Emerging models of Home Care providers in the UK

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ABSTRACT

The purpose of this paper is to investigate emergent Home Care models in the UK, to examine how these models' value offering differ from the traditional model of Home Care, and how these are shaping the care landscape. Home Care providers for older people in the UK are facing a rise in demand for their services which is driven not only by an ageing population but also from a market demand for personalised, customer-centred care. Combined with a turbulent political and policy environments, and the government's public need to maximize resource utilization and contain care costs, the current care landscape presented an opportunity for innovative and emergent Home Care models to establish themselves and disrupt the market by offering a more compelling service design and value propositions that better match customers' needs.

Research question: What are the emergent Home Care models in the UK?

Objectives: (1) to understand how the care landscape is influencing the emergence of Home Care Models; (2) to assess how these models differ from the traditional model of Home Care; (3) to assess how these models are being shaped and are shaping by the current policy and economic environment.

Methodology

This study used semi-ethnographic methods including 9 months of field observation and data collection. It includes a narrative summary review of academic and grey literatures, triangulated with 7 expert interviews. Fieldwork sampling was informed by the literature reviews and expert interviews that formed the different types of emergent models. Fieldwork included 17 interviews with businesses owners, managers and directors from two emergent Home Care providers, 4 short-term placements and 2 focus groups, including non-participant observations of working practices (including staff induction and training), and analysis of organizational documents (organizational charts, assessment reports, policy reports).

Findings

The study has shown that Home Care providers for an ageing customer base are becoming increasingly aware of emerging customer needs, and, in addressing these needs, are seeking to establish innovative models of care provision. Disruptive and emergent models such as uberisation, community-based, social enterprises and integrative models are becoming more pervasive in the current landscape.

Conclusion

Major shifts in the emergent models are in relation to their value proposition, partnerships and customer segments. The value proposition tends to focus on several dimensions of wellbeing, from health and physical to emotional, and psychological. Customer segments exist in two

separate groups, self-funders and the care workforce. A strong network of partners provides access to complementary services, investments and specialist knowledge.

Keywords: emergent Home Care models; Business Model Canvas; value proposition; ageing population

INTRODUCTION

The UK has one of the highest marketised Home Care sector in the world, only losing to the USA (Christensen and Pilling, 2017). The increasing demand for Home Care is occurring in tandem with government policies to minimise social care costs, and maximise the utilisation of the care workforce. In this context, emergent business model organisations, both for-profit and not-for-profit have emerged in the last decade. Data was collected through ethnographic methods including 9 months fieldwork observations, 7 key informant interviews, 17 interviews with business directors and managers, and contemporaneous document analysis. The findings presented here highlight how the policy and commissioning contexts impacted the autonomy of the participant organisations to drive the implementation of individual programs that compounded to collaborative outcomes, primarily related to the development of their workforce.

The UK Government's Industrial Strategy (DBEIS, 2017) is a recent example of policy which aims to drive productivity and growth. The recent UK Industrial Strategy (HM, 2017), determines that one of our great societal challenges is the need to harness the power of innovation to meet the needs of an ageing society. By focusing on particular needs of older people, such as mobility, care and housing, there is an obligation, as a society, to ensure innovative models and new technologies, services and products are in place to fulfil the needs of an ageing society. Innovation in age-related products and services can make a significant difference to UK productivity and individuals' wellbeing, and will find a growing global market. Thus, a new generation of innovative business, particularly in home and social care, has the potential to thrive in a growing market.

The Care Act 2014 can be considered a driver for the UK government to revaluate social care and the provision of care in general. Despite recent attention to care models that attempt to address the wellbeing of an ageing population and the care workforce, the focus of care providers has continually been predominantly based on "time and task". The impact of emergent home care models has remained relatively unexplored in the academic literature. Particularly, there is a paucity of a business model view, and how different components of organisations are interrelated.

LITERATURE

Home Care sector landscape

Home Care (HC), also known as domiciliary care, is a growing and vital sector to the UK economy. "Home care" refers to a range of care and support interventions delivered to people in their own home: domestic tasks, shopping, home maintenance, personal care, social activities, rehabilitation and recovery and support for people who are at the end of life. It can be preventative, providing companionship, engagement or early intervention to avoid a

deterioration in health and wellbeing. It can be used to delay or prevent the need for residential care, or following illness or injury. Home care can involve domestic tasks, shopping, home maintenance, personal care, enabling access to the community, social activities, rehabilitation and recovery, palliative care.

The population in the UK is ageing at a fast rate, and the Department of Health estimates that the percentage of people aged over 85 will double in the next 20 years (DH, 2015b). Among the biggest challenges are giving older people more control of their own care; removing the silos between physical and mental health and health and social care; and delivering new models of care. Growth and development in Home Care are essential for the sector to be able to respond to the strong and increasing demand for its service. The growth of the Home Care industry is, a phenomenon that not only parallels the ageing of the population but the higher levels of disability among those 65 years of age and older. The industry's growth may be partially due to its potential to reduce the rates of institutionalisation, hospitalisation, and emergency room use.

Market condition and market share

The Home Care market can broadly be divided into two sectors: the commercial domiciliary care market, which includes provision by local authorities, the National Health Service (NHS), private and voluntary sectors; and the informal care market, which includes care provided by neighbours, friends and relatives on an informal basis, often free of charge. In 2017/18, the market value for home care reached a 5-year high at £85 billion. Informal care continues to account for the majority of the total market value, at an estimated 78% in 2017/18, and valued at £66.4 billion (Cone, 2018), compared to £13.14 billion purchased by local authorities and £2.3 billion by the independent sector and £3.15 billion by the NHS. Informal care is normally used for low intensity customers and often to supplement local authority and private domiciliary care. Home Care supports and assists individuals with various health and care needs to live as independently as possible in their own homes. The majority of the independent sector's business activity is still derived from local authorities. However, the ability to win local authority business at the time when many social services department are reducing the number of suppliers remains a critical barrier to market entry. Providers struggle to survive in a high-cost, low-profit climate and whilst some are running sustainable businesses, many are on the verge of becoming unsustainable.

Historically, the HC market in the UK has been highly fragmented on the supply side. Compared to other healthcare sectors, Home Care is relatively young, and there is clear evidence that greater consolidation has occurred in the sector in recent years - with several smaller businesses withdrawing from the market or being acquired by larger corporate companies. Despite recent consolidations, the top four independent sector providers have an estimated collective market share of only 8.4% (Cone, 2018). The independent providers serving the publicly-funded market have suffered from reductions in prices and profitability. There is also a trend for larger providers to move their business to privately-funded market, which is seen as more buoyant with higher fees than state-funded care. In 2016, adult social care had around 20,300 organisations, a workforce of around 1.58 million people (SkillsForCare, 2017). Of these organisations, 10,176 regulated providers of domiciliary care operating in the UK and registered with the Care Quality Commission (CQC) but possibly many more - around one third - are not registered (Holmes, 2016). The UKHCA estimates that

874,000 people receive domiciliary care in the UK, out of which 228,000 are self-funders service users (Holmes, 2016).

<u>Regulation and Commissioning</u>

The Care Quality Commission (CQC) is the regulator for health and social care in the UK since April 2009. All services are registered under a common set of registration requirements that focus on safety and quality, with an outcome-based focus, and regulation intended to be proportionate and based on risk. Health and social care providers are audited under a set of compliance criteria. Home Care providers must vet home care workers before engaging them by taking up references and carrying out Disclosure and Barring Service (DBS) checks on potential employees. The UKHCA is the official regulatory body for care agencies in England, Scotland and Wales. Membership isn't compulsory, but it is therefore the sign of a responsible reputable agency. Home Care providers vetted by the UKHCA are subject to strict, frequent checks and must attend training in order to maintain a high standard of care.

Their commissioning practices in the UK tend to be cost-focused and associated with low user satisfaction scores. Since the 2000s, the policy framework has increased the attention on personalisation and personal budgets. Despite the strong push for personal budgets which is delivered through Direct Payments, most councils remain contracting with local home care providers, and the majority of care at home is purchased by councils in that way across the United Kingdom (Bolton and Townson, 2018).

The HC ecosystem is an essential, complex sector which has, over a short period of time, become of the fastest-growing sectors for its services. Besides the growth in scale of the services needed from an ageing population, the scope of services is also expanding, with recipients demanding new services. According to Peng and Yeandle (2017, pg.i), the growing demand for eldercare is driven by "rapid demographic ageing, changes in family patterns and gender relations, greater distanciation between generations, and institutional and ideational changes…and the meaning and practices of care". Because of all these environmental changes, cross-national policy learning has become more prevalent, and encompass a range of social, economic and political dimensions to adopt new policy models that tackle changing physical, emotional and cognitive needs (Peng and Yeandle, 2017).

When looking at homecare services, data from CQC shows that locations providing care to a smaller number of people were performing better than larger services. They show that in 2016, 85% of small services (for one to 50 people) are rated as good or outstanding, whereas only 73% of larger services (for 101 to 250) achieved the same results. Recent changes to the funding of care mean that more people are directly funding their own care, creating room in the market for smaller niche operators working at a local level. Up until the early 1980s, the availability of care tended to be mainly residential in either residential or nursing homes, albeit with some additional provision of state-funded 'home-helps'. In fact, 98% of all institutional care was provided by the state. The introduction of Community Care Act reforms in 1993 (DH, 2015a) dramatically changed the care structure in the UK. The act diverted the budgets held by the now-defunct Department of Social Security to fund residential care to local authorities' social services departments. Anyone who felt they required care and funding for care had to apply for an assessment by their local authority.

The development and growth of the current home care market was driven by changes in legislation for care and commissioning. For example, in the 1990s there was a move by social services departments to purchase more community-based care from the independent sector, where costs were significantly lower, rather than provide care services themselves. However, private domiciliary care providers have also been pressured by the continuing cuts made to LA budgets, the introduction of the National Living Wage, a shortage of trained nurses, and tougher immigration rules making recruitment more difficult.

The majority of the independent sector's business activity is still derived from local authorities. This dependency is exacerbated by the high level of exposure many companies have to individual authorities. The ability to win local authority business at the time when many social services department are reducing the number of suppliers remains a critical barrier to market entry. Private equity investors have been largely successful in aggregating small home care providers into businesses operating on a national scale. These providers have proven attractive to outsourcers, who are increasingly looking to enter the market. There is a sizeable, privately funded domiciliary care market in the UK. Because there is no routine data collection, the assessment of the market is based on estimation derived from surveys and comparative socio-economic structure of the nation. It is estimated that the self-funding market in the UK has an annual expenditure valued at over £741 million with over 223,000 service users (Holmes, 2016).

METHODS

Purpose

This research seeks to understand the current state of the Home Care landscape in the UK, and to investigate emergent models of home care providers in the UK through the value propositions and value creation. It has adopted a narrative summary review (Dixon-Woods et al., 2005) of the Home Care sector, which included both academic and grey literatures. The selection of emergent Home Care providers was determined through theoretical sampling (Van den Hoonaard, 2008), informed by the literature results. Interviews and placements were used to understand the models in depth, why they were set up and what are their main challenges. The Business Model Canvas (Osterwalder and Pigneur, 2010) was adopted as the analysis framework to investigate how organisations create, deliver and capture value and to understand how the current care landscape influenced the formation of these models.

Methodology

This study draws from a larger action-research project, and uses semi-ethnographic methods for its data collection. Ethnographic research seeks to gain an emic perspective, or the "natives" point of view on what is happening in a certain scenario or setting, which includes performing research without imposing conceptual frameworks on the empirical world at the beginning of the research process. Understanding the emic perspective is often the most challenging feature of ethnographic research for researchers who are more familiar with what is called the etic perspective. However, some ethnographers also claim that it is necessary to learn to combine the emic and the etic views in the same study (Barley, 1996). One way to achieve this was to enter the fieldwork with a good understanding of the market and business environment but keeping the process as open as possible. There was not a single theoretical framework or

concept imposed from the outset of the research process. The main tool used to start the process of discovery was the use of the Business Model Canvas and discussions around each of its components. This is a tool that most practitioners are familiar with and are comfortable in delving into their business environments. Organisational ethnographies provide in-depth descriptions on a wide range of topics within the field of management and organizations, such as managerial action, organizational cultures, human resource practices, interaction of professional groups, work behaviour and co-worker relations, emotional labour, and so on. The objectives of organisational ethnographic research can be to understand the working practices and social structures, and to explore the meanings of organisational outcomes. Attention to language and rhetoric is important, and talk is conceptualized as a social practice: what people say and what they keep silent about produce meaning and value in social life.

Principles of selection

The selection of Home Care providers was determined through theoretical sampling (Van den Hoonaard, 2008). Providers were chosen based on (1) type of business model; (2) the scope of their offering and (3) geographical location. Interviews with key experts (7) in the social care and home care sector, including national associations, regulators, commissioners and think tanks, together with grey and academic literature reviews, offered an overview classification of emergent and disruptive Home Care models. From this initial classification, organisations were selected to participate in the research project. The scope of their offering included providers that operate solely in Home Care for older people, and excluded providers that operate in residential or nursing homes. The last criteria involved providers that are based and operate in the UK (England, Scotland, Wales, and Northern Ireland) or international providers with branches in Britain.

Data collection

Data was collected through semi-ethnographic methods including 9 months of field observation via short-term placements, 17 interviews with businesses owners, managers and directors from two Home Care providers, and pertinent document analysis over the same period. Interview ranged from 40 to 75 minutes and placements were for 1-2 days. A semi-ethnographic approach was used with short-term placements in the selected home care organisations. This placements offered a rich source of data and observational opportunities, enables a close relationship of trust with participants and businesses to develop and revealing unarticulated needs, discrepancies and behaviours. These methods allowed the identification and explorations that explained the process of formation of these businesses, allowing the phenomenon to be viewed in the context that it occurs. This method makes an ideal partner to the Business Model Canvas framework. In applying this framework, the findings are based on observational data and details fleshed out during interviews. Details of data sources collected on each organisation are summarised on Table 1.

Table 1 – Data Collection

	Interviews	Observations	Documents
Case Study 1: Uberisation model	8 interviews, including CEO, directors, and managers 2 focus groups discussions on organisational innovation	2 Short-term placements (1-2 days) allowed the observation of business practices Care workers induction & training Informal conversations, field notes	From digital platforms, including their website: brochures, information sheets, blogs, and job descriptions. From media and grey literatures:
Case Study 2: Live-in model	9 interviews including CEO, directors, and managers	2 short-term placement (1-2 days), including informal conversations & field notes CEO lunch Care workers training	From digital platforms, including their website: brochures, information sheets, and blogs.

All scheduled interviews were digitally recorded and transcribed for analysis by a professional transcription service. Transcripts were then uploaded into NVivo 9 for management and coding. Once coding was completed, it was analysed on Strategyzer Business Model Canvas platform. In addition, communication, guidance, leaflets and organisational documents which were provided to the participants were collect and analysed, together with their website content Copies of documents used in the analysis were kept electronically (hard copies were scanned) on an encrypted server at the author's institution.

Research ethics

This research has received formal ethical approval from the Research Ethics Committee at the University of Sheffield, UK. A full application was submitted which included detailed project information, detailed methodology, personal safety, participants, including recruitment methods for participants, advertising methods, consent, potential harm for participants, data confidentiality, storage and security. The application was approved by the committee under reference number 020368.

Analysis

The Business Model Canvas was selected as the framework to systematically analyse how the organisations create, deliver and capture value. The canvas is recognised both in academia and industry and it is well established as an analysis tool, and empirically validated by experts (Osterwalder and Pigneur, 2004). The nine business model components featured in the canvas are described by Osterwalder and Pigneur (2010, pg.20-40) as follows:

- Customer segments: comprises of the various groups of people or organisations an enterprise aims to reach and serve;
- Value proposition: outlines the bundle of products and services an organisation utilises to create value for its customer segments;
- Channels: describes the manner in which the organisation reaches and captures its customer segments in order to deliver its value proposition;
- Customer relationships: defines the types of relationships the organisation establishes with its customer segments;
- Revenue streams: represents how the organisation generates revenue from its customer segments;
- Key resources: identifies which assets are most significant in ensuring the business model is operational;
- Key activities: identifies which activities must be performed by the organisation for the business model to work;
- Key partnerships: outlines the network of partners and external suppliers needed by the organisation to make the business model work;
- Cost structure: describes the organisation expenditures in operating the business model.

Data collected from fieldwork with the Home Care providers were coded in accordance with the predetermined categories featured in the canvas. A content-focused approach was followed and triangulated with observational data and documents, which provided clarification and further details to compose the canvases. Once data were sorted and coded, it was compiled using the Business Model Canvas, with an individual canvas being utilised for each provider.

Findings

The initial exploratory stages of this project where literature revealed that emergent and disruptive providers operating in the Home Care industry can be categorised into five broad models, as outlined below. The session is then followed by showcasing two in-depth case studies that were investigated over a 9 month period.

Emergent Home Care models

Costs and consumer preference have driven a shift from the institutional care of older people to home and community based care. HC providers are starting to innovate their business models to address current challenges such as an ageing society and to respond to new technological trends. At present, a worldwide uniform definition, as well as a standard model of home care does not exist, causing the offered services to differ across countries and in different areas of the same country. This lack of precision in defining activities, actors involved and goals, as well as the diffusion of heterogeneous applications have led countries like the UK to sometimes have poor levels of coordination and integration of care delivery. On the other hand, this offers great opportunities for businesses to develop innovative models and value chains that can address specific home care needs within an ageing society. Home Care entrepreneurs who have developed a more specialised sector outlook, have a tendency to adopt new business models based on a wellbeing, technology and personalisation.

As observed in the previous session, Home Care in the UK has been traditionally provided by local authorities on a means assessment basis. The sector is experiencing a progressive overhaul

across its value chain, accommodating new business models and models of care that increase the usage of dedicated services for care service users. However, the demand for this kind of services has grown considerably and the independent sector has followed this trend with emergent models, which are summarised below.

Type I: Uberisation Model

In many industries, the term "uberisation" has become shorthand for a business model that cost-effectively leverages underutilised assets to completely disrupt an existing ecosystem. In home care this trend is not an exception. This model is reflected in agency-type providers that have a large database of care workers which are used to match service users' specific requirements. Care workers are self-employed, and will have a detailed profile including specific skills, languages, and cultural background. Within this model, the care worker needs to take on certain responsibilities such as paying for taxes, their own salary, pension and liability insurance. These platforms do not provide services directly and are not regulated by the CQC, however they do offer better value for money for service users. This is where the uberisation model fits in. All unused capacity or idle care workers are integrated onto a service aggregator platform, which has a clever algorithm that is continually matching care workers with care recipients' requirements. As the model integrates these requirements, well-matched options become available for both sides, and the agencies' job is to provide this platform.

The implementation of the uberisation model has its own challenges. For example, even though care workers are self-employed, they need to be vetted to ensure their qualifications and working status are appropriate to fulfil the work. Another challenge faced by the agencies that provide this platforms is that they still require either phone or face-to-face communication with service users, as detailed information on their service needs can sometimes be difficult to capture online. Some care workers joining this kind of model come from more traditional providers and becoming self-employed sometimes require

Apart from the enhanced utilisation of resources and reduced operational complexity and costs, an uberisation model is also direct and disruptive. Firstly, it allows care recipients and care workers to connect directly with each other. Secondly, it attracts new entrants to the market in the form of both care workers that are looking for work flexibility, and care recipients that are looking for personalisation and choice. Any home care provider organisation using cheaper operations and successfully demonstrating its capabilities may end up setting off the next disruptive phase of the care ecosystem. As uberisation picks up speed, service users (care recipients) and service providers (care workers) will inevitably reap benefits and gains, with the latter likely to incorporate value-added services from the streamlined platform offered by the agencies. The uberisation of home care might be a winning and sustainable business model that the sector desperately needs to serve a considerable proportion of the market.

Type II: Managed live-in Model

Whilst home care agencies usually offer a range of care services, managed service models are organisations that frequently offer only specific care services such as live-in care or dementia care. These independent organisations provide home care services through a bank of skilled staff vetted and employed by them. A fully managed live-in care model will employ, train and supervise the carer workers directly. They will interview them, check references, do background and criminal record checks and will provide ongoing training. They take complete

responsibility for the management of the live-in care service, rather than this being the responsibility of the customer. They are regulated and continually assessed by the Care-Quality-Commission (CQC) who inspect the services that are being offered. They must meet the CQC's national minimum standards and regulations in areas such as training and record keeping. The CQC has the power to inspect them and enforce standards. The Live-in carers are employed directly by the organisation therefore they are responsible for paying the carers for sick pay, holiday pay, and to make national insurance and pension contributions. One of the main benefits for the service user is the continuity of care and usually 24 hour access to a call service which is managed by a care management team.

They match a carer to the client based on individual needs, and will try to take into account any personal preferences or religious requirements you may have. They are usually dedicated to providing a certain type of care, whether that's companionship and everyday tasks such as shopping and errands, or more intensive care provision, including personal care. The organisation will provide a service through a trained team of care workers, which means you may not always have the same person visiting your home.

Type III: Social enterprise Model

A social enterprise is an organisation that applies commercial strategies to maximize social impact alongside profit and financial returns (Wry and York, 2017). They can be seen as a mechanism for building social capital and provide opportunities to expand social networks, develop social trust and cooperation, strengthen peer support groups and enhance career prospects (Roy et al., 2012). Social enterprise models of care are delivering and influencing social care provision in the UK. This model allows for greater organisational autonomy which oftentimes comes in the form of social prescribing. Social prescribing is when health professionals, which in the UK is dominated by general practitioners from the National Health System (NHS), refer patients to a social prescribing specialist who is able to suggest local social groups that they can participate to improve their health and wellbeing (TheKingsFund, 2017).

Recent social care policies have sought to promote social enterprises as a significant form of social business model. The white paper "Our Health, Our Care, Our Say" (DHSC, 2006) was the first major initiative to promote the active development of social enterprises as a means to encourage further entrants into the social care market. It established a range of initiatives including the Department of Health's Social Enterprise Unit, the Social Enterprise Investment Fund and the Social Enterprise Pathfinder Programme. These initiatives have been independently evaluated and the results have shown that they were successful means of providing business and financial support in the form of grants to new and existing social enterprises in health and social care, including Home Care (Alcock et al., 2012). However, evaluations also highlighted potential challenges for social enterprises: (1) they can take a long time to be developed; (2) the benefits of this model is not always clear to potential commissioners and stakeholders; (3) staff perception that they would lose favourable conditions such as final salary pensions.

One of the main challenges of social enterprises is being able to conceptualise and measure the social value that these organisations are expected to deliver. Factors such as service user involvement, investment in staff development and how profits are reinvested could offer a more balanced approach, besides commissioning and procurement.

Type IV: Community based Model

Community based models usually include autonomous teams of care professionals that deliver services in a community. The Netherlands-born Buurtzorg (Bowen, 2017) approach to care, which has strong evidence on cost savings and positive user and staff experiences, is a prime example of this model which has been recently adopted in the UK. Buurtzorg, which translates from Dutch as “neighbourhood care”, enables continuity and relationship-based care as well as efficiencies from reduced travelling time. Although originally consisting of a team of nurses, in the UK and other countries, this model has been adopted by the care sector and care workers, working in the local community and getting to know local general practitioners, therapists and other professionals. A small team of 12 work in a neighbourhood, taking care of people needing support and managing the team’s workload. The team decides how they organise their work, share responsibilities and make decisions in a case management approach to each service user. This model moves away from an isolated and fragmented, task-oriented approach towards a focus on team working, autonomy for care workers, as well as relationship-based and person-centred care for service users, which leads to improved working environments as well as efficiencies in travel and overheads.

Another example of community-based models are wellbeing teams. Inspired by the Buurtzorg approach, they are self-managed teams that focus on person-centred care and supporting people in their communities. They tend to be formed by a small team of four care workers and care is based on a support sequence co-designed with the person to deliver their priorities. This sequence is repeated every six months to ensure that people are able to live well at home and are connected to their community. Wellbeing teams design an ideal week for the person, where visits have an indicative time but they are not monitored, instead they are trusted to get the job done. Rather than following a list of set tasks on each visit, they are outcomes focused and each worker has the autonomy to make decisions and explore a range of options to achieve the desired outcome.

Type V: Integrated Home Care Model

Illness and hospitalization often trigger functional decline among older persons. Home care services implemented for functional decline provide an opportunity to intervene to improve outcomes. Integrated Home Care (IHC) refers to when the care takes place in the patient’s home as part of an integrated care pathway among primary care, hospital and social services for patients with specific health and social needs and it is performed by a multidisciplinary team in collaboration with the patient at home (Larsen et al., 2012). This model arises from a critique of the often-fragmented delivery and lack of clinical continuity that is mostly used in the current system. According to (Van Servellen et al., 2006), the relationship between continuity of care for chronic conditions and quality outcomes relies on the impact of three values of social patient psychology: (1) Perceived control over their care (feeling safe) (2) Great involvement in decision-making (participation) (3) Knowledge about their illness and its treatment (primary health feedback). Thus, the IHC model represents psychological values of safety, participation and transference for patients that use them.

Case Study 1: Uberisation model

This case study investigated an introductory agency based in England, which offers a matching platform for care users and care workers. They perceive themselves as a social business that

seeks profit as a financial return to shareholders but take very seriously their role in society and the social return for care recipients, their families and care workers. This model is not regulated by the CQC and has an independent auditing and quality assessment system. The Table 2 below illustrates the different components of their business model.

Table 2: Business Model components for Uberisation model

Business Model Canvas component	Case Study 1: Uberisation model
Customer segment	Elderly care recipients; care recipients' families; care workers.
Value proposition	Choice; cost saving; wellbeing.
Channels	Online presence (website, Facebook, Twitter, YouTube), word of mouth, telephone, email, advertising, referrals
Customer relationships	Empathetic and understanding, by listening to clients' needs; flexible care arrangements.
Revenue streams	Transaction fees for their service only.
Key resources	Digital platform; database of care workers; database of clients; partners.
Key activities	Online marketing; care workforce recruitment; offline marketing; digital platform update and maintenance.
Partnerships	Counselling services; investors.
Cost structure	Streamlined; digital; staff.

Customer segments are divided in three groups: (1) elderly care recipients that are both self-funded or recipients of government direct payments; (2) care recipients' families, usually represented by a son, daughter, spouse or friend; and (3) care workers. The main value proposition discussed by all the interviewees was choice. Choice for both the care user who is empowered to choose from a range of carers in a timely fashion, and for care workers who get to bid for jobs that have the best fit with their skills, location and availability. Another proposition is cost-saving, as care users are contracting directly with the carer worker, who is earning the vast majority of what the clients pay. They are also committed to improve the wellbeing of care recipients by addressing their needs through a large database of professional carers; and to improve the mental health of their families, that are offered support such as partnerships with counselling services. There is also a focus on improving the livelihood of care workers and to formalise an informal economy. Customer relationship is described as empathetic and understanding, by listening to clients' needs. They offer flexible arrangements for care without upselling unnecessary hours of care. Furthermore, suggestions such as counselling if asked or if they feel it is needed by the customer or their families. The only revenue streams is through transaction fees for their service only, as care workers are paid directly by the clients. They have a considerable network of partners and a large number of investors, therefore due diligence for each investor is intense and time-consuming.

Case Study 2: Live-in model

This case study investigated a live-in care provider based in England and Scotland, which offers primarily live-in care support for older people with dementia or other conditions such as Parkinson, multiple sclerosis (MS), stroke, palliative, cancer and respite. They offer teams of two care workers to each client, as continuity is one of the most important aspects of caring for someone with these kinds of conditions. This organisation is strongly focused on the recruitment and training of the care workforce, using ground-breaking approach to dementia

care at home. They currently hold the highest ranking – outstanding - from CQC, which typically translates into high quality of service provided. There is a great focus on the care workforce as they are required to be highly skilled and understand complex conditions. This model also differs from an hourly home care model, where the care worker lives with the care recipient for long periods of time, which requires a particular kind of workforce. There is an inclination to work with preventative measures such as regular testing clients for UTIs (urinary tract infections), which often cause disorientation and the perceived worsening of their condition. Their approach is to train care workers to interact with clients by communication rather than through medication, and they include innovative specialist training during their induction. In many traditional home care and care home settings, conditions such as dementia are treated with medication to keep people docile, quiet and well-behaved. The Table 3 below illustrates the different components of their business model.

Table 3: Business Model components for Live-in model

Business Model Canvas component	**Case Study 2: Live-in model**
Customer segment	Care recipients; care workforce.
Value proposition	Live-in care with specialism in dementia care.
Channels	24/7 support team, online presence (website, Facebook, Twitter, YouTube, app, LinkedIn, Chat now).
Customer relationships	Family support, including advice and expertise in care planning, costs and financing.
Revenue streams	Fee for services.
Key resources	Care workforce; admiral nurse; occupational therapist; district nurse; 24/7 on-call support team; care managers; peer-to-peer support forum.
Key activities	Care worker recruitment; care worker training and induction; weekly CEO lunch with care workers; brand awareness; IT support and maintenance; on-call support and scheduling; client services; compliance.
Partnerships	Charities; hourly home care providers; financial advisors; solicitors.
Cost structure	Employees shares option; staff; workforce; administration; workforce travelling.

Customer segments are divided in two groups: (1) elderly care recipients, mostly self-funders and with complex conditions such as dementia; and (2) care workforce. The value proposition is their specialism in live-in care, with particular focus on dementia care and similar conditions, which 85% of their clients require complex care arrangements. Their customer relationship includes advice and expertise in care planning, costs and financing, as well as support for families around care options and wellbeing. Their key resources consist of a strong care workforce, and an admiral nurse who is a dementia specialist nurse that support care workers with clients with complex conditions. They also have an occupational therapist that assists with fall management, health & wellbeing outcomes, and a district nurse that support care workers with clinical tasks. Additionally, they have a 24/7 on-call support team, an in-house technology where care workers use Chromebooks to record their care notes, a forum for peer-to-peer support, and each care manager supports a small group of care workers.

Key activities consist of rigorous care worker recruitment and rigorous care worker training and induction, with only 5% of care workers finishing the process and starting a job. Recruitment is based on skills and personality rather than qualifications. Weekly CEO lunch with care workers to discuss any challenges, issues and feedback on what is working well; brand

awareness, including events at local communities such as talks, singing groups, loneliness awareness groups; IT support and maintenance; on-call support and scheduling; client services; compliance. They have close partnerships with charities such as Dementia UK and Parkinson's UK, particularly for specialist training for care workers. They have partnerships with home care providers that provide hourly care, as not all clients require 24h care. Financial advisors and solicitors for the elderly for things such as power of attorney.

DISCUSSION & CONCLUSIONS

The results from the narrative summary review highlighted five types of emergent business models in the Home Care landscape in the UK: the uberisation model, live-in model, social enterprise model, community-based model and integrated model. It can be observed that these models have shifted the terminology and a focus from care to wellbeing, personalisation and choice. This more value-based care system in the sector will require close attention to specific complexities such as integration and the application of technological interventions. Home Care providers will need both strategic planning and rapid response to market changes that are required to leverage the alignment of their businesses with customers' needs. These providers are aware of the shifting demands as a result of increasing ageing population where life expectancy is rising faster than healthy life expectancy. This has triggered an increase of organisations that offer a more integrated way of care, providing support and personalisation from different angles, including community engagement, prevention of health deterioration, reliability and continuity of care, and the development of a highly skilled care workforce. Home care and community support services are becoming increasingly interrelated, as well as links to healthcare systems and the used of technologies such as apps and digital platforms.

There is clear evidence that a rise in demand and changes in access to funding have influenced how users choose and pay for care. However, the emergence of these models, which in some cases have disrupted the market, could be further explained. It could be argued that this move is a response to important unmet needs: (1) personalised care services, (2) continuity of care by the same care worker, (3) choice of service and carer, (4) real time availability. Personalised care services is an unmet need that all emergent models offer in common. The traditional "time-and-task" model does not provide the level of personalisation required by customers. Similarly, the continuity of care enables an improved relationship between care workers and care recipients, particularly those with more complex health conditions. This relational continuity also enables a more effective work environment due to improved communication and trust, and consequently improved wellbeing outcomes. Many of these models have captured this need, and offer continuity of care with the same care worker or the same small group of care workers and other professionals. Furthermore, these models work with integrated electronic records that are shared with the care team and oftentimes with doctors and nurses, offering good continuity of information.

Choice is essential in living a more independent life and allows a care plan to be tailored to someone's needs. It must be genuine and the right guidance and listening skills are important to interpret the needs. Although "choice and control" is an overused term in social care, in reality care users rarely get to choose or if they do, the options offered might not fit their needs. The choice of carer and service is an unmet need that many emergent models are addressing. For example, the uberisation model gives a detailed description for both care workers and users to choose from. Similarly, clients can choose how many hours are required, and if they need a companionship service or respite service. Real time availability is another unmet need captured

by these business models. They achieve this by making full use of technologies such as apps, monitors and digital interactions with clients. Models such as the integrative one often include wearables that enable continuous connectivity and monitoring of clients health.

From the case studies, it can be observed that the major shifts in the emergent models are in relation to their value proposition, partnerships and customer segments. In fact, it could be argued that these models are an entirely new business model composition compared to the "time and task" model. The value proposition tends to focus on several dimensions of wellbeing, from health and physical to emotional, and psychological. They understand that customer base is becoming significantly more assertive in demanding services that prioritise quality of life, longevity and wellbeing.

Customer segments seem to exist in two separate groups. The first group is composed by self-funders and a mix of self-funders with direct payments. It could be argued that one of the underlying reasons for this group is the change of social care policy funding (direct payments) and the means tested assessment, which leaves a great number of people not eligible for government funding. Although customers typically engage with care providers as a result of a specific event, or rapid decline in health, they are much more inclined to look for choice, personalisation, availability and proximity of services, and are oftentimes not prepared to wait or not eligible the bureaucratic system from government provision. Another segment are the care workforce. This is not traditionally view as a customer segment by the traditional model. However, in both the uberisation and live-in model, care workers are viewed as a "customer" for the business. Because these models tend to offer high quality care, they also require highly skilled workforce, therefore the investment in training a support, as well as including the wellbeing of care workers is important.

The partnerships are another key component that is unique to these models. Whilst the traditional models works with other service providers in a tendering or transactional basis, both uberisation and live-in models have strong partnerships established with charities, counselling services, financial services and investors. This large network of partners provides access to complementary services, investments and specialist knowledge. Although they offer services nationally, they are strategic with the placement of their facilities, targeting areas of high demand.

Under the existing highly regulated Home Care market, where the traditional model of care is determined by someone's eligibility to receive funded care, many customers feel they lack choice, continuity, control and personalisation over the services being offered. New Home Care providers seem to capture these unmet needs and offer more suitable models. Potential changes that need to be anticipated is related to the pursuit of managing unintended demand and also transparency and good working relationships between commissioners and providers.

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REFERENCES

ALCOCK, P., MILLAR, R., HALL, K., LYON, F., NICHOLLS, A. & GABRIEL, M. 2012. Start up and growth: National Evaluation of the Social Enterprise Investment Fund (SEIF). Department of Health Policy Research Programme.

BOLTON, J. & TOWNSON, J. 2018. Messages on the future of domiciliary care services. Oxford Brookes University: Institute of Public Care.

BOWEN, M. 2017. Buurtzorg could work in the UK, but why must it fit into the existing system? *In:* BOWEN, M. (ed.).

CHRISTENSEN, K. & PILLING, D. 2017. *The Routledge Handbook of Social Care Work Around the World,* London, Routledge.

CONE, L. 2018. Domiciliary Care. *Mintel Report.*

DBEIS, D. F. B., ENERGY & INDUSTRIAL STRATEGY. 2017. *Building our Industrial Strategy* [Online]. https://www.gov.uk/government/consultations/building-our-industrial-strategy. [Accessed].

DH 2015a. Care Act first-phase reforms. *In:* HEALTH, D. O. (ed.). National Audit Office.

DH 2015b. Department of Health Report. 2010 to 2015 government policy: health and social care integration. http://bit.ly/1ezQX3Z.

DHSC 2006. Our Health, Our Care, Our Say: a new direction for community services. *White Paper.* Department of Health and Social Care.

DIXON-WOODS, M., AGARWAL, S., JONES, D., YOUNG, B. & SUTTON, A. 2005. Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy,* 10**,** 45-53.

HM 2017. Industrial Strategy: Building a Britain fit for the future. *White Paper.*

HOLMES, J. 2016. An Overview of the Domiciliary Care Market in the United Kingdom United Kingdom Homecare Association (UKHCA).

LARSEN, T., JAARSMA, T., STRÖMBERG, A., LANGHORNE, P., ALONSO, A., SANTANA, S., TUROLLA, A., LEE, A., JEPSEN, B. G., GASPARETTO, T. & SANDVEI, M. 2012. Integrated Homecare in Europe for elderly frail somatic patients – focusing on stroke, heart failure and COPD. *A Health Technology Assessment.*

OSTERWALDER, A. & PIGNEUR, Y. 2004. An Ontology for e-Business Models. *In:* CURRIE, W. (ed.) *"Value Creation from E-Business Models.* Butterworth-Heinemann.

OSTERWALDER, A. & PIGNEUR, Y. 2010. *Business model generation: a handbook for visionaries, game changers, and challengers,* Hoboken, N.J., John Wiley & Sons.

PENG, I. & YEANDLE, S. 2017. Eldercare policies in East Asia and Europe: mapping policy changes and variations and their implications. *UN Women.*

ROY, M. J., DONALDSON, C., BAKER, R. & KERR, S. 2012. The potential of social enterprise to enhance health and wellbeing: a model and systematic review. *Social Science & Medicine,* 123**,** 182-193.

SKILLSFORCARE. 2017. *The state of the adult social care sector and workforce in England* [Online]. http://www.skillsforcare.org.uk/Documents/NMDS-SC-and-intelligence/NMDS-SC/Analysis-pages/State-of-17/State-of-the-adult-social-care-sector-and-workforce-2017.pdf. [Accessed].

THEKINGSFUND. 2017. *What is social prescribing?* [Online]. Available: https://www.kingsfund.org.uk/publications/social-prescribing [Accessed].

VAN DEN HOONAARD, W. C. 2008. Theoretical sampling. *In:* GIVEN, L. M. (ed.) *The SAGE Encyclopedia of Qualitative Research Methods.* Thousand Oaks, California: Sage.

VAN SERVELLEN, G., FONGWA, M. & MOCKUS D'ERRICO, E. 2006. Continuity of care and quality care outcomes for people experiencing chronic conditions: A literature review. *Nursing & Health Sciences,* 8**,** 185-195.

WRY, T. & YORK, J. 2017. An Identity-Based Approach to Social Enterprise. *Academy of Management. The Academy of Management Review,* 42**,** 437.