Appendix D - Expert testimony papers

Expert witness 1 – James Crawley

Section A: NCCSC to complete	
Name:	James Cawley
Job title:	Associate Director - Adult Care Commissioning, Safeguarding and Housing
Address:	Wiltshire Council County Hall Trowbridge Wiltshire BA14 8JN
Guidance title:	Home Care
Committee:	Home Care Guideline Development Group
Subject of expert testimony:	Home care for older people living in the community – planning, commissioning and delivering for outcomes.
Evidence gaps or uncertainties:	Despite the importance attached by service users, carers and providers to personalised home care, the pressures on Local Authority budgets has tended to limit home care services to short visits focussed on specific essential personal care tasks. Studies of views of service users and carers consistently tell us that this approach ignores their priorities and aspirations, and in particular those which might help them maintain social participation and meaningful pursuits, and combat loneliness and boredom. Outcomes-focussed home care is thought to be able to deliver more flexibility and personalisation of home care, but we only found one small research study (Gethin-Jones, 2012, Pts 1 & 2) which considered the potential benefits, and this is insufficient to assess either why or how to implement outcomes-focussed home care.
The review questions we sought to address were: **Q 3.1: What approaches to home care planning and delivery are effective in improving outcomes for older people who use services?** **Q 3.2: What are the significant features of an effective model of home care?** **Q 3.3: Are there any undesired/harmful effects from certain types of homecare approaches?** Our searches were for research published in 2004-14, concerned with older people specifically, and the material analysed constituted evaluative evidence	

(systematic reviews, RCTs and other controlled studies) from Europe (inc.UK), Denmark, Norway & Sweden, Canada, USA, Australia & New Zealand. We also included research (surveys, qualitative) regarding users', carers' and practitioner/provider views on the topic, but analysed only those views papers which related to home care in UK countries as being most relevant to our context (homecare in England).

We found plenty of qualitative evidence that home care organised according to 'time and task' focusses on personal services which commissioners and providers consider essential, while service users may attach more value to, for example, being taken to the library or spending time in the garden, than having a bath. Outcomes-focussed home care is of particular interest as it appears to offer the opportunity for service users to gain greater control and choice over what they, or the commissioning body, funds. Service users also report that it enables them to save up time, forgoing some routine care for longer episodes of care, perhaps to visit family or attend a football match. We are also concerned with approaches showing good outcomes for people with specific needs, such as people with dementia, sensory impairment, and people from minority social and ethnic backgrounds.

We are aware, however, that such flexibilities must be considered within the commissioning of care, and may be difficult to organise and plan for within the busy schedules of home care providers. The GDG highlighted that Wiltshire County Council is building a reputation for innovation in this area and, as a result, they would be interested in expert testimony on the cycle of commissioning, care planning implementation and review, and outcomes for service users and carers from this innovative model. The GDG would also be grateful for signposting to any research evidence on outcomes focussed home care from any international context.

Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

In 2009, Wiltshire Council held an event with representatives from every part of the care and social support system, asking them how its services could be improved. Among the feedback was a consensus that the care system was characterised by poor recruitment, terms and conditions, training and pay for care workers, which led to poor outcomes, increased needs, increased demand and increased cost.

The council decided that changing the financial incentives for providers would help to improve this situation. Tying providers' revenues to outcomes had the potential to maximise customers' independence, improve cost-efficiency and improve pay and working conditions for care providers.

Wiltshire introduced Help to Live at Home (HTLAH), which has a focus on personalisation, recovery and prevention. People who need support receive a person-centred assessment that focuses on outcomes – particularly outcomes

that will leave them better able to live well with less care. The aim is first to help people recover their independence, and second to reduce their reliance on care and prevent it from increasing.

HTLAH pays providers for the results they achieve, rather than the work they do – namely improved or preserved independence. The council applies financial penalties when outcomes are not achieved, and it rewards providers when people recover faster than planned.

Wiltshire's "payable outcomes" are about simple activities of daily living– getting up, bathing, dressing, cooking and eating, shopping, seeing friends. Unlike traditional community care assessments, customers are asked what they want from their care. Knowing this helps to define the outcomes (for example being clean, cooking a meal, or not falling in the bath).

Following an initial assessment, the provider and customer produce a support plan explaining how they will work to achieve the outcomes, how long they will need and how much the plan will cost. Reviews are frequent and are used to decide whether providers are paid in full. The decision depends on the customer, provider and council agreeing that the outcomes have been achieved.

If not, the council decides whether the provider caused the failure, in which case it can apply a financial penalty. The decision can be appealed.

The service began in 2011 and is delivered by 4 providers who provide domiciliary care, housing support to sheltered housing, reablement and prevention. Each provider has a geographical monopoly and is responsible for delivering all care and support in that area. They also have a responsibility for delivering preventive services into the community from sheltered housing.

The system has simplified the council's trading relationship with providers. Ninety separate domiciliary contracts worth £14 million have been reduced to eight payment-by-results contracts worth £11 million. Besides creating economies of scale, consolidating to a few providers was intended to reduce the financial risk of recruiting and retaining a high-quality workforce.

Results at April 2014:

- Numbers of people placed in residential care has reduced.
- Hourly rate for care reduced from £18.78 to £16.06
- Initial assessments are completed in 20 days rather than 20 weeks
- 1,523 customers accessing HTLAH care and support a week
- 320 self funders are using HTLAH
- Number of people going into nursing care reduced from 905 to 872
- Number of people going into residential care reduced from 1126 to 872 between 2010/2011 and 2013/2014
- 48% of those receiving the reablement service had not further need for care
- 23.7% needed less care after reablement.

Further work is required at a national , regional and local level on

- Engagement and involvement of customers implementing outcome based commissioning
- Engagement and involvement of providers implementing outcome based commissioning , which should include support and training for small and medium sized providers to adapt to deliver outcome focused opportunities for customers
- Development of clear actions to ensure the workforce is developed and sup[ported to meet the challenges of outcome focused commissioning

Expert Witness 2 – Trevor Brocklebank

Section A: NCCSC to complete	
Name:	Trevor Brocklebank
Job title:	*CEO*
Address:	Home Instead Senior Care Unit 2 Walnut Tree Business Centre Walnut Tree Farm Lower Stretton Warrington WA4 4PG
Guidance title:	Home Care
Committee:	Home Care Guideline Development Group
Subject of expert testimony:	An international perspective – what does good home care delivered to older people in the community look like?
Evidence gaps or uncertainties:	We found 11 systematic reviews (which we can send you a summary of), and some controlled studies, but most of the included studies were about healthcare delivered at home (not SOCIAL care approaches, staff or outcomes); and/or were published before 2004. Many interventions were not described; the population was not specified as older people, and outcomes concentrated on effect on admission to long-term or hospital care, not impact on life for users and carers (e.g. ASCOF).

The review questions we sought to address were:

Q 3.1 What approaches to home care planning and delivery are effective in improving outcomes for older people who use services?

Q 3.2: What are the significant features of an effective model of home care?

Q 3.3: Are there any undesired/harmful effects from certain types of homecare approaches?

Our searches were for research published in 2004-14, concerned with older people specifically as this is the focus of the guideline. The material analysed constituted evaluative evidence (systematic reviews, RCTs and other controlled studies) from Europe (inc.UK), Denmark, Norway & Sweden, Canada, USA, Australia & New Zealand. We also included research (surveys, qualitative) regarding users', carers' and practitioner/provider views on the topic, but analysed only those views papers which related to home care in UK countries as being most relevant to our context (homecare in England).

We found some papers evaluating models explicitly related to social (personal and personalised care) delivered at home, including outcomes-focussed care,

consumer-directed and/or consumer-funded homecare, and social home care delivered within, or coordinated with, a joint health and social care team or care plan, for example through case management. Few of these papers showed conclusive results. These are generally complex approaches, and little attention is given to the specificities of home care as a social care intervention in its own right. We are also mindful of the UK context of home care as a generally low-paid sector, with huge pressures on Local Authority commissioning budgets, where thresholds of eligible need for LA-funded services are high, and episodes/visits are short and often focussed entirely on essential personal care. Although we included small-scale, innovative approaches, such as formal volunteering, Shared Lives/Homeshare in our inclusion criteria, evaluation has not yet been undertaken. (NB: Reablement is the subject of a separate guideline. Reablement as an intervention is therefore out of scope for this guideline, although the principles of promoting independence are relevant.)

In requesting expert testimony, we are mindful that we may have missed data on home care in other advanced industrial societies (such as Japan); and that there may be more recent research published from the included countries which focusses on ways of delivering home care to support social care outcomes. Cost-effectiveness data has also been extremely sparse – for example, we found no studies which demonstrate that providing Local Authority commissioned home care saves the NHS money. We are also concerned with approaches showing good outcomes for specific groups of people, such as people with dementia, sensory impairment, and people from minority social backgrounds.

Section B: Expert to complete	
Summary testimony:	[Please use the space below to summarise your testimony in 250–1000 words – continue over page if necessary]

Q 2.1.1: What approaches to home care planning and delivery are effective in improving outcomes for older people who use services?

Home Instead Senior Care provides an innovative and effective care model, which fills a critical need as the global population ages, and which is replicable across the world. Home Instead Senior Care now operates in 18 countries, as over 1,000 offices, more than 65,000 professional Caregivers and delivers over 50 million hours of care per annum. In the UK we have over 150 offices and over 7,000 caregivers.

Our model of delivering high quality care works, because although the countries in which we operate have diverse cultures, our relationship led approach with the client's needs placed firmly at the centre has universal appeal.

We promote active and healthy living and we aim to extend life by providing the highest quality care. We help seniors stay at home since we know that is where up to 90% of seniors prefer to live as they age. This is achieved by

delivering person centered and relationship-based care. We focus on relationships, not tasks. We understand that each situation demands a personalized care solution, which often includes care coordination, and the solution is devised in collaboration with the client, their family and often involved health or social care professionals.

We know that family caregivers put the health of their loved ones ahead of their own and often neglect their own wellness. Our type of care helps them balance. We alleviate some of the physical and emotional burdens and give family caregivers peace of mind and time to focus on their work, personal health and other family obligations.

We assist with healthy behavior that leads to active aging including staying physically active, eating well and practicing good wellness habits. But it also includes staying socially engaged and intellectually curious. Key to this is continuity of care, caregivers are matched to clients based on shared experiences, backgrounds or interests, and this approach builds trust between client and caregiver and fosters relationships based on dignity and mutual respect.

What we have learned is that, whether in the UK, US, Japan or The Netherlands, personalised care produces positive outcomes.

Companionship: regular social interaction keeps the mind active and helps prevent social isolation that can lead to depression. Furthermore depression can lead to deterioration of physical health and potential hospitalisation. One of our clients, a jazz lover, had become depressed and withdrawn as she was unable to get out of our home. Our caregivers now accompany this client to a local jazz club on a regular basis, which has opened up a former circle of friends that the client had lost touch with over time.

Improved nutrition: Our relationship focus means mealtimes become a social event where a caregiver will cook with and eat a meal with a client. This focus on healthy balanced meals and good hydration helps prevent hospitalisation.

Reduction of anxiety: routine and familiar surroundings are important as we age, and particularly so for clients living with dementia. Continuity of care, and the relationship that ensues helps to reduce the often challenging behaviours caused by anxiety and confusion. We ensure our clients are engaged and supported, while remaining safe in their homes.

Peace of mind for family members: caring for a loved one can be a stressful experience, especially when trying to juggle the often conflicting elements of modern life, our service alleviates some of the physical and emotional burdens families feel, providing peace of mind and time for them to focus on their work, personal health, family obligations, allowing them to return to being the daughter, son or partner.

Q 2.1.2: What are the significant features of an effective model of home care?

There are a number of elements which work together to build an effective model of home care, but perhaps the most important, and often most often overlooked, is putting the client and their needs first. The development of a care plan which is needs based rather than task oriented is the foundation stone. It is important that the plan is personalised, provides flexibility and is a collaborative process including input from the client, their family and involved health or social care professionals.

We believe that continuity of care and calls which last a minimum of one hour are also significant features of effective home care. Building strong relationships with clients has many benefits, including stimulating memories, re-engagement with previously enjoyed activities and preserving a sense of independence and "self", all which can help reduce loneliness. Therefore as previously mentioned we match caregivers to clients and give them time to deliver a high quality service.

Regular assessment and feedback to family members is also important as clients' needs can change overtime. Perhaps surprisingly we find that for some clients care packages can reduce over time, as they become revitalised and feel more confident to do things for themselves, for others their care needs increase, especially if they live with a chronic condition such as dementia or Parkinson's disease. This can be a fine balancing act, and often involves integration with health services.

Q 2.1.3: Are there any undesired/harmful effects from certain types of homecare approaches?

Each year we survey our clients to benchmark our performance to ensure that we continue to deliver high quality care that meets our clients' needs, we therefore can be confident that our innovative approach to home care is delivering the outcomes that we desire, we are helping people live longer, more independent lives in their own homes.

Our understanding, from our clients' and their families who have previously used other home care services, or from media and other reports, is that other home care approaches may not deliver the high quality outcomes that we believe clients deserve.

Client visits that generally are under thirty minutes long encourage focus upon delivery of tasks rather than building a relationship with the person and in addition the delivery of care can be rushed. This can cause anxiety and stress for both the client and the carer. The client, especially if they have mobility issues or dementia, becomes both physically and emotionally uncomfortable and may feel they have lost control around what is happening to them. Carers often say that they are under pressure to complete a visit and

to move on to the next. They feel unable to engage socially as they don't have time, and also due to the way visits are scheduled, may not see the same client twice.

Short task based visits, coupled with no continuity of care, can increase social isolation, there is little time for social interaction, leaving the person being cared for feeling unimportant. Often their needs and wishes, about things that we take for granted, such as what time to get up in the morning, are not taken into consideration. This can lead to depression and feelings of being a burden or unworthy.

In addition, a focus on delivery of task can facilitate a reduction in the ability of clients to do things for themselves, leading to more and more dependence upon the care services. So rather than supporting and enabling the client to maintain a level of independence at home, the situation can deteriorate leading to hospital admissions or ultimately the move into a residential care facility.