Agenda Item No: 8

DEEP DIVE: NEIGHBOURHOOD CARES PILOT

To:	**Adults Committee**
Meeting Date:	**24 May 2018**
From:	**Executive Director: People and Communities**
Electoral division(s):	***All***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To note this 'deep dive' report provides an update on progress on the Neighbourhood Cares Pilot to date as well as future plans for the pilot.**
Recommendation:	**To consider the report and provide comments on progress, proposed developments and issues raised by the pilot so far.** **To endorse the recommendations for the next phase of the pilot as set out in Section 8 of the report.**

Officer contact:		***Member contacts:***	
Name:	Louise Tranham	Names:	Cllr Bailey/Cllr Howell
Post:	Neighbourhood Cares Manager	Post:	Chair/Vice-Chair
Email:	louise.tranham@cambridgeshireshire.gov.uk	Email:	annabailey@hotmail.co.uk / mark.howell@cambridgeshire.gov.uk
Tel:	01223 729139	Tel:	01223 706398

1.0 BACKGROUND

1.1 What is the Neighbourhood Cares Pilot?

1.1.1 The Neighbourhood Cares Project (NCP) is piloting a radically different model of social care work and social work with funding approved by the General Purposes Committee (GPC) and the Strategic Management Team (SMT) in November 2017.

1.1.2 Buurtzorg Model

The Neighbourhood Cares pilot is based upon the principles of the Buurtzorg model of care that involves the creation of self-managing nursing teams to meet the short term health and care needs for people living in their own homes. This model of care is now offered by over 10,000 nurses and care staff in Holland. The success of Buurtzorg is a natural fit with the direction of travel we have for adult social care and we are applying the Buurtzorg principles to accelerate our transformation of the care and support to older people and people with physical disabilities.

We are also collaborating with the East of England Local Government Association as part of a regional programme, supported by Public World, to promote awareness and learning about the Buurtzorg approach and how it might be applied in the UK in adult social care. http://www.publicworld.co.uk/project/buurtzorg/

1.1.3 The key outcomes set out in the business case are:

- Shift as much resource as possible to the front line.
- Free up staff to have more direct contact with people enabling them to do the right thing, at the right time in the right place and improve job satisfaction because they can see the difference they can make.
- Improve the quality and continuity of care and support to people.
- Increase capacity where we currently have capacity gaps, particularly in home care.
- Reduce the cost of care.
- Set ourselves up for the future, learning from the pilot sites to form the basis for the wider transformation of the whole system.

1.1.4 The NCP has two pilot sites with a population of 10,000, one in an urban setting and the other in a more rural setting. The decision on the sites was taken following analysis of the demographic information and in consultation with key stakeholders such as the NHS, voluntary sector and the Older People's Partnership Board. Performance of and outcomes from the pilot sites will be evaluated and compared with two similar sites, Eaton Socon and Littleport.

1.1.5 While the Soham NCP covers the town itself the St Ives NCP is attached to the Spinney GP practice. Consequently this NCP covers a larger geographical area as patients live in surrounding villages including Fenstanton, Hartford, Houghton and Wyton.

There are four other GP practices in the St Ives area. This has meant that the St Ives team has not actively promoted itself in community settings because residents not registered at the Spinney Practice cannot participate in the pilot. This has not prevented other residents receiving advice but has highlighted the issue of pilot sites covering part of a larger town.

1.1.6 A new job role, 'Neighbourhood Cares Worker' (NCW), has been created for this project. Each self-managed team is made up of the equivalent of four full time workers recruited at Senior Social Worker (MB2) level. The recruitment process has successfully brought together staff from a range of professional backgrounds. The teams are committed to working flexibly and creatively and are equipped to take on new challenges and responsibilities.

1.1.7 Following the completion of a comprehensive training and induction programme the NCP teams went live from October 2017. The topics covered in their induction that were additional to the induction of other social workers were:

- Networking and understanding the local community by listening and spending time with those that live, work and volunteer in the community.
- Developing the ground rules of being a self-managed team, agreeing day to day operational practice of the team and the role and responsibilities of each NCW.
- Building relationships with key partners and stakeholders to raise awareness about NCP.
- Training to provide personal care and support with daily living.

1.1.8 A Neighbourhood Cares Manager was appointed to support the NCP teams to operate in a different way. This role involves being:

- A coach /manager to ensure day to day performance requirements are met.
- A 'heat shield' for the NCWs that allows them to test new ways of working, and maximise their autonomy.
- A consistent link to corporate colleagues, partners and members to ensure that the NCP is fully testing the principles set out in the business case.
- Identifying and working with external evaluators and other sources of external support and challenge such as 'Public World'.

1.1.9 York Consulting has been appointed to complete an external evaluation and will provide an interim report in September 2018 and a final report in March 2019.

2.0 IMPACT AND LEARNING FROM THE NEIGHBOURHOOD CARES PILOT TO DATE

2.1 Work with local people

2.1.1 NCP has worked with 180 people in St Ives and 260 people in Soham. 47% of the people in Soham are already known to other adult social care teams compared with 12% in St Ives. This reflects the significantly higher number of people in St Ives who may have eligible needs but are funding their own care.

Cases are now being transferred from the Older Peoples and Physical Disabilities Teams. This is being done prior to a person's annual review of their care and support plan to test if NCP can achieve better outcomes using different care and support options including community solutions. To date 56 people in St Ives and 90 people in Soham have been transferred.

2.1.2 One of the differences between NCP workers and other adult social workers is that they are trained to provide personal care and support with daily living. This is provided in urgent and unplanned situations. This enables short term support to be provided quickly by someone already known to the client. This approach can also help to bridge a gap until longer term care is sourced. 12 people in St Ives and 10 in Soham have been supported in this way.

For example:

- Family carers needed to go away for a few days and their father refused to have respite care in a care home. The NCWs visited him three times to support him with his personal care and help him prepare meals.
- The neighbour of a woman who was seen wandering at night contacted the team for advice. The NCW visited the woman and thought that she may be suffering from a urinary tract infection. The worker stayed with the woman while arranging for a urine test to be done, collected the antibiotics and made her a meal to ensure that the medication was taken appropriately. The NCW checked that she was recovering over the following days.
- After a woman had broken her arm she was visited by a NCW for three days. This involved helping her work out alternative ways to do everyday tasks while her arm was in plaster and arrange for her to have equipment to help her.

The key role of the NCWs is co-ordinate the care and support needed to ensure that long term needs are met safely, and the ability to provide some short term care provides a rapid response and an opportunity understand, prevent or meet longer term needs, if required.

2.2 A new approach to recruitment, selection and team building

2.2.1 The importance of appointing the right people to the role of NCWs cannot be underestimated. We have used an assessment centre approach to select staff for the NCP. This has helped increase confidence that the people we are appointing have the skills we need. Whilst it is more intensive and costly it has also helped to promote the pilot and the Council.

2.2.2 For the teams to be ready to operate on the 'go live' date, it required a considerably longer induction period than is offered to other social workers. To be effective the NCWs needed time to network with key partners, understand and be known to community organisations, and begin to understand the needs and gaps in local capacity. This confidence building and community appraisal phase will be a prerequisite when creating new teams.

2.2.3 It has also been important to enable the people appointed to have time to work through what it means to be part of a self-managed team and make the best use of each worker's knowledge and strengths.

2.2.4 The two NCP teams meet every four weeks to share learning and compare challenges and talk about how best to meet them.

These challenges have included:

- Testing a new way of working while operating with existing systems and the adult social care legal framework.
- Ensuring that all the information needed to support the evaluation is being collected when one of the aims of the NCP is to reduce paperwork.
- Managing expectations of NCP while its future is uncertain.
- Recognising that the presence of NCP may be threatening to others.
- Balancing responding to requests for information with the need to deliver and implement.
- Providing evidence on reducing the cost of care.

2.3 Promotion and marketing of the NCP

2.3.1 Encouraging people to access good quality information and advice is a key part of NCP's offer which enables people to act for themselves to prevent or delay the need for support. It has been important to develop a distinct branding from NCP that is welcoming and also recognises that some people may be wary of talking to "Social Services".

2.3.2 The NCWs have designed and developed their own marketing materials and leaflets and shared them with all local groups. These will be developed to reflect local feedback to include the information and advice people want.

2.4 Accommodation

2.4.1 Having the Soham library as the team's base has been beneficial in terms of foot fall and access to a range of meeting spaces. The NCP has been able to use the library building during and outside of normal opening times. A common response from people attending events run by the NCP at the library is "I have not been in the building since I was at school. I will now come in again it's got such a welcoming atmosphere". However, the unreliable IT has been a real challenge and has affected the team's ability to function effectively.

2.4.2 The St Ives NCP is based in the Broad Leas Centre in St Ives. In the early days there was plenty of space for the NCWs. Following changes in Children's Services less space is now available and the Centre is not particularly accessible for people with disabilities who need space to have a private conversation.

2.5 Working with Primary Care and community health services

2.5.1 The Staploe Surgery in Soham has been very welcoming to the NCP but has not been able to provide space within the surgery for the NCWs to work. Once the NCP went

live the practice quickly saw the benefits of the work done by the team and invited the NCWs to their monthly multi-disciplinary meeting. The number of referrals from the practice is significantly lower than in the St Ives NCP. In Soham 6 of the 184 referrals have come from the GPs. Some people who have made contact themselves, have said that the surgery recommended that they did so.

2.5.2 The Spinney Practice has been able to offer the NCWs a meeting space in the practice once a week and have arranged for workers to have access to their IT systems. Having a regular presence in the practice has helped build relationships with all staff and is reflected in the relatively high number of referrals (42 out of 116) from GPs. The practice has actively promoted NCP to all patients over 80 years of age and hosted a social event which 60 patients and 11 local organisations attended. One of the outcomes from the event was that NCWs have supported the development of new community groups e.g. a lunch club.

2.5.3 A number of the Case Studies in Appendix 2 demonstrate the benefits of gaining the trust of health colleagues and working collaboratively with them.

2.6 Developing social capital

2.6.1 The people of Soham have shown a high level of interest in developing community groups. The NCWs in Soham are responding to this by re-energising and re-establishing community groups and encouraging them to work together to prevent duplication. For example the NCP is working with a number of groups in Soham is ensuring a range of opportunities are available to ensure that "No one is ever alone in Soham".

2.6.2 The NCP also hosted a Volunteers Fair from which 15 people have become involved in:

- Libraries at Home
- IT Buddy
- Age UK Visiting Scheme
- Pos+Ability
- Ely Social Car Scheme
- Neighbourhood Cares Volunteers
- Soham's first Repair Café will happen on 20 May at Soham Library
- A local resident is exploring setting up a ' Men in Sheds@ project
- New 'Friendly Dogs' session being set up at the library. This will be delivered by volunteers from a local Dog Training School
- Finding volunteers to help produce a Soham newsletter
- Supporting residents to develop a Community Map of local activities

2.6.3 In St Ives the following activities have been supported by NCP to create new solutions to emerging needs:

- Men linked into existing volunteering opportunities including the St Ives Timebank, Men's Sheds in Bury (Ramshed) and Mind, Body and Soil

- Collaborative approach to setting up a Men's group with Care Network Cambridgeshire at the Norris Museum
- Partnership working with local community car scheme and Time bank offering transport to community events
- An intergenerational project with Thorndown Primary School. This included letter writing exchange between children and adults in St Ives. We intend to build on this to include a regular meeting between adults and children on a monthly basis
- Development of monthly 'Coffee and Cake' at Bests coffee shop. This was popular between Christmas and New Year and has continued on a monthly basis
- St Ives has a new lunch club. Twenty people now meet at the Haywain pub which has started an OAP menu
- New craft group held at the library once each month

2.6.4 Both teams have been working to attract volunteers to work as part of the NCP. For example one volunteer is being used to visit and befriend a woman with Multiple Sclerosis whose husband provides all her care and is reluctant to give himself breaks. The volunteer has been able to establish a positive relationship with both the husband and wife and both are benefitting from her support. Another is providing an ambassadorial role for the Soham NCP linking with other community groups and promoting the role of NCP in Soham. Other volunteers have done leaflet dropping and regularly attend drop ins and community meetings to make cups of tea and welcome people and record who attends.

3.0 FEEDBACK FROM EXTERNAL EVALUATOR, YORK CONSULTING

3.1 The Evaluation Process

3.1.1 Much of their initial work has focused on gaining an understanding of the implementation processes, the model of delivery, early successes, and challenges and issues faced by the project. Researchers have consulted with managers, visited the teams, spoken to key partners and had initial consultations with clients. The next stage will be to undertake 20 in-depth, client case studies (10 in each team). These case studies will provide evidence of the benefits to clients/family members and services supporting them. The evaluators will also use the case studies to provide a detailed cost-benefit assessment of the pilot.

3.1.2 The main implementation challenges arise from an approach which is innovative, flexible and responsive but must fit within existing structures. York Consulting advised that lack of control of the care budgets for the people supported by the teams has impacted on the teams' ability to provide a truly flexible response. This is now being addressed. See Section 8.

They also stated that in the early stages a lack of understanding of the teams' role and what they can do, was evident amongst other services. This is not surprising given the nature of the pilot and that it is a new approach to delivery of care and support. Concerns were also expressed that the teams are duplicating work already undertaken by other services. In response, the teams have worked hard to raise awareness of their offer and how it fits with and can add value to existing provision and this will be an iterative process as the project develops.

Cover over weekends and outside normal working hours has been raised as an issue. To address this NCWs are making contingency plans with people that will help them access appropriate support from family, friends, NCWs, re-ablement and primary care services.

Early successes have focused on the experience and calibre of the teams and their ability to provide an immediate, local response without a formal assessment. What has made the difference is their strengths-based, client-centred, localised approach and ability to deliver on what clients say they need. "*I was invisible, now I'm visible*" (Client).

York Consulting has commented that the approach being taken by the team enables them to treat clients as individuals, work on reducing their dependency and help them to manage their own conditions, which in turn is reducing demands on other services such as GPs and 111. The teams are helping clients manage the services involved with them, as well as identifying and accessing other individuals, groups and/or services that can help meet their needs more effectively. They are also helping to step down support because it is no longer required. There is evidence to show that the teams are helping to de-escalate potential crises, such as mental health crises and emergency hospital admissions. They are also supporting clients who currently do not meet thresholds for services but whose needs are likely to escalate with age and increased frailty. They are helping clients develop protective mechanisms /support that they can draw on to build their resilience.

4.0 FEEDBACK FROM PUBLIC WORLD AND SHARED LEARNING WITH OTHERS IN THE UK USING BUURTZORG PRINCIPLES

4.1 To ensure we are using the Buurtzorg principles in delivering the project outcomes we asked Public World to carry out a 'health assessment' on our approach.

Public World concluded: "We have met many enthusiastic and energised individuals in this pilot, which clearly has inspired many people. As a result, it was a great pleasure to carry out this brief 'health assessment'".

Public World recommend that in order to support the aim of having self-managed teams we should

- Give the NCWs the opportunity to meet with Buurtzorg Nurses to set a bench mark on what is achievable.
- NCWs to receive training on Buurtzorg's Solution Driven Method of Interaction. This would support the teams in decision making, conflict resolution and enhance their ability to operate as self-managed teams.
- Develop a framework that defines the boundaries for the teams to work in and organisational requirements to deal with budgets and appraisals.
- Provide Coach Training and ongoing support.
- Provide Heatshield training and ongoing support to simplify, protect and support the teams and review what care solutions are possible/needed.
- Develop a framework with the teams that addresses the need for performance data.

We plan to continue to work closely with Public World in order to strengthen the pilot and its outcomes.

4.2 We are also in regular dialogue with other local authorities using the Buurtzorg Principles. These include Suffolk, Newham and Tower Hamlets and have planned learning opportunities and workshops with them.

5.0 CASE STUDIES

5.1 Appendix 2 provides a number of case studies to illustrate the work of the pilot as were outlined in the business case for NCP:

- Understanding their communities. Identifying people at all levels of need who might require help, as well as the people within communities with the capacity to help others.
- Building community capacity. Working to encourage the development of social or micro enterprises as new care provision or to support other community-led activities to establish.
- Complementing the Adult Early Help (AEH) team where face to face contact is needed to advise on ways people and their carers can organise help for themselves and resolve issues without the need for a formal assessment or care plan.
- Visit people that go into hospital or other settings and help them plan a return to living as independently as possible.
- Assessing needs. This might be a statutory assessment but a lot of the 'assessment' work is part of the regular home visits and is built into "hands on" care.
- Identifying where housing adaptations, community equipment or assistive technology should be used and making sure it is put in place.
- Identifying and investigating (or escalating) safeguarding concerns.
- Identifying where people need ongoing care and working with them to make and organise a plan.
- Providing "hands on" care where appropriate, including ongoing care.
- Liaising with local health teams and other key partners to ensure wider needs are met.
- Reviewing people's needs, not as a formal process, but constantly, responding flexibly to needs day to day by working as a team.

6.0 FEEDBACK FROM PEOPLE WHO HAVE RECEIVED SUPPORT FROM THE NCP

6.1 "What you're doing for me is really useful. It's made me think about widening my networks and getting involved with things."

6.2 A quote from a couple who are keen to move their mother to this area to live with them for extra support: "Thank you so much for taking your time with us and explaining everything" (in relation to disabled facilities grants and local support and voluntary agencies). "We didn't know where to go before".

6.3 From a woman who lives alone: "I'm telling people how good you have been, you have given me confidence. It's a very nice life line, to be able to call someone if needed".

6.4 Mr Q in St Ives asked to speak to me directly to say that the NCW was very good and had gone the extra mile in supporting him and his wife. He also felt that the service was a brilliant service and much needed by the local community.

6.5 It's more about sharing, than caring. People like to be cared about, but not to have care done to them. When you change that mind-set to sharing time with someone, it changes the whole perspective and experience for both parties. A problem shared is a problem halved and a cost saved.

6.6 One person when asked if she would like a photo taken with a caption of what the NCWs meant to her said she would love to say how important they have been to her, except that she was welling up with tears when she related how much NCW had changed her life and didn't want to be red-eyed in a photo!

6.7 "I just wanted to drop you a line to thank you for coming out to meet my father yesterday. It was so lovely to meet you and having someone as experienced and communicative as yourself to chat to, is so reassuring for him. I and my sister were so delighted that you spent so much time with him, listening to his opinions. He was very, very impressed to meet you. Thanks for arranging to see him independently. His partner can be tricky and has some mental health issues which mean that she struggles with caring for him at times and struggles to communicate well with myself and my sisters so having someone as professional and experienced as yourself to be an outside eye at times is invaluable."

7.0 QUOTES FROM FOUR OF THE NEIGHBOURHOOD CARES WORKERS

7.1 "Being able to do what is right for the person, building relationships so that the person gets to know you and the Neighbourhood Cares Team, and the NCW knows the person they are supporting. Being able to support the person flexibly and with the approach that is best for the person and what they want not just with a set process. Being able to support someone ongoing for as long as required and not just for one or two visits, then no support until the next review or assessment. Building up a network of support and knowledge of the local community so that people can access and get the most out of the community they are living in".

7.2 "By being allowed the freedom to do what is right for the person makes such a huge impact of all involved".

7.3 "I really enjoy the fact that - most of the time – we can flex the service to suit the needs of the people we work with, rather than forcing them into a system. I like the fact that we get to know the community in depth, so that we have a real understanding of what is on offer for people locally, and how we can develop that. I like the fact that we can have an ongoing relationship with the people we work with, so we can see them develop their strengths, their confidence and their resilience, and of course, the point I keep coming back to, this job allows me to be the social worker I always wanted to be."

7.4 "Working in one community makes so much sense. We know the people, we know the place. By supporting people early on - before they hit crisis – we can prevent them needing our services later, and we do that in the best possible way by connecting them to the wealth of local assets. Assets you only know about when you really get to know

a community. A centralised team can't possibly know about the tiny local bereavement group or the family who want to offer their help with respite, we do."

8.0 NEXT STEPS IN THE DEVELOPMENT OF THE NEIGHBOURHOOD CARES PILOT

8.1 We want to be more ambitious in the next phase of the pilot and will test the application of the Buurtzorg model by implementing the following actions.

Until now NCP has been operating broadly within the same framework as other adult social care teams. Now that the teams are established we want to fully test the Buurtzorg principles. To do this it is proposed that each team becomes financially accountable for a devolved budget that is made up from the personal budgets from all the people in the pilot. In addition each team will have a capitated sum from their share of preventative services such as assistive technology and re-ablement.

In making their decisions the NCWs will aim to achieve one or more of the following outcomes:

- Improve outcomes for service users.
- Manage costs by achieving the same or better outcomes in a more cost effective way.
- Manage demand by care and support.

8.2 We will continue to work with York Consulting to develop the evaluation process to provide evidence of improved outcomes. A baseline devolved budget is being created for each site using financial data for October 2017 i.e. at the point NCP went live. The trend in overall spend and by type of service will be monitored to provide evidence of the financial outcomes. The NCP financial position will be reported in the July Finance and Performance Reports that are presented to committee in September.

8.3 We will allocate some of the funding identified for recruitment of additional re-ablement staff to the teams and allow them to decide how they wish to recruit staff to work as part of their team.

8.4 Develop new ways to meet unplanned and ongoing personal care needs. This will include promoting a more personalised approach through direct payments and micro enterprises or having alternative operating models with partner providers. Any alternative arrangements that are made would be coordinated by the NCWs as the main point of contact.

8.5 Increase the number of personal care assistants working in both communities to deliver personalised care as part on the NCP.

8.6 Change our relationship with local domiciliary care providers to achieve more flexibility and a focus on prevention and outcomes.

8.7 Recruit and support more volunteers who will work as part of the NCP and with existing or new community groups.

8.8 Working closely with discharge planning colleagues to ensure people exit hospital with the help they need as soon as they are fit to do so ensuring they do not stay in hospital longer than is necessary.

8.9 Ensure that the implementation of the new adult social care information system (Mosaic) enables the NCP approach.

8.10 Continue to facilitate the growth of social enterprises, community groups and local businesses to reduce dependency on traditional statutory services.

9.0 ALIGNMENT WITH CORPORATE PRIORITIES

9.1 Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

9.2 Developing the local economy for the benefit of all

9.2.1 *The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the benefits for both the local economy and the benefits for all living and working in the communities piloted.*

9.3 Helping people live healthy and independent lives

9.3.1 *The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the best way to support people to live independent and health lives.*

9.4 Supporting and protecting vulnerable people

9.4.1 *The overall approach and purpose of the Neighbourhood Cares Pilot is to test and learn the best way to support and protect vulnerable people.*

10.0 SIGNIFICANT IMPLICATIONS

10.1 Resource Implications

10.1.1**.** *The Neighbourhood Cares Pilot has an allocated budget**:***

10.2 Procurement/Contractual/Council Contract Procedure Rules Implications

10.2.1 *There are no significant implications within this category*

10.3 Statutory, Legal and Risk Implications

10.3.1 *There are no significant implications within this category*

10.4 Equality and Diversity Implications

There are no significant implications within this category

10.5 Engagement and Communications Implications

The neighbourhood Cares pilot is working with the council's communication team in order to provide updates on the pilot with in a communications plan.

10.6 Localism and Local Member Involvement

Local Members have been informed of the Neighbourhood Cares Pilot and their engagement and involvement in the pilot is welcomed at all times.

10.7 Public Health Implications

The aim of the Neighbourhood Cares pilot is to ensure a better coordination of health and social care service for the people in the communities the pilots are delivered in. To ensure that the right support and services are delivered at the right time in the right place to enable people to make the choices they need to make to live well and independently

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	**Yes** or No Name of Financial Officer:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	**Yes** or No Name of Financial Officer:
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	**Yes** or No Name of Officer:
Have any engagement and communication implications been cleared by Communications?	Yes or No Name of Officer:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	**Yes** or No Name of Officer:
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

Source Documents	Location
Key Trend graphs	Laura Jane Winter and Patrick Killenny 2nd Floor Octagon Shire Hall Cambridge

Appendix 1

In this Appendix, information is provided to give a statistical overview of the NCP to date. Data provided includes both the two pilot communities of Soham and St Ives and the two comparison communities of Littleport and St Neots (Eaton Socon).

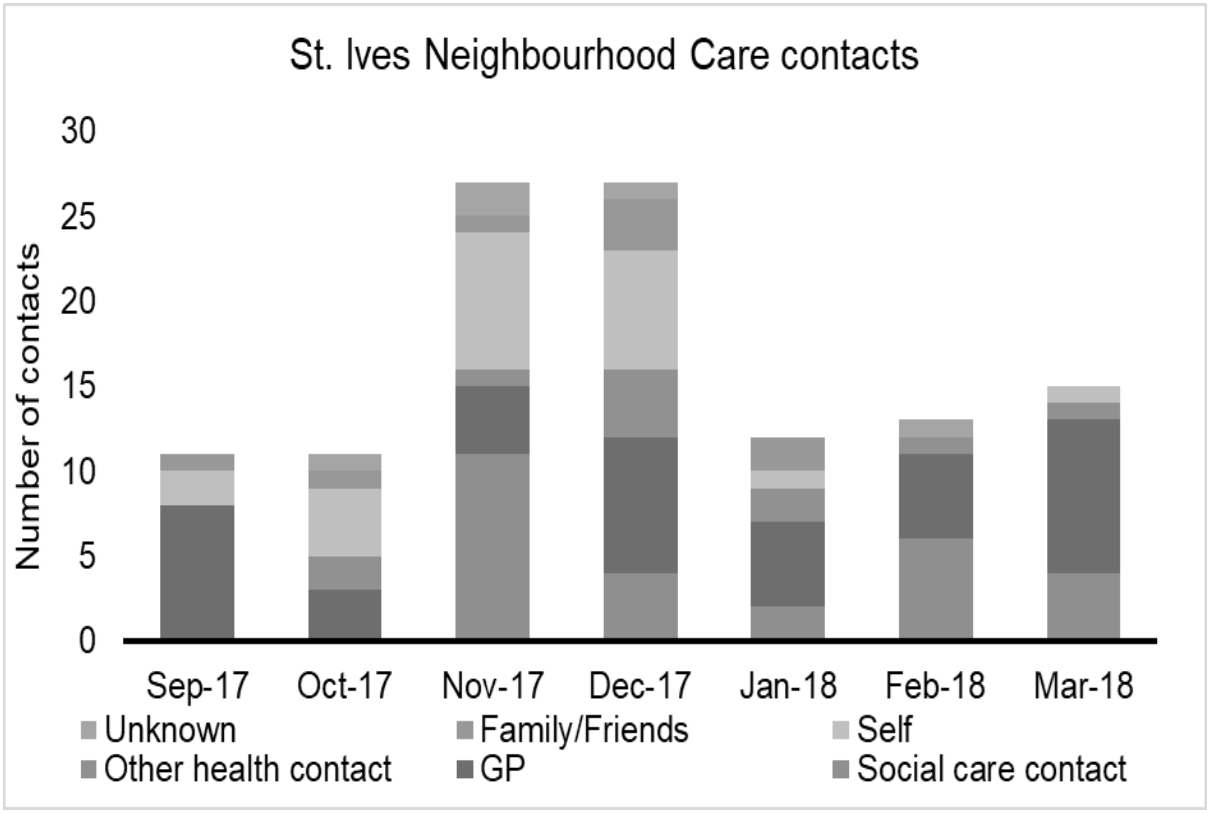
Number of service users receiving home care and rates of home care per 1000 population for Neighbourhood Care Pilot areas and their comparator areas

- This is based on data from the October 2017 statutory return.
- All service areas are included.

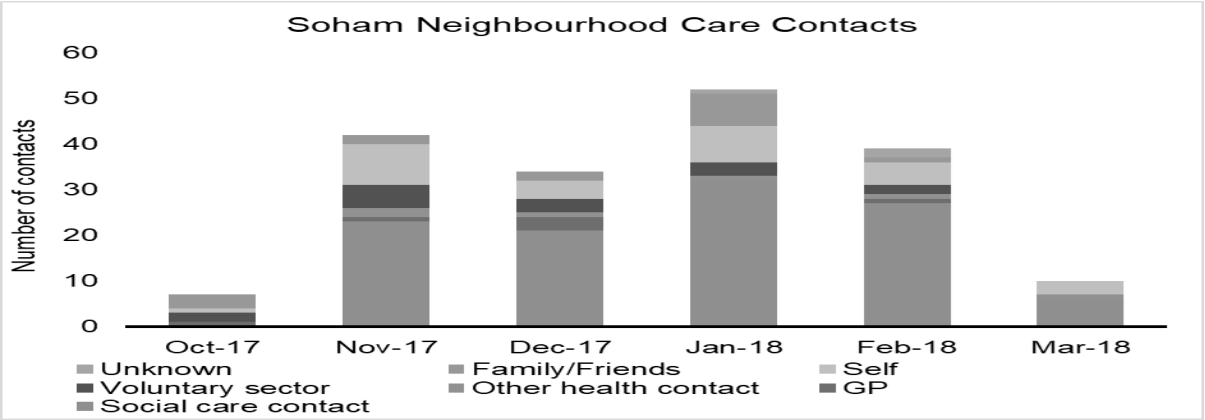
NCP patch	Age band	Population	Number of homecare provisions	Rate per 1000 population
Littleport	18-64	5480	22	4.0
	65+	1680	42	25.0
	All adults	**7160**	**64**	**8.9**
Soham	18-64	8020	22	2.7
	65+	2020	43	21.3
	All adults	**10040**	**65**	**6.5**
St Ives	18-64	10310	17	1.6
	65+	3300	65	19.7
	All adults	**13610**	**82**	**6.0**
St Neots	18-64	20130	30	1.5
	65+	6040	132	21.9
	All adults	**26170**	**162**	**6.2**

Monthly referrals/contacts to the Neighbourhood Care Teams

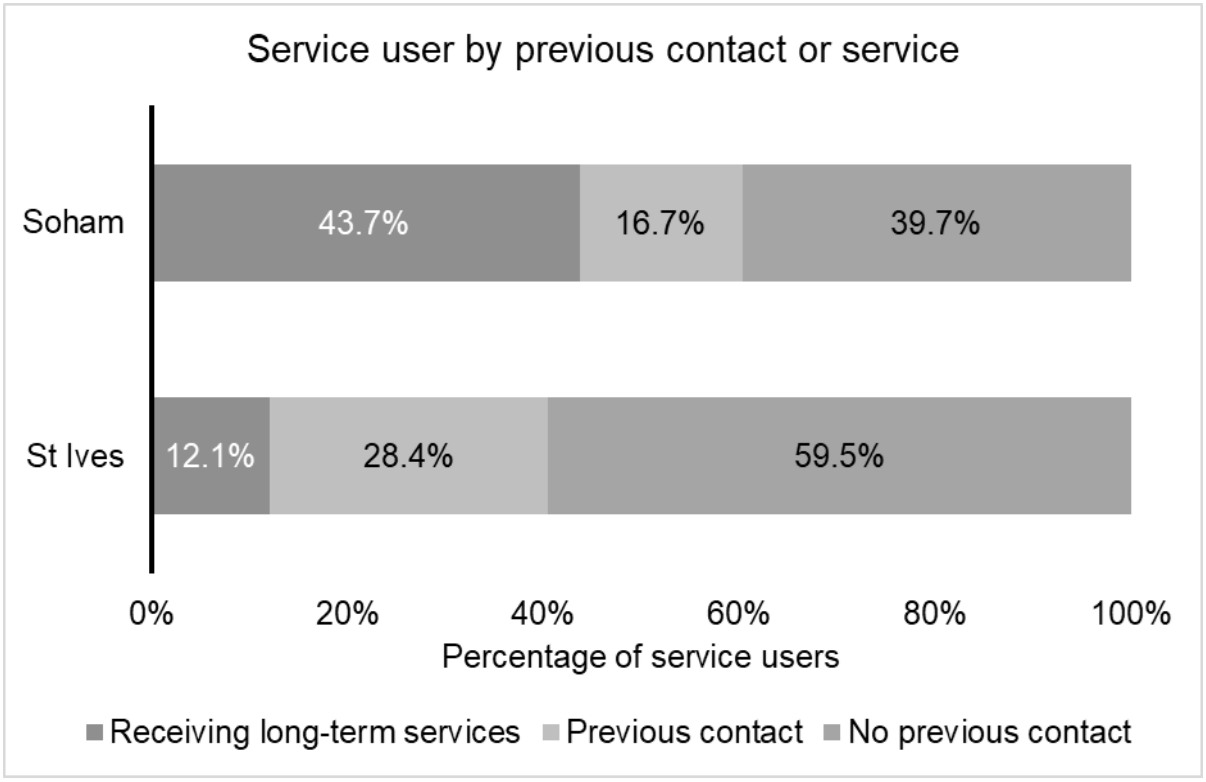
(Although both teams went officially live during October 2017, St Ives did start taking on work at the end of September 2017).



Month	Social care contact	GP	Other health contact	Self	Family/ Friends	Unknown	Total
Sep-17		8		2	1		11
Oct-17		3	2	4	1	1	11
Nov-17	11	4	1	8	1	2	27
Dec-17	4	8	4	7	3	1	27
Jan-18	2	5	2	1	2		12
Feb-18	6	5	1			1	13
Mar-18	4	9	1	1			15
Total	**27**	**42**	**11**	**23**	**8**	**5**	**116**



Month	Social care contact	GP	Other health contact	Voluntary sector	Self	Family/Friends	Unknown	Total
Oct-17		1		2	1	3		7
Nov-17	23	1	2	5	9	2		42
Dec-17	21	3	1	3	4	2		34
Jan-18	32		1	3	8	7	1	52
Feb-18	27	1	1	2	5	1	2	39
Mar-18	6		1		3			10
Total	**109**	**6**	**6**	**15**	**30**	**15**	**3**	**184**



	St Ives	Soham
Receiving long-term services	14	76
Previous contact	33	29
No previous contact	69	69
Total	**116**	**174**

Appendix 2

Case Studies

Case study 1 - Mr A and partner Ms M

Mr A is a gentleman over 65, referred by GP due to immobility and low mood. I went to visit but he was very ill and was admitted to hospital that day. I supported his partner, she was struggling with medication as Mr A usually took care of this for her. She had been without medication for 3 days as Mr A had been ill in bed for that time. I arranged with GP surgery and pharmacy to switch her meds to a Dossett box which was done that day. Mr A was in hospital for a week; I kept in regular touch with his partner and I also spoke to the hospital. Following discharge, I visited to see if there was any support needed. On second visit post discharge I was able to identify with Mr A that he would like to be more socially active, as he spends most of his time in the home reading and watching TV. He also expressed an interest in volunteering opportunities. I have found a book group for him to join and also put him in touch with the Volunteer Bureau and with the Time Bank. I am visiting this week to support him to complete an application for Attendance Allowance. I have also spoken to his partner about her needs as a carer, and whether she would also benefit from additional support.

Key Outcome: Working with GP and Pharmacy ensured partner can self-medicate even if partner not well, also preventing need for formal care. Visit post hospital discharge helped ensure appropriate support to enhance recovery.

Mr A and Ms M both receiving all benefits eligible for so have additional income. Hands on support has prevented any need for commissioning of formal support and regular contact has enhanced mental wellbeing by reducing social isolation and promoting self-worth.

Case Study 2 – Mrs B

Mrs B is in her 80s. Following a stay in hospital was discharged to a nursing home. Nephew contacted the team as aunt keen to return to her own home and he did not know how to support her to do this. Mrs B has daily care needs and is financially able to pay for the care she needs, but requires support in setting this up to ensure it is the most appropriate care and is also linked into all support available to Mrs B and her family and friends who wish to support her living in her own home.

NCW worked alongside CPFT colleagues in assessing what support Mrs B needed to live at home. This included ensuring the right equipment was in place, as well as assisting Mrs B and her nephew in finding who could provide the care to assist with all Mrs B's personal care needs. Using personal care assistants was discussed but initially Mrs B wanted to use a care agency she had previously used. Following Mrs B's return home, NCW visited regularly and as Mrs B's confidence grew, was able to support her in reducing the amount of daily help she needed. This was done by the NCW keeping in regular contact by visits and phone calls to ensure that Mrs B is not only getting the practical support she needs, but is also in contact with friends and opportunities in the community to prevent her feeling isolated.

Key Outcome: Mrs B does have ongoing care needs but the NCW's intervention has meant that this care is being provided in her own home rather than residential care. That the most

appropriate equipment and technology to support her independence is in place. As someone liable to fund her own care, she is paying for the most appropriate care that meets her needs so that her own finances will last longer. Ms B does not feel isolated and family and friends also feel able to access the advice and support they need so they feel able to support Mrs B.

Under current model, people who self-fund their own care are at risk of spending more than they need to. NCP is establishing relationships with providers who work in the communities to ensure that if ongoing services need to be commissioned either privately or via the Council, the support provided is the best value for money. The key to this and the best interests of the person receiving the care is to listen and ensure everyone involved is clear of their roles and responsibilities and agree how they will communicate with each other.

Case Study 3 – Mr and Mrs S

Both are in their 80s. Mr S has been diagnosed with prostate cancer and is having investigations to see if it has spread; he is also blind and hard of hearing. Both Mr and Mrs S have heart conditions and Mrs S has leg ulcers which are dressed regularly by the District Nurse. NCW is supporting both Mr and Mrs S to receive all the care and support they need that enables them to continue living at home. This has included staying with Mr S so Mrs S could attend hospital appointments; preparing Mr S's meal and assisting him to the toilet; supporting Mr and Mrs S's family in coordinating a rota of support and assisting with daily living tasks as well as others to provide support.

Key Outcome: Over a period of 4 weeks as Mr S's health declined, his family's wish was for him to die at home. NCW provided care and support as and when it was needed. This enabled Mr S to die at home supported by his family and nurses and without the need to involve commissioned services. In the final few days, NCW was not required to provide any support as the family and nursing team were with him. Since Mr S's death, the NCW has kept in touch with Mrs S who currently has family living with her and feels at this time does not need ongoing support from NCW. However both she and her family are aware they can make contact if needed in the future.

Case Study 4 – Mr F

Having completed a review for Mr F, the NCWs will now provide the lunch time call for him on Monday to Friday as he does not need assistance every day. The arrangement is that the NCWs phone to check if a visit is required and if it is, they will deliver the care, which is assistance with pulling up trousers and redressing. This clearly demonstrates the benefits of a locally based team which can allocate a task to be performed by any member of the team only if it is needed.

Key Outcome: Following the review, Mr F's care package was reduced by the five lunch time calls which meant a saving of £41 each week on the amount of weekly commissioned care needed to meet Mr F's ongoing care needs.

Case Study 5 – Jim

Jim is 72. He lived all his life with his mother until she died 4 years ago. The GP has referred Jim to NCP as Jim is becoming more socially isolated and also has developed some cognitive loss. The GP referral also says that Jim is becoming muddled about his medication and his paperwork and has missed several important appointments recently.

Jim is due to have an operation in hospital in the next couple of weeks. This is a rescheduling as he was due to have this operation last month but failed to turn up. He had previously had contact

with the AEH team who had arranged for him to have a bath step put in place. Jim was quite happy to have a visit from a NCW but wasn't sure what help if any he needed.

Over a number of weeks, NCW built up a relationship with Jim. It was clear that he had memory issues but that he was also coping independently and had done for a number of years. However, he was also struggling with paperwork, with keeping appointments and with some social activities. NCW did try to find a volunteer who could support him with his paperwork but so far have drawn a blank. However, I pop in when passing to catch up with him and see if he has had any important letters which need dealing with. I was able to support him through a medical procedure earlier this year. Jim was unable to understand the instructions regarding his medication prior to the op. I accompanied him to the local pharmacy, arranged with the pharmacist to adjust the medication in his Dossett box and wrote out the instructions for the medication he had to take instead in an easy-to-follow format. The medical preparation (Moviprep) which he had to take at 7 pm the evening before and at 7am on the day was provided by the hospital. I spent some time going through the instructions with Jim, and phoned him the day before the operation to remind him to not eat after lunchtime and to take his Moviprep that evening. However, Jim managed to mislay the Moviprep the night before the operation and so the operation was unable to go ahead. I therefore rebooked the operation, liaised with the pharmacy again and a member of the team stayed with Jim on the afternoon/evening before to ensure that the Moviprep was taken correctly at the right time. Another team member returned at 7am to ensure that Jim took the morning dose and that he had everything he need for his hospital stay. The operation went ahead successfully.

Jim has gained confidence in the team and has attended some social events we have arranged including a lunch club and coffee afternoons. We were recently informed by the receptionist at The Spinney that Jim used to take up a lot of their time as he was always turning up at the surgery asking the receptionists to help him with his paperwork, but that since we have been working with him he has not needed their help.
Key Outcome: This case study demonstrates the value of providing "Hands on Care' that is flexible and able to do the right thing at the right time. Without the active involvement of NCWs, Jim would not have had received the hospital treatment he needed or may have had to be admitted over night to ensure that he received the correct pre-operative care in order to have the operation he required. People such as Jim who have no family support, could potentially cost both health and social services time and money in cancelled appointments or use of staff time inappropriately. They are also at risk of not being able to live independently if they do not have access to support that can assess the risks they face on a daily basis and put in place support that will prevent an escalation of their needs.

<u>Case Study 6</u> – Amanda

Amanda is in her 50s and lives at home in a housing association bungalow with her beloved two cats. She has had previous involvement with under 65 mental health services including long term, crisis and inpatient services and has been diagnosed with personality disorder, anxiety and depression and psychosis. Amanda also has physical health problems including fibromyalgia, ongoing back problems and COPD.

Amanda was referred to Neighbourhood Cares by her GP who feels that she is struggling as a carer for her mum and needs "social care support" due to her current levels of anxiety and social isolation. She is very distrusting of people she identifies as 'professionals' and feels that she has been let down over and over again by statutory/support services.

Amanda has very few social relationships and describes not having anything to live for outside of looking after her mum, who lives in sheltered housing a short drive away. Caring for her mum is a very important aspect of her life. She tells you she would love to have "something else to live for" or she will "likely go when mum goes".

Amanda loves art and has explained how beneficial having a creative outlet has been in the past, but she has no motivation to do this on her own and feels her current level of anxiety prevents her from accessing anything on her own. She is also concerned about going out because she has no motivation to wash or brush her hair (doing so also causes her shoulder and neck pain). She has thick curly hair and describes how in the past this has become so matted during times of deep depression she has had to have the majority of her hair cut off.

There are several things she says need sorting in her home as there is a hole in the roof and no access to the back garden she can use due to her mobility. Amanda used to love to garden and be outside but does not feel able to contact the housing association as they "don't listen to her" when she calls.

The NCWs have spent time getting to know Amanda and gaining her trust. They have supported her in liaising with her housing provider and getting the repairs required completed. Amanda is considering the best way to maintain her garden and NCWs have provided her with all the contacts and information regarding local garden services and community groups.

Visits with Amanda have been combined with providing her with "hands on care' that has included washing her hair. Also spending time with Amanda and her mother separately and together to maintain their relationship and appreciating each other's strengths.

Key Outcome: This case demonstrates the benefits of accessing needs while delivering hands on care and supporting two people who also play a key role in supporting each other, but require some coaching/family therapy to appreciate each other's strengths and focus on those rather than difficulties or problems. The support of a skilled professional that is locally based that is promoting positive messages is having a positive effect on both Amanda and her mother.

Case Study 7 – Nicki

A case study that demonstrates the benefits of a team that has no labels of whom it supports other than the person is over 18 years old and a patient of the GP surgery and that people can refer themselves.

Nicki is a woman in her early 40s and contacted The Neighbourhood Cares Team in early December after seeing a poster in her GP surgery. In her first telephone call, she said she "didn't know where to start" with trying to work things out. She said her children had been removed from her care which has also meant the breakdown of other family relationships. Nicki is at risk of eviction and is trying to end years of substance misuse, her benefits are changing, and she is really angry with statutory services.

A member of the team arranged to visit that day and learnt that Nicki had been off substances for nearly 3 months. It really saddened her that the difficulties within her family meant that this wasn't recognised or celebrated by anyone. Nicki also said she loved writing, especially stories for children. She had a job working a few hours a week doing cleaning and that and the children no longer living with her meant her benefits needed changing but she didn't have easy access to the internet or the benefits office which was in another town.

Nicki had an appointment with a mental health team but didn't know whether that was something she wanted to engage in. Nicki described how not having her children with her had taken the structure and joy out of her days – she loved cooking for them, for example, and now she had no one to cook for. Nicki talked about a relationship she had developed with a friend's mother, who she was able to spend time with to alleviate the older woman's loneliness. The most pressing issue was a court date regarding eviction because of rent being unpaid. Nicki had missed a previous court date because of anxiety and the practicalities of getting into Cambridge, and was feeling unable to go along to this one, but knew that not attending meant that she would lose her home.

The NCW has attended court with Nikki and ensured that she has maintained her tenancy and has an agreed payment plan in place. Nicki is in contact with her children and is being a good friend to an older person in the community. Nicki knows how to contact the NCWs if she has issues she needs to discuss or check. The most common way she does this is by text.
Key Outcome: For Nicki, knowing she has someone she can discuss things with before they become a major issue helps her deal with the ongoing issues she faces. It is helping her to value herself and therefore reduce the risk of her addiction. It is also a benefit for her family and friends who see the positive effect it has on Nikki being able to maintain her home and her own well-being.

Case Study 8 – Lenny

The GP surgery contacted the Neighbourhood Cares Team to ask if we could support 68 year old Lenny to an appointment at Addenbrookes due to a serious medical concern. They were concerned that Lenny often didn't attend appointments and that he would not be able to get to Cambridge, find his way around the hospital, or understand medical information. One of the Neighbourhood Cares Team telephoned him and arranged to go with him to the appointment.

On the journey, Lenny said that has lived alone since his parents died over 30 years ago. He used to work for a supermarket and in some firms around his home town, but has some bad memories of being bullied in these settings. He said he went to what he describes as a "special" boarding school, while his brother went to grammar school. He talks about the towns he likes visiting and shares his knowledge of reptiles. He talks about having been burgled and assaulted on several occasions in the recent past.

At the hospital, Lenny is told that it is likely that he has cancer, which will mean that he is going to need surgery in the near future. He is given several appointments for biopsies and scans. It is unclear whether Lenny understands all the information he has been given. The NCWs arrange a rota to ensure some from the team is available to accompany Lenny to his various hospital appointments.

In doing so, the NCWs are able to establish Lenny does have the capacity to understand the treatment he requires and the risks associated with it. The NCWs, also with Lenny's permission, liaised with the hospital regarding the pre and post operative care Lenny would require and ensured that Lenny was given the time to discuss with them the implications of all that it involved. The NCWs supported Lenny to get together all he needed for his admission to hospital for surgery and took him to the hospital.

During his hospital admission, the NCWs visited and liaised with the hospital to ensure that he was discharged as soon as he was medically fit. On discharge, the NCWs provided the hands on support he needed encouraging him to follow his post operative care and on one occasion taking him to the GP as they were concerned he was developing a chest infection which was in fact the

case. Without them having actively encouraged Lenny to see his GP, this could have resulted into a readmission to hospital. Again, with Lenny's consent, the NCWs made contact with his brother so he was aware of Lenny's health issues. They normally communicate infrequently via Christmas cards and this appears unlikely to change.

Lenny is now about to start a programme of radiotherapy and the NCWs are supporting Lenny to ensure that he attends each session. If, as is likely, the radiotherapy has a detrimental effect on his health, the NCWs will ensure he receives the support he needs.

Key Outcome: To date, Lenny has not had any commissioned care and has undergone surgery that he may never have received had the NCWs not been there to gain his trust and provide both the emotional and practical support he required. At all times, NCWs have respected how Lenny chooses to live and made sure he had the opportunity to discuss with them what the implications of his treatment and what help he requires to continue living in his own home. The fact that health professionals in both the hospital and community have an open pathway of communication with the NCWs means they feel able to provide Lenny with ongoing appropriate support and advice regarding his postoperative care and treatment.

Case Study 9 – Ralph

Ralph's daughter got in touch having seen our details, wanting to know if we could support her father. We arranged that she would check with her dad if he was happy for us to visit and then arranged a visit to him when his daughter would be present. Ralph's initial feeling was that we couldn't help him with anything as he was managing fine. However, during our first conversation, he said he was struggling with a couple of things, including putting his bins out for collection. As he walks with two sticks, he found it almost impossible to move the bin bags to the end of his driveway and was scared of falling in the process. I arranged an assisted bin collection for him via HCDC. I also suggested to him that a referral to an OT and to the Fire Service might be appropriate as he was finding it difficult to mobilise in his home, and he felt that he was at risk of falls as he tried to carry plates of food and hot drinks form the kitchen to his dining table. Neither he nor his daughter were aware that the Fire Service offered "Safe and Well" checks but took up the offer of a referral. The Fire Service subsequently visited and made some suggestions, fitted additional smoke detectors and also arranged for the smoke detectors to be linked to Ralph's lifeline. We also identified with Ralph that he was finding his social life had shrunk and he wanted more social interaction. I gave Ralph information about the voluntary car scheme in St Ives and also about various activities and social groups. Ralph and a friend subsequently attended a lunch group. I am currently supporting Ralph to complete an Attendance Allowance form.

Key Outcomes: It is not uncommon for people to not know what support is available to them or how to access it. The value of having a single person who can inform you about the range of support that is available and help you access it, that reduces the risk of falls, prevents social isolation and increasing a person's income so they themselves can pay for additional support is evidenced by this case, plus the fact that Ralph and his daughter both have a point of contact if they require further advice or support.