RADICAL HOME CARE

How self-management could save social care
A briefing paper

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Executive summary

For too long, the prevailing narrative about social care has been focused on funding. Even the new prime minister has made a voluntary saving scheme the focus of his efforts to address the "social care crisis". While it is true that the combination of austerity and an ageing population has placed a growing strain on social care finances, too little attention has been devoted to models of social care delivery and the challenge of sustaining a workforce that is motivated and empowered to care.

This briefing paper considers a brief history of social care and why it has always been something of a 'cinderella' service in comparison with the NHS. It identifies four contemporary challenges which go beyond the simplistic idea that it simply lacks adequate funding. These four challenges are:

- The lack of knowledge about people's rights and options regarding their care
- The inability of bureaucratic, hierarchical organisational models to respond effectively to complex needs
- The physical and emotional burden placed on care workers who have to perform to a 'time and task'[1] model of service delivery
- Commissioning models based on the delivery of short-term outputs rather than long-term wellbeing.

Despite this, there is considerable innovation in social care. One of the most innovative models being explored at the present time is that of 'self-managing teams'. The principles of self-management were originally developed by Frederic Laloux and have been adopted most famously by Buurtzorg in the Netherlands. Evidence from experiments around the world suggests they can bring:

- More flexibility of service provision
- Increasing quality of work life
- Less absenteeism and employee turnover
- Increased job satisfaction
- Organisational commitment.

The RSA has been exploring a number of case studies where domiciliary home care services in the UK are being delivered through pioneering self-managing teams. These include:

1. Time and task definition provided by National Institute for Health and Care Excellence: "..a time and task approach, whereby services are delivered in short time slots and focus on completing personal care tasks". See Social care guidance scope at www.nice.org.uk/guidance/ng21/documents/home-care-final-scope3

- Wellbeing Teams
- Cornerstone in Scotland
- Neighbourhood Midwives in London and
- Neighbourhood Cares in St Ives.

Drawing on these case studies we identify four ways in which self-managing teams are addressing some of the challenges within the current social care system in the UK. These include:

- Adopting a relationship-focused approach to care
- Empowering the care workforce
- Changing the culture of care to prevention rather than time and task
- Enhancing commissioning and trust.

We conclude our briefing with a series of recommendations:

- Review how home care is currently delivered and ensure that people are aware of their rights, that frontline staff have the knowledge, skills and time to explain people's options that will best meet their needs.
- Develop systems with reduced bureaucracy that do not prevent swift action that can lead to better care and more preventative support for those accessing social care.
- End the use of the time and task commissioning in home care that prevents true relationship-centred care, does not enable services to work in an outcomes focused way and prevents home care staff from working well or being suitably supported and paid.
- Move towards a model of commissioning that better reflects the complexity of the system.
- Build and enable trusting relationships between commissioners, providers and staff to enable self-managing services to develop and thrive.
- When commissioning new services, create an environment that enables them to develop, this means moving away from short, overly prescriptive pilots that are designed to achieve unrealistic outcomes.
- The Care Quality Commission (CQC) must drastically review its model to ensure that it doesn't crush innovation; most of its requirements are based on organisational hierarchy which deters organisations exploring new ways of working like self-management.

The RSA's Transform project on self-managed teams will continue into 2020 with a series of roundtables, further research and support to pioneering initiatives with a view to scaling and spreading good practice in the UK.

Introduction

Social care is 'stuck'. Not just because it is in desperate need of funding but because it doesn't truly fulfil its purpose. Although the wider social care system has been severely impacted by funding cuts, affecting children, young people and adults with disabilities, unpaid carers and more, home care has been particularly affected. Home care is the conventional model by which most older people are provided with support and it is this that is stuck.

Home care has become stuck because the system is stuck. Home care providers may try to innovate or experiment but they do so in isolation as opposed to looking at where the system is now, what's not working, what people want and need from it and where it needs to go. Combine this with the pressures of funding and commissioners who are risk averse and home care commissioning has become increasingly about funding and cost and less about the people. We have come to a place where a home care package for an older person will likely include the most basic tasks: washing, dressing, meal preparation; the same thing every day, delivered by different people who don't have the time to get to know the individual, don't have the time to support someone to make the most of life, to get any satisfaction from their role, unsure if they'll have enough money to cover bills.

But it doesn't have to be that way; there is hope. There are great examples of commissioners being brave and doing something different, putting people (including workers) at the heart of what they do. Monmouthshire county council took bold action in 2014 after two care staff came to the head of their service to say they 'couldn't go on'. The council listened. Too many workers feel worthless, stuck in a system that is driving down the money paid for home care so those at the sharp end pay the price. But there is another way.

In this briefing paper we'll explore what has happened in social care, what some of the key challenges currently facing home care might be, aside from funding, and what some of the solutions could be too. We look in particular at the work of self-managing teams.

> "In the old way I was a nobody, now I'm a somebody" Care worker, Monmouthshire

The RSA, self-management and social care

The RSA has been interested in self-management for several years. Two of its leading protagonists have spoken at the RSA: Frederic Laloux[2] who

2. Laloux, F. (2014) Reinventing Organisations. Brussels. Nelson Parker.

started to discuss a different model of work called Teal, and Jos De Blok[3] who established Buurtzorg - an incredibly successful health provider in the Netherlands which works according to self-management principles. In recent years, the RSA has wanted to explore how self-management could translate to the UK in teams who are in public sector organisations or delivering public services.

In 2019 the RSA held an event in partnership with the Health Foundation that brought together those who are working radically; the event was called Next Stage Radicals. Since then we have started to explore how self-managed teams can be organised in a home care setting, how staff are enabled can affect how services are delivered and experienced. We have done this primarily by exploring the early experiences of a small number of home care providers in the UK who have begun to experiment with whether a Buurtzorg type organisation is enabled to deliver home care in a different way. This briefing paper shares some of their experiences and learning.

3. Buurtzorg is a Dutch healthcare provider which began in 2007 as a team of four community nurses, it now has 850 teams with 10,000 staff. Jos de Blok is the founder of Buurtzorg. See: www.buurtzorg.com/

A brief history of social care

The NHS has been in existence since 1948, it has been one of the greatest social reforms ever undertaken in the UK: universal healthcare from cradle to grave. Beveridge's view of what our health system should look like was based on the needs of the population of the UK in a post-war Britain, but his idea of the welfare state was one designed to catch us if we fell, not necessarily enable us to thrive – something Beveridge recognised by the third iteration of his report.[4]

The health care system, combined with rapid improvements in pharmaceuticals and other medical technology, worked better than was ever anticipated, and as a result meant that life expectancy was transformed in Britain increasing from 66 years for men in 1948 to 79 years in 2019 and from 70 years to 83 years for women.

Unlike the NHS and universal healthcare, the development of social care has been less clear and less concrete, it has focused largely on residential need and has not been not regarded as something universally required. The National Assistance Act 1948 left social care as the responsibility of local authorities.[5] There was no national social care service. The act was primarily focused on residential care; the society of the period didn't anticipate the needs of an ageing population or those with long-term conditions or disabilities. Discussion of a growing need for community care began in the 1960's with this continuing into the 1970's but social care continued to be the poor cousin to health services. Care in the Community[6] set out the basis for the 1990s community care reforms (Caring for people White Paper, 1989) which shaped the social care system that many of us will recognise today.

The 1989 White Paper's key objectives are eerily familiar for many working in and accessing social care in 2019:

1. To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.
2. To ensure that service providers make practical support for carers a high priority.
3. To make proper assessment of need and good case management the cornerstone of high quality care.

4. Cottam, H. (2018) Radical Help: How We Can Remake the Relationships Between Us and Revolutionise the Welfare State. London. Virago.
5. Wanless, D. (2006) Securing Good Care for Older People – Taking a Long-term View. London. The Kings Fund.
6. Griffiths, R. (1988) Community Care: Agenda for Action. London. HMSO.

4. To promote the development of a flourishing independent sector alongside good quality public services.
5. To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
6. To secure better value for taxpayers' money by introducing a new funding structure for social care.

One of the main issues for many was the focus of these reforms on 'those in greatest need'; something that would have long-term impact until it was addressed in the 1998 White Paper[7] which finally looked at prevention as well as at those who may need lower levels of support but, by not receiving it, risked an increased need in the long run.

Nevertheless, as policy has shifted, social care has moved to an almost industrial model of care and support. This presents challenges to those innovators and micro-providers who may be innovating in the sector. The system of care provision has not changed substantially for many which can mean those who are innovators find it difficult to scale their model to enable more to receive a type of support they would like.

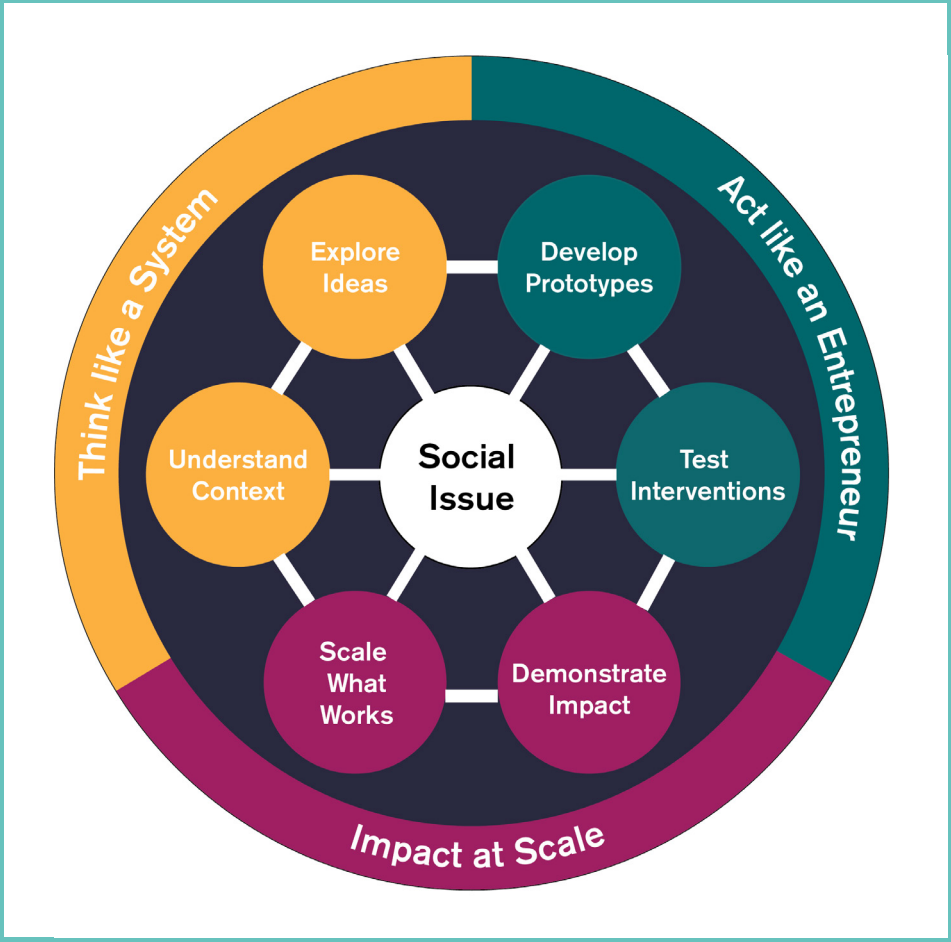
We now find ourselves in a very different place than when discussing health than in 1948. Research by Lancaster University[8] found that the dominant framing of social care in the media was that it is a problem that is hard to control due to financial cuts and a rising elderly population. This narrative has become so dominant that recent campaigns about cuts to funding have begun to overshadow conversations about the quality of support services available, whether they meet the needs of the population and what the experience is of those working in social care. Understandably, the focus from sector leaders has been on how to increase funding and professionalisation of the care workforce; which has meant that the primary focus of social care reform is on how to fund it and where to find that funding.[9]

The social care Green Paper, which was initially featured in the March 2017 Budget, had been widely anticipated to address some of the hopes and concerns for the future of social care[10]; New prime minister Boris Johnson set a clear commitment to deal with the social care crisis, however with a focus on funding linked to a voluntary saving scheme. By solely focusing on funding the government misses an opportunity to develop a social care system that focuses on wellbeing for those accessing it and the opportunity to improve the system for those working in it.

7. Modernising Social Services, Department of Health, 1998.
8. Karen Kinloch, Elena Semino and Paul Baker are from the Centre for Corpus Approaches to Social Science, and Department of Linguistics and English Language, Lancaster University.
9. Home Care Insight 23 July 2019. Available at: www.homecareinsight.co.uk/what-are-boris-johnsons-plans-for-adult-social-care/
10. Jarret, T. (2019) Social Care, Forthcoming Green Paper. House of Commons Library.

Box 1 The RSA model of change:

The RSA has a unique approach to understanding the world and why change so often fails, which we call 'think like a system, act like an entrepreneur.' This, at its simplest, is a theory of how to achieve change. It is illustrated in this graphic:



At the RSA, while we understand that the pressure to move faster is unrelenting and every organisation must transform for a digital world, we also maintain that it is vital to think deeply about wider societal context that digital users are living in. Through our research we see how incessant technological and digital change is disrupting business across sectors – but true transformation requires more than technology. Two other things are just as critical. First, agility: delivering change through quick steps, learning as you go. Second, adoption: taking your people with you. Our model, think like a system, act like an entrepreneur, allows for both.

In our application of the think like a system, act like an entrepreneur mindset, we do not attempt to take on grand societal challenges in their entirety. Rather, by seeking to understand the wider system that an innovation will be born into, our methods aim to surface ways to successfully affect systems change.

The challenges facing social care

The current narrative presented by campaigners and the media is of a system in crisis, caused by cuts to funding and an ageing population; however, requests to social care services have only increased by 2 percent from 1.8m in 2015/16 to 1.84m in 2017/18, with just under one third of these being requests by working age adults.[11]

This is not to say that there aren't significant pressures on social care funding, but that we need to look more widely if we are to properly understand the wider challenges facing the system. In this section we consider four: knowledge of rights and choices, an overly bureaucratic system, practitioner burden and commissioning.

Rights and social care

The problem we have with social care is that most people don't truly know what it is. As such when people come to a point in their life where accessing it may benefit them to live fuller, more empowered lives they are not fully aware of their rights, options and that they have choice in the type of support they can access. For those (and their families) who would benefit from the support of social care they may make requests without understanding (or being informed) what their rights are, the purpose of social care and what their options may be. As a result, those accessing social care can feel that they have little choice other than to use (often, large scale) time and task providers that are commissioned by local authorities. But there is a plethora of innovators and micro-providers who are delivering social care in an empowering, person-centred way which enables staff to build strong relationships with those they support, and their families, to enable a better future for all. [12]

Beyond this, with the focus being placed on older adults, conversations about social care tend to be dominated by terms such as 'frail' and 'vulnerable' which can lead to an emphasis on the 'care' element of social care as opposed to the 'social' element. For this reason, when services are commissioned, and people's needs are assessed an unconscious bias bleeds in.

Bureaucracy

Public services were designed as bureaucracies, to solve a problem and remove responsibility from the individual. These bureaucracies were

11. Bottery, S. et al. (2019) Social Care 360, London. The Kings Fund.
12. Think Local, Act Personal. (2019) Innovations in Community Centred Care. Available at: www.thinklocalactpersonal.org.uk/innovations-in-community-centred-support/

designed to be stable and deliver solutions to problems. Getting people back into work, solving crimes, fixing broken bones; these all benefitted from hierarchy and stability, not only to solve the problem but to do so effectively and efficiently.

Yet the social challenges these bureaucracies are now required to address are increasingly complex; this complexity highlights the ineffectiveness of traditional, hierarchical approaches. It is the person on the frontline who knows the context, the person and the situation the best: a teacher, a social worker, a town planner, a community engagement worker, a care worker. For people like these, hierarchical decision-making processes slow down the ability to act, respond nimbly and in a timely fashion to what they see in front of them. By the time authority is sought, and given, the optimum moment to act has often passed.

We see social care contracts delivered by traditionally organised teams whose managers can be as concerned about meeting the performance targets required of the contract as they are about the welfare of the people receiving the home visits.

Graph based on discussion with home care managers in focus group.

Practitioner burden

Practitioner burden is the physical and emotional weight borne by those staff on the frontline who, every time they visit someone, sometimes every day, are forced to confront the dynamic tension between meeting the needs of the person and the requirements of the contract. This tension should not exist, as in principle, the contract should have the same goals as the practitioner and yet it is all too real for too many care workers. Care work has some of the highest vacancy rates of any industry and the "churn" of staff for some companies is over 60 percent.[13]

13. Viney, M. (29 January 2019) Care Workers forced to cut short home visits or be left out of pocket. The Guardian.

> "I worked out over one month, I did 210 hours work and was actually paid for 105. Over a working week I don't get to see my kids for three or four days, and I'd be paid for seven and half hour's work, when with travel, I'd actually done 15 hours." Care worker

A recent report published by the All Party Parliamentary Group (APPG) on Social Care[14] considered the need for professionalisation and identified the fact that care workers were under incredible time pressure (due to time and task) and earning far below minimum wage, but did not explain how this would be addressed. Instead their recommendations looked solely at creating a training body, governance, oversight and having parity with the NHS. Whilst all these things are worthwhile, there is a concern that it will add more layers of bureaucracy that will stifle innovation and care worker creativity. Despite mentioning funding, the report still seems to place a lot of the responsibility of improvement onto the provider as opposed to those with significantly more power, ie commissioners.

> "Very long hours for very little pay. I'm in this job for the people who need the care, certainly not the money. It is rewarding and challenging. My family do get affected, especially with late finishes and no pay for travel time." Care worker

Commissioning

Commissioning models are consistently cited by providers as a challenge to the provision of good quality home care. A time and task model of care where both clients and staff are reduced to numbers, activities and timing on schedules leads to poor staff satisfaction and retention. As a consequence, there is a revolving door of workers so clients and workers are unable able to build therapeutic and beneficial relationships and this also leads to a commissioning model that focuses on basic domiciliary tasks as opposed to person-centred care.

Home care commissioning is unusual in the social care sector; it is still commissioned on a time and task model where most other services are commissioned with health and care outcomes as their focus. As other services in health and social care become integrated, home care continues to stand as an outlier. Fees for home care are being driven down and staff recruitment and retention continue to be a significant challenge. Recent research has shown that there is a correlation between low fees and the quality of service provided. However, commissioners are less likely to acknowledge this correlation[15].

Many new models of care struggle to demonstrate that they are scaleable; Buurtzorg presents an example of self-managing teams that can scale up (the Dutch service has 4,000 staff). The challenge for self-managing teams in social care is the need for commissioners to trust services and that investment will lead to long-term savings as has been shown in the Raglan model. But many new care models are reviewed at

14. Elevation, Registration and Standardisation: The Professionalisation of Social Care Workers. APPG Social Care. (2019).

15. Bottery, S. Jefferson, L. et al. (2018) Home Care in England, Views from Commissioners and Providers. London. The Kings Fund.

a six-month point (when most organisations are still establishing) and expected to be delivering outcomes. In addition, they are often commissioned as pilot projects and are not given adequate time to demonstrate the types of outcomes expected of them. Many new care models are also commissioned for one reason: to evidence that they save money rather than providing better outcomes identified by clients in their support plans.

Torbay Council (which is a unitary authority) are looking at radically changing their home care provision, working in partnership with providers and looking at system design; they are currently piloting 'self-optimising teams' with a view to moving their whole model of care over to this. In addition, they hope to develop domiciliary care to a service with a focus on wider wellbeing as opposed to limiting it to basic care needs.

Despite these challenges, there are attempts to innovate. Toby Lowe has begun to present commissioners with a new way of commissioning which better suits our 21st century system of social care. The new model that Lowe looks at goes beyond budgets and instead embraces the complexity of working in a way that is human, prioritises learning and takes a system approach.[16] Furthermore, a collection of small providers, people with lived experience, carers, commissioners, community organisations and politicians have come together to present an alternative future for social care.[17] And as this briefing paper now goes on to show, self-managing teams are well-placed to address some of the challenges we have identified.

16. Lowe, T. Plimmer, D. (2019) Exploring the New World: Practical insights for funding, commissioning and managing in complexity. Newcastle. Collaborate CIC.

17. Social Care Future. Available at: www.socialcarefuture.blog

Self-managing teams

Although there are many innovations in social care, self-managing teams hold genuine potential not only to influence how services are delivered but also present potential for transformative experience, the reclaiming of power (in what is often a powerless experience) and most significantly the opportunity to scale.

The idea of self-managing teams came to prominence though Frederic Laloux's Reinventing Organisations (2014). Laloux described a new system for organisations which challenges the conventional hierarchical model of leadership. Laloux called these 'Teal organisations', setting out a series of characteristics that needed to be in place to work differently, in a purpose driven, self-organising, self-managing way.

One of the most well-known organisations to adopt Teal principles is Buurtzorg which describes itself as "a pioneering healthcare organisation established 10 years ago with a nurse-led model of holistic care that has revolutionised community care in the Netherlands".[18] Buurtzorg has developed an international reputation for improving the quality of care through empowering nurses which, in turn, increases their job satisfaction. Research has shown that although the 'unit costs' of provision are more expensive, the amount of time required to support people back to good health is reduced, therefore generating significant savings for the wider social care system.

Since the publication of Laloux's book and the awareness of Buurtzorg in the Netherlands, a number of health and social care organisations have begun to explore this model of working in the UK. Before we discover some of the examples of self-managing organisations in the UK it is important to understand what is meant by self-management and how this model is different to the conventional hierarchical models that many of us are familiar with.

The principles of self-managing teams

The central principle behind self-managing teams is that "the teams themselves, rather than managers, take responsibility for their work, monitor their own performance, and alter their performance strategies as needed to solve problems and adapt to changing conditions"[19]. They are therefore teams without a manager taking overall responsibility, setting direction and allocating work. Rather, these functions are undertaken by the whole team.

Self-managing teams are usually defined as "groups of interdependent individuals that can self-regulate their behaviour on relatively whole

18. For further information see: www.buurtzorgnederland.com

19. Wageman, R. (1997) Case Study: Critical Success Factors for Creating Superb Self-Managing Teams at Xerox. Compensation & Benefits Review, 29(5), 31–41. Available at: doi.org/10.1177/088636879702900506

tasks"[20], and generally include the following work design: "a whole task for the group; workers who each have a number of skills required for completion of the group task; autonomy for the group to make decisions about methods for carrying out the work; compensation and feedback about performance based on the accomplishments of the group as a whole".

These same design characteristics are described by numerous other researchers in later studies, with extra characteristics such as employees planning and scheduling work, acting on problems, meeting organisational goals and gathering information.[21]

Vregelaar goes on to identify the advantages of self-managing teams as:

- Bringing more flexibility
- Increasing quality of work life
- Reducing absenteeism and employee turnover
- Increasing job satisfaction
- Organisational commitment.

It follows that there are some critical success factors for the effective implementation and operation of self-managing teams:

- Defining success
- Group task design
- Encouraging supervisory behaviours
- Group characteristics
- Employee involvement.

Wageman notes the challenges involved in moving towards a self-managed team including staff being slow to adapt to the new way of working, and many organisations having an embedded tradition of hierarchical decision-making and management.

The benefits of such teams are summarised by Wageman as the enhancement of the organisation's performance and learning, as well as the enhancement of employee commitment.

A number of organisations in the UK have been inspired by this new way of working that presents opportunities to work in a more person-centred manner, free frontline staff from the shackles of over-bureaucratic systems and improve conditions and opportunities for staff.
A health system based on hospitals is working efficiently when the beds are full as much of the time as possible. Yet a healthy society is one in which people do not need to go to hospital at all.[22]

Creating organisations and working in ways that maximise the health and wellbeing of our staff and respect and value our communities is a moral imperative. The complexity of team functioning precludes reducing

20. Vregelaar, T. (2017) Identifying factors for successful self-managing teams: an evidence-based literature review. Available at: essay.utwente.nl/72758/1/Vregelaar_ten_BA_BMS.pdf

21. Goodman, P. S., Devadas, R., & Griffith Hughson, TL. (1988) Groups and Productivity; Analyzing the Effectiveness of Self-Managing Teams.

22. Leadbeater, C. (2007) The DIY State. Available at: www.prospectmagazine.co.uk/magazine/thediystate

teams to their least number of components. Rather, a systems theory approach recognises the relationships and interdependence between and within teams.[23]

There are several organisations that are working as self-managing services in health and social care in the UK; they are applying a set of theoretical principles to the complex landscape that is health and social care. The RSA spoke to a number of them to understand how they are achieving this, what they believe the benefits of working in this way are, and what the challenges or barriers are.

UK case studies

Wellbeing Teams

Established by Helen Sanderson and inspired by the Buurtzorg model, Wellbeing Teams deliver care and support in the community. The service is based on a Support Sequence model which is focused on self-care, digital tech, social prescribing, then paid support. The teams have key components that differentiate them from other home care services. These are:

- Small, community-based teams, built on self-management principles with staff trained to understand, and be able to function in this way
- Values-led including values-based recruitment, led by co-production and with a focus on wellbeing.

Wellbeing Teams with Community Circles[24] build their 'Circles' directly into the Wellbeing Teams model, making it a key component of their offer. Circles activate people's personal relationship networks to support them to achieve their personal outcomes and reduce social isolation, with the help of a volunteer Circles Facilitator, who in turn is recruited and trained by the Community Circles Connector. This way of working enables Wellbeing Teams to achieve better outcomes for people without having to jump directly to paid support.

Wellbeing Teams currently work across three locations in England and are expanding into others. The service challenges many problems that are extensive in the care sector: high turnover of staff, low pay and the ability for clients to access a service they choose rather than one that is allocated.

- Some of Wellbeing Teams firsts include:
- Paying staff for seven-hour shifts as opposed to zero-hour contracts
- Weekly self-managing team meetings
- Rated outstanding by CQC (a first for a self-managing team)
- A social prescriber/community connector embedded in their team
- Using virtual reality, Alexa and wearable technology

23. Micken, S. & Rodger, S. (2000) Characteristics of effective teams – A literature review. Available at: www.publish.csiro.au/ah/pdf/AH000201

24. For further information see: www.community-circles.co.uk

- Staff using electric bikes
- Providing a monthly programme of community events
- Co-production partnerships
- Using a values-based recruitment model
- Monthly team surveys on wellbeing, engagement and acting on result
- And finally, that staff carry pamper kits and life story books.

Wellbeing Teams has a radical approach to openness and sharing their learning, they have developed an open source website: Open Teams which has drawn together resources, governance documents and guidance that new or developing self-managing teams can utilise to aid their development.

Cornerstone (Scotland)

One of the largest social care organisations in Scotland delivering care to 2,700 people each year, Cornerstone started moving towards a 'local branch' structure made up of self-organising Local Care and Support Teams (LCASTs) of social care practitioners devolving autonomy and accountability to the frontline. This was inspired by the Buurtzorg model and other innovative social care providers in the Netherlands and has been adapted to work in a Scottish context.

They now have 80 Local Care and Support Teams that have transitioned to self-management (31 percent of their workforce); training on self-management is provided. Cornerstone anticipate that when the organisation moves completely to self-management they will reduce overheads by 40 percent which is essential to delivering this model at scale. One of the main factors for success was working with Health and Social Care Partnerships who are willing to relinquish some power, and to take some risks in testing alternatives to traditional commissioning. The University of Stirling has recently completed an evaluation which looked at 11 of the LCASTs, early indications show that compared to a more traditional structure:

- Recruitment and training costs are reduced
- Staff retention and engagement are better
- There is less reliance on agency staff.

Key Performance Indicators are focused on staff experience as well as client experience; looking at staff retention, recruitment costs, staff engagement/happiness and sickness rates.

> "Working for Cornerstones in the old days, we used to feel shackled. We often needed simple, common sense decision making but we didn't have the authority or the information we needed to make the decisions." LCAST worker

> "In April 2018, we became a LCAST and everything changed. We could buy a new pair of boots or replace a ripped jacket for the individuals we support without having to ask anyone other than our own team. It's

so reassuring for us that a group…who really knows the individual are the ones making the decisions which are in their best interests." LCAST worker

Neighbourhood Midwives (London)

Annie Francis made the decision in 2012 to start the process of launching Neighbourhood Midwives as a private service with the hope that the NHS would be in a position to adopt it. Neighbourhood Midwives started with four independently minded midwives in 2014 after meeting with Jos De Blok and reading Fredric Laloux's book Reinventing Organisations. They are a private, independent midwifery service offering personalised care packages for women throughout their pregnancy, birth and beyond.

Each midwife and team are responsible for building up their caseload in their local area, whilst the service is self-funded. This gives the midwives many opportunities to be innovative and creative in their job roles. They developed effective governance structures and a robust IT system, to support excellence in practice. Evidence-based clinical guidelines are woman-centred and reflect best midwifery practice. A team up was set up in Waltham Forest which implements case load midwifery – each midwife has their own caseload of around 35 clients per year but works in a team. A major challenge had been to get people to self-manage when they were not used to it, with limited tools and found it difficult to access experienced coaches. They worked with Wellbeing Teams to help train their coaches and Easier Inc to develop their values.

Unfortunately, Neighbourhood Midwives has had to close, despite clients and midwives being incredibly positive about the organisation; when the midwives were told of the closure the overriding sentiment was: "what about the women?".

Neighbourhood Midwives feel strongly that key external factors contributed to their closure: the bureaucratic culture of the health service and the restrictive commissioning models; two of the big challenges that face social care more generally.

Neighbourhood Cares – St Ives Cambridgeshire

Cambridgeshire county council had a domiciliary care shortfall. Cambridgeshire has a high older population and made the decision to pilot a self-managing team model in two locations. The two-year pilot is an early intervention, holistic assessment service working on prevention. Key outcomes include: patients having a better quality of life; improved staff wellbeing and retention; the avoidance of hospital admissions, reduced length of hospital stays and the reduction in the use of domiciliary care services and residential nursing care.

The pilot sites in St Ives and Soham each cover a population of 10,000 people. Each team has slightly different demographic and referral routes (St Ives has five GPs and several villages, Soham has only one GP). The services had a Values Based Recruitment process where interested applicants were initially invited to an information/assessment day, and those who were interested after this were invited to apply. The teams are made up of qualified social workers and there are different tiers in the teams, but all staff are called 'Neighbourhood Care Worker'.

There is a shift in the way of working with increased freedom, reduced stress as staff can make decisions, less waiting time and a move from an open/close case way of working. However, the pilot of the Neighbourhood Cares service has now ended and has not been renewed.

Monmouthshire

Monmouthshire council faced similar challenges to other local authorities when funding cuts began affecting services, but they approached the challenge in a different way, so that they weren't passing the impact on to those accessing services and those working in home care.

As mentioned earlier Monmouthshire's decision to change was based on staff talking about the futility of the existing model; but there was a commitment from the whole service and an awareness that something needed to be done differently. The commitment from senior managers who weren't risk averse and recognised the need for a different approach enabled the service to try a different model. Key principles that the new service would be based on were set out:

- Care workers to be salaried
- Social and emotional wellbeing of clients is as important as their physical wellbeing
- Teams to be given the autonomy to make decisions and those decisions are trusted
- A shift from care workers asking "can I" to "I have"
- Unpaid carers to be supported in addition to the person they care for
- A relationship with the carer to be maintained after they person they care for has passed away
- Active work to connect and reconnect people to their community
- The teams to be as small as possible and as local as possible.

Monmouthshire council are now in the process of rolling out their model beyond their own services to those commissioned providers.
It is clear from the case studies that self-managing teams can work and benefit their client group as well as their staff; however, they have faced, and continue to experience, some significant challenges.

Self-management and social care - addressing the challenges

It's important to be clear that there are extensive social care innovators who deliver incredible services to support and empower people to live well. These innovative models of care often enable those accessing social care services to remain in their own home, live independently and achieve the things they want from life. However, there are crucial challenges for many who access social care and these innovative providers.

A recent Kings Fund report looking at new models of home care showed the tension that exists between current service delivery and what is identified as good practice. The report states that home care 'may include' things like washing and dressing but for many this is all that it includes. Good practice shows that the wants and needs of both staff and those accessing the service are very different[25]:

1. Person-centred care – caring for all the person's needs together in a holistic, integrated way. This may include communicating with others who are providing support and care for the person to ensure that care is joined up.
2. Valuing and involving people, as well as their carers and family members – ensuring that people are able to express their preferences, views and feelings. This may include ensuring that people have choices and that their views about how to make improvements are sought, listened to and acted on.
3. Continuity of care – ensuring that care is consistent and reliable. This may include ensuring that people have a properly reviewed care plan, that care workers are known to the person and limited to a small number of people visiting, providing reliable and flexible visit times, planning for missed or late visits, and ensuring that people are able to contact services between appointments.
4. Personal manner of staff – a caring and compassionate approach to care. This may include effective communication, getting to know the person and building relationships to ensure that care happens the way the person likes it.

25. Bennett, L. Honeyman, M. Bottery, S. (2018) New Models of Home Care. London. The Kings Fund.

5. Development and skills of staff – ensuring that staff are equipped with the training, supervision and experience to do their jobs effectively. This may include regular meetings for staff, personal development and training on particular conditions such as dementia.
6. Good information about services and choices – ensuring that people know where to get advice and understand their choices about local care options, including quality and financial advice.
7. Focus on wellbeing, prevention, promoting independence and connection to communities – to be able to stay in their own homes and be supported to do things themselves. This may include linking people to be able to contribute to their local communities and social groups.

In the rest of this chapter we will consider a number of these points and explore the challenges faced in the existing time and task service model and the difference self-managing teams make in these areas.

A person-centred approach

One of the greatest challenges for (and complaints about) time and task type care provision is the lack of consistency it creates. Clients are having to ensure new workers know them, their wants and needs whilst workers are unable to build therapeutic relationships with clients, build on previous experience and empower clients to live more independently. It is far from being person-centred.

Many people accessing the system are not familiar with their rights and choices or how services are commissioned to support people, and as a consequence the system tends to focus on domiciliary care (also known as home care) as opposed to services that work to enable people to live independently, as well as support their basic needs.

Self-management in social care presents an interesting opportunity to address this. Providers can develop services (beyond small-scale providers) that can meet a wider population's needs and then build on these to empower people to live as independently as they are able.

There is evidence from Monmouthshire that consistent, relationship focused care that moves away from time and task can reduce the need for the services. The service (although not fully self-managed) has a great deal of control over how it runs and relies on staff's knowledge of their clients to develop the service and support.[26] Over a 32-week period the planned number of support hours reduced by 152 hours due to the empowerment of the clients. This would be less likely to happen as a revolving door of care workers can often mean they are not aware of clients' abilities and instead focus on the things they can't do or may find more challenging.

Empowering the care workforce

Self-managing teams look to empower workers to have more control over their schedules, build relationships with their clients and receive better working conditions. For many who work in self-managing teams, it is

26. Raglan Domiciliary Care Model Evaluation Report. (2014) Monmouthshire. Available at: Raglan Evaluation Report Web Version

often the bureaucracy and lack of control in large hierarchical organisations (like the NHS) that draws them to self-management.

Many of us might take for granted easy access to team meetings and training but for many care workers this is more complicated as they are on zero-hour contracts and paid for contact time with clients only. Wellbeing Teams has committed to paying staff for shifts, enabling staff to work more effectively with clients but also covering travel time and providing time and space for team meetings and training.

Changing cultures

Self-managing teams present an opportunity to develop social care to achieve good practice for clients and workers. But there are challenges as a move towards a new system of working requires not only system change but culture change.

The Kings Fund report cites Wellbeing Teams (as well as Buurtzorg in the Netherlands) as examples of "autonomous teams". They recognise the challenges presented by the UK system include: regulation (something that Wellbeing Teams has effectively overcome and received an outstanding CQC rating for) and the culture of commissioning with its focus on time and task commissioning for home care. The Kings Fund speculated that these cultural barriers in the UK may hinder self-managing teams that are purely focused on social care (as opposed to an integrated health and social care model). However, Cornerstones in Scotland has demonstrated that this can be overcome, but it needs commissioners who show trust in their service providers, are not risk-averse and have an ability to develop flexible commissioning models.

Through the RSA's own interviews with our case studies it became clear that many of these organisations felt that risk-averse commissioning models or rigid outcome targets significantly impacted on the delivery of the service.

Commissioning and trust

Self-management in social care presents an interesting opportunity to look at how home care can be delivered differently for the benefit of those accessing it and those working as frontline workers, however like any development key factors need to be in place to enable these new models of care to thrive.

One of the fundamental elements is trust; trust between commissioner and provider and trust between organisational leaders and teams. Self-managing teams are based on trust between organisational leaders and workers and between colleagues; however, this trust doesn't always extend to commissioners. To enable new models of care, (especially self-managing teams) commissioners must build and show trust with providers. The focus for service outcomes must shift from saving money to achieving outcomes for those accessing services; self-managing teams are well placed and well designed to meet the wellbeing outcomes of those they work with, but it's crucial that flexibility beyond delivering basic domiciliary care is enabled. Wellbeing Teams in Thurrock have been commissioned to deliver a service that incorporates domiciliary care, social prescribing and reablement. This new model of commissioning gives the team the freedom to meet the needs of clients beyond basic care.

Recommendations

If we are to enable a new way of working in home care that can move the current system towards one of empowerment and enablement, as well as providing workers with better conditions and a healthier work environment then it is the system that must change to enable this. We cannot continue, in good conscience, to maintain a system whereby the experience of those in it is akin to a factory production line; where only providing the most basic tasks is sufficient and the opportunity to create human connection and provide a compassionate service is almost impossible.

To ensure there is a different way of working, and to enable home care to develop into self-managing services several actions need to be taken: A review of how home care is currently delivered, ensuring that people are aware of their rights, that frontline staff have the knowledge, skills and time to explain people's options that will best meet their needs.

- Developing systems with reduced bureaucracy that do not prevent swift action that can lead to better care and more preventative support for those accessing social care.
- An end to the use of the 'time and task' commissioning in home care that prevents true relationship-centred care, does not enable services to work in an outcomes focused way and prevents home care staff from working well or being suitably supported and paid.
- A move towards a model of commissioning that better reflects the complexity of the system.
- Building and enabling trusting relationships between commissioners, providers and staff to enable self-managing services to develop and thrive.
- When commissioning new services, creating an environment that enables them to develop. This means moving away from short, overly prescriptive pilots that are designed to achieve unrealistic outcomes.
- CQC must drastically review its model to ensure that it doesn't crush innovation - most of its requirements are based on organisational hierarchy which deters organisations exploring new ways of working like self-management.

The RSA believes that self-managing teams present a key opportunity to deliver social care in a way that best reflects the complexity of the 21st century. We intend to build on this briefing paper by supporting Fellows working to improve the social care sector through better commissioning, working practices and awareness of different models of home care. We will be holding a series of events across the country to engage with

stakeholders to enable them to deliver services that meet the needs of a complex world, raise awareness of the opportunities that self-management present in home care and bring together stakeholders to develop strategies to achieve radical solutions.

We will continue to support those radical leaders, like Helen Sanderson of Wellbeing Teams to develop services that meet the needs of clients and that aren't at the expense of workers.

Resources

Open Teams – www.openteams.co.uk - an open source resource site for people and organisations working towards and working as self-managing teams.

Easier Inc – www. Easierinc.com/books-and-articles - a resource books, videos and other resources that enable those working in next stage organisations.

Better Work Together – www.betterworktogether.co - creating a platform model for online courses in self-management and other aspects of next stage working.

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