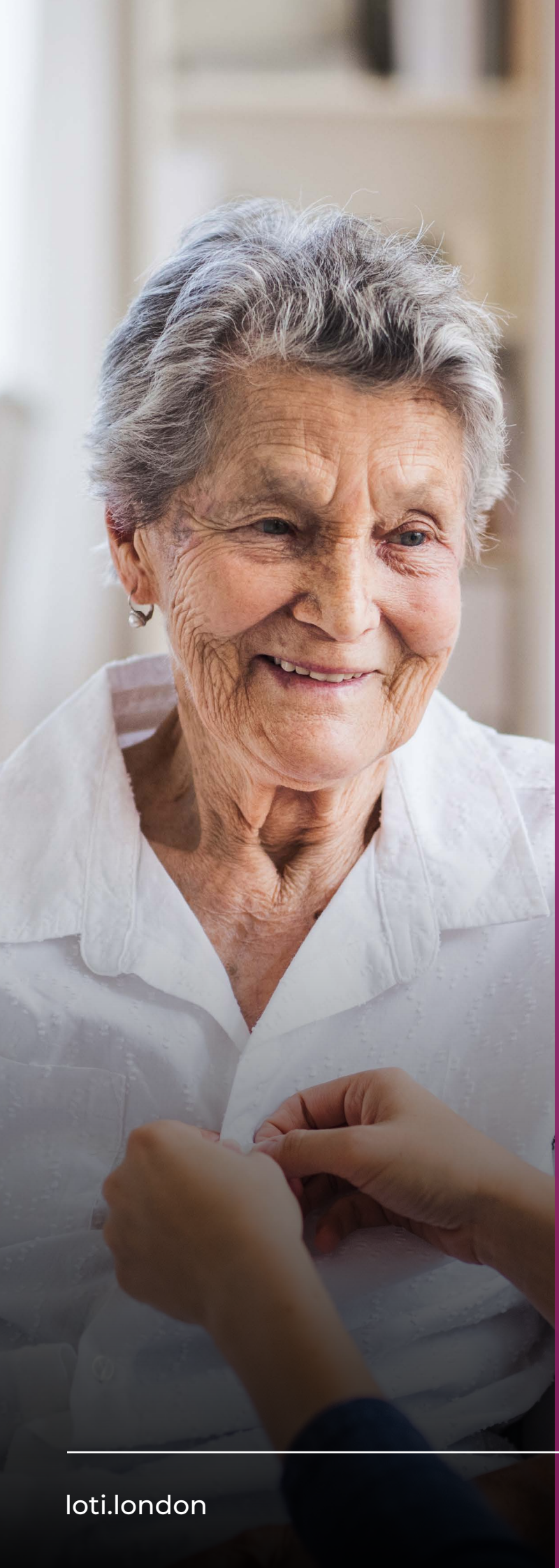

loti | PUBLIC

Innovation in Procurement Adult Social Care Deep Dive:

New Service Models and Innovation

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Executive summary

In December 2021, the government released a white paper setting out a 10-year vision for adult social care.[1]

The focus is on improving housing options, supporting carers, and promoting new technology and digitisation in the sector - with insufficient investments to meet the existing and emerging demographic pressures on the sector. With the workforce, demand pressures, impact of COVID - the pressures on local adult social care directors and teams to deliver quality care within the available budget are astonishing.

In this paper, LOTI and PUBLIC set out to learn from innovative models of social care delivery around the globe, to understand whether London Local Authorities can develop new approaches to delivering high quality adult social care. We found a wide variety of models that improve wellbeing, independence, costs. We also found a number of innovative approaches that helped to prevent or delay the need for care provision - which is important both for local authorities' budgets but is typically people's preference too[2].

PUBLIC has researched 53 bright-spots (see full list here) of innovation in social care internationally, and selected the 8 most relevant case studies for local authorities across 3 themes:

Wider social support models

Beveridge famously bemoaned the absence of the voluntary and community sector in the establishment of the welfare state in Britain. A growing body of evidence has pointed to the importance of social capital in independence, personal change and recovery from health shocks. A number of initiatives, often using new technologies, look to link older, frail people together with community resources to promote their wellbeing and resilience. These case studies show the potential benefits of focusing on community and preventative care in patient outcomes.

[1] Department of Health and Social Care. Ten year vision to improve adult social care, December 2021. Accessed at: https://www.gov.uk/government/news/ten-year-vision-to-improve-adult-social-care Richardson, P. Independence Well-being and Choice: Our vision for the future of social care for adults in England, Department of Health (United Kingdom), 2005.

Executive summary

New approaches to caring for people in their homes

We found that new approaches are enabling in-home care which is not only preferred by patients, but is cheaper for local authorities compared with care homes. These approaches can be further subdivided into technology-driven and co-operative models, both offering new ways of delivering high quality home-care, but with different focuses.

Homes that Care

We found models of residential care facilitating greater independence and quality of life.[3] The models we examined promoted a person-centred approach, including significant cost-savings and scalability with the Shared Lives Plus model.

We also arrive at a number of **cross-cutting themes** in the paper. These themes and insights, which have emerged from interviews with innovators, are not documented or searchable online - but are critical to local authorities seeking to commission or stimulate innovative approaches to social care.

We heard that **person-centred care** was the primary motivation of the innovators we spoke to, enabling fun, full lives where they could - but that the high-trust models that allowed this led to **changes in the way that performance and safeguarding were monitored and managed**. We saw that cultural or **business model innovation was more powerful and promising than tech**-based innovation - even if those innovators **used technology creatively** to deliver their innovative models. We heard evidence that **new models of care can attract a new pool of carers** in a similar way to the gig economy, adding to the workforce at a critical time for the sector.

For all innovative approaches, there were a number of common enablers: **good leadership** was critical, as was local government support, especially where integrated or **joined up**. And while improving social care innovation was seen unanimously as a or the pressing societal issue in **response to financial pressures** faced by governments globally, paradoxically most innovation outside of a health context, especially in the UK, has happened for **paying clients**. Which, combined, set out an implicit blueprint for Authorities looking to make the most of innovation in how adult social care is delivered.

This report is not intended to be technical but rather, to highlight the breadth of innovation across the adult social care sector both in the UK and internationally, share insight for commissioners and other innovations, and act as an aid to discussions among commissioners in London about how we can promote, pilot and practice innovative social care delivery for our residents.

[2] Department of Health and Social Care. Ten year vision to improve adult social care, December 2021. Accessed at: https://www.gov.uk/government/news/ten-year-vision-to-improve-adult-social-care

[3] Richardson, P. Independence Well-being and Choice: Our vision for the future of social care for adults in England, Department of Health (United Kingdom), 2005.

Our Approach

The research approach was structured into three distinct stages: desk research, selection of case studies, and stakeholder engagement. Research was approached through a global lens in order to reflect diverse and innovative approaches to the delivery of social care in different geographic settings.

1. Desk Research:

To establish a baseline understanding of the wider social care landscape and innovative social care models, the project began with a combination of desk research and mobilisation of PUBLIC's HealthTech network. Desk research included:

- **Geographic search:** Research included a multilingual search for innovative social care delivery across the USA, Europe, Africa, and the UK.
- **Thematic search:** Desk research and interviews with networked SMEs were conducted targeting different social care sectors, including adult social care, home care, mental health support, learning disability support, shared accommodation schemes, alternatives to institutional care, wider social support models, and COVID-19 Innovations.

2. Selection of Case Studies:

From desk research, PUBLIC consolidated and prioritised a list of 53 identified examples of social care innovation globally down to 8 key case studies to include in the final report. The selection process was based on mapped objectives of each innovative model across the different sectors of adult social care, as well as a high-level assessment of the:

- Diversity of innovative approaches
- Relevance to the challenges of ASC commissioners and the UK context
- Impact of the innovation model on end users
- Availability of evidence around impact of the model

The selected case studies were then analysed further with desk research, and grouped around three key sectors of Homes that Care; New Approaches to Caring for People in their Homes; and Wider Social Support Models.

Our Approach

3. Stakeholder Engagement:

PUBLIC reached out to different organisations to integrate their insights into the report. Eight stakeholder interviews were conducted to cross-reference and deepen our understanding of the innovation models.

Interviews covered topics including the organisation's inspiration and journey, innovation (technological and non-technological), problems faced and lessons learnt. These interviews were used to validate research and analyse the innovation and dynamics between commissioners, staff, users and leaders in greater depth.

Figure 1: the selected case studies

Wider Social Support Models

While medical schools and researchers now commonly reference Bio-Psycho-Social models of disease and recovery, the social element is often missing.

The Wagner Chronic Disease model and the House of Care, for example, both omit reference to people's social dynamics in recovery despite the growing evidence base that they matter.

Initiatives such as the Expert Patient Programme in the NHS found that by failing to address these, they had a model that worked well for people that didn't have challenging social situations, but that wasn't working for those that did. High profile projects that have worked well in the UK to improve people's reported health, wellbeing, and connection to others[4], such as HMR Circle, have focused carefully on fostering natural, strong relationships and social capital to support people in living resilient lives.

Receiving wider support, combating loneliness, and tapping into available resources are increasingly areas of focus in the social care space. Research across a number of health and social care domains supports this - for example, those suffering from mental health have better outcomes if they perceive their social support as strong.[5]

Some innovations have focused on technology to reach larger support networks than previously thought available. GENIE uses a digital platform that links patients with health and well-being activities as well as a wider support network. Its technology helps make connections that otherwise would be missed and allows for continued self-management of long-term conditions.

Other approaches have been focused on being even more proactive. As the private sector has become increasingly invested in corporate social responsibility there are more opportunities to leverage the sector to improve social care.[6] One way is through public-private partnerships like the NY COVID-19 Coalition to reach those who need care. Formed of 80 organisations, the Coalition was able to reach out proactively to those in greatest need during the COVID-19 pandemic in order to access services available in the community. Financed through philanthropic donations, the coalition was able to quickly and effectively respond in a crisis. It also leveraged private sector innovations such as CanDo's tech for seniors, UniteUs's dynamic referral technology, or SMS chatbot technology to link users to services. Excitingly, this coalition has grown and there is now a foundation for effective responses to future crises.

Finally, other innovators are focused on proactive care approaches relying on multidisciplinary approaches of a larger than average care team. In the Netherlands, U-PROFIT looks to preserve health by identifying and targeting seniors who need additional support to avoid costly trips to health facilities.

Using software applied to electronic medical records with an algorithm based on polypharmacy and frailty assessment of diagnoses, U-PROFIT identifies vulnerable seniors who then are supported by a multidisciplinary intervention program. It is a useful example of using technology to help identify areas of need but linked with in-person services.

[4] Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review. BMC Psychiatry. 2018 May 29;18(1):156. https://pubmed.ncbi.nlm.nih.gov/29843662/

[5] Effanga, B (2018) The Circle of Life: A Quantitative on Social Isolation in the Older Population accessed at: https://hmrcircle.org.uk/evidence

[6] International Finance Corporation. Corporate Social Responsibility: Private Self-Regulation is Not Enough. 2011. Accessed at: https://www.ifc.org/wps/wcm/connect/6078df23-a976-4c1d-abb7-a71c3bcbe678/PSO24.pdf?MOD=AJPERES&CVID=jtCxiKA

Wider Social Support Models

A. GENIE:

Organisation	
Innovation	A digital platform that helps patients (especially with long-term health conditions) to **identify wider support networks**, and link them with health & wellbeing communities to improve **care self-management** and tackle loneliness.
Cost	GENIE facilitated NHS **savings of c.£170 - £400 per user**, currently being assessed as a NIHR trial with 200 people in each arm. These savings are mainly derived from decreased use of NHS services such as hospital stays, A&E and GP appointments (Reeves et al, 2014; Blakeman et al. 2015, Welch et al. 2020). The cost per user is dependent on the salary level of the person helping to implement the tool. There are more savings to the system if the intervention is delivered by a Band 3 (£35 per patient) versus a Band 8 (£94 per patient).
Benefit	GENIE generates user involvement, improves patients' capacity to self-manage by widening their support networks, and reduces the inappropriate use of costly services. It has been applied in Southampton, Dorset, Isle of Wight and Ontario, Canada.

B. NYC COVID-19 Rapid Response Coalition

Organisation	
Innovation	Public-Private partnership that harnesses the power of private organisations to reach at-risk, underserved populations during COVID-19. It links vulnerable individuals to services and care using SMS, chatbots and other technologies to improve efficiencies.
Cost	Currently has an annual budget of $1 million USD. This budget is entirely made up of philanthropic donations.
Benefit	They follow a proactive approach, reaching out to vulnerable individuals who may not be aware of such services in their communities. It also reduces the burden for overwhelmed emergency services.

Wider Social Support Models

C. U-Profit

UMC Utrecht

Organisation	
Innovation	A **nurse-led intervention** for frail elderly people living at home. Its aim is to transition from reactive to proactive care, to preserve daily functioning, improve quality of care and health, and to reduce costs.
Cost	It involves an initial investment of approximately €131 additional per patient, but the overall ROI is positive. U-PROFIT patients cost on average between €6651-€6825 versus control patients' cost of €7601 (10-12.5% cost savings) across health and care combined.
Benefit	It combines a patient's wishes with best practices from a care giver's perspective. It leads to slower deterioration of health and independence, and fewer emergency visits than traditional care models.

New Approaches to Caring for People at Home in the UK

Another approach innovators have taken to avoid institutionalisation in residential settings is by meeting people's needs more effectively through home-care models.

CeraCare and North West Care Co-Op represent two different examples of this approach that have emerged in the last 5 years. In this space, there are two types of initiatives: technology-focused home-care start-ups like CeraCare, Elder or SuperCarers (which has now been bought by Home Instead); and community-based initiatives that seek a place-based model of supporting personal carers using co-operative and inclusive principles such as NW Care Co-Op, the Equal Care Co-Op, or BeCaring. These place a greater emphasis on either technology (Equal Care Co-Op), community involvement (NW Care Co-Op) or collective ownership (BeCaring).

Tech-driven organisations seek to combine operational management and onboarding software workflows with a start-up mentality of developing and selling a model of care that can be scaled quickly and repeated with a better offer than the rest of the market. The Co-Operative movement, however, looks to build strong relationships with local carers, and empower them with roles that involve decision-making about the direction of the organisation as well as how care is delivered.

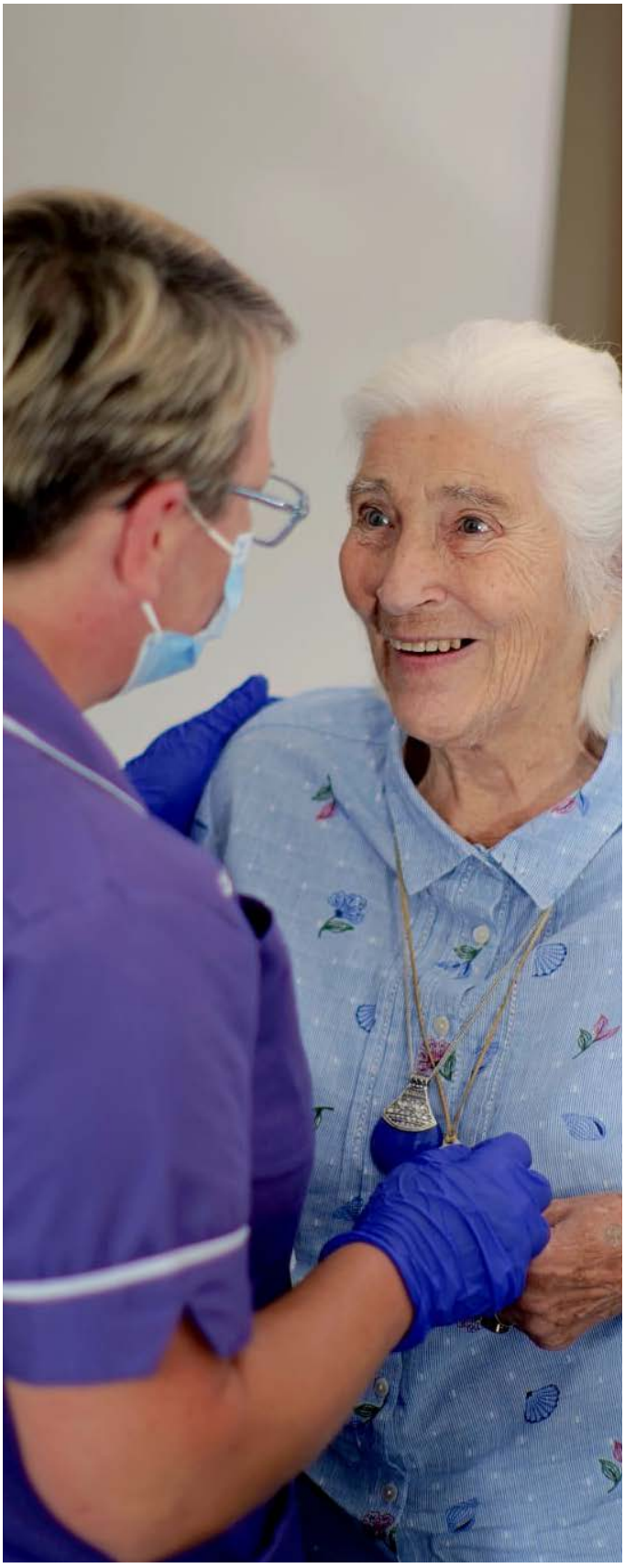
The teams are often driven by solving the same problems, and often use similar models of face-to-face support that differ from the traditional home-care market. Instead of 15 minute transactional visits, they encourage flexible care and stronger relationships between client and carer - including offering live-in care. This is usually easier for these organisations to deliver to the private market, but some such as the NW Care Co-op have forged alliances with local authorities; while others - BeCaring - have developed a range of services from hospital discharge and reablement to assisted living for people with learning disabilities that support this relational model of care.

There is a Cooperative Councils Innovation Network that has supported small grants to local authorities to promote cooperative models, which Kirklees, Plymouth and Tameside used in 2020 to develop approaches to stimulating co-operative care models in their areas.

New Approaches to Caring for People at Home in the UK

Both the tech-driven and co-operative organisations champion the virtues of person-centred care in their models, can point to some evidence of admission avoidance (homes or hospitals) and better relationships with carers, family and the community of their clients. Both point to their ability to recruit a different type of carer who wants more control over their hours and wants to build stronger relationships with those they care for with more flexibility and control. Both put a lot of effort into matching clients with the right carers for them - even if this is done algorithmically by one, and via face-to-face assessment by the other.

But both types have quite different motivations, behaviours and styles - and different relationships between their organisation and the carers they employ or connect with clients. The small care co-operatives can struggle to fit into the shape that the Care Quality Commission (CQC) expects. They do not have registered managers that are fundamentally responsible for elements such as safeguarding, but instead have distributed models of care which organisationally resemble supporting personal carers. Tech-based home care companies can more easily hire a registered manager and conform to that way of working. However, both still pose risks: both are decentralised, high-trust models of care that look and feel different to traditional care models.



Summary

Both co-operative and tech-based home-care companies are offering a new way of delivering high quality home-care models - and both justify a greater focus on generating evidence of their impact financially and on people. Local authorities have an opportunity to engage with them in order to redefine, shape and iterate how home-care is delivered. This offers hope not only in terms of keeping people in their homes with a better experience of care and more independence, but also in terms of avoiding care home admissions and promoting reablement in new ways - which may be more effective.

New Approaches to Caring for People in their Homes

D. North West Care Co-Operative

Organisation	
Innovation	It is a not-for-profit domiciliary care provider that is different from traditional services. North West Care Co-Operative's governing structure allows users to have a voice in their treatment models, providers to have more buy-in, and for cost-effective care to be delivered with a collective and collaborative ethos.
Cost	Not only are health outcomes better than traditional models, the services are consistently cheaper. Although no formal evaluation has yet taken place, the hourly costs per worker are approximately £18 versus the typical £19-£25 costs found in the market. Part of the explanation is that this model avoids shareholders which lowers cost and the need for high profit margins.
Benefit	Patients have control of their care and the system is set up in a way that allows them to quickly make changes. It also groups patients with similar needs so that best practices can be shared. Personal assistants grow to know patients and have strong relationships. They are given more independence than traditional models and provide tailored care.

E. Cera Care

Organisation	
Innovation	Recruiting professional carers to expand the pool of available help, providing innovative training methods including e-learning, apprenticeship opportunities, and university partnership programmes. Additionally, their digital platform replaces paperwork and uses machine learning to predict potential care needs.
Cost	Cera's model is more efficient than the home-care benchmark based on economic modelling they've conducted. Much of their savings is based on reduced health care utilisation, for example, their technology has reduced hospitalisations by 45%. Other savings revolve around reduced administrative burden and efficiencies.
Benefit	Patients benefit from access to more and better carers. Carers benefit from technology that helps ease the administrative burden as well as additional opportunities for career advancement through training programmes paired with universities. There are also better health outcomes as the collected data is analysed to flag issues and predict future ones.

Homes that care - escaping the problems of institutionalisation in residential settings

Of the 53 innovations, a number of them were on a mission to create alternatives ways to deliver residential or nursing care homes.

Innovators here saw residential and nursing homes as places to avoid or transform. In their view, traditional homes tended to be expensive, separate people from those that love and support them, and can slowly strip people of their activity and independence, subsequently leading to increased frailty, learned helplessness and associated declines.[7] Innovators also presented a concern that institutional settings made people more vulnerable to safeguarding risks.[8]

PUBLIC selected two cases - the Green House Project and Shared Lives Plus that have found ways to successfully deliver innovative, person-centred forms of residential care. This included caring for people with high care needs such as dementia.

Shared Lives Plus, based in the UK, has created innovative models premised around the belief that support in the home and community is vital in securing positive outcomes. Although home sharing traditionally has not been viewed as social care, Shared Lives Plus is changing that perception. Rather than residing in expensive institutions, those needing substantial help move into a carer's home after a careful matching process. While at home, personalised care can be provided in a place where everyone feels at ease.

Shared Lives Plus has expanded its services to include not just those who need significant care but those who remain independent but need a bit of extra help to remain so.

Those with a spare room, and looking for company, are matched with someone who wants an affordable, sociable place to live.

[7] Average care home costs are ~£800-900 per week in London, and cost Local Authorities £7.8bn annually National Audit Office. The adult social care market in England. March 2021. Accessed at: https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

[8] Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. Eur J Public Health. 2019 Feb 1;29(1):58-67. doi: 10.1093/eurpub/cky093. PMID: 29878101; PMCID: PMC6359898. Accessed at: https://www.nao.org.uk/wp-content/uploads/2021/03/The-adult-social-care-market-in-England.pdf

Homes that care - escaping the problems of institutionalisation in residential settings

This win-win scenario helps solve the increasingly intractable problem of affordable housing and allows those renting the space to remain independent and connected to the community. SharedLives Plus has demonstrated that a model revolving around facilitating mutual support, reducing isolation and person-centred support in the home and the community plays a key role in promoting quality of life and independence. Hence avoiding the problems, poor outcomes, and often high costs of either late intervention, or poorly designed institutional care. In addition to improving lives, it has led to demonstrable cost saving of £30,000 per annum for those with a disability.

The Green House Project across the USA has developed an interesting combination of estates, staffing and daily activity innovation designed to coach and lead small communities of vulnerable elderly residents to achieve a high quality of life.

It was interesting to note their focus on the little details of communal areas, private bathrooms and living areas to nudge elderly residents into feeling in control. An example, was the design of 'external' doorbells for each flat, to create a greater sense of privacy, or communal kitchens to support residents to cook for themselves. By combining the design, staffing and approach, they report being able to create a different experience focused on empowering residents safely rather than simply caring for them - which is born out in the studies conducted showing an improvement in well-being across a number of dimensions.

Homes that Care

F. Shared Lives Plus

Organisation	
Innovation	Shared Lives Plus coordinates national adult placement services. It focuses on a **personalised approach** to care, **community-based support**, and **building social capital** through new network opportunities.
Cost	This model costs approximately **£30,000** less per person per year than traditional care models with weekly costs for a Shared Lives client of around £650.[9] It is also scalable: in five years (2012-2017), Shared Lives **grew by 34%**, to support over 14,000 people across the UK.[10]
Benefit	This model can provide a **15% increase in day-to-day support** for patients. At the end of 2018, My Shared Life platform revealed 94% of patients felt more involved with their community, and 83% found it easier to have friends.[11]

G. The Green House Project

Organisation	
Innovation	Green House Project (GHP) has innovated around how care is delivered and how homes are designed to **replicate a "real home" experience** in its care homes. GHP commits to small homes, high quality and longer care-contact, and promoting deeper relationships between residents and care-givers in order to achieve a meaningful living experience for the elderly.
Cost	The operating costs are similar to other care homes in the USA. However, the GHP model **increases occupancy rates and revenues**. Green Houses (buildings) are architectured with lower capital costs.
Benefit	Green House residents reported **improvement in seven domains of quality of life** (privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, and individuality) and emotional wellbeing.

[9] Shared Lives Plus. Growing Shared Shared Lives and Homeshare: our consultancy offer. 2022. https://sharedlivesplus.org.uk/news-campaigns-and-jobs/growing-shared-lives/strategic-advice/

[10] Shared Lives Plus. Shared Lives in England Annual Report. 2018. Accessed at: https://sharedlivesplus.org.uk/wp-content/uploads/2019/04/Shared-Lives-in-England-2017-2018-Exec-summary.pdf

[11] Shared Lives Plus. Shared Lives in England Annual Report. 2018. Accessed at: https://sharedlivesplus.org.uk/wp-content/uploads/2019/04/Shared-Lives-in-England-2017-2018-Exec-summary.pdf

Findings: cross-cutting themes

Social care financial constraints demand innovative approaches.

Current financing levels are not meeting the needs of the social care sector. There are more people in need of care and less money available per person.[12] Unless new revenue streams are created, social care will have to become more efficient which often comes at the expense of quality. However, these innovations have shown ways to maintain or even improve quality of care while still having cost savings. Local authorities must look to implement new approaches or face cuts to social care services.

Those innovating and delivering care on new models were often motivated by a commitment to person-centred care.

Typically, both people who are being cared for and those who care for them, are empowered to make more decisions in these emerging models of care. The management approach is high-trust, allowing carers more flexibility to respond to people's needs - for example if a wheelchair user with learning disabilities wanted to go sky-diving that would be a legitimate goal for the carer to support them to achieve that. In a traditional care agency that might be laughed off quickly, with the carer worried about risk assessments, forms and what their manager would say.

These are often the moments the innovators celebrated and galvanised their care workers around to deliver high quality care.

[12] The King's Fund. A fork in the road: next steps for social care funding reform. 2018. Accessed at: https://www.kingsfund.org.uk/publications/fork-road-social-care-funding-reform

Findings: cross-cutting themes

...but the high-trust models that supported this led to issues demonstrating or managing performance.

As more freedom and autonomy is given to people, it can become harder to observe the productivity and performance of a care team. Often innovations are designed around addressing these issues. The Co-Operative model relies heavily on ethical principles and the strength of relationships between a local leader and each carer, typically using a coaching model. The tech-based model relies on algorithms and data collection as well as instant messaging and management support. U-PROFIT and Buurtzorg rely on a higher paid caring team that has professional nursing registrations and experience of decentralised, responsible care from other settings. We can imagine future models of care that authorities could bring about that combine the best of these different approaches to create sustainable and person-centred provision in their markets.

...and safeguarding

These models are attractive for people to work in and who use them because they are based on trust, decentralisation, and low levels of documentation or process. This helps shift from a time-and-task approach to a relational approach to care.

For the cooperative or ethically driven models, it is challenging for them to demonstrate that they are safe, but they argue that empowering their clients and supervising and coaching their staff with high levels of ethical standards keeps people safer than in traditional service - where there is less continuity of care, and people using services are not empowered to speak up or regularly contacted for feedback. For the tech-driven models, they often have an easier job of demonstrating safety, but may leave people open to greater risks as their level of supervision or understanding of each employee is weaker on a scaled, tech-based approach to managing carers.

Cultural, ethical and business model innovation was more important than technological innovation.

Lots of the innovation we've seen, and the models that work, are about finding ways to deliver care in a way that is more relational. We sought technology and business model innovation equally in our search and interviews, but the business model and cultural or ethical aspects of delivering care in different ways has come out as a very strong theme where the technology is only seen as an instrumental enabler and not yet central to the stories of innovation in social care in the UK and abroad.

Findings: cross-cutting themes

...however, successful innovators did not fear technology.

Those with successful models often looked at how technology could supplement traditional personal care; whether using algorithms to flag potential patients in need of care like Cera Care and U-PROFIT; or more efficient carer recruitment like Shared Lives Plus; or NY COVID-19 Coalition's use of dynamic referral technology platforms for coordination. They believe that the right technology tailored to social care can provide value if paired with the right in-person support. There will continue to be increasing opportunities for technology to play a role in this space but it must be used selectively and prudently. We also found that digital exclusion and digital poverty was a relatively straightforward challenge for tech-based innovators to overcome by carefully thinking about platforms, devices and how supplementary communication channels are used like phones or SMS.

New models of care create new, attractive roles for carers - increasing the total local workforce.

Across all the innovation categories, a consistent finding was that the greater flexibility in terms of shift patterns and how to care for people helped these organisations to attract staff in a way that traditional care providers struggled to. This offers hope to local authorities struggling with local workforce challenges, as they can pursue new models of care and staffing being confident that they will attract a new set of people to the workforce rather than competing for the same carers with existing providers. These new models often have higher retention rates as well so less time is spent on recruitment and more is spent caring for patients.

The new care models require good leadership.

A common feature of the cases that we explored was the need for good quality leadership to make the new care models work. Our finding is that the need for leadership goes beyond the requirement for business management, into the need to inspire and motivate your workforce in a different way - as the success of these models tend to be more reliant on the intrinsic motivations of carers, rather than to pursuit of reward or avoidance of admonition. This is both the strength of these models, as this is how to get the most from people - but also one of their key vulnerabilities as the quality of leadership may not be sustainable where these leadership roles are hard to recruit for or replace people in.

Sponsorship by local government was critical.

Nearly all social innovations relied on the government for financial support. However, the resourcing model is challenging. Leaders must address how governments support the right services for the right kind of people. This support may include procurement reforms that encourage innovative approaches. Yet challenges remain for local governments to balance care for different socio-economic classes in a just manner. Although means tests exist, they are often politically difficult as they are perceived as an added tax on the elderly. Yet, the government may need to be more creative about using luxury private sector services to supplement others' care. It may need to examine statutory public services as well.

Yet more than just financial support, innovators relied on local authorities' knowledge and expertise. In fact, there are organisations that work closely with councils to stimulate the community to initiate new care models and new market entrants. Community Catalysts (see case study) is an organisation that specialises in supporting local authorities to stimulate more micro-businesses and home-care providers in a local area as they have done successfully in Somerset.

These approaches can address some of the issues around sustainable leadership, and promote safety as local authorities can use the levers available to them to replace organisations that fold due to a leadership gap, or set standards (trading standards or via contracts) to promote people's safety in innovative ways.

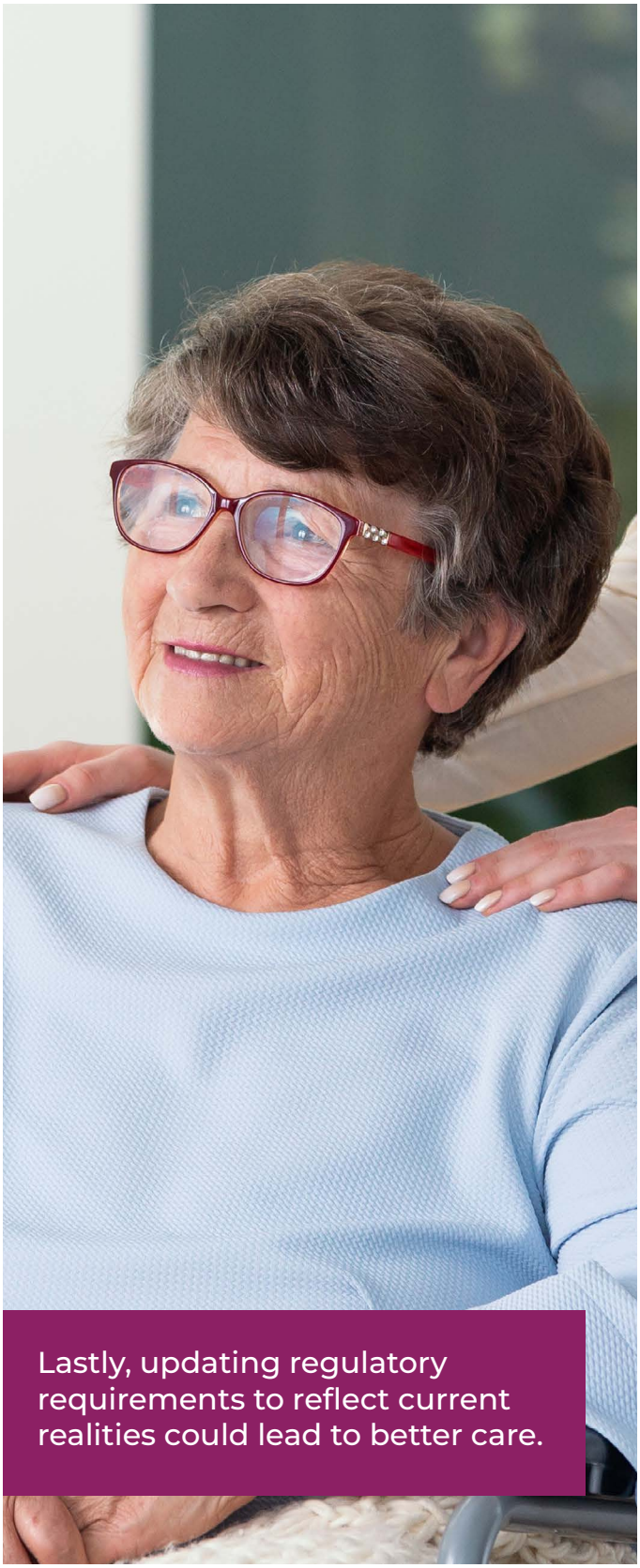
Findings: cross-cutting themes

Most innovation in care models were for paying clients.

We saw that while unit costs were often as good as or lower than traditional care models, most of the clients of these organisations and services were private, paying clients. We suspect that for home-care, this is because the new models and relational care provided didn't fit with how much local authorities typically spend on home-care services. We also suspect that authorities could find ways of supporting more people at home and avoiding residential care costs if they looked at how to commission these home-care services in different ways. There are many exceptions such as BeCaring, NW Care Co-Op and CeraCare that undertook a substantial proportion of council-funded care. Councils could look at models such as the Green House Project and Rand Aid Association that leveraged clients who had the capacity to spend more on their care and redistributed investment in care plans for people less able to pay.

Social Care innovation needs integrated government systems to thrive.

Currently, the social care system is convoluted and confusing with multiple systems and funding streams. For example, one provider, NW Care Co-operative has to coordinate six different payment systems in order to be reimbursed for services. Streamlining and simplifying the process would lead to fewer administrative tasks for care providers and more time caring for patients. There are also opportunities to have these innovators have better integration with existing systems in order to have better data sharing and improve preventative care options.



Lastly, updating regulatory requirements to reflect current realities could lead to better care.

Discussion and summary

With a rapidly ageing population and increasing budget pressures, the UK social care system is in need of innovation.

Reduced birth and death rates means more people requiring care and fewer to provide it.[13] By 2023/24, the Health Foundation has estimated that an extra £1.9 billion will be needed simply to meet demand for adult social care.[14]

Fortunately, we have shown that successful models currently exist and new innovations are being tested that will serve to improve efficiency and effectiveness of social care to help meet these future challenges if given an opportunity.

£1.9 billion

extra will be needed simply to meet demand for adult social care

105,000

vacancies advertised each day for care workers

New models of social care and innovations from around the world need to be harnessed and managed by commissioning teams to help address fundamental challenges around capacity and demand across the sector.

[13] Bloomfield, Peter and Ruiz de Villa, Cristina. Care Tech Landscape Review, December 2021

[14] Bottery, Simon and Ward Deborah. Social Care 360. May 2021.
Accessed at: https://www.kingsfund.org.uk/publications/social-care-360#what-needs-to-happen

Discussion and summary

Social care innovation comes in many forms. One area that is particularly exciting, is the development of new ways to support and upskill carers.

Carers are the backbone of the social care system and have been particularly challenged by the pandemic especially as many formal services closed.[15] They would benefit from better pay, training and development opportunities. Equipping carers to deal with challenges and empowering them to personalise care will ensure better health outcomes for patients. New models reveal better training, career advancement opportunities, and stronger bonds with patients facilitates better care. Carers no longer feel like a cog in a machine, but rather are professionals, trusted to make important and correct care decisions.

To ensure a sufficient pool of carers exists, new carers will have to be recruited and current ones retained. New models have excelled at finding carers in unexpected places, allowing part-time work with flexible hours to permit new entrants into the field, and ensure carers are treated with dignity, having more autonomy in their jobs. Existing carers are paid fairly, trained well, and valued to increase retention. Ultimately, a stronger carer community leads to people's needs being effectively met and a chance for personalised care. Without skilled carers, technological or methodological innovations will make no significant impact.

The innovations we have selected show that appropriate models and technology can help enable carers to be more efficient and provide the best care possible. It is important to reiterate that these innovations supplement carers, but do not replace them.

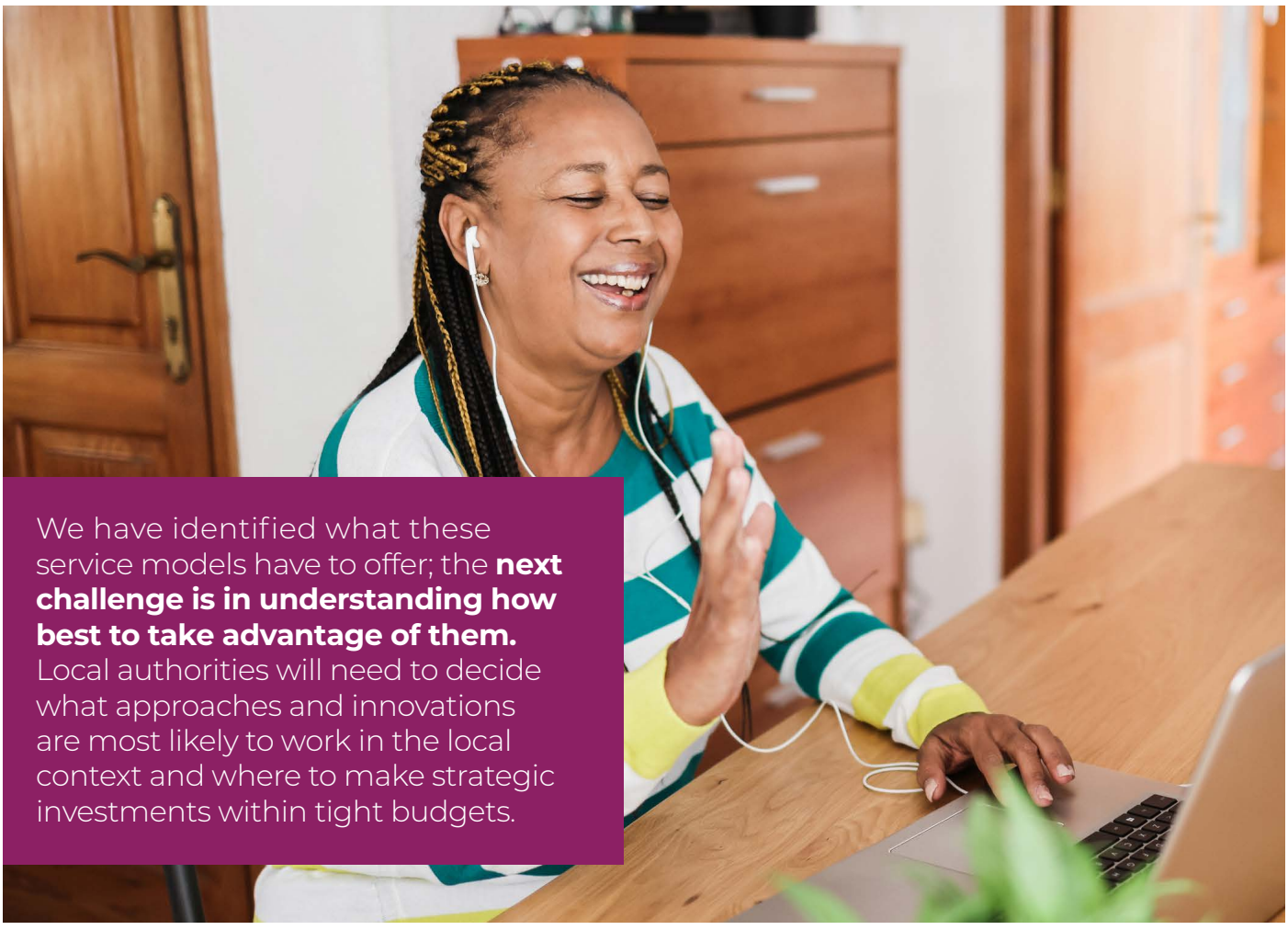
[15] Ibid.

Discussion and summary

The other challenge in social care is how to provide the best care in the face of budget shortfalls. These models have shown that significant cost savings are possible.

Preventative measures are the key to cost savings and these innovations demonstrate new possibilities for primary, secondary and tertiary interventions.[16] By preventing costly hospital visits and allowing patients to remain independent in their own homes, large cost savings are achieved. With the increased use of data monitoring and machine learning, technology will only improve the preventative measures that carers can take. The return on investment can be significant if local authorities can find the initial budget for it.

In general, local authorities have only just begun to develop ways to make the most of services that use these ways of working. And, although the UK social care market is dynamic, there are steps local authorities could take to promote new innovations and ensure easier entry for those trying to break into the space with novel social care solutions. Their convening, commissioning, and quality assurance powers over the market position them very well to do so. They can play an active role in supporting or developing local care providers; their commissioning power could be used to set broader, social value objectives; and some services may even need to be brought in-house to effectively manage service gaps.



We have identified what these service models have to offer; the **next challenge is in understanding how best to take advantage of them.** Local authorities will need to decide what approaches and innovations are most likely to work in the local context and where to make strategic investments within tight budgets.

[16] Levine S, Malone E, Lekiachvili A, Briss P. Health Care Industry Insights: Why the Use of Preventive Services Is Still Low. Prev Chronic Dis 2019;16:180625. Accessed at: https://www.cdc.gov/pcd/issues/2019/18_0625.htm

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About LOTI

The London Office of Technology and Innovation (LOTI) was established in July 2019 to help its members (currently 21 London boroughs, the Greater London Authority (GLA), and London Councils) to collaborate on projects that bring the best of digital and data innovation to improve public services and outcomes for Londoners.

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