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Doing Research on Homecare: The Views and Experiences of UK Homecare Providers and Researchers

RESEARCH

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ABSTRACT

Context: In the UK, increased investment in social care research provides an opportunity to extend the currently sparse evidence base on homecare. However, experiences of doing research in care homes suggest there may be challenges to achieving successful collaborations between homecare providers and researchers.

Objective: The aim was to explore homecare providers' experiences of supporting research, and researchers' experiences of such partnerships.

Method: A qualitative approach was used. Six homecare providers and nine researchers were interviewed. Collectively, they had been involved with/led 14 studies. The data was analysed thematically.

Findings: Researchers described the challenges of identifying homecare providers to act as research sites, and the value of developing relationships with local providers in anticipation of potential research collaborations. Multiple factors influenced homecare providers' decisions to support a study, including researchers' attitudes and behaviours. Homecare providers described unanticipated demands on staff time. Most found they were under-equipped to do the research tasks required of them. This may have resulted in deviations from the protocol or ethical practice. However, such difficulties had typically been overcome, supported by a positive relationship with the researcher/research team.

Limitations: The representativeness of the homecare providers recruited (against all homecare providers who have supported research) is unclear. All those recruited held a positive view about research.

Implications: Findings highlight the support and resources homecare providers need to get involved with and support research. This, in turn, points to a need for strategic investment in training and research support to the sector, conceived and developed in partnership with them.

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INTRODUCTION

Despite the central role homecare plays in the care of older people, the current evidence base is very limited (O'Rourke and Beresford, 2022), as is the case for most social care when compared to healthcare (Bayley and Ray, 2022). However, in the UK at least, there is growing investment in social care research (NIHR, 2022a). Such initiatives acknowledge current deficiencies in research capacity and capability in social care and strategies have been put in place to address this, particularly within the public sector (i.e., local authorities) (e.g., NIHR, 2024a). However, private, for-profit businesses who provide the great majority of homecare in the UK (Laing, 2022) remain largely outside of such developments. Furthermore, within the health and social care research community, as well as there being few researchers with experience of conducting research on homecare, there is also limited experience of partnering or collaborating with the private sector.

There is, therefore, a need to understand what is required to support successful research collaborations between academic researchers and private sector homecare providers. If not, there is a risk that homecare will not benefit from the research funding being made available for social care research, or that research investment is wasted because studies fail to finish or only partially deliver the evidence promised.

In terms of the UK context, the picture is complex, with over 12,000 organisations registered as homecare providers, providing care to around one million people, (Berg, 2021; Laing, 2022). Most are for-profit organisations ranging in size from single office businesses (some with caseloads in the 20s) through to national chains and franchises. Furthermore, the sector faces multiple challenges including high staff turnover, insufficient public sector funding and narrow business margins (Care Quality Commission, 2022; The Kings Fund, 2018). This complexity is likely to present different and additional challenges to delivering research in this context compared to research on and with public sector services.

A key source of existing evidence on experiences of conducting research in the private social care sector comes from care home research. These are settings where the past decade has seen a growing amount of research. However, this has not been without setbacks, delays and study closures (Davies et al., 2014), to the extent that, in England, there has been national investment in resources to support research in care homes (NIHR, 2022c).

A systematic review of experiences of conducting research in care homes (Lam et al., 2018) identified several challenges or barriers. Some (e.g., mental capacity/consent, resistance from family members, the lack of suitable outcome measures) are, arguably, not specific to the care home context and arise from the characteristics of the target population or study design.

However, some can be understood as directly related to features of the care home context, or non-public sector services more generally.

These include organisational characteristics (e.g., chain businesses may have corporate policies around research involvement, limited capacity to support research among smaller businesses or not-for-profit facilities) and knowledge of, and attitudes, towards research among key decision-makers and those in managerial or administrative roles responsible for research delivery. Lam et al. also report that whether a research topic is regarded as relevant, and the findings likely to be useful to them, may affect the decisions and actions of these individuals. More recent work (Law and Ashworth, 2022) supports and develops this, describing the critical role of key decision-makers not only as gatekeepers but also as securing (or undermining) wider support for the research within the organisation and facilitating the researcher/research team to build relationships and trust with other staff, residents and families.

Care home staff's knowledge and understanding of research, and sufficiency of research skills, were also identified by Lam et al.'s review as having the potential to impact successful study delivery. Research with care staff published subsequently (Stephens and Knight, 2022) adds to this, reporting a lack of any previous exposure to, or knowledge of, research among many of its participants. Importantly, the authors observed that this lack of knowledge could foster a mistrust about research or the researchers' intentions which, in turn, led staff to want to protect residents and families from the research.

Finally, the Lam et al. review found that the way care home managers and staff perceived the research team, and the nature of the relationship between them, affected study implementation and delivery. Here the researcher/research teams' commitment to, and skills in, develop trusting, collaborative relationships with care home staff was identified as critical. Research published since this review (Stephens and Knight, 2022) similarly highlights researchers' relationship building skills as a critical factor to successful research collaborations with care homes.

In contrast to evidence on care homes as a research setting (where there are at least 17 UK studies and over 40 in total), to our knowledge no studies have explored homecare providers' experiences of supporting research, or researchers' experiences of working with homecare providers. Given the differences between care homes and homecare services as research settings, and evidence of (even) lower levels of research activity in homecare compared to care homes, it is vital that the barriers and facilitators to doing homecare research are better understood in order to avoid the challenges and difficulties faced by care homes research in the past. This paper reports a study which go some way towards addressing this knowledge gap.

METHODS

STUDY AIMS

The aim was to explore private sector homecare providers' experiences of supporting research and researchers' experiences of collaborating with homecare providers. Specifically, we wanted to identify factors or issues that facilitate or obstruct successful research collaborations between homecare providers and academic research teams, including providers' ability to deliver on the research support activities involved. (By research support activities, we mean work carried out by a homecare provider to support recruitment, data collection or delivering an intervention being trialled or evaluated). The research team's intention is to use the findings to inform the creation of a 'homecare research toolkit' for homecare providers and researchers.

STUDY DESIGN, ETHICS, AND RESEARCH TEAM

A qualitative, cross-sectional study design integrating a generic qualitative approach (Bradbury-Jones et al., 2017; Patton, 2014) was used. Ethical approval was received from the University of York's Social Policy & Social Work Ethics Committee (Ref: SPSW/S/22/9). Two applied health and care services researchers (GOR, BB) undertook the research. Both had experience of homecare research and one had previously worked in practice and managerial roles in adult social care.

SAMPLING AND RECRUITMENT

The sample comprised:

- owners and senior managers of homecare providers that had supported one or more university-led, externally funded studies in the previous five years.
- principal investigators or other research team members who, in the past five years, had worked on a study/ies which required the direct support of one or more homecare providers.

Homecare providers were identified via:

- existing data from a survey of franchise owners of a UK-wide homecare organisation conducted by the research team that included questions about any involvement in research.
- published research reports which identified the homecare organisations that collaborated in the research.

In addition, researchers (see below) recruited to the study were asked if they would contact the homecare providers they had collaborated with and ask permission to pass on their contact details to the research team. Fewer than half of researchers agreed to do this, and it did not result in anyone being recruited to the study.

Researchers were identified via:

- information provided by homecare provider study participants.
- searches of key UK social care research funders.
- the researchers' existing professional/research networks and contacts.

Potential participants were contacted by email with brief details about the study. Those that responded positively were sent the study information sheet and data privacy notice via an email correspondence that was also used to arrange the interview.

DATA COLLECTION

Individual interviews were conducted via video call apart from one researcher who chose to provide information by email instead. Data collection was carried out by one researcher (GOR).

Two core topic guides were developed, one for homecare providers and one for researchers, with some topics/issues appearing in both. Prior to each interview, desk-based research (e.g., published articles, study webpages) was used to gather information about the study/s the interview would cover. This was used to 'individualise' the topic guides for each interview, alongside any information known about the role the interviewee played in the research.

Interviews with homecare professionals covered: experiences of being approached by a researcher/research team; factors affecting their response to the approach; the types of research support required/requested; and the delivery of that support, including what went well and any challenges that presented. Interviews with researchers covered: identifying and approaching homecare providers; the types of research support required/requested; and the delivery of that support, including what went well and any challenges that presented. Homecare providers and researchers were also asked to reflect on their experience as a whole and if they had views/suggestions following from it regarding factors likely to influence the quality and effectiveness of research partnerships between homecare providers and research teams.

Prior to the interview, participants completed an electronic consent form. With permission, interviews were audio recorded and verbatim transcripts produced. Interviews lasted, on average, 50 minutes and ranging between 30 and 67 minutes.

DATA ANALYSIS

A thematic approach (Braun and Clarke, 2006) to data analysis was taken with one researcher (GOR) leading on this. Both researchers met together regularly to discuss the analysis and the second researcher (BB) typically independently reviewed analytical outputs before these meetings.

Two high level coding frameworks setting out core themes/topics were developed (one for each sample, but with some shared across both). Informed by the research objectives, these were derived from the topic guides and listening to interview recordings and reading of the transcripts. Examples of themes/topics are: anticipated benefits of supporting research; barriers to supporting research; experiences of approaching homecare providers. Word versions of transcripts were then systematically worked through and data relevant to any theme/topic marked and labelled according to the coding framework. This data was then extracted into excel spreadsheets. (Each column contained data on one theme/topic and each participants' data relevant to that theme/topic extracted into a single cell.) The extracted data in each cell was then summarised with verbatim quotes also retained. All the data on a theme/topic was then scrutinised (including, where relevant, across both samples) and more granular conceptual/thematic labels developed and used to systematically label the data within each broad theme. Analytical notes on each topic/theme were then generated from scrutiny of the final versions of the spreadsheets. Where relevant, these drew together and further summarised homecare professionals' and researchers' data. These notes formed the basis from which study outputs were produced collectively by the authors.

FINDINGS

SAMPLE CHARACTERISTICS AND STUDIES REPRESENTED

Overviews of the samples and the studies represented in this research are set out in Tables 1 and 2 (see Supplementary Files 1 and 2, respectively).

Six homecare organisations were represented: all had supported one or two studies (total $n = 9$). All were private, for-profit providers. Five were single office franchises: here the owners were recruited as they had been the 'research lead' within the organisation. One was a homecare chain: here the manager at the head office who had assumed a key role in supporting the research was recruited.

Nine researchers (from across seven study teams/groups) were recruited. Five were Principal Investigators (PI), one was a trial manager and three were research team members selected because they played a key role in working with homecare providers. All described experiences of working with private, for-profit providers, one researcher also had experience of collaborating with third sector homecare providers.

Overall, a total of 14 studies were represented. A range of study designs and study methods, including one randomised controlled trial and two observation studies, were represented. Across all studies homecare providers

had supported study recruitment by identifying eligible participants (clients, family members and/or staff) and seeking consent for contact by the research team. In five studies, homecare providers had also been involved in consenting, coordinating or conducting data collection from clients, intervention delivery, and/or facilitating participant observation sessions.

HEMOCARE PROFESSIONALS' OVERALL REFLECTIONS ON SUPPORTING RESEARCH

All homecare professionals described challenges or difficulties associated with supporting research and which we report on later. Despite this, all reported that, overall, it had been a positive experience and could identify specific positive impacts. These included drawing personal satisfaction from contributing to the evidence base on homecare and benefits to staff (office/management and homecare workers) in terms of skills/career development. All said they would consider supporting research in the future, although they felt it may prove challenging given ever increasing pressures on homecare providers.

I think people are working on the edge all the time. That's just doing their day job, just trying to get out to support people with their basic needs. Let alone have the time and the capacity to be able to research... [Homecare Provider5 - hereafter 'HCP']

RESEARCHERS' EXPERIENCES OF SECURING RESEARCH SUPPORT FROM HEMOCARE PROVIDERS

Identifying and approaching homecare providers

Researchers had used different approaches to identifying homecare providers to act as research sites. Some had drawn on existing relationships established through teaching or past research collaborations, membership of a local body (e.g., Health Improvement Team), or either party having previously made contact about possible research collaborations.

Those without existing contacts, or needing to recruit additional homecare providers, described difficulties identifying and then securing their involvement. They had resorted to using web-based information (e.g., Care Quality Commission reports, providers' websites) or had cascaded study information via newsletters distributed by local or national homecare/social care organisations. High rates of non-response to unsolicited emails were reported. Early and apparently enthusiastic expressions of interest did not necessarily result in sustained interest or a commitment to support a study. Some researchers described being frustrated or surprised by this, contrasting it with their experiences of doing research in an NHS context. However, they also observed that the pressures on the sector and the inevitable differences between

public and private sectors services meant the research context was very different.

It's just I find it's almost the rules that I'm familiar with [from doing research the NHS] don't apply in that sector. For example, you set up a meeting and people don't turn up..... It's new to me, they just disappear. It's all about firefighting it seems to me. They're so focused on who's doing what today that perhaps there's very little in terms of planning ahead and seeing the bigger picture, or maybe they're able to see but not able to move away from that perpetual firefighting. [Researcher 3 – hereafter 'R']

Securing the involvement of homecare providers

Researchers often referred to the absence of a 'research culture' and that, unlike the NHS or other public sector services, research was not a core, or required, activity. This affected how they went about securing homecare providers' involvement.

...obviously, they're a mix of for profit and not-for-profit, and they typically do have a public spirit about the sort of work they do, but they're still enterprises that have to make [money]... You can't make any assumptions, like some might with the public sector bodies, that there's in some way a moral duty for them to engage in research. (R7)

All believed care was needed when making an initial approach. In introducing themselves, they felt it was important to convey their knowledge of homecare, including the pressures providers operated under. Equally important was the need to clearly signal the potential benefits of the research to the sector.

I believe that all the home care agencies know the importance of the quality of the care that they are providing. But then [they don't see] research as being something which can contribute to that quality. So improving that information on how much research can be helpful and how much research is dependent on homecare providers. (R4)

Researchers also described being careful to limit the amount, and level of detail, of information contained in initial approaches. They believed in the value of using direct dialogue (via telephone calls or visits) to develop the relationship and explain further about the research. The need to pace this process and not put time pressures on a homecare provider was stressed. Some noted that they had avoided, where possible, making contact during homecare providers' busiest days/periods (e.g., avoiding Mondays and Tuesdays, mornings, winter).

Implications of the unfamiliarity of research to homecare providers and their staff

Researchers with experiences of working with research active organisations, such as the NHS, reflected on how 'research naivety' among homecare providers laid greater responsibility on them to ensure all aspects of the possible research collaboration (e.g., recruitment processes and targets, study timelines, eligibility criteria, ethics/research governance approvals) were explained and discussed.

They were amenable in a friendly kind of way, but if I had been approaching an organisation that was research active, I would have been asked much tougher questions ... (R2)

More broadly, some also recounted encountering suspicion or anxiety on the part of individual staff or staff groups about them or their service being the subject of research. They had learnt the importance of both being clear why they were doing the study and its objectives.

I had experiences of care managers asking if they could take me out for coffee in a break and really scrutinising me about why I was doing this. I think in that sense being able to share my motivations as good rather than being someone who's going to scrutinise their work.... Yes, I'm not exactly neutral. I don't want to shine a bad light on home care. I want to do the opposite which is why I went into this field. (R5)

Researchers who had used observational methods spoke about the work they had to do to secure trust and support across the whole organisation. They noted risks around staff feeling threatened or resentful, and recounted the careful work they had done to minimise perceived disparities in power and status and establish a sense of trust.

When I started to go into homecare agencies to talk about the research, people made comments that I was far less intimidating than they had imagined. ... [Then getting to a point where] I'm going out with homecare workers who saw me more as 'friend' than a researcher, of not abusing trust. (R5)

HEMOCARE PROFESSIONALS' ACCOUNTS OF RESEARCHERS' CONTACTS AND DECIDING TO GET INVOLVED

Reflections on initial contacts and developing relationships with researchers

Reflecting on their experiences of initial contacts from researchers, homecare professionals described responding positively when such approaches were

individualised and their own expertise was acknowledged. They also appreciated and valued clear explanations of the research and, crucially, the potential impacts of the evidence it would generate. Finally, homecare providers stressed the importance they placed on initial contacts from researchers including information which established the researcher's credibility (e.g., track record in home/social care research, seniority, the university's status compared to other institutions).

As conversations around a potential research collaboration developed, homecare professionals described responding positively to researchers who actively listened and were willing to discuss and have some degree of flexibility in the way research tasks and processes might be carried out.

Homecare providers' reasons and motivations for supporting a study

Homecare professionals' accounts of the decision to get involved in supporting research conveyed some degree of awareness of the potential risks and benefits it afforded, and the trade-offs which had to be made between supporting research and the primary reason for their business's existence.

'There's got to be a benefit to the client. There's also got to be a business case for it. Also, you want to make sure that it works.'

(HCP5). They described multiple reasons as to why they had agreed to their organisation supporting one or more studies. All believed in the importance and role of research *per se*, with many referring to the lack of existing evidence and the impact this has had on policy and commissioning. Some firmly believed that homecare providers had a responsibility to get involved in research 'for the public good'. Furthermore, all believed involvement in research had reputational benefits, presenting their organisation – to the public, potential clients, and staff – as one which was involved in thought and knowledge leadership and being at the cutting edge of innovative practice. In addition, some regarded research collaborations as offering new opportunities for skills and career development for staff.

Alongside these more global values and motivators, sometimes study-specific reasons played a key role in the decision-making process. These included having an existing interest in the research topic, seeing the topic as a good fit for their own organisational/business priorities (e.g., growing partnerships with community health providers), or research involvement as an opportunity to inform and influence the research agenda on that issue.

In addition, for studies which included qualitative research with clients, homecare professionals referred to the fact that they believed their clients would enjoy having the opportunity to share their views and

experiences with a researcher. Finally, and perhaps reflecting a limited understanding of research, where the research was evaluating an intervention, they were motivated by the belief that their clients would benefit from receiving the intervention, or that supporting the research would offer them the opportunity to integrate the intervention on trial within their usual service offer.

The need for wider organisational buy-in

Whilst ultimately the ones taking the decision, some homecare business owners stressed that this had been informed by discussions with other staff. In some instances, securing the interest, confidence and support of other staff (e.g., middle/junior managers, administrators, homecare workers) had been essential. Importantly, these staff were reported as being likely to have different perceptions of and attitudes towards research, and different concerns.

The difficulty is engaging our organisation in [a study] without really gauging the interest from other people within the organisation, and I think that can be challenging. If I say to them, "I want us to do this research", they'd be kind of like: "Well, great. But that's going to use my team's time, so how am I going to balance the budget?" (HCP4)

HEMOCARE PROVIDERS' EXPERIENCES OF ACTING AS RESEARCH SITES

All homecare professionals described encountering unanticipated difficulties or challenges acting as a research site. This was attributed to an incomplete understanding of what was involved in supporting a study and had meant that, in many cases, the time and staffing resource that had been allocated to these activities was inadequate. We consider each of these issues in turn below.

Unexpected demands on staff time

Most homecare providers reported that research support tasks had taken longer than expected or that they had not understood the full extent of the work required. Most had, at some stage, considered withdrawing their research support because of this and, indeed, one had reluctantly come to that decision. Homecare providers described feeling pressured and conflicted between supporting the research as had been agreed and ensuring service delivery and quality was not compromised and staff were not over-committed. The highly unpredictable nature of running a homecare service (e.g., staff sickness, urgent referrals, unanticipated increase in a client's care needs) – and with many issues requiring an urgent or rapid response – was often referred to as increasing the challenge of adding research support tasks on to the roles and responsibilities staff were employed to carry out. In some cases, research support activities and processes

had been adjusted so that they better aligned with usual ways of working or recruitment targets renegotiated.

Feeling under-prepared or under-informed

Homecare providers also described, to varying degrees, feeling under-prepared and under-informed, with this only becoming apparent once they started to carry out research support activities. Some believed the researcher's lack of understanding of the homecare context (e.g., lack of research experience, daily pressures, limited staff time, dispersed workforce and clients) meant they had not fully grasped what was involved in asking homecare providers to act as research sites, leading to unfeasible targets and inadequate planning or training. Crucially, homecare providers' lack of research experience meant they were not able to appreciate and judge the feasibility of work-plans or targets, or the adequacy of the training and support being offered or provided by the research team.

... but the main thing is lack of real understanding of the impact on most of our [office] team. The people that they [researchers] are interested in are either our employees working in the field, or our clients and their families who are obviously also not in our office. ...so across 70 employees and 100 clients, is harder than it might first sound'. (HCP4)

Homecare providers also described experiences of having to make decisions (or advise staff) on issues encountered whilst carrying out research support activities (e.g., capacity to consent, eligibility criteria) which, they believed, had not been adequately covered in the training or information provided to them. In the following sub-section we report on these issues in more detail with respect to experiences of identifying and supporting the recruitment of study participants by securing consent to contact: a research support activity carried out by homecare providers for all the studies we investigated.

Reflecting on these experiences, homecare providers believed that more detailed 'process and activity mapping' work with the research team, supported by clear documentation, would have helped decision-making about supporting the study, revealed information needs and areas of misunderstanding to address, and enabled them plan more realistically how they would integrate research support activities into usual ways of working.

Homecare providers' experiences of supporting recruitment

All homecare professionals reported that work to support recruitment had been more time-consuming and complicated than they had anticipated. In addition,

in some instances, their descriptions of the way they had done this suggested *possible* deviations from the study protocol or selection bias. Specifically, providers described screening potential participants (clients, family members, staff) who fulfilled study inclusion/exclusion criteria and then approaching those they thought would be most willing or capable to participate in the study, or would likely to derive most benefit.

I suppose we talked to the people who we felt would potentially be more amenable. In a way, we were doing an element of pre-screening. (HCP7)

...we've got staff who've been working with us for all the time we've been open. We know some of them have been involved in research programmes of the past. They'd probably always be the go-to's again, because they're confident about doing that. (HCP1)

In terms of introducing a study (particularly where clients were involved), homecare providers presented their/their staff's role as including making the case for the research, vouching for its status, safety and trustworthiness, and confirming the credibility of the research team. In addition, many described 'translating' the study information sheet into language thought to be better understood by the target population. In describing these interactions, some used language which may suggest a neutral position was not necessarily maintained. (It is important to note individual differences in the way particular words are understood and used, and to also stress there was no evidence of coercion).

'We could talk to our clients on a non-technical level. It was really - we had enough information that we could persuade people it was worth participating'. (HCP7).

Importantly, in describing these activities, it was not always clear whether these were in accordance with, or out-with, the research team's instructions (see *next section*). However, some did say they had done these things because, having agreed to support a study, they felt under pressure to reach recruitment targets and did not want to let the research team down.

Studies recruiting people with cognitive impairment or mild/early-stage dementia emerged as particularly challenging. Homecare providers said they were not necessarily made aware of a formal diagnosis or felt uncertain about their ability to make judgements about capacity to consent. These situations left homecare providers feeling uncertain and concerned. However, in all instances, these situations were discussed with the researcher and appropriate and effective strategies put in

place. That said, homecare providers reflected that these situations should have been pre-emptively planned for by the researcher and sufficient training and support put in place before recruitment started.

RESEARCHERS' EXPERIENCES OF WORKING WITH HOMECARE PROVIDERS AS RESEARCH SITES

Our interviews with researchers suggest some were aware there was a potential for selection bias. However, they did not appear overly concerned about this, either because of the very exploratory nature of the study or that the study design specified convenience sampling. However, they also referred to tolerating selection bias as a trade-off against achieving the study's recruitment targets. Researchers also shared experiences of encounters with potential research participants (i.e., clients or staff who had consented to contact) where it was clear that the individual did not understand what the research was about or what taking part involved.

Reflecting on ways to mitigate against deviations from the protocol or agreed processes, researchers noted it is unfeasible to cover, in advance, all possible eventualities and decisions which homecare providers may face whilst supporting a study. This was both because some decisions or situations cannot be predicted and because of the difficulty of setting out all potential eventualities, and how they should be responded to. Instead, researchers believed spending more time developing homecare providers understanding of core research concepts and processes (e.g., eligibility criteria, capacity to consent) so they had sufficient knowledge, skills and understanding to make 'safe' decisions was a better and more sustainable strategy.

EXPERIENCES AND VIEWS ON FINANCIAL RECOMPENSE FOR SUPPORTING RESEARCH

Two homecare providers had received payments from their local clinical research network (CRN) for the costs associated with supporting a study. Neither regarded these payments as significantly influencing their decision to support a study. However, the time lag between carrying out research support activities and receiving payment meant they did not have access to this funding when staff were being diverted onto research support tasks. This prevented or limited the extent to which they could cover this additional demand in staff time. They described being frustrated and disappointed by this.

DISCUSSION

In the UK, at least, we are seeing welcome and significant increases in government investment in social care research, with some targeted specifically at homecare (NIHR, 2023). Alongside this has been an

acknowledgement of the need to increase research infrastructure, capacity, and capability within social care (NIHR, 2022b; NIHR 2022d). So far, this investment has primarily been directed at public sector organisations and its workforce. For example, funding for research partnerships between universities and local authorities (NIHR, 2024c) and research fellowships targeted at local authority employees (NIHR, 2024b).

There are multiple reasons why the UK homecare context presents particular challenges with respect to developing research infrastructure, capacity and capability, and securing engagement in research. First, to date there has been very little homecare research (O'Rourke and Beresford, 2022), meaning both that research is unfamiliar to the sector, and there are few researchers with experience of doing research on and in this context. Second, almost all homecare providers are private or, less commonly, third sector organisations. Furthermore, many do not provide homecare commissioned by a local authority, serving instead those who self-fund their care (Laing, 2022). This means that many homecare providers are without the nascent but developing research culture within local authorities and the expectation or requirement to support research that public sector, or publicly funded, services may work under. Third, aside from some national chains, most are small businesses, existing in a climate of business precarity, and with little capacity to take on 'non-essential work' (Care Quality Commission, 2022; Laing, 2022). Taken together these offer a sharp contrast to the NHS context where most health/care research in the UK takes place and where, to date, the majority of research funding has been directed. This means that systems and structures in place to support research may not easily translate to the homecare context.

To our knowledge there has been no research into the experience of conducting homecare research, either from researchers' or homecare providers' perspectives. This study sought to address this gap and thereby contribute to informing debates about what needs to be in place to ensure the sector's engagement with research and the successful delivery of studies.

Overall, we identified multiple challenges or threats to conducting homecare research, many of which align with those reported for care home research, a context similar to homecare in terms of research unfamiliarity and being primarily private sector provision (Lam et al., 2018; Law and Ashworth, 2022; Stephens and Knight, 2022). These ranged from research infrastructure issues (e.g., the lack of a national register of homecare providers interested in supporting research), researchers' inadequate understanding of the homecare context and the implications this may have for research support and delivery, homecare providers' fragile and limited capacity to support research, and a lack of knowledge, understanding and research skills among homecare

staff, both managerial and frontline. The potential impacts of these challenges were multiple, including delayed study completion or missed targets (e.g., recruitment), deviations from the protocol/research processes, staff being diverted away from essential business activities and responsibilities, and heightened stress among homecare staff responsible for supporting study delivery. The implications of these findings concern both individual research teams and organisations which fund or commission research, including the government-funded National Institute for Health and Care Research (NIHR). We consider each in turn.

For research teams, our findings highlight the importance of not making assumptions about what homecare business owners/senior managers know or understand about research. This has implications both in terms of them making the decision to support a study and carrying out research support activities. Specifically, researchers need understand how homecare organisations operate and to be realistic and transparent about the time demands supporting their research will entail, both for office and front-line staff. They also need to ensure study documentation setting out research processes is in place and sufficiently fine-grained so that those overseeing or managing the research do not find themselves making *ad hoc* decisions or find themselves unsure of what to do. We would suggest that researchers need to expect to be more proactive in supervising and supporting homecare organisations to fulfil research support activities than they may have found is needed for healthcare settings. Research teams also need to be ready and prepared to adjust research processes to minimise disruption to and demand on usual procedures and practices. Finally, and no less important, researchers should understand and recognise the (considerable) operational and business pressures that homecare providers operate under (Care Quality Commission, 2022; Skills for Care, 2023).

Over and above these specific responsibilities is the importance of researchers recognising the relational nature of the collaborations they are seeking with homecare providers. We found that homecare providers were attuned to, and made judgements about, researchers' attitudes, behaviours, and authenticity. Work was required to build trust and a sense of partnership, and researchers needed to exhibit a genuine respect for the expertise homecare staff brought to that partnership. Parties had to listen to each other, with difficulties encountered when researchers made assumptions about what information, training and support was needed based on experiences of doing research in other settings or with other homecare providers. It is also clear that, to secure support from the homecare sector, research needs to both speak to their issues and concerns and is presented and understood as an ally, rather than a threat.

None of these arguments are necessarily new: we know that successful 'research-practice' partnerships are underpinned by effective communication, trust and respect (Boaz et al., 2023; Cooper, MacGregor and Shewchuk, 2021) and, for research to be impactful, it needs to respond to the questions and priorities of the sector or population it is concerned with (Grill, 2021). Perhaps less explicit in this literature, and a contribution this study makes, is to highlight the importance of paying attention to *what* needs to be communicated between partners: this requires not making assumptions and, rather, actively seeking to establish what the other partner already knows and understands.

Turning now to implications for organisations which fund or commission research.

This study yielded examples of the way individual research teams worked to develop research awareness, knowledge, and skills within the homecare organisations they were partnering with. However, if we are to see a significant uptick in the amount of research on homecare, this is neither effective nor efficient.

The findings from this study suggest that existing national strategies and programmes to increase research engagement, capacity and capability within social care may need to be adapted and developed if they are to be successful in the homecare context.

First, whilst there has been an opening-up of access to UK government-funded training (provided by NIHR) on 'research basics' to non-public sector staff, even materials specifically developed for social care settings (e.g., the ENRICH programme; <https://enrich.nihr.ac.uk/>) focus mainly on educating staff to support clinical trials. Such training/education courses and resources are unlikely to be relevant to the homecare context where the focus of research is more likely to be *about* homecare, rather than it being setting from which patient groups are recruited to clinical trials. This suggests that national level investment in research awareness, capacity and capability is needed that is tailored both to the homecare context *and* the sorts of research taking place in these settings.

Furthermore, such efforts should not focus only on training and upskilling those *directly* involved in supporting research. As important, or perhaps more important at this point, is the need to invest in awareness-raising, educational and engagement activities directed at gatekeepers. Working in partnership with national organisations representing homecare providers (e.g., National Care Association, Care England, Homecare Association) and organisations running national conferences for the sector could be ways to achieve this. Until this is in place, we would suggest that UK research funders should be prepared to resource research teams to train and equip the homecare providers they work with, and require evidence in funding applications on the strategies by which research teams will achieve this.

Finally, we draw attention to homecare providers' experiences of regarding financial support for supporting research. Some were not offered any. Two received payments from a national research support programme known as clinical research networks, shortly to be transformed into the NIHR Research Delivery Network (NIHR, 2024d). Both highlighted the mis-match between when financial support would have been helpful (at the time staff were diverted onto to research support tasks) and when it was received. This is another illustration of how research support systems and resources designed for large, public sector organisations are not fit for purpose for use with small, private sector organisations.

STUDY LIMITATIONS

Fourteen studies were represented in this research. The homecare providers recruited to the study (all for-profit businesses, and typically the owners of a single homecare franchise) had, together, supported nine of these studies. Researchers from 10 of the studies were also recruited. The lack of a national level data on homecare research means we do not know how much our sample reflects the entire body of UK homecare research, nor the homecare providers which have supported these studies. In addition, the study did not identify any third sector homecare providers to recruit to the study: it is possible the different nature of these organisations generates different barriers (or facilitators) to supporting research. Furthermore, we cannot gauge whether the experiences we present here are typical or represent the more successful research collaborations. That said, criticisms and difficult experiences were discussed but, typically, resolved or overcome. Given a key objective of this study was to generate evidence to support the development of an on-line 'doing research in homecare' toolkit, the fact our sample could reflect what helped to pre-empt or overcome difficulties is pertinent and valuable.

CONCLUSION

This paper reports the first study to investigate homecare providers' (specifically, owners or senior managers) and researchers' experiences of research collaborations. The study is very timely given the significant and sustained increases in research funding available for social care in the UK. Challenges were reported on both sides: researchers described difficulties identifying and then securing homecare providers to act as research sites. Homecare providers recruited to the study were keen to support research but encountered unanticipated demands on staff time and found they were under-equipped to do the research tasks required of them. Findings highlight the support and resources homecare providers need to get involved with and support research. This, in turn, points to a need

for strategic investment in training and research support to the sector, conceived and developed in partnership with them.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Supplementary file 1.** Study participant characteristics. DOI: <https://doi.org/10.31389/jltc.250.s1>
- **Supplementary file 2.** Characteristics of studies represented and research support activities undertaken. DOI: <https://doi.org/10.31389/jltc.250.s2>

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COMPETING INTERESTS

The authors have no competing interests to declare.

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