NIHR | Policy Research Unit Older People and Frailty

Preferences for new models of care research study

Phase One

Magdalena Walbaum, Martin Knapp,
Raphael Wittenberg and Jane McDermott

Executive Summary

December 2022

Preferences for new models of care research study:

Phase One

Executive Summary

Magdalena Walbaum, Martin Knapp, Raphael Wittenberg and Jane McDermott

September 2022, revised December 2022

National Institute for Health and Care Research (NIHR) Older People and Frailty Policy Research Unit, Care Policy and Evaluation Centre, London School of Economics & Political Science, London, UK.

Acknowledgements: We are grateful to the Caribbean and African Health Network (CAHN) and the Greater Manchester Older People's Network (GMOPN), Health and Social Care Working Group for supporting the focus groups and this work.

This report presents independent research funded by the National Institute for Health Research Policy Research Unit in Older People and Frailty. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care. Policy Research Unit Programme Reference Number PR-PRU-1217-2150.

Background

The objective of this study was to understand current preferences for different aspects and models of social care and to explore, on the basis of the best evidence, how those preferences might change in the future. We undertook a scoping review of new models of care in England and conducted five focus groups to discuss people's preferences regarding different components of the models of care.

Findings

New models of care: The new models of care identified emphasise the importance of providing services for individuals to build strong relationships, support independent living in one's own community (whenever possible), promote well-being and help older people maintain their dignity and autonomy.

Community-based models of care: There has been increasing advocacy for models with a more community-based approach in the funding and delivery of care for older people, connecting people to their communities and local support (particularly from the voluntary sector). This suggesting a leading role for communities in recognising links and connections for support and providing both formal and informal care.

Integrating care models: These models of care address aim to address the existing fragmentation of care. Some of these models commission from a specialised organisation the integration of different providers to form a more comprehensive network of support and care. This enables these models to provide better access to information on available options of care and advice, enabling people to make more informed choices regarding their care in case of need. Other integrating care models work in multidisciplinary teams aiming to integrate the work done by different sectors such as health and social care, housing and other community organisations around the individual who needs care to maximise uptake of the resources offered by each sector and thus ensure more co-ordinated and personalised care.

Components of the new models of care

1. Housing

Housing with care settings: We categorised the various housing with care settings into two big groups: home care and residential care. Home care includes all settings where the person can live independently in an owner-occupied or rented home with their own front door. This group can be further categorised into mainstream home, with family and community settings. Residential care settings comprise nursing homes and residential care homes.

In general, participants preferred to stay living independently in their own homes for as long as possible. Community settings were also positively accepted as a housing option if care needs increase. Participants considered moving to a community setting as an opportunity to receive good quality care while maintaining their independence. This was especially highlighted by participants from lower socioeconomic groups. Participants from African and Caribbean descent also preferred to stay living in their own homes for as long as possible. Their preference was driven not only by the value they placed on their independence, as with other participants, but also by their culture, where there is a more intimate relationship between families and their communities.

People to share their home with: Preferences were mixed between participants regarding sharing their home if they were not able to live independently. Some participants would prefer to live with a family member, but there was a strong preference for maintaining their independence and privacy even if that meant living on their own and receiving care from a person who comes every day to support them with their daily activities, while others would prefer to live with a formal carer in their own homes.

Age of co-residents: Participants agreed that, if living in a community housing setting, they would prefer to live with people of mixed ages with a minimum accepted age, as they considered being able to talk about different topics and socialise with people of different ages was important. Participants agreed that an age limit of 50 years and over would be appropriate for this type of community housing setting.

Geographical location: Regarding the geographical location, participants preferred to stay living in their current neighbourhood, this being the main driver for choosing where to live when they age or as their care needs increase. We discussed the high value of living in a familiar place, where they know all the resources available and the social connections they have with neighbours and families.

2. Community assets

All participants agreed that the new models of care should promote community-based care and value community life and social gathering as necessary for their wellbeing. They mentioned that key assets were the availability of good public transport, local shops, library, pubs and community centres. People from the African and Caribbean descent group mentioned the importance of having good access to Afro-Caribbean food shops and accessibility to participate in Sunday church services.

3. Use of technology

Assistive technology: All participants acknowledged the use of technology as important and beneficial to maintain their independence. However, they recognised the existence of the ‘technological divide’ and the knowledge barrier to fully engage with technology. They highlighted the importance of receiving appropriate training so they could understand the usefulness of different devices and so make more informed decisions about whether they would use them. Also, they mentioned the importance of receiving ongoing support because of the rapid and continuing changes in technology.

Tele-care: The use of tele-care might provide an opportunity for better care, if it works alongside options that are person-centred, and focuses on what individuals need, and responds to their preferences. Participants of our focus groups generally agreed that there is a place for both face-to-face and remote care. They acknowledged the benefits of the latter, such as making care more accessible for some people, but also indicating that, with remote care, they felt that the service was less engaged or personalised compared to face-to-face contacts.

4. Provision of care

Provider of care: Participants in the focus groups acknowledged the burden involved in caring and mentioned that their preference would be to receive care from a formal care worker as their main provider of care. When we discussed if they would prefer receiving care from regular or varying carers, all participants agreed

that they would prefer to receive care from the same person and not different staff on different days, as they considered it essential to building a relationship and trust.

Use of direct payments: There was incomplete understanding among focus group participants of the funding system for social care in England. Given the purpose of our focus groups, we only provided a brief explanation of social care funding and then we focused on discussing their preferences regarding the use of direct payments, but only a few participants had experience with this approach. They agreed that, if using this scheme, they would prefer to manage it through an agency. This would make them feel safer and they would be able to hold the agency accountable for the spending.

5. Control and dignity

Decisions on daily routine and flexibility of care provision: Participants mentioned the importance of being able to decide what to do in their daily lives, as a way to maintain their independence, control and dignity as individuals. They mentioned that they considered it important to have routines, valuing models of care where they could have flexibility in decisions about their daily routines and their care.

Management of money: Participants all agreed that managing money was an important aspect of their lives, and they would prefer to manage their own finances for as long as possible. Some of them also mentioned that they would consider power of attorney for a family member.

Spiritual, cultural, religious and sexual identity: Knowledge and respect of the person's identity, culture and beliefs are key aspects when providing good-quality care. The more intimate interaction between family members that we discussed with participants in the African and-Caribbean descent group highlights the importance of considering cultural backgrounds when planning and providing care. Participants from this group mentioned the importance of having flexibility in their care and good access to the life of their community, their religious ceremonies, and celebrations as a way of respecting their cultural and religious beliefs.

Conclusions

New models of care are shifting towards being more person-centred, where care is provided in a holistic and integrated way. They emphasise the role of the community, the coordination and integration between different service providers to provide more flexible care arrangements, to ensure people are better informed of the choices available and receive high-quality care related to their preferences.

People value their independence and having control over their lives. Consequently, they prefer models of care that allow them to stay living in their own home or moving to a community housing setting with their own space for as long as possible. They emphasised the importance of community assets when planning their care and attached high priority to maintain social connections with their neighbours, valuing community life and having access to local facilities. People felt that building a relationship with their care provider based on trust was essential to receiving good quality care. We found differences in preferences for some components of care between the participants from different ethnic and socioeconomic groups; these highlight the need to ensure the care packages align with the people's individual preferences, beliefs, and values.

NIHR | Policy Research Unit Older People and Frailty

This document is available in large print.

Please contact the NIHR Older People and Frailty PRU for assistance.

Email: pru-manager@manchester.ac.uk

Telephone: 0161 306 7797

Front Cover Image
From Centre for Ageing Better image library
Source: https://ageingbetter.resourcespace.com/?r=8675&k=21d1426ac5

The University of Manchester

Newcastle University

CPEC CARE POLICY AND EVALUATION CENTRE
Research at LSE