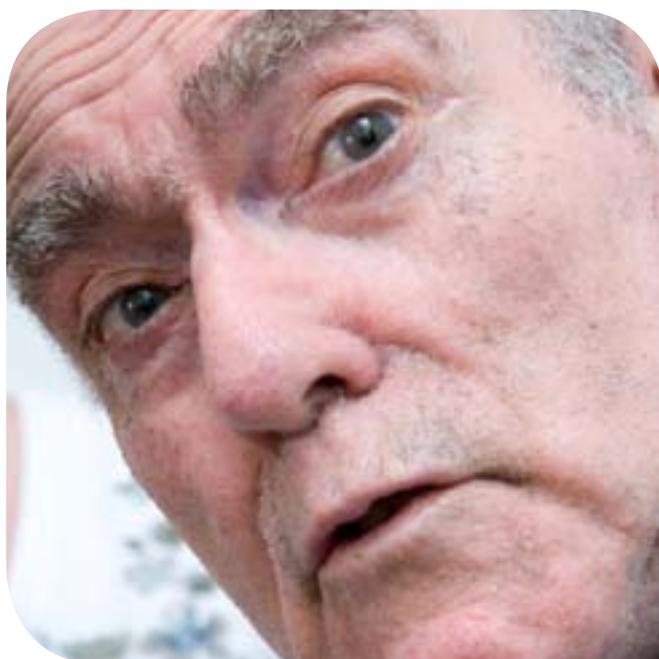
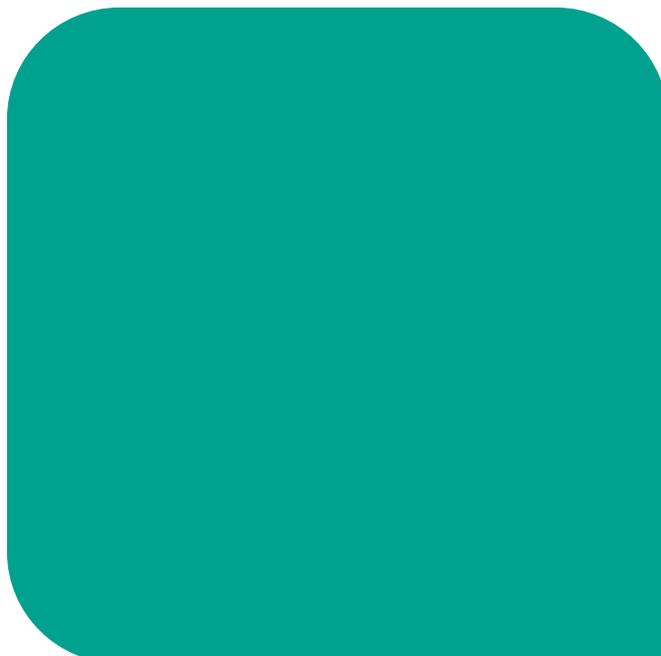
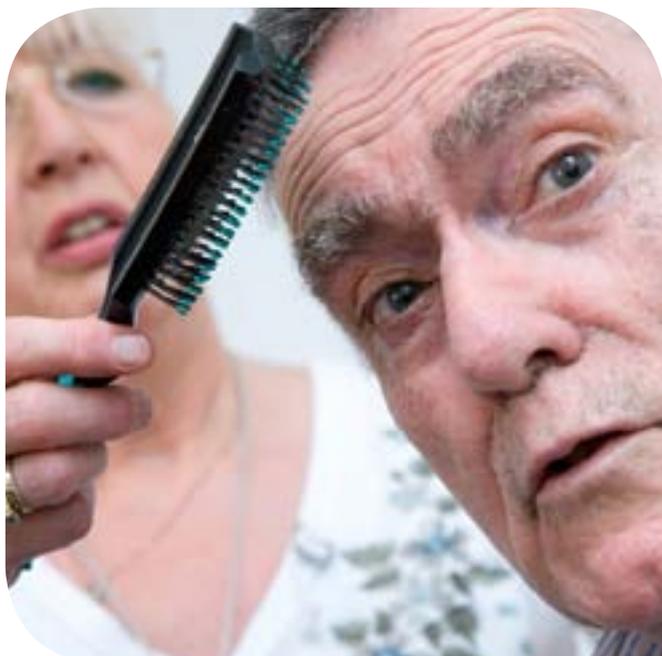


Commissioning home care for older people



The guide is aimed at health and social care commissioners of home care services for older people with complex needs.

The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom.

We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

- disseminate knowledge-based good practice guidance
- involve people who use services, carers, practitioners, providers and policy makers in advancing and promoting good practice in social care
- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

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Foreword



I welcome the publication of this new guide. It is very timely, focusing as it does on how we can arrange better home care for the increasing number of older people with complex needs. It will sit alongside and complement the new Care Act and its associated statutory guidance, which will come into effect in April 2015. A central theme of the Act will be that the wellbeing of individuals must be placed at the centre of all local authority activity in arranging care and support.

SCIE is absolutely right to emphasise that the needs of older people, especially when those needs are complex, must be considered holistically and not as a series of separate conditions. The focus must always be on people themselves – their needs, wishes and aspirations. This guidance rightly stresses that they should have choice about and control over services that meet their needs flexibly and that they should be part of the design and development of those services.

This focus echoes our recent publication, [Transforming primary care: safe, proactive, personalised care for those who need it most](#). The heart of this vision is that people with the most complex needs, often older people, should benefit from more proactive care. Such care must focus on identifying risk early and putting in place the holistic care needed to support the full range of their physical, mental and social needs.

I wholeheartedly support the ambition set out here: that local authorities should move towards commissioning services to meet the outcomes people want, rather than buying services on a time and task basis. We need to work collaboratively and raise our game, to improve the way that home care is arranged and delivered, so it can enhance the quality of life for all who depend on it. I thank SCIE for developing this guide, which I believe will play an important role in achieving this aim.

A handwritten signature in black ink, appearing to read 'Norman Lamb', with a horizontal line underneath.

Norman Lamb MP, Minister of State for Care and Support

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Introduction: Commissioning home care for older people

'Home is a powerful symbol of autonomy and independence, whereas institutions are associated symbolically with the loss of autonomy.' [2]

This guide captures the latest research findings on an important and emerging area of social care – that of home care for older people with complex needs. It also provides some practice examples of innovative work in this area.

The number of people aged 65 and over is projected to increase by 23 per cent from 10.3 million in 2010 to 12.7 million in 2018. Growth in this age group is projected to continue for the foreseeable future, with the 65+ population expected to reach 16.9 million by 2035. [27] More people are living alone in old age and can access less informal care than in the past. [3] The cost of home care is forecast to rise from one per cent of the UK's Gross Domestic Product (GDP) now to between 2 and 4 per cent by 2050 (GDP being the total market value of all final goods and services produced in a country in a given year).

As the population grows older and the political and financial drive to keep older people out of hospital increases, the way home care is provided must change.

The home care market will have to respond to the needs of this expanding group of older people who use services (referred to in the rest of this guide as 'users'). As people are living longer, the number of older people with complex needs who live at home is increasing. A tightening in eligibility criteria for those in receipt of home care means that those receiving care have more complex conditions including long-term, chronic health conditions and multiple conditions. [4]

What are complex needs?

There is no set definition of 'complex needs' in the home care situation. They can include one or more of the following:

- long-term conditions or multiple conditions, such as heart disease, diabetes, osteoporosis, arthritis, epilepsy, needs following stroke or frailty
- mobility and continence difficulties
- dementia
- mental health issues.

A higher proportion than ever before of older people receiving home care are now considered to have complex needs. Seventy-two per cent of councils only offer home care services to those with substantial or critical needs. [4] Users typically have an average of three diseases and 10 different complaints. [5]

The current situation

The home care market is currently valued at £5.5 billion, with six million hours of regulated home care delivered each week. [6] The private and voluntary sectors supply 84 per cent of this. [1]

Home care is sometimes seen as a low-paid, low-expectation service held together by the goodwill of frontline staff – not the professional integrated service capable of substantially improving the health and wellbeing of users that will be needed in the future. [4]

Home care services are often experienced as impersonal, inflexible, underfunded and poorly integrated with other health and social care services. Services are not designed around the person, but depend on how organisations are structured or who is doing the commissioning.

Sometimes staff are poorly trained and poorly paid, which leads to high turnover of paid carers (32 per cent leave within 12 months; 56 per cent within two years). This can mean a lack of continuity of care for older users and a lack of flexibility in changing care arrangements. Home care users may feel that their care staff are indifferent to their needs. [6]

Users also have problems accessing the right services for their needs because of:

- organisational barriers such as a lack of information about what is available
- a lack of support from an unpaid carer or advocate
- social isolation
- depression.

Social isolation can be a real problem for:

- users from black and minority ethnic groups
- users in rural areas
- people who use mental health service users
- older people with high support needs.

Funding cuts continue to have an impact on home care services, with commissioners finding that they are having to drive down costs to meet their own restricted budgets. [1] This has an effect on the service provider market, with service providers that are dependent on local authority/health and social care trusts in Northern Ireland (HSCs) contracts having to reduce costs to a minimum. This has an impact on staff levels, skills and morale. The ageing care workforce will also start to have an impact as currently 50 per cent are over 45 years old. [7]

Recommendations

‘Both my parents have been enabled to stay independent as long as they can due to the adult social care they have been provided with ... [They] are able to enjoy a dignified life, in their communities, at little cost to the state, and remain in control and as independent as they can be.’

Daughter, West Midlands [1]

Around the world, commissioners are being challenged by how best to care for rising numbers of older people with complex needs. The aspiration is rightly to give people the choice as to whether they receive care in their own homes if local resources allow because home care is what many people with complex needs want. And it is also cheaper than care that is provided in institutions such as hospitals and care homes.

The following recommendations show what commissioners can do at different stages of the commissioning cycle to improve how they assess, plan, contract and monitor home care services that satisfy what older people want, and make it less likely that they will need the costlier health-based services of hospitals and care homes. The recommendations are based on the emerging evidence of good practice in the UK and abroad.

Assessment

Commissioners should:

- develop their understanding of older people with complex needs and see them as people rather than as a series of individual needs
- involve older people who use services and their unpaid and paid carers in designing services
- understand the particular needs of older people within their local area and look at what provision already exists in the area
- establish clear and unambiguous criteria for acceptance into domiciliary care services that are designed to address unmet needs.

Planning

Commissioners should:

- develop values that inspire a positive attitude to home care such as flexibility and person-centeredness
- design a clear plan of how to commission integrated services to improve the outcomes that can be achieved
- work together with others, involving users and unpaid carers and encouraging health and social care staff to work together too
- consider a single point of entry to services

- investigate the role that assistive technology can play.

Contracting

Commissioners should:

- use evidence-based intervention programmes
- create diversity among providers
- think about how effective provision can be achieved with existing staff
- make sure that staff development and training are considered in the contracting model
- embed an outcomes-based approach in the contracting process
- contract with clear expectations regarding quality of care
- have robust contractual arrangements in place and monitor outcomes.

Monitoring

Commissioners should:

- move away from task-focused to outcomes-based commissioning
- develop quality monitoring methods that place older people's views at the heart of assessing quality of care
- think about the impact on carers when commissioning increases the number of care packages that people receive at home
- pay attention to the extra needs of people from black and minority ethnic groups and other excluded groups.

Further research

- Home care for older people with complex needs is an emerging and important area of social care. More evidence is needed on certain aspects of such care, for example what a personalised service looks like and the costs of specific services.

What older people want

‘What would matter more is a wee bit of attention, not to be in such a rush. Now they do everything, and everything is done, but ... well he wouldn’t feel that he was just, a vegetable, that he wasn’t a person. It’s all about personality ... the friendly touch.’

Unpaid carer [2]

The number of older people with complex needs who are staying at home with the support of home care services is growing. Research evidence tells us what older people need and want from their home care service.

People who use services need significant support, which they receive through an intricate and varied system of formal and, often unpaid, care. [8] The greater a person’s disability, the greater are their likely needs as there will be a wider range of tasks they cannot do for themselves. [6] Many are at risk of not having their needs met this way. They are therefore at ‘the margins of independent living’. [9]

When asked, most service users say that they are satisfied with the quality and level of care they receive. But the evidence shows that older people tend not to complain. [2] Qualitative research with service users that took account of this reluctance produced four themes of what is important when it comes to care. These are now described.

Older people want to remain in their own homes

Older people prefer to stay in their own homes and communities until it is impossible for them to do so, rather than move into residential care. Most older people enjoy being in their home surroundings and view residential care with suspicion. [9]

Older people may struggle to adjust to receiving home care and fear the loss of their independence.

Older people want to have a good quality of life

Home care is not seen simply as fulfilling practical needs – older people want their home care to meet their social and emotional needs too. [10] No matter how frail or physically disabled they are, they want to go outside, continue friendships and take part in community life. [2] Yet relatively few care packages include support for activities outside the house. [1] They talk about having to rely on the goodwill of their paid carers simply to get out into the garden, let alone further afield.

Loneliness is a major problem for older people living at home. There are high rates of depression and loneliness particularly among those with complex health problems or who have suffered bereavement, which social interaction can alleviate. [2, 5, 6, 11]

People who use services feel that their carers do not motivate them to take part in activities and communicate with other people, or help them to make better use of their own resources. [5]

Older people want to develop good relationships with their carers

Most people being cared for at home want a warm relationship with their paid carers and place a lot of value on conversation. [1] A friendly and sociable carer is regarded by service users to be a marker for whether they are a good paid carer or a poor one. Paid carers themselves complain that they often don't have time to talk to their clients, and that this part of their role is not recognised as important. [11] Many users feel that their paid carers are constrained by time during their visits – they can either talk or do, but not both. [5]

Continuity of care is seen as vital by users, who want a few regular carers who they can get to know well. [6] A high turnover/variety of staff has an emotional impact on service users, who get embarrassed when strangers carry out intimate personal tasks for them, or find it exhausting having to constantly repeat personal information to new people.

[Practice example 1](#) shows how a good relationship with a carer transformed a user's home care experience.

Older people want to receive high-quality, personalised care

Older people being cared for at home have varying and multiple support needs, and a 'one-size-fits-all' approach is not appropriate. People want a personalised and flexible approach to their care, which respects them as individuals. This is especially important for older people who do not have family or friends living nearby who can give them help.

- People want care that is tailored to their needs.
- They want to be able to get in touch easily with those who organise their care.
- They want support from one person who can help them prioritise the competing demands of their multiple conditions. [12]
- They want a care plan that is explained to them clearly and is easy to understand. [2]
- They want information about all the different services that are available to them in their local area.

Also:

- People who use services want to be seen as individuals.
- They want a care package that takes into account what they want and need, and that can be changed if their needs change. But many feel that carers are not encouraged to make changes to care packages.
- They want to be listened to, but many feel that their paid carers have no time to listen. [4]

The relationship that develops when people are cared for by familiar, regular care staff is the key to flexible and personalised care. [6]

However, service users feel that care provision is often based on what commissioners or carers think is important, and that they do not take the time to talk to them to find out

what is important to them. Older people value professionals who provide care services that meet their own understanding of their needs and help to give them a feeling of being in control and of wellbeing.

What is good home care?

'I think to look at how people were and what people used to do is absolutely vital and [to] try to extend that into everyday life.'

Care provider [1]

Good commissioning of home care helps older people to stay in their own home, when otherwise they would need to be in residential care. To do this successfully, home care should address not just the person's domestic and physical needs, but also their social, spiritual and emotional needs. This is challenging, as each person's needs are individual and no one approach will suit all.

Good home care should:

- support people to live well in the community
- prevent people with significant health or care needs from having to use emergency services or being admitted to hospital inappropriately
- help people with care needs to look after themselves in the community. [4]

Regulations and standards

The Care Quality Commission is the independent regulator of health and adult social care in England. A consultation on a new approach to regulating, inspecting and rating community adult social care services concluded in June 2014. [13]

The intention proposed is that inspectors should use their professional judgement, supported by objective measures and evidence, to assess whether services are safe, effective, caring, responsive to people's needs and well-led. Services will be rated to help people to compare them and to highlight where care is outstanding, good, requires improvement or is inadequate.

The handbook for providers will be updated in September 2014 set out how community adult social care services will be inspected from October 2014.

[Dementia Quality Standard \(QS\)](#) relates to all settings and could be used by commissioners to inform what does good and excellent look like in home care for people with dementia.

NICE is developing quality standards on [home care](#), due in 2015.

In Northern Ireland there are Minimum Standards for Domiciliary Care Agencies, which are used by the Regulation and Quality Improvement Authority to assess the quality of services provided by organisations. [26]

Taking into account the human rights of older people, and embedding their human rights into the way home care is provided, can deliver high-quality care without necessarily increasing costs. [1]

Prevention

The aim of home care should be to keep people healthy at home for as long as it is in their best interests. Good reablement services – which work with the person to be as independent as possible by helping them to learn or relearn skills that they need for everyday life – can prevent older people from being admitted for acute hospital, nursing home or residential care. If admission is necessary, they can help the person to be discharged as early as possible.

Services should focus on the right outcomes for the person based on the achievement of goals that are related to rehabilitation and independence. This would mean paying by results rather than per task. At the moment, reablement provision is often limited to a six-week time period, based solely on funding rather than a person's potential to recover their capacity to live independently. Services should also think about how reablement is being supported.

Reablement provision can also be haphazard, in that it can be up to the older person or their unpaid carer knowing what is available and how to obtain it. [4]

When reablement is done well, there can be substantial efficiency savings for local authorities or health and social care trusts – along with increased skills, confidence and independence for the person using the service. But it needs careful planning and integrated working, especially around the time of hospital discharge, to prevent inappropriate readmission. [4]

See [practice example 2](#) how reablement can be facilitated by training existing staff.

Personalisation

If older people are to be properly supported at home, practitioners need to provide social and health care services that meet the person's own understanding of their complex social and health care needs. [5] Flexible, personalised care is particularly important for older people who do not have family and friends living nearby to give them such help. [6]

The best home care takes a personalised approach that:

- focuses on the person using service
- provides quality of life
- meets assessed needs
- meets the quality standards for both services and care staff [2]
- supports unpaid carers.

People who use services should be involved in their care in the following ways:

- They should be given the information they need to make their own choices about their care.
- Care plans should be created with the service user and should meet their individual needs and respect their rights, privacy and dignity.

- There should be detailed and up-to-date documents on what services are available locally.
- Agencies should have a guide to their services that gives information on their aims and objectives.
- Care workers should be given the flexibility to vary the care they provide on a day-to-day basis, depending on the needs of the user.

Also, the particular needs of the following groups of users should be taken into account:

- people who live in rural areas
- people from black and minority ethnic groups
- people from the lesbian, gay, bisexual and transgender (LGBT) community [15]
- people who misuse substances
- people with learning difficulties
- refugees and asylum seekers.

The ability to personalise care varies a lot between service providers and local authorities. Issues around the following all have an impact:

- contracting
- funding
- staffing
- monitoring
- the attitudes of individual care managers.

Some service providers are willing to allow flexibility in care plans and cater to users' individual preferences. But others stick rigidly to the care plan and focus only on users' essential needs. This may be because local commissioning or social work practice forces a more rigid approach, and may need every variation in care delivery or timing to be approved.

The values and policies of those buying care services have an important influence on how flexible and personalised the service offered by providers is. [6]

Integration

For good home care to respond properly to the needs of older people with complex needs, it should be well integrated with health care and other support services, including those in the voluntary sector. [16]

Integrated and joint working, where health and social care staff work together, can be difficult to organise. Also, each organisation will have its own ethos, roles and responsibilities and these may clash. [17]

If health and social care staff are located in the same place, or there are other ways in which their organisations are integrated, this does not necessarily lead to professionals

from different background working much closer together. So the emphasis should be more on the processes of team working at the personal level. [3, 19]

There are some successful models of integrated care for older people with complex needs. Features of these include:

- single shared assessments
- care management and intensive care management
- home care reablement
- intermediate care, such as hospital discharge teams and admissions avoidance schemes.

There is no 'best' way of providing integrated care as providing such care is a dynamic and complicated process. [18]

Staff and case management

Home care staff

Staff are crucial in helping people to be cared for at home, making it possible for service users and their unpaid carers to take part in decision-making and restoring their faith in their own resources and their sense of control over their lives. [14]

Staff morale needs boosting: better pay, training and management that gives them the confidence to do more and be more flexible are all important. [20]

[Practice example 3](#) shows how care can be improved by enhancing staff conditions and increasing the flexibility that staff have in their caring role.

Case management

In many areas, service provision is so complex that individual service users cannot find out what is available and what they may be entitled to. The main factor in whether a user takes up a service is whether they have a person to help them with investigating and following up referrals, such as a family member, a general practitioner or other professional. Many older people do not have such an advocate, and would benefit from a case manager who can navigate health, social care, housing and educational matters on their behalf. [14]

[Practice example 4](#) shows how an advocate helped a centenarian to have a 'good death'.

In conclusion

This section of the guide is by no means an exhaustive survey of what constitutes good commissioning practice. But it does show that this user group needs services that provide consistent care, with a focus on what can be achieved. Also:

- A whole-needs approach – where attention is paid to the needs of the whole person rather than treating them as a series of discrete problems – should become embedded in every stage of service delivery, from assessment and treatment to aftercare.
- Service providers should be encouraged to be flexible and creative in their responses to older people with complex needs.
- What users and their unpaid carers have to say should be listened to and valued – even the frailest and most-vulnerable older people can be helped to take part in their own care.

The commissioning cycle

‘Talking to staff and service users and commissioners, we realised that people did not necessarily want a five-day-a-week service in place, they wanted different activities and they wanted some form of activities out and about, out in the community, away from the day service.’

Service manager [8]

To improve the quality and value of services, commissioners should look at all areas of the commissioning cycle – from assessment through planning and delivery to review. It has been found that commissioners sometimes focus most on the buying of services and less on other stages of the process that have been found to be just as important. [8] Commissioners may benefit from training to understand the strategic nature of their role. [8]

The growing numbers of older people with complex needs, combined with severe budget constraints, mean that commissioners have to think creatively about how to commission home care that:

- makes it possible for people to remain in their own homes
- protects their dignity
- protects their human rights
- reduces unnecessary admissions to hospital
- improves users’ and their unpaid carers’ quality of life.

Growing evidence of what service users and their unpaid carers want and what the best home care looks like shows that the following are important, so commissioners to think about:

- commissioning that is based on evidence
- commissioning that incentivises providers to achieve defined outcomes
- having a diverse range of service providers
- all staff involved joining forces and working as a team.

Evidence suggests how commissioners can improve their practice in each area of the commissioning cycle.

Assessment

Well-targeted home care interventions can have a positive effect on overall demand for other services. They can also have a positive impact on cost and efficiency. [4] This suggests that if commissioners had a better appreciation of the needs and service provision in their local areas, this will help them to plan and commission more useful services.

Commissioners should:

- **develop a clearer understanding** of the complex needs of older people in their area, so that they can commission the right services for them [8]
- they should consider the whole needs of the person – from practical and medical needs to social and emotional needs
- read [practice examples 5](#) and [6](#) to see how services can cater for the whole needs of a person
- **identify which are the areas of poor performance** in their locality that stoke up demand and develop a clear integrated plan for how they might commission services differently to improve the outcomes that can be achieved
- particular areas to focus on are strokes, falls, incontinence, dementia and community dental services [4]
- **involve people who use services and unpaid carers** at this and every stage of the commissioning process
- it is only through listening to what users and their unpaid carers want from services that commissioners can really know how to develop services [1, 13]
- when service users and their unpaid carers take part in the process, services are more responsive to their needs, and policy and the quality of services improve. This leads to better outcomes in care, an increased sense of ownership over services and greater knowledge and confidence among users and their unpaid carers [16]
- take care when asking the views of older people who may have difficulties in communicating, such as people with dementia. To find out useful information, staff should be trained and have experience with the people concerned [11]
- be aware that older people may be reluctant to complain
- improve their knowledge of the services that are provided in their area and how they are performing
- lack of knowledge of service providers and the options available can lead to some voluntary sector providers being excluded. Ultimately this prohibits the development of the best service. [8]

Planning

At the planning stage, commissioners should be looking at how services can be designed to improve outcomes for people who use services and their unpaid carers, and creating the structure and processes that allow this to happen.

This may involve a **change of approach** within the local authority or health and social care trust: a move away from the idea of home care as a series of domestic and health tasks done for the user, towards the concept of home care as a preventative service

with a focus on impact, a service that can improve the lives of users and their unpaid carers with the ultimate aim, where possible, of reducing dependence on that service. [4]

Southwark ([practice example 6](#)), Bristol ([practice example 7](#)) and Wiltshire ([practice example 8](#)) have all set about changing the values and definitions of home care to transform the way services are commissioned.

Local authorities/HSC trusts should consider adopting **an outcome-led approach** to contracting for preventative services and have the confidence to pay by outcomes – what is achieved – rather than by the number of hours or length of the service.

The values that drive a local authority/HSC trust are crucial to outcomes: caring values are known to be the motivating force behind good home care and are vital throughout the system. [6] Elected members play a part here and may benefit from a better understanding of their important role in protecting the human rights of users. [1]

Skills and understanding are also necessary. Commissioning should be led by people who have a detailed knowledge of home care and what is provided in the local area. [1]

Good home care needs **a teamwork approach**. Commissioners should involve providers of health and social care services in planning and delivery. [4]

See [practice example 7](#) for an example of health and social care staff in Bristol working together.

To support the wide range of needs of older people with complex needs, it is important that **staff work together** and that health and social care **services are integrated**. No single structure works across the country – integrated care approaches are dynamic and complicated and are difficult to replicate. [18]

Commissioners should:

- **have a genuine commitment to partnership working and collaboration** – working together
- **have the ability to work across different budgets** to create seamless services that range from practical and social through to more rehabilitative/reablement [8]
- **involve people who use services** at the planning stage alongside their unpaid carers
- people with complex needs may struggle to express their preferences
- unpaid carers can provide invaluable information to help with the organisation of services [16]
- **think about the benefit of designing services around a single point of entry**

- a big complaint of users and their unpaid carers is that they are not aware of the full range of services available and do not know how to access that information
- many of those involved in the care process are also unaware of what is on offer and are unable to provide advice [6]
- **think about the role that ‘assistive technology’ can play** in the provision of services to older people with complex needs
- this is a device or system that helps people to do things they would otherwise not be able to do or increases the ease or safety with which they do things
- evidence suggests that ‘telecare’ – care provided remotely – can create efficiency savings by reducing the number of bed days and the level of home care needed, but success depends on the attitudes of older people towards it [14]
- the use of a lifeline system (an emergency button connecting users to a 24-hour helpline) should be encouraged, particularly for users with complex needs who live alone, and those with mobility problems
- technology has also been shown to be an effective way of providing support to unpaid carers [11]
- See [practice example 9](#) to learn how the London Borough of Hammersmith and Fulham is working to promote the use of assistive technology in home care.

Contracting

The buying of home care is a powerful tool for making sure that services meet the needs of people who use services and their unpaid carers and for engineering the kind of provision that allows for the personalised care that is so desirable.

Commissioners should:

- **use interventions that are based on evidence**
- a service should be funded only where there is clear evidence that it will deliver the desired outcomes or, where such evidence does not exist, the service should be tried out and then evaluated [4]
- **make sure that there is a wide range of service providers**
- commissioners should encourage a range of small to large service providers in the statutory, independent and voluntary sectors
- they should do this by working closely with service providers, users and their unpaid carers to develop services that respond to needs within the local community [4]
- **encourage the role of voluntary organisations**

- voluntary organisations can be particularly helpful to people with complex needs, providing niche services such as personal care for very complex cases and end-of-life care – see [practice example 10](#)
- to secure the future of useful but vulnerable voluntary organisations, the following would all help: longer-term contracts, the ability to raise funds for the development of capital and a standard form of contract between voluntary organisations and health and local authorities/HSC trusts [8]
- **consider the value that can be created by working closely with service providers** to create services that meet needs in the local area
- **consult users and their unpaid carers** on any major changes in the way support is delivered – sudden changes can result in anxiety, loss of a valued service or paid carer or increased expense [17]
- **look closely at staff recruitment and retention**
- paid carers are a major component of good home care and, particularly in rural areas, are in short supply
- commissioners can have a big influence on the pay, conditions, training and freedom of paid carers to perform their tasks well [6]
- they should consider how developing the social care workforce might attract new people to social care
- better terms and conditions could help staff retention
- **consider how effective improvements can be achieved with existing staff and resources**
- for example, staff can be trained to work at a higher level with users so that users can stay in their own homes
- **identify the cost-effectiveness of different forms of intervention over a longer time period and across funding streams**
- for example, intensive post-stroke recovery services that reduce dependency may initially appear expensive but be a cheaper option than long-term care and support [4]
- **consider establishing a lead professional or case manager role**, especially for complex cases
- this would include care planning, assessment, taking account of users' personal goals, monitoring and reviewing care
- it is not currently available for most older and frail users, even though it potentially reduces unplanned medical admissions and makes a difference to those 'on the margins of independent living'. [9, 14]

Monitoring

Opportunities to improve services and make sure that they are sustainable – through consistently reviewing and monitoring them – may be missed. There is a mixed picture but there is evidence of a lack of attention to measuring the impact and outcomes of services in any systematic way. [18]

Commissioners should:

- **make sure that services are continually assessed** in terms of how effective they are in meeting the needs of the people they are supporting and whether they represent value for money [8]
- **encourage service providers to show how they will increase users' independence and measure the outcomes of the service/what has been achieved** to determine success – rather than measure the number of people provided with a service or what activities are performed [4]
- **work collaboratively with the Care Quality Commission** (or in Northern Ireland the Regulation and Quality Improvement Authority) **in sharing information and in ensuring the quality of service providers**
- **include the principles of human rights and the quality of outcomes** (rather than just checking outputs and processes) to make sure that providers prioritise and deliver on these areas [1]
- **take into account the particular needs of certain groups including:**
 - people living in rural areas
 - people from black and minority ethnic groups
 - people from the lesbian, gay, bisexual and transgender (LGBT) community [15]
 - people who misuse substances
 - people with learning difficulties
 - refugees and asylum seekers
- **set high standards for monitoring**
- high-quality monitoring involves face-to-face interviews with service users and their 'unpaid' carers
- it places older people's views at the heart of the assessment of the quality of care
- examples include training older people from the local community as 'citizen assessors' to talk to other older people receiving care at home, or involving voluntary organisations that specialise in working with older people [1]
- commissioners should act on the feedback they receive.

Funding and costs

The home care market in England is valued at £5.5 billion, covering six million hours a week. Public spending accounts for £2.2 billion of this figure and the rest is privately funded – although some of the privately funded care is publicly provided. [4]

Demand for long-term care is growing and is set to reach a peak in 2040. Funding issues include:

- funds falling short
- the multiple funding streams involved, which create complexity and confusion with regard to paying for services. [14]

The following could go some way to alleviating these problems:

- a genuine commitment to working together in partnership
- an ability to pool or work across different budgets and funding streams [8]
- service line management of all health-related groups under the leadership of an appointed care manager.

It is suggested that local authorities or health and social care trusts start looking now at how to set up funding mechanisms that straddle the current boundaries of the different organisations involved in care. [4]

The literature reviewed for this guide puts forward a range of ideas on the affordability of home care for older people. But none was able to provide comprehensive cost-effectiveness analysis of home care provision for those with complex needs.

There are tentative claims that flexible, personalised care may not cost much more than conventional home care roles. [6] Pay, conditions and training of staff are seen to play an important part here. Staff working for independent service providers are paid less than those working for local authorities, have fewer benefits and get less training. This is often due to the reduction of costs implicit in commissioners driving down the price they are prepared to pay service providers for care. [6]

To provide the kind of personalised care that older people want and deserve, staff need to be better paid, better trained and receive specialist training in working with older people with complex needs. [4, 14, 20] Well-treated and enthusiastic staff can provide extra help, which costs the public purse nothing. [6]

Good home care for older people can and should be preventative, to reduce the use of services such as ambulance call-outs, Accident & Emergency departments and unplanned hospital admissions.

This is dependent on sufficient funding being available to fund personalised packages of care and approaches. The fact remains – the needs of people with complex needs require intensive specialist support for long periods of time, which costs more than standard care. [10]

If home care is to fulfil a preventative role and make it possible for people to stay in their own homes – no matter how complex their needs are – the following are likely to be helpful:

- services that are integrated
- single agencies that have staff from a variety of professional backgrounds
- approaches that are focused on what can be achieved rather than on the number of hours of care received or the type of care received
- an emphasis on real user choice.

Practice examples

Practice example 1: St Monica Trust, Bristol

St Monica Trust is a Bristol charity for older people funded by a combination of income from residents and a well-established endowment fund. This allows the trust to make its high-quality services available to a wide range of older people, regardless of their financial background.

The trust's Care at Home service works in a range of domestic settings with people who have highly complex needs. The creative and flexible care it offers has allowed it to help people whose needs have proven too complex for other agencies.

One of its staff has recently worked with Mr A, a paranoid schizophrenic who has lived in supported housing for the last six years. Mr A, who had a history of violence and spent time in mental health institutions throughout his adult life, had developed penile cancer but was refusing all treatment. He had not bathed or received any personal care since arriving, and this, along with his social problems, was making it difficult for him to stay in his home.

A carer from St Monica Trust, who had experience in mental health, gradually built up a relationship with Mr A. The carer got to know him at his own pace and found out that he was interested in crystal therapy and spirituality. The carer read up on the topic and worked with Mr A to choose the right crystal to help him sleep. Mr A is now receiving regular care for his tumour and personal care. He uses a bed rather than an upright chair and will accept other care staff to provide end-of-life care for him.

The commissioning authority highly recommends this service, which relies on well-trained carers who understand the importance of flexibility and creativity in care provision. A Citizens Advice Bureau case worker is also employed by St Monica Trust who can provide free and impartial advice on how people can fund their care.

Contact: info@stmonicastrust.org.uk

Practice example 2: Maximising Mobility

Maximising Mobility is a reablement project with a difference. It is delivered by the carers of users with limited mobility after the intensive work of the hospital physiotherapy home team has come to an end.

Double-up teams – carers who work exclusively with people who use equipment to get around – are given training by physiotherapists to continue mobility exercises with their users.

For example, Mr P had received intensive support from the hospital physiotherapy at-home team but continued to need practical support if he was to regain his independence. His carers helped him to carry on with the walking and stair-climbing exercises (home care providers are not usually expected to offer help on stairs) so that he was able to work towards using his shower rather than having to wash from a bowl in the living room.

The benefits of this project have been felt by users and carers:

- in many cases, users have been able to reach parts of their homes they had been cut off from
- staff have developed the confidence and skills to provide the support they know their users need
- physiotherapists know that exercises are being done regularly and in an appropriately supervised way.

There have been some practical problems getting people reassessed for equipment or physiotherapy due to waiting lists, which have delayed progress and reduced motivation of both the user and staff. Finding the right training has been difficult and costly.

Where the scheme has been incorporated into a user's existing commissioned package of care, it has been shown to reduce the amount of care needed – if not the number of visits, definitely the length of them – and long-term savings have good potential.

Most users of home care services want to return to have as much independence as possible – Maximising Mobility helps them to achieve that outcome.

Contact: info@stockshall-care.co.uk

Practice example 3: The Raglan Project – Monmouthshire County Council

The Raglan Project is a pilot project looking at how to deliver a high standard of relationship-based home care to people with dementia. It is replacing task-based care with flexible care that is focused on the social and emotional needs as well as the physical needs of the person being supported.

Five full-time salaried staff work on a fixed rota with 12 to 15 people with dementia. Before the care begins, staff members establish a relationship with the person receiving care. Staff are then given the freedom to decide for themselves how the relationship and care should be managed – and their decisions are supported rather than controlled by management.

Feedback from interviews, care management reviews and the journals that each staff member completes provides evidence that the project is consistently successful.

It has been possible for people with complex care needs to stay at home rather than moving to permanent residential care or hospital. People who had disengaged from their local community and were neglecting themselves have been supported back to independence and re-engagement with their local community. Community-based social events that were established for all sections of the community are now independent and self-sustaining.

There is also clear evidence that staff have better morale, health, wellbeing and job satisfaction. Sickness has remained at 0 per cent for 18 months.

Contact: homecare@monmouthshire.gov.uk

Practice example 4: Helping a dying centenarian man achieve a 'good death' at home

Most older people die in hospital, many alone. When asked where they would like to be when they die, most say at home, with their family around them. This practice example shows what quality of life at home means for a dying older person.

When Mr S was consulted on where he wanted to be cared for and where he wanted to die, he was in a care home to give respite to his carer. He stated that he wanted to be at home 'as long as my wife can cope'. He subsequently went home where he was bedbound for two years.

A care package involving five care agencies was put in place and the case was managed by a community matron. General practitioners (GPs) visited when requested.

An advocate supported Mr S and his carer and helped to improve their quality of life as much as possible throughout the two years, for example by fighting for a wheelchair and ramps to allow Mr S to get outside.

The advocate stepped in again to get Mr S back home after a hospital admission for a chest infection after a GP, who didn't know him and without consultation, instructed that he was 'too ill to go home'.

During Mr S's two years at home, he celebrated his 100th birthday and 65th wedding anniversary with a party organised in his bedroom. He enjoyed watching the Olympics and Wimbledon and saw Andy Murray win. He saw family and friends, stayed close to his home and life and was well-looked after.

Mr S eventually died what his family all felt was a 'good' death. His wife feels fulfilled knowing she carried out his wishes and does not suffer the typical guilt of many former carers. The rest of the family have become more emotionally connected with each other, having been able to connect with Mr S during his end-of-life journey.

Could Mr S's experience be replicated for other older people? A 'good death' should be the norm instead of the exception as it is now. But it will only become so if attitudes change to value older people and home care properly and help them to have more control over their lives. Cases like this need to be properly led by a GP and managed by a case manager to make sure that all the relevant services work together to achieve this.

Contact: annie.stevenson@integrationincare.org.uk

Practice example 5: Learning for the Fourth Age

Learning for the Fourth Age (L4A) provides learning opportunities to older people receiving care.

Older people receiving care are rarely viewed as able to progress, develop and learn. And yet learning in the later stages of life can boost confidence, give people a more positive outlook on life and delay the onset of dementia.

L4A older people receiving care are matched up one to one with volunteers who they share an interest with, for example learning to paint, local history or information

technology. The volunteers visit weekly and together they work on shared learning and development projects. The volunteer works at the user's pace and is sympathetic to the user's wants, needs and personality.

Mr H is in his eighties and has recently lost his wife. With reduced mobility, he needs some help with his shopping. He is grateful for his family's help and support but wanted to stay as independent as possible for as long as possible. Specifically, he wanted to learn to use email so he could order his supermarket shopping online. Having gained confidence with email and shopping online, Mr H is exploring other possibilities such as writing documents and finding information on the web.

An independent evaluation by researchers from NIACE (the National Institute of Adult Continuing Education) and Middlesex University have reported a range of different benefits, including:

- less use of medication
- improved attention span and remembering
- the inclusion of a wider range of different people within a care home
- more people taking part in activities
- partners being more included
- more mutual support.

For staff and relatives, benefits have included:

- new skills and knowledge
- misconceptions being dispelled
- new experiences for all participants, including younger volunteers
- immense satisfaction for everyone taking part.

Staff, relatives and other stakeholders have found themselves more able to see older people as individual people and understand them better.

Contact: info@l4a.org.uk

Practice example 6: Transforming home care: seeking quality of life in care at home in Southwark with stakeholders

How do you achieve quality of life through home care and raise its value and status? That is a question Southwark Council asked itself in the light of the publication of 'UNISON's Ethical Care Charter' [21] and a slew of press coverage of zero-hours contracts, 15-minute care visits and a lack of pay for travelling time that typify the jobs of many home care workers in Britain.

In summer 2013, Southwark Council explored ways to transform home care and improve users' experiences. It started by convening a series of stakeholder/user meetings to create a vision of what quality of life in home care looks like, what the values are that underpin this and what the ideal behaviours should be. The discussions started with the views of users and their carers, and continued around the themes

from 'My Home Life' [22] and 'The Senses Framework' [23], which underpin 'relationship-centred' care and were shown to work in home care.

From the discussions it was identified that home care providers are crucial in fostering the right conditions for a relationship-centred approach to the delivery of care alongside better working conditions. Both of these are necessary to deliver improvements in the quality of care. To achieve this, the council recognised that it would have to change its commissioning practice to support the providers to change, as well as try to influence a change of attitude towards home care workers.

One of the other conclusions of the 'visioning' work was that home care services as they currently exist and are commissioned need to be valued as part of a wider system. So the relationship that home care has to wider community health services, and activity in general practice and hospitals, is crucial to consider. These relationships are an important part in valuing home care and its workforce. As a result, Southwark has changed the language it uses to describe home care and now calls it 'integrated community support'.

The vision and values that emerged from the discussions were put to Cabinet, who agreed that they should drive a new commissioning strategy for home care in Southwark that would honour the Ethical Care Charter and raise the bar for home care.

The exercise showed that by using existing models and work already done by other organisations as a starting point, it is possible not to reinvent the wheel. The work done in Southwark is the foundation for a wider culture change programme and a new way of commissioning home care.

Contact: jonathan.lillistone@southwark.gov.uk

Practice example 7: Joint working between health and social care in Bristol

For the last two years, Bristol City Council has been looking at how to improve its home care services, through closer working with partners such as the National Health Service (NHS) Continuing Healthcare team and providers. The council's new Home Care Commissioning Plan [24] redefines home care services: they are no longer divided into 'personal care that includes physical contact and domestic care that does not'. A broader description of care now defines it as 'help to live in a safe and dignified way, and support that helps users maintain or improve their independence'.

Notable elements of the new partnership working include the following:

- There is a meeting every two months called the 'provider forum', which is an opportunity for providers to meet together and for them all to meet with health and social care commissioners. Commissioners use the meeting to give providers feedback from users, talk about gaps in the market and changing demands.

- A pilot project has been set up in which the NHS commissions support from the local authority's integrated carers team to support the carers of users of NHS Continuing Healthcare. Carers are now referred for assessment to the team who use NHS resources to commission respite care.
- Joint health and social care quality assurance monitoring has been developed. Two members of the Continuing HealthCare team have been appointed to join the local authority's monitoring teams, so that providers are under greater scrutiny in all areas of their provision.
- A joint commissioning contract for health and social care has been developed, so that providers, who often supply both services, are asked to deliver to the same requirements, no matter who is commissioning the services.
- With the introduction of personal health budgets, Continuing Healthcare is hoping to benefit from the authority's experience of direct payments. The aim is to join up processes involved and support for those in receipt of the payments.

Contact: chcprogrammenhsbristol@nhs.net

Practice example 8: Wiltshire Council's Help to Live at Home service

Wiltshire Council developed its Help to Live at Home service for older people and others who require help to remain at home. The approach focuses on the outcomes that the older people wish to gain from social care. It involved a complete overhaul of the social care system from the role of the social worker working alongside the customer to determine the required outcomes to the role of the providers of the service who must deliver these outcomes and receive payment based on that delivery.

A case study report on the approach was completed by Professor John Bolton of the Institute of Public Care at Oxford Brookes University based on a series of interviews with stakeholders in February 2012. It comprises a short summary of work completed and progress made, and is intended to encourage further discussion about how outcomes-based, personalised support can best work in social care in England in the future. [25]

Contact: careathome@wiltshire.gov.uk

Practice example 9: Promoting assistive technologies

In the London Borough of Hammersmith and Fulham, the role of technology in keeping people at home and out of hospital is taken so seriously that in January 2013 it created a dedicated Assistive Technology Coordinator post. The aim of the post is to raise the profile of assistive technology and engage partners across a three-borough partnership: Hammersmith and Fulham; Westminster; and Kensington and Chelsea.

Time has been invested in building relationships with health and social care colleagues throughout the three boroughs, including those in hospital occupational therapy, mental

health services, district nursing, learning disability services and care management teams. Carers' groups and voluntary organisations such as Age UK and the Alzheimer's Society have also been targeted.

Before this dedicated coordinator post was established, the occupational therapy team was dealing with all assistive technology enquiries and referrals but did not have the necessary time to keep up with the latest products, research or policy. Having a designated coordinator means that stakeholders have access to up-to-date information as well as support for complex cases. Support includes a Telecare Prescribers Guide, a formal assistive technology induction programme as well as an online resource site.

The service can reach and benefit a greater number of users and carers as more professionals have the knowledge and skills to prescribe assistive technology solutions.

With this model, assistive technology becomes everybody's business. It also becomes the default option for helping people to stay in their own home and prevents or delays unnecessary admissions to hospital or care homes. The number of referrals for assistive technologies has doubled in the lifetime of the post and the coordinator role has a good reputation.

Contact: AssistiveTechnology@lbhf.gov.uk

Practice example 10: Caring Support, Croydon

Caring Support in Croydon is a community cooperative and charity that provides bespoke personalised care in an innovative way through well-trained and empathetic staff working with users in their own home.

The idea behind it is for care to be provided in clusters – matching up users to home care workers and volunteers living locally. This creates formal and informal levels of support in users' local areas.

An integral part of its ethos is to help those who do not want to die in a hospice to stay in their own home. Here they can be supported by family and nursed by dedicated carers who they know well, who can call on other professionals for support at critical times.

The end-of-life service aims to provide care and companionship for those approaching the end of their lives and their families, matching care to the person and to family support needs through a flexible and personalised staff culture.

It does this by liaising with the user, the family and the professionals involved via meetings at the user's home and by phone and text, to make for a seamless service. It can provide 24-hour care if needed and signposts the family to information such as:

- carers' information services
- training for unpaid carers so they can support their relative
- advice about claiming Attendance Allowance
- advice about Continuing Healthcare funding.

What makes this approach work is that Caring Support:

- offers both pastoral and social care
- is flexible
- has an ethos of care and good training
- has the support of local people and health and social care colleagues
- gives staff training about the end-of-life stage, so that they understand the need to give care that is focused on the person and do not panic when faced with someone who is dying
- makes sure that trained volunteers are on hand to provide practical support.

Contact: sheila.kelly@caringsupport.org.uk

www.caringsupport.org.uk

Practice example 11: The Debenham Project

The Debenham Project, which started in 2009, is an innovative community-based approach to supporting those caring for someone with dementia in the rural village of Debenham and its surrounding area in Suffolk.

The aim of the project is to make sure that those living with dementia can be supported locally, instead of having to travel miles for local authority or NHS-funded care services. Volunteers are recruited locally to lead a comprehensive range of activities that support people with dementia and their unpaid carers. Professional support is drawn in where required from health and social care services and charities.

The project provides the following:

- advice
- signposting and information services
- lunch clubs
- an exercise club
- a carers' club
- an information cafe
- activity sessions
- confidential telephone support
- emergency care
- respite support
- professional care
- volunteer transport
- dementia awareness

- clinical services.

The project places a big emphasis on supporting the carer and cared-for together, and on recognising that quality of life comes mainly from maintaining family, social and community relationships – ‘Interaction is the chemotherapy of dementia’ (Henry Simmons, Alzheimer’s Scotland).

The project has had positive results, including the following. It has:

- increased people’s understanding of dementia in the community
- reduced stress
- helped carers to cope
- reduced isolation
- reduced the number of crises and, with that, potential hospital/residential care admissions
- meant that more people with dementia can continue to be cared for in their own homes and community.

The project is a model that can be directly applied in most rural and semi-urban communities and adapted for use in more urban environments.

Debenham has been accepted as one of the first ‘dementia-friendly communities’ as part of the Prime Minister’s Challenge on Dementia.

Contact: enquiries@the-debenham-project.org.uk or www.the-debenham-project.org.uk/feedback.shtml

www.the-debenham-project.org.uk

Further reading

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Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders (February 2014), London: NHS England.

Making our health and care systems fit for an ageing population (March 2014), Chapter 3: Helping people live with complex co-morbidities, including dementia and frailty, London: King's Fund.

Better care for frail older people, working differently to improve care (2014), London: Deloitte.

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Commissioning home care for older people

'Home is a powerful symbol of autonomy and independence, whereas institutions are associated symbolically with the loss of autonomy.'

This guide captures the latest research findings on an important and emerging area of social care – that of home care for older people with complex needs. It also provides some practice examples of innovative work in this area.

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