Emergent homecare models are shaping care in England: an ethnographic study of four distinct homecare models

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Abstract

This paper addresses the grand challenge of an ageing society and the subsequent growing demand for in-home care for the elderly – often referred to as homecare. It examines how emergent homecare models in England differ from the 'time and task' model and how they are shaping the care market. These models offer new approaches regarding what, how, and when care is delivered at home. Homecare providers face rising demand driven not only by population ageing but also by market demand for personalised care, choice, continuity of care, and real time availability. The landscape presents an opportunity for innovative models to become established, by offering a more inducing service design and value propositions that respond to customers' needs. Using the 'Business Model Canvas' to guide data collection, this study presents an ethnographic case analysis of four homecare organizations with distinct emergent homecare models. The study includes 14 months of field observation and 33 in-depth interviews. It finds that providers are becoming increasingly aware of evolving customer needs, establishing models such as the 'Uberisation', 'Community-based', 'Live-in' and 'Preventative' described in the paper. These models are becoming more pervasive and are mostly market-driven, however, some of their innovations are market shaping. The major innovations are in their value propositions, partnership arrangements, and customer segments. Their value propositions focus on wellbeing outcomes, including choice and personalisation for care users; their workforces are perceived to be a major stakeholder segment, and their networks of partners offer access to complementary services, investments, and specialist knowledge.

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Introduction

Nine out of ten older adults prefer to live independently at home as opposed to residential care (UKHCA, 2019). Our ageing population is creating new demands for technologies, products, and services, including new homecare models. Homecare, sometimes termed domiciliary care, is a growing and vital employment and business sector in England that supports and assists individuals with health and care needs to manage activities of daily living that they cannot manage unaided. Growing demand for homecare is occurring in tandem with government policies to minimise social care costs, and maximise the utilisation of the care workforce (Charlesworth et al., 2018). The last decade has seen the birth of numerous organisations offering new ('emergent') models (for-profit and not-for-profit). These models offer diverse approaches to care provided at home ranging from unique different organising style (i.e. Community-based model) to the introduction of technologies to support care delivery (i.e. Preventative Model).

The UK Industrial Strategy is a long-term government plan to boost productivity and earnings in the UK by addressing a series of grand challenges (HM, 2017). It offers a recent example of a policy aiming to tackle the challenges of an ageing society. Focusing especially on the needs commonly experienced by older people for support with mobility, care, and housing, the strategy argues the need to ensure innovative models and new technologies, services and products are in place to address an ageing society grand challenge. Furthermore, it claims that innovation in age-related products and services can make a significant difference not only to UK productivity and the wellbeing of individuals but can also find a growing global market.

A new generation of innovative organisations, particularly in homecare and other aspects of social care, thus has the potential to thrive in an expanding market. The Care Act 2014 is a legislation that outlines local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. The Act focuses on personalisation, wellbeing, and prevention, and it can be seen as a driver for actors in the care market 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 been described by analysts as based predominantly on a 'time and task' model

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(Bottery, 2018), which prioritizes standardized procedures and amount of time spent on care over meeting the needs of individual people (NICE, 2015).

The impact of emergent homecare models is relatively unexplored in the academic literature. A few exceptions include Low et al. (2011) which evaluated the outcomes of case managed, consumer directed homecare and Sawyer (2005) that looked at commissioning and providing homecare on the basis of outcomes. In particular, very few analyses adopt a business model view, or examine how different components of organisations interrelate. This paper considers these issues to contribute to the grand challenge of an ageing society. The main research question is: how have emergent homecare models shaped the care market in England in the last decade? The paper's other objectives are to: (i) identify examples of emergent homecare models in England; and (ii) assess how these differ from the 'time and task' homecare model.

To understand these emergent homecare models, inspiration is drawn from scholars who have combined a business model perspective (Amit and Zott, 2010, Chesbrough, 2010, Osterwalder and Pigneur, 2010) with insights from market shaping concepts (Jaworski et al., 2000) as a way of generating theory (Nenonen et al., 2019). This approach enables us to understand if emergent homecare providers can act as market-shapers, how they generate value creation from their business models within a market, and how this impacts a larger system of relevant stakeholders within adult social care.

The paper is organised as follows. First, a market overview of the homecare market in England is presented, describing market shaping, and an overview of the time and task model. The next section describes the study methods, including principles of selection and the analytical framework adopted. The findings are then presented, with four types of emergent homecare models discussed, each using a case study example. The discussion and conclusions then consider how these new homecare business models differ from the time and task, how they have emerged, and their implications for the wider care market.

Homecare Market

Homecare is a subsector of the wider adult social care (ASC) sector in the UK, which involves the provision of services for personal care and practical assistance for people over 18 years old

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who need extra support. In England, the delivery of ASC services is the responsibility of local authorities (Gray and Birrell, 2013). Homecare refers to a range of care and support interventions delivered to people in their own home: domestic tasks, shopping, housework, personal care, social activities, rehabilitation, 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 and / or to prevent admission to residential care, or rehabilitative, for example following illness or injury (Bennett et al., 2008). Care and support are provided to people who need homecare in two main ways: through services provided in the care market (which comprises private, public and voluntary sectors), and through support offered by family members and friends (mostly unpaid). In 2017/18, the market research agency Mintel estimated that the market value of homecare in the UK had reached a 5-year high, at £85 billion. It claimed that informal care was continuing to account for the majority (78%) of its total market value in 2017/18, and was 'worth' £66.4 billion, much more than the care purchased by local authorities (£13.14 billion), offered by the independent sector (£2.3 billion) or the National Health Service (NHS), which is the government funded medical and health care services provided to everyone living in the UK (£3.15 billion) (Cone, 2018, HM, 2017).

The homecare market in England is highly fragmented on the supply side. The independent sector (commercial and not-for-profit employers supplying 78% of the workforce in 2018) delivers both state-funded and privately purchased care, with some care providers specialising in one funding model, and others a mix of both (SkillsForCare, 2019). The privately purchased homecare sector is expected to grow in real terms (as the population ages) and as the share of all homecare services delivered. This is due to tighter financial means testing of persons assessed as needing support by local authorities, and a greater awareness of the role of homecare as the preferred alternative to residential care (UKHCA, 2019). Most business activity in the independent sector is derived from local authorities, although the ability to win local authority business at a time when many social services departments are reducing the number of suppliers remains a critical barrier to market entry. Independent providers serving the state-funded market have experienced reductions in the prices local authorities will pay with impacts on profitability, with some struggling to survive in a high-cost, low-profit climate (Cone, 2018).

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There is a major trend for larger providers to move their business to the privately-funded market, which is seen as more buoyant with higher fees than state-funded care (LaingBuisson, 2020). In 2019, adult social care in England (all types) comprised around 18,500 organisations and a workforce of some 1.49 million people (SkillsForCare, 2019). Of these organisations, 9,100 were regulated providers of domiciliary care registered with the Care Quality Commission (CQC), the regulator for health and social care in England since April 2009. Possibly many more - around one third - are not registered (Holmes, 2016). Registered services must meet a common set of requirements that focus on safety and quality, with regulation intended to be proportionate and based on risk. Health and social care providers are audited under a set of compliance criteria. Homecare providers must vet homecare workers before engaging them by taking up references and carrying out Disclosure and Barring Service (DBS) checks on potential employees.

On the demand and purchasing side, homecare is either commissioned and paid for by local authorities, often (since the 2000s) via personal budgets (Yeandle and Stiell, 2007) or direct payments (introduced in 1997 for non-elderly disabled people and for older people from 2000) allocated to individuals following a care assessment; or privately purchased by individuals who pay for and arrange their own care, called self-funders (Bolton and Townson, 2018). More recently, care policy in England, under The Care Act (2014), aims to improve personalisation and puts local authorities on duty to fulfil social care outcomes. Thus, shifting discourses of accountability from the state to the individual can be observed by the introduction of direct payments. Direct payments are a funding choice in personal budgets that involve cash payments given to service users, and are intended to give users greater choice in their care (AgeUK, 2018). State funded care is arranged and provided in a care package based on an individual assessment by local authorities that commission it largely from their preferred providers (Glasby and Littlechild, 2016). People receiving direct payments will choose providers who they feel will best meet their individual needs, which makes them similar to self-funders. Homecare for older people in England is commissioned through local authorities working predominantly with independent providers of care. Commissioners operate in a market model, planning and procuring homecare services for local populations (Davies et al., 2020). Commissioning practice typically involves assessing local needs, overseeing procurement of services and developing service specifications as part of a competitive contracting process.

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There are 351,680 people receiving local authority purchased domiciliary care services in England, 156,155 receiving direct payments, and a further estimated 70,000 self-funded service users (UKHCA, 2019). The state-funded market is considered a quasi-market where budget-restricted public purchasers represent a diverse public and purchase services on their behalf from both non-profit and profit-seeking providers (Bode et al., 2011). This differs from a fully competitive market in its lack of effective competition among providers, high transaction costs, and weak incentives to act as representatives of users' needs.

The self-funded market is more likely to act as a traditional competitive marketplace, where consumers choose services that best meet their needs and expectations of quality, service and price. Here the relationship between service users and care providers can take the form of longer care visits, consistency of care workers and the ability to build relationships over time, highly trained care staff, and more specialised services (LaingBuisson, 2020). However, because homecare can be purchased in a time of crisis, assessing the quality of providers in advance can be a difficult task. People who use direct payments are likely to have similar expectations to those funding their own care with regards to quality and flexibility of services to meet their specific needs, even though their funding originates from the state. Combined with an increased demand for specific services, this has enabled the emergence of homecare providers that are better placed to meet these sorts of needs as they often have less of a reliance on a 'time and task' model that is often employed by those delivering state commissioned care packages (NICE, 2015).

Market Shaping

Organisations are continually scanning the market and responding to changes within their wider environment such as competitors, government policies, and consumer demands (Robinson and Simmons, 2018). Some organisations use market shaping strategies to create new business opportunities through a range of approaches such as niche construction (Santos and Eisenhardt, 2009, Luksha, 2008), shaping strategy (Gavetti et al., 2017) and value appropriation (Jacobides et al., 2006). Within adult social care, market shaping is defined as an "activity to understand your local market of care providers and stimulate a diverse range of care and support services to ensure that people and their carers have choice over how their needs are met and that they are able to achieve the things that are important to them. It is also about ensuring that the care

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market as a whole remains vibrant and stable" (DHSC, 2017). The Care Act (HMGovernment, 2014) and the statutory guidance on market shaping stipulates that local authorities' commissioning and procurement practices should take account of market shaping duties such as to facilitate a diverse, sustainable high-quality market (section 5) and ensures that no one goes without care if their provider's business fails (section 48 to 56). Therefore, the law makes local authorities the market shapers, but in practice care providers are also shaping the market through the choices they make. In other words, there are macro guidelines of the market but there is little to no guidance on the role of organisations with new models of homecare in driving or shaping the care market.

From a market orientation at a meso angle, organisations can be market-driven, or they can be driving (shaping) markets. Whilst market-driven refers to learning, understanding, and responding to stakeholder perceptions and behaviours within a given market structure, market driving entails shaping the market structure and/or behaviour of players in the market. From this perspective, markets can be shaped by organisations in three ways: (1) "eliminating players in a market (deconstruction approach), (2) building a new or modified set of players in a market (construction approach), and (3) changing the functions performed by players (functional modification approach)" (Jaworski et al., 2000, pg.45). This article approaches market shaping from this market orientation outlook which can be either market-driven or shaping markets. Thus, market shaping implies purposive actions by an organisation to change market characteristics by re-designing the content of exchange, and/or re-configuring the network of stakeholders involved, and/or re-forming the institutions that govern all stakeholders' behaviours in the market (Nenonen et al., 2019). From the analysis of each organisation's business model canvas, key components of each market orientation will be considered to understand if these organisations are in fact shaping the care market or simply being market-driven by current demands.

Time and Task homecare model in England

Homecare in England is often commissioned by local authorities using a time and task model, whereby services are delivered through care packages in short time slots and focus on completing personal care tasks. Homecare providers commissioned by local authorities can be for-profit, not-for-profit or charitable organisations. There is evidence from both service users

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and homecare workers that the demands of 'time and task' contracting by local authorities create unhelpful inflexibilities in the service. This approach can, for example, leave little time for homecare workers to talk to service users or to help them with additional activities they mention during the visit (Bennett et al., 2008).

The time and task model prioritises procedures (tasks) and the amount of time spent on care over meeting the needs of individual people. Under the Care Act 2014, local authorities have a statutory duty to 'shape' the care market and ensure that there are enough services of a sufficiently high quality to meet needs. An indication that this is not the case comes from the increasing wait for homecare packages for people ready to leave NHS hospitals (Bottery, 2018). Local authorities are suffering from budget pressures that directly influence the commissioning and provision of care. State-funded care is partially available (need and means tested) for people with higher dependency and needs, whilst low dependency individuals are having to rely more on alternative providers such as micro-providers, community catalysts or the self-funder market.

Methods

Purpose

The purpose of this paper is to investigate emergent homecare models in England, and to examine how these models are shaping the homecare market through their value propositions, value creation and value delivery. It is based on four case studies with homecare providers that represent the different emergent homecare models. These models derived from interviews with sector experts and a review of the literature (Dixon-Woods et al., 2005) of the homecare sector, which included both academic and grey literatures.

Case Selection

The review of homecare models included academic literature from Web of Science Core Collection and Scopus databases with focus on management, social sciences and social care peer-reviewed journals. Grey literature included Nexis database; government and think-tank reports; policy statements and papers; fact sheets and organisations relevant to social care such

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as SCIE, Skills for Care, Association of Directors of Adult Social Services, the Kings Fund, and UK Home Care Association.

The review of grey and academic literatures, together with interviews with sector experts (n=7 - homecare associations, regulators, commissioners and think tanks) produced an initial classification of emergent homecare models: (1) Uberisation; (2) Live-in; (3) Community-based; and (4) Preventative. From this, organisations were selected, invited and recruited to participate in the research project, using theoretical sampling (Van den Hoonaard, 2008) based on: type of business model; scope of their offering (only providers that operated solely in homecare for older people were included and those that operate in residential or nursing homes were excluded); and geographical location (based and operating in England).

Data collection

The Business Model Canvas (Osterwalder and Pigneur, 2010) was adopted as the analysis framework to investigate how these organisations create, deliver, and capture value and to understand how the current homecare market influenced the formation of these models. A business model is "the rationale of how an organisation creates, delivers, and captures value" (Osterwalder and Pigneur, 2010, pg.14). The 'business model canvas' is a template used for developing new business models and documenting existing ones. The canvas was adopted as the main analytical tool to examine the time and task and emergent homecare models found in the literature and through the case studies. The usefulness of the canvas stems from its explicative and predictive power in regard to the value created by a new venture (Amit and Zott, 2010). Thus, rather than debating the accuracy and efficiency of emergent homecare models (Doganova and Eyquem-Renault, 2009), this study examined the homecare providers by focusing on their value propositions and market orientation within the care market. The Business Model Canvas and its constituent categories were used to structure discussions with interviewees. These categories included: customer segments; value proposition; channels; customer relationships; revenue streams; key resources; key activities; key partnerships and cost structure (Osterwalder and Pigneur, 2010).

During the fieldwork, a focused ethnographic (Knoblauch, 2005) assessment was carried out with each homecare provider. Focused ethnography is a concept used to describe an

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ethnographic methodology based on limited fieldwork predicated on "data intensity" and "time intensity" rather than "experiential intensity" (Knoblauch, 2005). In other words, data was generated through focused engagements via short-term placements with each provider, observations of workforce training, and interviews with senior managers and CEOs. In this study, the objectives of the focused ethnographic research were to understand their working practices and value propositions, and explore the similarities and differences of their model to `time and task` homecare model. 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.

Data was collected during 14 months of field observation that included 33 interviews with businesses owners, managers and directors from four homecare providers, and pertinent document analysis over the same period. Interviews ranged from 40 to 75 minutes and placements were for 1-2 days. The placements offered a rich source of data and observational opportunities, enabling 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 is an ideal partner for applying the Business Model Canvas framework, fleshing out the findings based on observational data and details collected in interviews. Data sources for each organisation are summarised in Table 1.

_____Table 1 here_____

All scheduled interviews were digitally recorded and transcribed by a professional transcription service. Transcripts were uploaded into NVivo12 for coding and analysis using the Strategyzer Business Model Canvas platform (Strategyzer, 2020). Leaflets, guidance notes, website content and organisational documents provided by the participants' organisations were also collected and analysed. Copies of documents used in the analysis were kept electronically (hard copies were scanned) on an encrypted server at the author's institution.

Analysis

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Fieldwork data were coded in accordance with the predetermined categories in the Business Model canvas: customer segments; value proposition; channels; customer relationships; revenue streams; key resources; key activities; key partnerships and cost structure (Osterwalder and Pigneur, 2010, pg.20-40). A content-focused approach was followed and triangulated with observational data and documents, which provided clarification and further details for each canvas. Once data were sorted and coded, it was compiled using the Business Model Canvas mapping design tool, which produced an individual canvas for each provider.

Findings

Emergent homecare models

Emergent homecare models differ from the 'time and task model' in their value proposition, value delivery, and value capture. These new models have become more prominent in England since the 2000's likely due to an increase in demand combined with availability of direct payments. These organisations tend to be smaller, sometimes niche homecare providers, with value propositions that reflect current needs, mostly consisting of self-funded and direct payments users (Needham et al., 2017, Hall et al., 2019). These emergent models have a greater focus on personalisation, wellbeing, choice, and workforce development (Bottery, 2018, Low et al., 2011).

The review of the literatures shows that costs and consumer preference have driven a shift from the institutional care of older people to home and community-based care. Homecare 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 homecare 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 England 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 homecare needs within an ageing society. Homecare entrepreneurs who have developed a more specialised sector outlook have a tendency to adopt new business models based on wellbeing, technology and personalisation.

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As observed in the earlier literature review section, homecare in England has been traditionally provided by local authorities on a needs and means assessment basis, and a task approach to care. 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. The demand for personalised homecare services has grown considerably and the independent sector has followed this trend with emergent models, some of which are summarised in the table below. The next section will elaborate on each of these emergent models, followed by a case study example where key emergent features are highlighted.

_____Table 2 here_____

Uberisation model

"Uberisation" has become shorthand for any business model that cost-effectively leverages underutilised assets to completely disrupt an existing ecosystem. This trend can be seen in homecare in England. There have been many studies that highlight the precariousness of this type of model, particularly related to fluctuations in working time, pay levels, and overall vulnerable working conditions (HMGovernment, 2018, Corujo, 2017). The model involves gig economy care platforms and agency-type providers that have a database of homecare workers and match these to service users' specific requirements. The homecare workers are self-employed, and the database holds their detailed profile (specific skills, training, experience, languages, cultural background, etc.). Within this model, the homecare worker is expected to take on certain responsibilities such as paying tax on earnings, and determining their own salary, pension and liability insurance. These platforms do not provide services directly and are not regulated by the CQC, but aim to offer better value for money for service users. In the Uberisation model, all unused capacity or idle homecare workers are integrated into a service aggregator platform, which has an algorithm that continually matches homecare workers with care recipients' requirements. The model integrates these requirements to ensure well-matched options are available for both sides; the agencies' job is thus to provide the platform.

Implementation of the Uberisation model has some challenges. First, although care workers are self-employed, they need to be vetted to ensure their qualifications and working status are appropriate for the work. Second, the agency providing the platform requires phone or face-to-

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face communication with service users, as it can be difficult to capture detailed information on their service needs online. Third, some homecare workers joining the platform have previously worked for traditional homecare providers as employees, and therefore they require support in setting up as self-employed.

While there are implementation challenges, the Uberisation model offers not only enhanced utilisation of resources and lower operational complexity and costs but it is also direct and disruptive. First, it allows care recipients and homecare workers to connect directly with one another. Second, it attracts new entrants to the market (homecare workers looking for work flexibility, and care recipients looking for personalisation and choice). Any homecare provider organisation using cheaper operations and successfully demonstrating its capabilities may also set off the next disruptive phase of the care ecosystem. As uberisation picks up, service users (care recipients) and service providers (homecare workers) could reap benefits and gains (value-added services) from the streamlined platforms the agencies offer. However, challenges around work conditions, employment protection, wages and irregular hours remain seen as increased risks for workers in gig economy care settings (Flanagan, 2019, Prassl, 2018, Stewart and Stanford, 2017, Macdonald, 2021).

Case Study: Uberisation model

This case study investigated an introductory agency, which offers a matching platform for care users and homecare workers. The owners perceive their organisation as a social business that seeks profit as a financial return to shareholders but they argue that they take their role in society and the social return for care recipients, their families, and homecare workers very seriously. Their business is not eligible to be regulated by the CQC but uses an independent auditing and quality assessment system. Key aspects of the business that differ from the time and task model are summarised in the quote below. The minimum time for homecare visits is one hour and their homecare services vary from companionship to more complex cases. Customer and main stakeholder segments are divided into three groups: (1) elderly care recipients who are either self-funders or in receipt of a local authority direct payment; (2) care recipients' families, usually represented by a son, daughter, spouse or friend; and (3) care workers.

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> *"One customer segment is the care recipient and how do we improve the world being involved with older people. Second is families, how do we improve the mental health of their families…many of whom are very stressed and anxious when thinking of care. And care workers and how do we improve their livelihoods."* Founder, case study 1.

The main value proposition discussed by all interviewees was choice (as summarised in the quote below). Choice for the care user (who is empowered to choose from a range of homecare workers in a timely fashion), and for homecare workers (who get to choose and bid for jobs with the best fit with their skills, location and availability). Another proposition is cost-saving; care users contract directly with the homecare worker, who is payed directly and earns the vast majority of what the client pays (the agency only receives a small percentage fee). There is also a focus on improving the livelihood of homecare workers and formalising an informal economy.

> *"Number one value is the fact that a client can exercise choice, and so rather than working with an agency where infrequently you have a choice of carer, as a consumer we believe that… I believe that most people want to choose their care worker, and it's not about the organisation you are working with it's about the carer, so you care about Jesse who looks after your mum. The second part of that choice, you can't simply give people choice without giving them the architecture to support it, so how do you know that Jesse has a right to work, a criminal record that's been checked, identity that's been checked, the schools and qualifications that she says she has, references that back up the fact she is to be trusted? So we, I, believe that what we are doing is formalising an informal economy that pre-existed us, whereas if we were to talk to consumers what they wanted for their parents, most would say I want a direct relationship with the carer."* Manager, case study 1.

Their value proposition of offering choice of services, flexibility and choice of rates has been confirmed during observations of the homecare workers' orientation (induction). Most of them had worked for 'time and task' type of providers before joining the agency. Homecare workers expressed the importance of developing an understanding of the service users' needs which, according to their views, cannot be achieved in short visits (e.g. 15 min visits). They also celebrated the fact that they could choose their work location, the hours they work and the kind of services they offered to best matched their experience.

Managed live-in model

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Managed live-in care businesses are independent organisations that provide homecare services through a bank of skilled staff vetted and employed by them. A fully managed live-in care service will employ, train, and supervise its homecare workers directly. Recruitment includes values-based interviews, reference checks, and background and criminal records checks. They provide ongoing training and take complete responsibility for the management of the live-in care service, rather than this being the responsibility of the service user. These organisations are regulated and regularly assessed by the CQC, and must meet national minimum standards and regulations in areas such as training and record keeping. A main benefit for the service user is the continuity of care and 24-hour access to a call service managed by a care management team.

The organisation matches a homecare worker to the service user. Unlike the Uberisation model, service users do not choose the homecare worker. They are allocated to them based on the users needs and personal preferences. The organisation provides its services through a highly-trained team of homecare workers, so service users may not always have the same person visiting their home. These organisations usually specialise in particular types of care that tend to involve more intensive care provision.

Case Study: Live-in model

This case study is a live-in care provider that offers live-in care support primarily for older people with dementia or other complex conditions such as Parkinson, multiple sclerosis (MS), stroke, palliative, and cancer. The company offers a pair of homecare workers to each client, as continuity is seen as a very important aspect of caring for people with such conditions. This organisation is strongly focused on the recruitment and training of its homecare workforce and uses a pioneering approach to dementia care at home. It also holds the highest CQC ranking (outstanding), which typically translates into high quality service.

Similar to the Uberisation model, homecare workers are perceived as an exceedingly valuable stakeholder segment for this model. Homecare workers are required to be highly skilled and to have a deep understanding of how to care for complex conditions. They are hired and trained based on values, as described in the quote below.

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> *"We spend a lot of time recruiting the right carers with the right values…we have to get somebody who can pretty well do the job from day one. They can shadow another carer so they can understand how we do things within our organisation, but they've got to be able to think for themselves, they've got to be self-managed, they've got to be self-motivated they got to be right in terms of wanting to be a carer and that's probably the hardest thing to find. So we only employ about 4% of those people that apply to work for us, so it's a very small, so it's very hard to recruit people in care, it's probably the biggest challenge that all care providers face."* Business Development Manager, case study 2.

This model differs from an hourly homecare model, as the homecare worker lives with the care recipient for extended periods of time. Their approach is to train homecare workers to interact with clients by talking rather than through medication; an innovative specialist training that is provided at orientation. There is thus a focus on communication and service users' wellbeing; this differs from many traditional homecare and care home settings, where conditions such as dementia are treated with medication to keep people docile, quiet, and well-behaved (Almutairi et al., 2018). Homecare workers are also provided with and use Chromebooks to record their care plans and notes, and for use as a forum for peer-to-peer support with other homecare workers from the same employer.

Another aspect of this model is the strength and value placed on partnerships. The business has close partnerships with relevant national charities (which provide specialist training for care workers) and exclusive resources, as summarised in the quote below. They also have partnerships with hourly homecare providers for service users that do not require 24h care. Partnerships with financial advisors and solicitors for the elderly are also part of their network. Their customer relationship includes advice and expertise in care planning, costs and financing, as well as support for families around care options and wellbeing.

> *"We are partners with the charity A and they are very much specialists in dementia care and they would have…an admiral nurse is a specialist dementia nurse with knowledge of every type of dementia… we have an admiral nurse working specifically for us… So the fact we've got someone we can call upon internally means that our clients have the advantage of that exclusive resource."* Marketing Manager, case study 2.

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The partnership element was quite visible during the observation of a homecare workers training session. Trainers and assessors from specialist charities were involved in delivering the framework that they use to promote communication with service users that have dementia. During the interactive classes, the trainers explained the condition in-depth, and provided tools to promote the wellbeing of both service users and homecare workers. One day there was a lunch with the CEO, where homecare workers were invited to bring any issues, concerns or activities that were working well within the organisation. By observing this activity, it was quite evident that this method worked well and issues were tasked and mitigated during the meeting. Homecare workers expressed their gratitude for being provided with a peer-to-peer support platform as they could share learnings from their experiences of looking after complex cases and feel connected.

Community-based model

Community based models include self-managed 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 and has recently been adopted and adapted by some providers in England. Buurtzorg (or "neighbourhood care") enables continuity and relationship-based care as well as efficiencies from reduced travel time. Originally consisting of a team of nurses, in England and other countries the model has been adopted by the care sector and homecare workers, working in the local community and getting to know local general practitioners, therapists and other health professionals. It involves a small team (no more than 12 homecare workers) who manage their own workload and scheduling, taking care of people who need support in their homes. The team decides how they organise their work, how they share responsibilities, and they make decisions about individual cases as a team. The model differs from an isolated and fragmented, task-oriented approach. The Community based model focuses on team working, autonomy, and relationship-based and person-centred care for service users. As observed in the case study, this approach tends to lead to improved working environments as well as efficiencies in travel and overhead.

Case study: Community-based model

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The case study is a community-based organisation that works as small self-managed teams of homecare workers. Each team is composed of up to eight homecare workers, and care is based on a support sequence co-designed with the person receiving care. This sequence is repeated often to ensure that people are able to live well at home and are connected to their community. The teams design an ideal week for the care recipient, where visits have an scheduled time but are not monitored; rather, homecare workers are trusted to get the job done. Instead of following a list of set tasks on each visit, they are outcomes-focused; each worker has the autonomy to make decisions and explore a range of options to achieve the desired outcome, as illustrated in the quote below.

> *"We focus on outcomes for the people we employ and the team, and there's outcomes for the people we support as well…so looking at employees, we provide a salary and not hourly rates, bespoke training, and shadowing a specialist. For the people we support, our initial conversations we'll ask things like 'what's a good day for you?'…that differs in the time and task model where someone would do an assessment and say, 'What can't you do?' and not what makes you happy and fulfilled, so the aim is to give you more of those good days. So, we'll find out what a good day for them is like today, and our aim is to try and help them have more of those good days".* Co-founder, case study 3.

Besides the strong commitment to service users' wellbeing outcomes, this model has a values-based approach to recruiting homecare workers and does not require previous work experience but the right values, attitudes, and mind-set. As the teams are self-managed, they work with confirmation practices rather than conventional performance management goals. Confirmation practices are a set of statements that help with accountability via reflective practice and are done individually and as part of the team. In developing these routines and reflecting on these statements, it becomes easier to clarify what success looks like, the barriers getting in their way, and what action should be taken to overcome these barriers. The process works as a mechanism for shared sense-making that goes beyond the narrow view that specifications, targets, and objectives offer. The model encourages people to use their peripheral vision, to surface their uncertainties early and often, and to offer each other constructive challenge along the way.

> *"We only use value-based recruitment…do we think that they would thrive in a self-managing environment where this would be the norm? We use confirmation practice as a normal part of management. So, the confirmation practices replace line management and they (care workers)*

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are using confirmation practices in pairs before weekly team meeting. For each role there is a progress document, a self-assessment that each team member uses to understand their progress against the key elements of their role. We used this to determine confirmation statements, so that they reflect the essence of the role." Founder, case study 3.

Workforce recruitment and retention are one of the biggest challenges in the care sector (SkillsforCare, 2020). By emphasising values recruitment and promoting resilience and autonomy within homecare workers, this model also reflects a better retention rate, as expressed in the quote below.

"We have less than 4% turnover. That's pretty remarkable in a sector where the average is over 40%...I think that's a reflection on our outcome type of model, our values-based recruitment, the autonomy and support for our workers." Care Manager, case study 3.

Preventative model

Emergent homecare models include innovative ways of delivering care and most will also include technologies. Keeping up with changing technology is vital, but it is just as important to evolve the consumer experience, care delivery methods and career development opportunities for the workforce. Preventative homecare makes use of technologies such as predictive analytics, machine learning, and digital monitoring systems to make risk assessments and design care plans that predict and prevent more complex care required in the near future, such as predicting unplanned hospital admissions.

The main aim of this kind of model is to provide more years to service users that are spent independently or with low dependency, and to compress functional decline (Gore et al., 2018). By anticipating which service users are transitioning to their intense years of care, it is possible to offer more personalised care and also maximise intense care savings. By promoting healthy living and focusing on prevention, service users with low or moderate care needs can experience better independence and improved wellbeing.

Case Study: Preventative model

The case study is a homecare provider with a strong focus on personalised care, providing relationship-led services for people interested in lifestyle support, complimentary healthcare,

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or companionship services. Services range from support with social activities, companionship and respite to more intense homecare services and live-in care. Its unique selling point is remote health monitoring, as summarised in the quote below. Additionally, the organisation works completely digitally with an app that offers real time updates so that loved ones can communicate with care recipients to provide reassurance of their wellbeing status.

> *"We work on the technology that provides real time updates to the family members, open lines of communication with people who…might be a neighbour, it might be a friend. You can get a snapshot. How's the client's mood? Anything to be concerned about? Any changing conditions? Is there any pressure sores? We have connectivity that monitors the vital signs, the motion and the activity of the clients within the home. So, we can push that data to GPs, hospitals…is this person likely to have a fall? A typical day is this and it's analytical and it's all movement, heart rates, oxygen levels, things like that we can monitor. Something's not right and we can send alerts out to the family members and all the loved ones but also, we can get access to that at real time and then we can say, 'Right, we're going to come because we think you've got a risk of fall or you've not drank enough or you've got a risk of infection'. We can basically prevent the person from becoming ill. Also behaviour…so if the kettle hasn't gone on by 9 o'clock and Mary has a cup of tea at 9 o'clock every morning, we receive an alert. Someone needs to know. But it might be fine. It might have gone on at ten past nine, its fine but if at 10 o'clock and it hasn't gone on, we'll investigate."* Founder, case study 4.

Similar to other emergent models, key resources and strong partnerships allow the organisation to build meaningful person-centred, flexible, and bespoke services that meet clients' needs and desired outcomes. In this case, having a nurse that evaluates the health monitoring of clients is a major asset for the business, as exemplified in the following quote.

> *"We have got a nurse…to monitor and set the tolerance levels so that if it's between three and ten it's okay, but if it's 15 that's a problem…we keep that information flowing and sharing that with health professionals, GPs, social workers. Whoever needs to know in a safe manner, we share that information so that we are all working together to keep that person in their home and out of hospital… we provide all of that sort Apps, so it's focusing on the diets it's focusing on exercise what he can do, he's very frail but let's strengthen him up. Mental stimulation. He's very clever, so let's look at some, like Sudoku or some games just the lifestyle, really making sure that within the care plan there's a good dietary plan, exercise and wellbeing plan."* Care manager, case study 4.

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Similar to the Community-based model and live-in care, another key feature in this model is that it recruits and retains staff with the right values, as noted in the following quote:

> *"We prefer people to have no experience and no qualifications because we can give all that. We can train all that and get them to understand what we're about and what good is. They might bring some bad habits and they may have worked for a company that does 15 minute drop-ins and I don't want that. Because we're minimum one hour and we're about building that relationship with the client and the family. So, if they're used to not taking their coat off, having a cup of tea with the client and asking them 'How are you today?' If they're in a habit of not doing that for 20 years I'm going to struggle to get them to do that…so really we want someone with the attitude of learning and developing and taking on our training rather than performing tasks."* Care manager, case study 4.

Observations of their homecare workers' orientation and also document analysis of the organisation's mission, values, and recruitment adverts highlighted the importance of hiring homecare workers with values that match the organisation's proposition. Furthermore, as the organisation is paperless and works with various communication technologies and monitoring systems, the workforce is required to be tech savvy.

Discussion

This paper has investigated emergent homecare models in England, how these differ from a time and task model, and some of the ways in which these are shaping the care market. Over the last decade, there has been a constant increase in demand for homecare services, and a strong trend of people choosing to stay at home and live independently for as long as possible (UKHCA, 2019). Furthermore, the advent of technology has accelerated a paradigm shift to more personalised, holistic, and preventative care. Users expectations have increased to have a more bespoke and personalised approach to their care needs. Although the national policy agenda and government statements call for a more personalised care and outcomes-based approach to care, the system is lagging in delivery of these expectations. On a practical level, most homecare commissioned by local authorities is still delivered on a time and task model. Innovative models appear to offer a closer match to users' needs and expectations.

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Results of the literature review and interviews highlighted four types of emergent business models in the homecare landscape in England: the Uberisation model, Live-in model, Community-based model and Preventative model. Similar to previous research (Low et al., 2011, Bottery, 2018) these models have shifted the terminology and focus from care to wellbeing, personalisation, and choice. Furthermore, they focus on prevention, workforce development, and values. This more value-based care system in the sector will require close attention to specific complexities such as health and social care integration and the application of technological interventions. Homecare 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. The providers included in the study are aware of shifting demands as a result of the ageing population, with life expectancy rising faster than healthy life expectancy. This has triggered an increase in the number of organisations that offer a more integrated form 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. Homecare and community support services are becoming increasingly interrelated, with links to healthcare systems and the use of technologies such as apps and digital platforms.

There is evidence that a rise in demand and changes in access to funding have influenced how users choose and pay for care (Bolton and Townson, 2018). It could be argued that this development 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, and (4) real time availability. Personalised care service is a response to 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.

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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 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 the 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 of 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 tighter means tested assessment, which leaves a great number of people ineligible 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 often unprepared to wait or ineligible in the bureaucratic system of government provision. Another segment is the care workforce. This is not traditionally viewed as a customer segment in the traditional model. However, in the Uberisation model, care workers are viewed as "customers" for the business. Because this model tends to offer greater flexibility of care arrangements, they also require an

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experienced workforce, therefore the investment in selecting and supporting skilled care workers is important.

The partnerships are another key component unique to these models. Whilst the traditional models works with other service providers in a tendering or transactional basis, the 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.

Market Implications

These models have several implications for policy and the care market. An outcome-focused rather than task-centred approach makes the market more flexible and responsive. Commissioning for outcomes enables providers to use their resources in a more efficient way and to target them at times when they make the biggest impact on individuals' needs. Whilst in a time and task approach there is little flexibility to a given care plan, emergent models offer flexible arrangements and a more efficient deployment of the workforce, enabling service users to make more informed decisions. The difficulty that exists is that time and task tend to be easier to standardise and to measure by identifying a unique cost per hour. Outcomes can be more difficult to standardise and measure, particularly when the system and organisational culture is based on tasks.

From a market orientation angle (Nenonen et al., 2019), it can be said that these homecare providers are mostly market driven rather than shaping the care market. However, it is important to keep in mind that a given organization can both shape markets and be market driven. Some of these models are becoming more prominent in England and aspects of their business models such as personalisation and the intense use of technologies are driving the homecare market. They have introduced innovations (in technology, services, resources, and the like) that not only benefit themselves but also fundamentally transform the business context for the care market. For example, outcomes based commissioning (Edmiston and Nicholls, 2017, Davies et al., 2020) and values-based recruitment (Rubery, 2011) are becoming more commonly used in the

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care sector. These innovative approaches are introducing a new dynamic into the co-evolution of homecare and the care market more broadly.

Partnerships also have implications in the market. In the emergent models, partnerships with services can add value and offer a more holistic care arrangement, enhancing the quality and experience of the person using the services. In state-funded care, partnerships are not incentivised, as they are seen as subcontracting. There are often elements in contracts with local authorities that prevent subcontracting, thus control, risk management and accountability are much stricter, preventing networks from developing and growing.

The case studies demonstrated that having care workers as a customer segment leads to more opportunities for workforce development, and better professionalization leads to better care, more fulfilled care workers, and consequently lower turnover. For service users, having more fulfilled care workers translates into an assurance that standards are high and consistent, whilst for providers there is improved retention, motivation, and performance because the workforce feels valued. As there is a steep undersupply of care workers (SkillsforCare, 2020), making care a highly attractive sector to work in is becoming critical for the sustainability of the sector.

Conclusion

Overall, under the existing highly fragmented homecare 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. Emergent homecare providers seem to capture some of these unmet needs and offer more suitable models. It is clear that these models have quickly learned, understood, and responded to customers' demands, introducing innovations within their value propositions, their workforce recruitment and training, and their development of strong partnerships. Whilst most traditional models have a dependency on the system, these emergent models have a dependency on participation and collaborations. Partnerships were linked in the discourse with collaborations that presented a focus on outcomes, problem-solving, and developing holistic services. They have not eliminated other providers or changed their functions, therefore did not directly reshape the market, but they did introduce or redesign their delivery models, which is observed by the whole market. Potential changes that need to be anticipated are related to the pursuit of managing

unintended demand and also transparency and good working relationships between commissioners and providers.

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Table 1 – Data Collection

	Interviews	*Observations*	*Documents*
Homecare Sector Expert Interviews	7 interviews with social care and homecare sector experts, including national associations, regulators, commissioners and think tanks	Care England Conference (London) November 2018 Professional Care Workers Day (London) September 2019	
Case study 1: Uberisation model	8 interviews, including CEO, directors, and managers 2 focus groups discussions on organizational innovation	2 Short-term placements (1-2 days) allowed the observation of business practices; homecare workers' orientation & training; informal conversations, field notes	From digital platforms, including their website: brochures, information sheets, blogs, and job descriptions.
Case study 2: Live-in model	9 interviews including CEO, directors, and managers	2 short-term placements (1-2 days), including informal conversations & field notes; CEO lunch; Homecare workers training	From digital platforms, including their website: brochures, information sheets, and blogs.
Case study 3: Community-based model	6 interviews, including founders, CEO, care manager, occupational therapist	No central office. Orientation and training done online and via shadowing.	From digital platforms, including twitter, Facebook and their website: company description, mission, vision, values, and job posts. From interviewers: values recruitment questionnaire
Case study 4: Preventative model	3 interviews, including founder and care manager	Homecare workers' orientation observation	From digital platforms, including twitter and their website: value statement, mission, services and job posts.

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Table 2: Business Model Categories for homecare models

Business Model Canvas component	Time and Task Model	Uberisation model	Live-in model	Community-based model	Preventative model
Stakeholder/ Customer segment	Service users (care recipients); local authorities	Elderly care recipients; care recipients' families; care workers.	Care recipients; care workforce.	Care recipients; care recipient's family; care workers	Care recipients; care recipients' loved one(s); care workers
Value proposition	Timely efficient focused on completing care tasks.	Choice; cost saving; wellbeing.	24/7 care with specialism in complex care such as dementia care.	Make life worth living; build trust and support meaningful connections.	Personalized care
Channels	Face-to-face means tested assessment; local authorities	Online presence (website, Facebook, Twitter, YouTube), word of mouth, telephone, email, advertising, referrals	24/7 support team, online presence (website, Facebook, Twitter, YouTube, app, LinkedIn, Chat now).	Link worker; online; phone; face-to-face	Automated (digital app communication with families and care workers); website; Facebook; Instagram
Customer relationships	Standardized care packages	Empathetic and understanding, by listening to clients' needs; flexible care arrangements.	Family support, including advice and expertise in care planning, costs and financing.	Online and call support; face-to-face visits	Personalized, choice of different levels of health monitoring
Revenue streams	Yearly grants from central government; local authorities' central budget; NHS income	Transaction fees for their service only.	Fee for services.	Monthly subscription fees.	Hourly rate for services (includes app services); monitoring systems services.
Key resources	"Preferred" supplier; national	Digital platform; database of care workers; database	Care workforce; admiral nurse; occupational therapist; district	Care workers; care managers; occupational therapist.	Nurse; care workers; partner organizations.

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infrastructure; workforce	of clients; partners.	nurse; 24/7 on-call support team; care managers; peer-to-peer support forum.		
Key activities	Setting up care plans; filing documents; recruiting and training care workers; residential care; homecare.	Online marketing; care workforce recruitment; offline marketing; digital platform update and maintenance.	Care worker recruitment; care worker training and orientation; weekly CEO lunch with care workers; brand awareness; IT support and maintenance; on-call support and scheduling; client services; compliance.	Values-based recruitment; online and face-to-face training; marketing; confirmation practice; pricing and financial management; care workers buddy system	Social prescribing; care workers recruitment (Facebook) and training (on-site); compliance (CQC)
Partnerships	Local authorities; commissioner; primary care networks (seldom)	Counselling services; investors.	Charities; hourly homecare providers; financial advisors; solicitors.	Training organizations; funding partners; business mentors and support.	Monitoring tech organization (lease); social prescribing organizations; online training organization; digital scheduling rostering organization.
Cost structure	Cost-driven; bureaucratic, long forms and paperwork.	Cost-driven; streamlined; digital; office staff salaries.	Value-driven; employee shares option; staff salaries; workforce salaries; administration; workforce travel costs.	Value-driven; staff salaries; marketing costs; travel costs.	Value-driven, streamlined; hourly rate for services; extended functions app services (included in hourly fee).