Agenda Item No: 7

NEIGHBOURHOOD CARES PILOT 'Deep Dive'

To:	**Adults Committee**
Meeting Date:	**15 November 2018**
From:	**Wendi Ogle-Welbourn: Executive Director: People and Communities**
Electoral division(s):	***All***
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide an update on progress of the Neighbourhood Cares Pilot to date and share the findings from the interim external evaluation report.**
Recommendation:	**To consider the report and provide comments on progress, proposed developments and issues raised by the interim external evaluation report.**

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1. BACKGROUND

1.1 On the 24th May 2018 The Adults Committee received a deep dive paper on the Neighbourhood Cares Pilot (NCP). This report provides an update on the progress of the NCP and shares the findings from the interim external evaluation report from York Consulting.

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

1.3 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 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 want to apply the Buurtzorg principles to accelerate our transformation of the care and support to older people and people with physical disabilities.

1.4 The principles we are testing are:

- Workers involved with each vulnerable adult kept to a minimum
- Personalised approach
- Reduced cost to the system
- Reduced demand on professional systems and minimum bureaucracy
- Shift as much resource as possible to the front line
- Self-managed local teams, focused on local delivery and solutions
- Maximise opportunities to collaborate with partners and develop an integrated response
- Devolved budget and decision making with teams empowered to solve problems
- Creative solutions developed locally. The care and support is determined by the team according to the needs and strengths of each person using community assets.
- Acceptance of a level of risk
- Reduced dependency on care agencies and try to move away from traditional models of care
- Responsibility for the whole population
- Increasing community resilience and building on social capital
- Delivery of statutory responsibilities and safeguarding duties in a person centred community connected, outcome focussed way.

1.5 The key outcomes are:

- Improve outcomes for service users.
- Manage costs by achieving the same or better outcomes in a more cost effective way.
- Improve job satisfaction for social care staff because they can see the difference they make as they have more direct contact with people enabling them to do the right thing, at the right time in the right place.
- Increase Community capacity where we currently have capacity gaps, particularly in home care.

- Use the learning from the pilot sites to inform the evolution of placed based models of social care for the wider transformation of the whole system.

1.6 York Consulting is carrying out an external evaluation of the NCP the key points from their interim report is provided in **section 3** of this paper.

2 NEIGHBOURHOOD CARES PILOT UPDATE SINCE MAY 2018

2.1 The number of people supported by NCP continues to grow.

The number of people having contact with both NC teams continues to grow each month.

	New referrals St Ives	Total number of people supported by St Ives	New referrals Soham	Total number of people supported by Soham
June	16	200	20	260
July	36	216	29	289
August	28	252	17	306
September	9	261	16	322

2.1.1 Of the 261 people known to the St Ives team, 120 have eligible needs and of those, 47 people receive a contribution to their personal budget from the council. The remaining 73 are not eligible for funding by the local authority.

From these 47, 32 have had a review and the remaining 15 have had Carers assessments.

2.1.2 In Soham 175 of the 322 people known to the team have eligible needs, 153 reviews and assessments have been completed (53, adult social care assessment, 14 Carers assessments and 100 reviews).

2.1.3 Therefore in St Ives 46% of the people known to the team have an eligible need and 28% of those people are not eligible for financial support from the Council. In Soham 54% of the people known to the team have an eligible need and in the region of 5% of those people are not eligible for financial support from the Council.

2.1.4 The difference in the number of people who have had contact with NCP in the 2 sites could be related to a number of factors.
The main ones are :

- While demographics are similar the needs of each community are different.
- The Soham team is able to interact and prompt itself with the whole community. Whereas the St Ives Team is linked to a population registered with one GP practice.
- The Soham Library provides a physical access point that the residents of Soham find welcoming and easy to access and the Neighbourhood Cares Workers (NCWs) can use the building as their work base and a venue to hold a range of events and activities that prompt the NCP.

2.2 **Mosaic**

Members will be aware that in October the implementation of the new adult social care information system, Mosaic went live. This system can accommodate self-managed teams and enables peer to peer authorisation.

2.3 **Devolved budgets to NCP**

Since July 2018 the care budgets for all older and physical disabled service users in the pilot have been transferred to the relevant Neighbourhood Cares Team. This gives the teams' ownership and accountability, resulting in them being even more focussed on individual and creative outcomes. It is too early to give a confident assessment for the spending trends of these budgets.

2.4 **Reablement workers integrated with the Neighbourhood Cares Teams**

2.4.1 Both teams now have reablement staff in the teams. This enables getting the right support to be offered to people when they need it particularly if they have a crisis or sudden change in need.

2.4.2 The reablement workers are also being used by the NCWs to assess the capabilities of people who are due a planned review, to see if there is scope to increase independence by using new types of equipment or technology, thereby reducing or avoiding the cost on long term care.

2.4.3 For example:
A gentleman receiving daily support from carers for his shower following a stroke. When reviewed by the NCW, it was felt it would be possible for him to manage his personal care needs with just his wife's supervision. This is something he wanted to achieve but both he and his wife were anxious about how he could manage without the support of a carer. The NCW arranged for a reablement worker to visit and support the couple so that he could shower independently and safely. The outcome was that within 4 weeks of having the initial contact with the NC team he was able to achieve this goal. The annual avoided cost is £5,987.

2.4.4 It is also important to acknowledge that this couple felt supported knowing if they had any queries they could easily contact the team for advice.

2.4.5 Mary is an 89 year old woman who has memory loss, lives alone and no family living locally. She was referred by her GP who felt she needed regular input from a paid carer to help her maintain her daily living routine. The NCW met with her and discussed the best way to help her remain independent. The NCW also supported her to claim her benefit entitlement which she used to employ a local company to clean her home, do her laundry, shopping and paperwork and support her to maintain her daily routine. The NCW arranged for the team's reablement worker to visit and assess that Mary had all the technology and equipment to meet her daily needs.

2.5 **Reviewing the skills set in the Neighbourhood Care Teams**

The initial composition of each of the NC teams was the equivalent of four fulltime senior social workers. This proved to be beneficial in the setup and initial roll out of testing social care self- managed teams. As we have gained an insight and knowledge into the needs of each local community we have followed the Buurtzorg model and introduced different bands of NCWs into the two teams.

The Buurtzorg teams successfully operate with 3 bands of staff, the NCP is testing a similar approach. This will bring a wider range of skills to the teams and reduce costs.

2.6 **Having accommodation that is meaningful to the community and effective for staff.**

2.6.1 Having been operational for a year the importance of the team base has become more evident. The Soham library provides easy access to the community and access to a range of meeting spaces.

2.6.2 The St Ives NCP is based in the Broad Leas Centre in St Ives. It is in the right location but is not particularly accessible for people with disabilities or those who need space to have a private conversation. The team therefore have to use other community buildings in St Ives. Having the use of a room in the Spinney surgery each week has partially compensated for the limitations of Broadleas.

2.7 **Working with primary care and community health services**

2.7.1 As both teams have become more established we have seen professional relationships develop with colleagues across primary care and community health services.
This good relationship has replaced the need for formal referral processes, achieving the best outcomes for the person and ensuring both health and social care staff time is used appropriately and productively. Our health partners now recognise the benefits NCWs can bring to the management of people with complex health needs.

2.7.2 For example :
A man with complex health needs including alcohol dependence, epilepsy and Type one diabetes was not compliant with his medication. Consequently he had repeated hospital admissions. The NCW had a conversation with him to understand why he required emergency care on a regular basis. They then worked with colleagues in housing, health, reablement and Technology enabled Care to support him to manage daily living tasks and maintain a healthier lifestyle. He was also encouraged to attend health appointments and get involved in local community activities. The outcome is that in the weeks that the NCWs have been providing support he has not required any emergency support from health services.

2.8 **Developing social capital**

2.8.1 NCP is working in partnership with Care Network's Connected Community project, funded by the Council's Innovate and Cultivate grant, to increase the number of social enterprises and personal assistants in St Ives and Soham.

2.8.2 At the time of writing the Connected Community project is actively promoting the support it can offer and has started conversations with people (4 in St Ives and 3 in Soham) who have shown an interest in starting a social enterprise or becoming a personal assistant.

2.8.3 Since May an additional 4 volunteers are now regularly supporting the NCP.
The roles and functions the volunteers perform have expanded and include:

- Running drop in and group sessions knowing they can call on NCWs if they are needed.
- Supporting people who need to make benefit applications to apply for a range of benefits including blue badges, bus passes and attendance allowance.
- Providing practical help to the team, for example, when a person needed their current bed dismantled and their new bed assembled to ensure they could be discharged from hospital that same day a volunteer went with a NCW to complete the task.

2.8.4 Both teams continue to develop their network and relationships with all other partners both voluntary, statutory and private. This has resulted in the teams having confidence in the appropriateness of the information and advice being given to people. It in turn means the NCWs are increasingly seen as a source of information by both people looking for advice and support and those people and organisations that provide services.

2.9 **Training with Public World and Buurtzorg Coach**

2.9.1 To ensure we are using the Buurtzorg principles in delivering the project outcomes we continue to work with Public World and link up with others in the UK using the Buurtzorg principles. In September Public World provided two days of training to NCP and concluded that :
"The Buurtzorg principles seemed to be in all the NCW's DNA and that their way of working demonstrated an exemplary way of delivering social care. What a positive experience it was to work with the NCP as the only local authority currently taking forward the model to deliver social work in the UK."

2.9.2 The NCWs felt that the training gave a detailed insight in to how Buurtzorg teams function and gave them further skills in how they deal with conflict in the team, and to organise and manage their team meetings to be as productive and effective as possible.

2.9.3 Public World will do a further session with the NCWs in December to improve their practice as self-managed teams and the Buurtzorg Coach is available by phone if specific issues need to be addressed.

2.9.4 The plan is to continue to work with Public World to both support the teams and support the Council in taking forward a placed base neighbourhood model beyond March 2019.

2.9.5 The NCP has shared its learning tools with others using Buurtzorg principles in the UK.

3 Interim External Evaluation Report

York Consulting has been commissioned by the Council to undertake an evaluation of the NCP. Their interim report presents early findings on the implementation of the NCP, the successes, challenges and outcomes evidence to date.

3.1 The key points outlined within the conclusion of the report are:

3.2 The final evaluation is seeking to provide evidence on:

- whether the service has prevented people's needs from escalating;
- the impact of the service on clients' quality of life;
- the benefit to community assets;
- the benefits to Neighbourhood Cares Team members;
- the cost benefit of the service;
- the cost of spend on support costs in each 10,000 population;
- the workforce needed to support populations of 10,000 to meet all the social care needs of that community and what that will cost.

1. At this interim reporting stage, we would suggest that the early signs are positive. Qualitative evidence suggests that the pilot has prevented the escalation of needs, impacted on clients' quality of life and had a positive impact on the development of community assets. However, these positive findings cannot be assessed to reflect the whole service cohort and we must wait for the final report to see whether these early indicators are evidenced across the board.
2. Evidence to date suggests that the teams have prevented crises by preventing hospital admissions or readmissions, preventing carer breakdown and preventing a deterioration in mental health issues. Teams have been able to identify issues before they escalate and helped clients and their families plan for the future. Hospital admissions have been prevented by ensuring better continuity of care and readmissions have been prevented by providing more appropriate care on discharge. Hospital admissions have been averted by the swift nature of the NCT response and the trusting relationships developed with workers which means that clients have been more willing to acknowledge the issues they are facing. Being community based the teams are accessible, responsive and seen as different to other services: clients know they can phone them up and they will receive a response.
3. The consultations undertaken so far have also highlighted the impact on clients' quality of life in terms of the teams' ability to provide a personalised response to clients' needs and supporting clients and their families to access more appropriate care to meet those needs. Workers have enabled clients to remain within their own homes, helped improve living conditions and addressed issues of social isolation. This in turn is reported to have had a positive impact on clients' mental health and wellbeing.
4. The teams have facilitated the development of community assets by identifying gaps in existing resources, galvanising existing activity and facilitating the development of groups which can become self-sustaining. Community assets have been developed in partnership with other providers and volunteers and there is evidence of the positive impact engagement in these activities is having on clients and volunteers. Community assets have been developed in St Ives, but the work undertaken has been constrained by capacity/workload issues and logistical challenges. There is a

need for protected time to allow the team to focus on developing this area of work further.

5. For team members, the main benefit of working in the pilot has been improved job satisfaction. This was linked to being in a role where they could provide preventative support, have the flexibility to respond to clients' needs and not be constrained by timeframes. Improved job satisfaction was also linked to the opportunity the pilot gave them to work in a new way, to shape service delivery and be autonomous decision makers within self-managed teams. They valued the learning opportunities presented by the role and the increased confidence linked to these opportunities.
6. At this stage, it is too early to draw any conclusions from the available data and therefore too early to comment with any authority on the cost benefit of the service. A longer analysis period is needed to be conclusive about cost savings, although the interim results allow for some cautious optimism.
7. The cost of spend on support costs in each 10,000 population and the workforce needed to support populations of 10,000 to meet all the social care needs of that community and what that will cost will be presented in the final report.

3.3 **Next steps**

- The evaluators and the County Council will agree on when the final assessment of cost savings will be undertaken. In doing this, the aim is to allow a sufficient analysis period for the findings to capture the impacts of NCP in a 'business as usual' state, whilst also recognising and adhering to the Council's planning cycles, Committee requirements etc. Regardless of what is agreed, further analysis of the comparison group data will be undertaken, and a clearer view formed on how similar the comparison group is to the NCP client group[1].
- Client-level assessments of cost savings will be incorporated within the qualitative case studies undertaken between now and the end of the evaluation. Within these, the aim is to showcase examples of where NCP has prevented or has delayed crises occurring for clients and to estimate the likely the cost savings of having done so.

4 A Case Study that demonstrates the key principles of the NCP being implemented:

4.1 By being a solution focused team that spends time getting to know people and their families the NCWs have been able to provide support to all the members of one family that are dealing with a number of complex health and social care issues**.**

4.2 The NCWs received a referral from the community matron in December 2017 about Mrs Cook, a 55-year-old woman who has a late-stage neurological condition. Mrs. Cook has had the disease for 12 years and had a period of respite care in March 2017 in a nursing home.

4.3 Mrs Cook struggles with her personal care needs, she has limited mobility and uses a mobility scooter outside of the home. Her 68 year old husband is her sole carer and

1 This first requires fewer NCP clients to be excluded from the analysis. This will happen in the final assessment as those excluded from the interim exercise because they have only recently engaged with the service will have been supported for a longer period.

struggles to cope at times. They are both reluctant to engage or accept support and feel that no one is listening or helping. No formal package of care is in place.
The Cooks have little confidence that support is available to help them and are reluctant to engage with services, but agreed to meet with the NCW.

4.4 The Cooks have a 20 year old son living at home who has learning difficulties and attends college and Mr Cook's 78 year old brother who has failing health.
Following this referral the team made contact and started working with the Cook family initially to build up trust and a relationship and to understand why this family haven't been engaging with services previously.

4.5 With lots of listening the NCWs were able to develop a relationship with each member of the family. This enabled the NCWs to introduce some support in the form of a volunteer who regularly spends times with Mrs Cook and gives Mr Cook the opportunity to go out. The NCWs started to discuss how things may change for Mrs Cook over the next few month/ years and did they know what to expect and how they would want to manage as those changes occurred.

4.6 They were at first reluctant to look to the future, saying that they will manage when the situation arises. A big step was Mr Cook realising that his wife's condition was deteriorating and that she was struggling to manage the stairs and that at some point soon they would need to move her bed downstairs.

4.7 The outcome was that an assessment was completed that introduced a wider range of equipment into the home and carers to assist with Mrs Cook's personal care needs. This ensured Mrs Cook received the care she needed and Mr Cook was supported in his role as her carer.

4.8 The NCWs were in continual contact with health services and on occasions attended health appointments with the Cooks so that they fully understood the consequences of what they were being told.

4.9 In June 2018 Mrs Cook's health deteriorated, resulting in an admission to hospital. During her hospital admission the NCWs liaised closely with the hospital to arrange her discharge home.

4.10 In discussions with the family regarding Mrs Cook's return home it became evident that her brother in law felt very uncomfortable living in the house with Mrs Cook and was aware that Mrs Cook now needed to use the lounge as her bedroom and as the only bathroom is downstairs he had to go through the bedroom/lounge to get into the bathroom. He asked the NCWs for help so he could have his own home. This was something he had always wanted but did not know or understand the process to make it happen.

4.11 Mrs Cook was discharge home in July with the appropriate equipment and care in place. The NCWs are continuing to work proactively with all the family. Mrs Cook is now dependent on her husband, son and the carers for all her needs. Mr and Mrs Cook are happy with the support and care being provided.

4.12 The NCWs were becoming aware that Mr Cook's own health was also deteriorating but he continued to say he was well and that he knew he could contact NCWs if he needed anything. The important thing for him was that his wife was at home receiving the care she needed.

4.13 In August Mr Cook was persuaded by a NCW to agree to a visit from his GP. This resulted in Mr Cook being admitted to hospital the same day as he required emergency surgery.

4.14 The NCWs arranged to put the carers "What if plan" into action to ensure Mrs Cook could receive the care she needed while her husband was in hospital. Staying with Mrs Cook so that Mr Cook was confident that she was safe. When it was realised 24 hours later that Mr Cook would be in hospital for at least 10 days Mrs Cook's care was reviewed and it was agreed that the most suitable way for Mrs Cook's needs to be met for that period of time would be in nursing respite care. Realising that Mrs Cook's son wouldn't be able to pack for his mum a NCW went round and helped pack her bags, medications and ensure that her DNR form went with her.

4.15 While in respite care Mrs Cook developed pneumonia that required hospital admission - unfortunately this was into a different hospital to the one her husband is in.
The NCWs contacted both hospitals, keeping everyone up to date on what is happening and planning for appropriate discharge home for both Mr and Mrs Cook.

4.16 The NCWs have also been in regular contact with their son checking he is getting to college and offering any support he might need.

4.17 The NCWs supported Mr Cook's brother to make an application for a sheltered bungalow very near to his brother's home. This was successful. The NCWs then helped him source the furniture and appliances he requires for his new home using the links with local charities to do this at minimal cost. They have also supported him with all the appropriate benefit applications he is eligible for. He is delighted with his new home and feels it would not have been possible without the team's intervention. However he is staying with his nephew while his parents are in hospital in order to support him.

4.18 At the time of writing this case study Mr Cook has returned home from hospital and is being supported by the NCWs both practically and emotionally as he has been informed that he has cancer and will require further treatment.

4.19 The Cook family's situation demonstrates the value of a solution focused team that is well networked in the local community that has developed a trusted relationship with each individual member of the family.

4.20 As a NCW in the team stated :
"By knowing all the family and what their needs are we have been able to support them all effectively and work together with other partner agencies to ensure the best and most appropriate care is in place. The family know that they can call us and we will get back to them and support them."

5 How we will continue to development in the Neighbourhood Cares Pilot from the learning to date.

5.1 Going forward for the remaining duration of the NCP both teams will continue to build on all their learning and deliver support to their respective communities in Soham and St Ives.

- Assessing the impact changing the skills of the NCWs has on the delivery of the outcomes of NCP.
- Apply the best practice from both teams e.g. recording of evidence of outcomes to ensure a consistent approach of practice across the NCP that will provide the required data for the evaluation of NCP.
- Minimise any duplication of resources by managing the interface between health and social care.
- Maximise the use of technology
- Continue to explore and develop using the reablement approach with existing service users. Currently reablement has only been used for new people.
- Work with local providers to deliver flexible solutions to fill the gaps in availability of services.
- Offer to trail the use of pre-paid cards for Direct Payments
- Look to apply the learning from the NCP to explore how a self-managed model of place based teams can be applied to the changing models of place based practise across Cambridgeshire. For example the Library Transformation Project.

6 ALIGNMENT WITH CORPORATE PRIORITIES

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

6.2 **Developing the local economy for the benefit of all**

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.

6.3 **Helping people live healthy and independent lives**

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.

6.4 **Supporting and protecting vulnerable people**

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

7 SIGNIFICANT IMPLICATIONS

7.1 Resource Implications

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

7.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category

7.3 Statutory, Legal and Risk Implications

There are no significant implications within this category

7.4 Equality and Diversity Implications

There are no significant implications within this category

7.5 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.

7.6 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.

7.7 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 GUIDANCE

Source Documents	**Location**
None	