The Community Wellbeing Pilot (CWBP) Evaluation.

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Glossary & Abbreviations.

Care Agency	CA
Care Agency Manager	CAM
Community Wellbeing Pilot	CWBP
General Practitioner	GP
Home Care Workers	HCW
Occupational Therapists	OT
Occupational Therapy Manager	OTM
Physiotherapist	Physio
Social Workers	SW
Social Work Manager	SWM

Executive Summary

A better community home care system is possible. The Community Wellbeing Pilot (CWBP) has provided a radical and innovative system of home care to service users and carers. The CWBP marks a radical change to the current model of care delivery: time and task. This model has created a system that places emphasis on organisational need, process and managing risks, it lacks adequate flexibility to meet the needs of service users and carers. The model introduced by the CWBP offers new methods based on principles of a co-produced person-centred care, which is flexible and adaptable. The CWBP was delivered in partnership with two externally commissioned Care Agencies (CA) across two geographical areas of the city. This new approach to care was delivered using a multi-disciplinary approach and working collaboratively with a range of health and social care professions. A core component of CWBP was a commitment by professionals to actively encourage community support networks.

This report provides an evidence base to illustrate not only was better care possible, it was delivered during a challenging and complex global pandemic. The significant challenges resulting from this difficult period were met by health and social care workers with professionalism, diligence, and commitment to the service users.

Evaluation Findings

The CWBP evaluation has highlighted the following key outcomes:

- Improved outcomes for service users and carers
- Increased job satisfaction for Home Care Workers leading to improved recruitment and retention.
- Improved efficiencies and savings
- The sustainability of the project
- The transferability of the project

Recommendations

To support the next phase of implementation we make the following recommendations:

Unified Financial Payments: Full shift payments to home care services are central to maintaining and delivering consistent and flexible home care services. These payments need to be monitored from start to end point with data collected by a central organisation. In addition to payments made to CA, an early positive for HCW was the move to full shift payments, this reduced their financial insecurity and enhanced their job satisfaction. Care must be taken to ensure that their shift patterns and hours are manageable

Integrated Care Services: Having a limited number of Care Agencies (CA) that work consistently with social work services provides better holistic care. A consistent consortium of services within dedicated geographical areas would be key to implementing the CWBP city wide. Service users were clear about the importance of consistent carers, who are known to them.

Flexible Care Delivery: Flexible care that is adapted at point of delivery without complex review has been key to the CWBP. The ability for HCWs to make adaptations to delivery based on service user needs is a central recommendation. This can be implemented through better communication systems and integrated care services.

Communication & Information Sharing: Better care has been delivered through improved communication between HCW, OT and SW and CA. We recommend a unified recording system for case work and improved communication systems for managing case allocation and care runs.

A Unified Model of Intervention & Outcomes: A consistent and clear method of intervention and outcomes monitoring is necessary. This needs to be linked to a unified data recording system. This system will allow for performance and outcomes to be monitored consistently across city wide provision.

Training & Staff Development: There is a clear need for joint training and education between HCW, SW and OT. This will create a universal system that is shared, and all roles are understood and valued. The value of multi-disciplinary partnerships working is to create training that benefits all. This means adopting the OT functional assessments and allowing them to lead on reablement strategies, whist sharing SW knowledge around strength-based assessments and the importance of co-production.

Multi-Disciplinary Working: The CWBP has highlighted that better care is delivered within a multi-disciplinary Team. We recommend that future roll-out include social workers, occupational therapists and home care workers delivering care within integrated teams and coordinated effectively with partnership agencies.

Career Development for HCW: The CWBP pilot has highlighted that there is a role beyond the traditional delivery of person-centred care for HCW. The advocacy, welfare support and general welfare interventions undertaken, suggest a possible community support worker role to enhance and develop the CWBP in its future integration.

Contact/further information.

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Introduction

The CWBP began in January 2020 and ended in March 2022. Overall, the data gathered throughout the CWBP provides positive evidence of a new and dynamic method of delivering care for the two sites that were chosen. In May 2021 the research team produced an interim report, which provided a full and thorough overview of the ways in which the CWBP was delivering services and the impact of those services on the service users. This report went into considerable detail about where improvements had been made but also offered critical insights into the ways in which the services could be improved in the second half of the implementation. In contrast, this final report will provide a summary of the CWBP, drawing out the key lessons, reflecting on good practice, and offering suggestions for adapting or scaling up a version of this Pilot. The report also contains four individual case studies, each detailing in unique and specific ways how for the individual service user the delivery of care was adapted to the service user, shaped by their needs, but also by their wants. The flexibility introduced by the CWBP into previously very structured ways of working, allowed for greater adaptability in care packages, and this is what the case studies highlight.

This report will document findings from the evaluation of the CWBP. The research was commissioned by Leeds City Council and undertaken by a small team of researchers at Leeds Beckett University. Research commenced during the Covid-19 pandemic, and this must be factored into the evaluation. During this period many local authorities struggled to maintain their core care tasks. Baginsky et al (2022) have highlighted the impact this had within adult social care and suggest we are yet to fully realise the scale or effect this had on service delivery. While not all local authorities publicised whether they were working to Coronavirus Act Easements to the Care Act, there is no doubting of the degree of 'indirect' easements in the lack of available services; for example, the closure of voluntary sector projects such as lunch clubs and befriending services, all of which had a major impact on the implementation of the the CWBP. One of the initial proposals of the CWBP was to encourage a more holistic and multidisciplinary approach to healthcare, which actively sought to encourage greater uptake of local, community services. Given the impact of the lockdown this is an area that we could not evaluate. We do have a few examples of staff on the CWBP referring to services where possible but encouraging service users to access the existing networks and support in their local communities was not a viable possibility. Additionally, it is important to acknowledge that the impact of Covid-19 and the adjustments to working lives was not just felt by the service users, but equally by the staff charged with the day-to-day implementation of the CWBP. Administratively, the lack of face-to-face meetings has driven up the volume of emails, team meetings have been more difficult to coordinate, and of course the most obvious is the continuous absence of staff through sickness and/or isolation.

The evaluation of the CWBP provides clear evidence that the Pilot can offer a radical and transformative change to the way home care can be delivered, and the different ways in which community-based support for adult social care service users can be provided. It can therefore be seen to be innovative in terms of delivering care. Braye and Preston Shoot (2020) argue that the Care Act (2014) was based on a person-centred approach, placing individual well-being and prevention at the heart of service delivery. Since its introduction, however, there have been questions as to how this can be realised within a contradictory care context governed by resources, with additional pressures of being able to change from a paternalistic model of care to a fully realised person-centred (and strengths-based) approach to care.

The process of deinstitutionalization has changed the offer of care and support to adults requiring assistance to live independent and meaningful lives within our communities (Lymbery, 2019). The move from warehousing those who were considered 'vulnerable' and infirm' in workhouses, hospitals, asylums, and state-led institutions has witnessed a significant change in how to conceptualise care and support (Brown, 2010). People are living longer, they want to stay at home, and require the appropriate support to do so. In managing community-based care since the late 1970s social work and community care have moved to a more business informed model of care management and rationalisation of economic resources based on needs and eligibility; this process is underpinned and supported by a system of safeguarding, risk assessment and community intervention that decides who is eligible and ineligible for community-based support. In developing a cost-effective economic model, care has become commodified and reduced to a focus on time and task.

The CWBP challenges the time and task model, and the case studies presented in this report demonstrate a focus on wellbeing as a principle moving beyond the historic care

management/economic risk management model of practice and stress the importance of supporting older adults in their homes. This shift in emphasis makes a clear statement that care and support should consider individual needs and preferences (NICE, 2017). Further, people should have the opportunity to make informed decisions about their care in partnership with health and social care practitioners. The underpinning of the model is person-centred care, meaning that the care offered must recognise that each person is an individual, with their own needs, wishes and priorities and that everyone should be treated with dignity, respect, and sensitivity. Strengths-based work focuses on goals and resources, both of which have been clearly identified as important elements that must be factored into service delivery.

There is a gap in the literature regarding outcomes that are in essence the 'intent' of the Care Act. Much of the available literature focuses on 'how to do' guides relating to implementing its principles. There is less focus on efficacy and or studies, which develop the transformative nature of the Care Act in relation to preventative social care with a focus on wellbeing. There is a lack of research, and evidence regarding the impact of these changes on front-line services. This is an area we feel the evidence gained through the evaluation will play an important role moving forward.

The CWBP provides evidence that care can move beyond time and task and become transformative in actualising the intent of the Care Act (2014) in both a meaningful and pragmatic manner. The CWBP addressed the key strategic aims of the Care Act by promoting a model of care that builds relationships with service users and works towards strategic outcomes, based on service users' wishes as well as their needs. For Leeds, this marks a radical break with previous models of care, which were based almost exclusively on time and task. The new model places the person at the centre of the care planning process. In other words, the CWBP represents a shift from time monitored care tasks to social support that looks at wider interconnected outcomes, aiming to give people greater independence and allow them more meaningful activity in the community. Measuring outcomes remains a difficult task and this report focuses on a qualitative approach to understanding what the participants reported. A useful metaphor was used by way of an explanation about the complexity of measuring successful outcomes on the CWBP in one of the early conversations the research team had with one of the stakeholders. Whilst time and task clearly remain important aspects of delivering home care, the metaphor posited that it would be similar to rating hospitality in a restaurant based on the time taken for your meal to hit your table; with no mention as to the quality of the ingredients, skills of the kitchen team, or the ability of the front of house staff in delivering your meal, with no acknowledgment given to either the quality of the ingredients, or the skill in the cookery. In both cases, time and task offer a very narrow concept for measuring success and quality.

The lack of available current literature underscores the importance of implementing the CWBP and undertaking this evaluation as it now becomes a significant contribution to a much-needed evidence base. In gathering their evidence, the research team obviously encountered some areas that worked better than others. There are examples of how the CWBP worked well, not just for the service users but also for all the professionals involved. On the other hand, there are elements of the project and individual cases where it could have worked better. The research was conducted independently at both sites, and differences were observed in some of the ways in which the Pilot was being operationalised, these were made clear in our interim report. This report will evaluate the data, neither site will be identified, and all identities of participants has been anonymised.

In June 2021 a team of Occupational Therapists were introduced to the CWBP, their role in the first instance was to pick care reviews because of the increasing backlog. Initially the OT lacked clarity as to their role in the CWBP but over time they began to pick up some of the initial assessments, which was a more beneficial use of their skills, knowledge, and time. *A* 'reablement approach in order to enable sustained independence' was part of the proposed service model delivery of the CWBP and has long term cost saving potential. This is an area which requires further development. Reablement, is a specific way of working that requires a different perspective for CA, a reorientation in terms of service delivery and training, and a shift towards positive risk taking. The addition of the OT to the CWBP offered new perspectives and improved assessments, and further underlines the importance of the multi-agency approach adopted by the project. Their addition to the CWBP at this later stage also draws attention to further specific training. By including the OT in the CWBP the challenges and benefits of multi-agency were very clear. The CWBP highlighted the strengths and differences between the professional approaches but underlined the importance of listening and responding to a range of voices. Their 'functional' assessments of need were well received by the CA, who preferred

the very specific details of their assessments in comparison to the more generic assessments of need from the SW teams. Embedding the OT's into teams will offer practical/functional/flexible support from the outset for the service user, their family, the CA and the SW teams. Their work to maintain a service user's independence and connection with their community has the potential to reduce immediate and long-term costs as well as providing a more empowering service. As one SW put it 'A happy client takes less time'. It's a win win situation.

Methodology

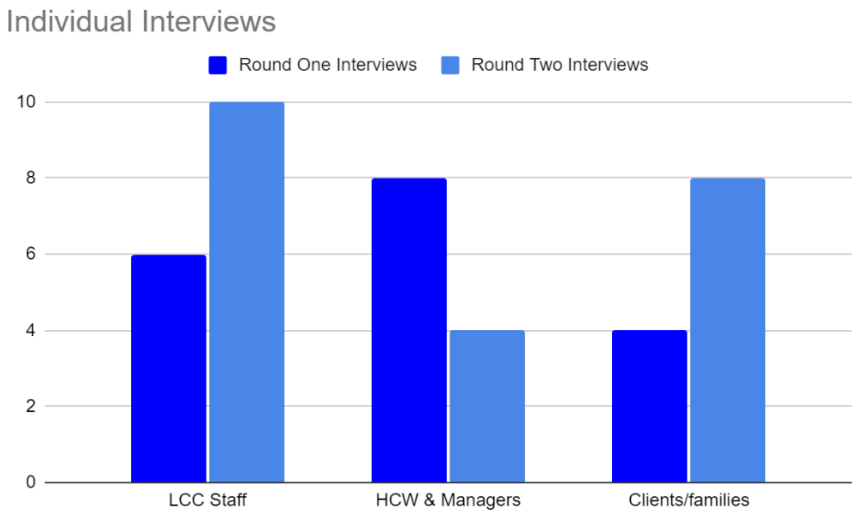
The evaluation employed a multi-method approach, primarily based on using qualitative data, drawn from a series of observations, interviews and focus groups with the care providers at the two pilot sites. For the purpose of the evaluation, we combined the data from both sites to create a strength-based qualitative analysis with identified themes and clear recommendations. Where possible we have included qualitative data delivered by Leeds City Council, however, this information has been limited due to the nature of the service provision and data collection process. We used a virtual ethnographic approach to operationalise the evaluation during a period of social isolation and global pandemic. With the ending of restrictions, where possible we undertook in-person interviews and met with stakeholders in focus groups. Qualitative and quantitative methods were used to strengthen findings and allow triangulation between different data sources.

Virtual Participant Observation

Using online platforms such as zoom and later with more frequency MS Teams, we integrated ourselves, alongside commissioners, social work services and community care services. This process was invaluable in allowing us to develop relationships, obtain feedback and gain access to key stakeholders. Reflecting on this process the evaluation would not have been as robust or successful without the virtual participant observation process.

Semi-Structured Interviews (Virtual/In Person)

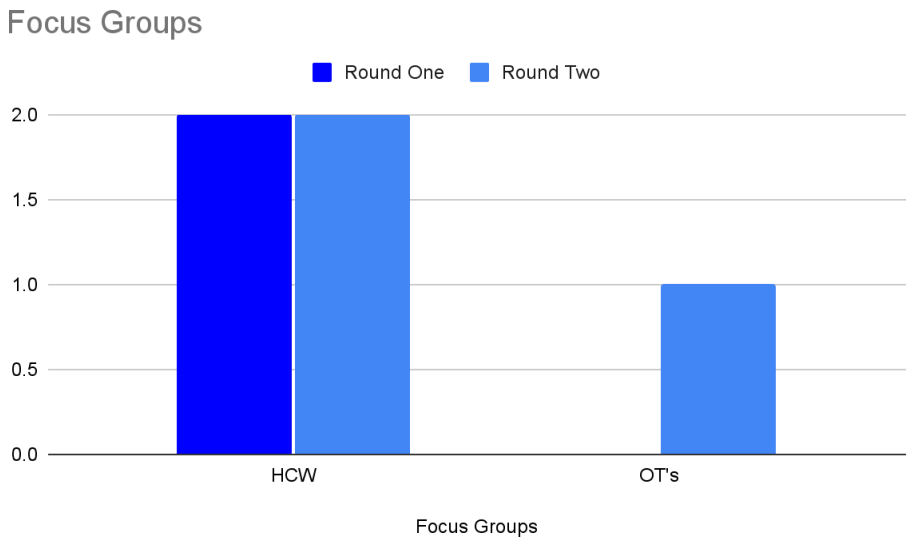
Supporting participant observation, we conducted a number of semi-structured interviews across both evaluation sites. The impact of isolation and Covid initially slowed participation, but as we all familiarised ourselves with remote working this too became the new normal. At the time of writing the report, we have undertaken the following interviews.



The interviews we have undertaken were informative, additionally they have highlighted key issues and possibilities for future work. In particular, the interviews with home care workers, social workers, and service users were insightful and really helped to develop an understanding of the importance of relational-based care, and the importance of maintaining dignity for service users.

Focus Groups (Virtual / In Person)

Focus groups were carried out with home care workers. The focus groups were undertaken via MS teams and later in person. Focus groups have been invaluable and have allowed us to correlate and identify consistent themes across isolated interviews.



Data Analysis.

The data collected from observations, interviews, and focus groups was subjected to a thematic analysis. This process involves the identification and organisation of themes into coherent subject headings. We have done our thematic analysis by hand, using a system of coding to support a coherent thematic analysis (Braun and Clarke, 2022). Coding by hand is an established and well-documented process within small-scale research and evaluation. The data provided a rich and detailed narrative from which we have made our recommendations. The identified themes have been coded, correlated, and reviewed to provide a series of reflections on an innovative and complex provision of social care services.

The organisation of the report will be as follows. From the data collected over the past 18 months, we developed some key themes, these were also previously documented in our interim report. The themes we will explore are; **time and flexibility**, **support communication and training;** how it is provided and with what consequences, increased lines of communication, **the importance of relationships,** and **the impact on finances and potential savings**. Each theme will be written about separately, although we acknowledge that they are completely entangled, interconnected, and correlated with one another. We have also written up four case studies, which can be found in the appendix. Each of these case studies takes the reader on a more personal journey from the service user's perspective. The case studies have been mapped against the proposed CWBP model of service delivery. Financial savings, where they are evident, have been highlighted here. The case studies will help to give deeper insight into the key themes identified in the main report, additionally we suggest that they showcase the interrelation between the key themes identified throughout the evaluation. One of the important elements to come from the case studies is to identify the flexibility that is required to implement a more person-centred, relational care, which is co-produced with the service user and works with them to best support their independence.

Theme One: Time & Flexibility.

“We have more time to go more in depth. It’s not a go in job and out again, it’s go in do and talk to them while you are doing it, you have more time. That’s what we needed. More time.” (HCW)

Time is a core theme within any social care and social work practice, a common theme is that there is never enough time, and it is something professionals are always trying to make, it featured heavily within the CWBP in a multifaceted way. The CWBP has opened up homecare delivery for HCW, they have become more flexible in managing their time and have begun to experience a degree of autonomy in regard to how they respond to care needs and specifically how that care is delivered.

The issue of time featured frequently in the data. Time taken both delivering care and spending time with service users was fundamental to the CWBP. This theme is central as HCW affirmed that the increased time they had because they were working on the CWBP enhanced their ability; often managing to fit in small additional tasks either for the services users directly, or indirectly by contacting other services in a timely manner. Better knowledge of service users and their needs, facilitated by time and flexibility created better relationships and ultimately, better decision making. Being able to do a better job for someone you have a solid relationship with created increased job satisfaction and commitment to the role. Ultimately HCW felt better rewarded for their input because of this.

Social workers highlighted that time in the management of risk, assessment process, and the provision of direct care is a central component of their workload. Time is often their most valuable commodity, and something they feel they do not have enough of and always require more of. Both social workers and HCW agreed that the pilot changed the concept of time, moving it away from simply the micromanagement of tasks, to one where time can be viewed flexibly and adapted to improve the quality of experience for service users and staff themselves.

Examples were also given of time being too tight, as a consequence of too many calls per run, which for the HCW, increased frustration with their role. For service users, reduced time meant the HCW were 'rushed', 'frazzled', and overly tired. For the HCW although flexibility was a positive addition, they were adamant that if their shifts were too long it impacted negatively on the quality of the care on offer. **Moving forward the allocation of time requires careful management and coordinated care runs or a clear case allocation system, which must be manageable and achievable for HCW. To achieve this a model of intervention needs to be developed with clarity over what tasks in the form of direct care and social support can be delivered.**

Closely allied to discussions about time were pertinent comments about the importance of flexibility. Flexibility was cited often and in a range of ways, but a common and recurring one was in relation to commentaries about time. In this way we can see that not only does time correlate to flexibility but being more flexible in the new service delivery requires people to become more flexible in the approach to working and decision making. One of the most obvious ways of connecting time and flexibility was first discussed in relation to the ways in which HCW were able to re-organise allocated times given for visits/sits, or the ways that the time during visits was used. The key to these discussions was an understanding that time could be used flexibly, and the CWBP offered this opportunity to be flexible. Where previously visits and the length of time HCW would spend with service users were determined by a social worker or a care plan, and then further (real) time was required attempting to change the length or number of visits that the service user actually required. In essence more time on calls and also during calls has brought about a degree of freedom and spontaneity and being able to determine what the client either wants or needs.

The introduction of the CWBP created two dedicated teams at each CA, these teams worked on ‘opposite runs’. The use of mobile phones and a dedicated WhatsApp group to communicate proved to be invaluable in being able to sort out problems quickly, to pass on valuable information and generally has resulted in a better level of communication. This greater communication between colleagues eased anxieties about issues, which prior to the Pilot were often left unresolved, for example messaging a colleague to alert them to the fact that a service user was in need of something

from the shops, something simple and small, a pint of milk for example. This form of instant communication has proved to be beneficial in being able to sort out problems quickly, to pass on valuable information and generally has resulted in a better level of communication all round. The importance of this simple tool has resulted in time-saving and better communication between all stakeholders. **Moving forward, a digital tool that links HCW, SW and OT together to synchronously record interventions and share information would be a positive step in improving the care experience for both service users and care workers.**

Throughout the evaluation, there were examples of increased flexibility in regard to ways of working. There are a number of benefits associated with increased flexibility. HCW were positive about some of the time savings introduced as a result of their increased responsibilities and abilities to make decisions that previously would have taken longer as they would have gone through a social worker to be approved. They expressed greater satisfaction in regard to this aspect of their work, feeling it validated their personal knowledge of the service users in their care. The majority of HCW reported an increased level of satisfaction with their new roles and reported that when it worked the CWBP was changing the way that care was delivered and changing the service into a more responsive one overall.

The CWBP introduced a new payment model to HCW. Paying them for a full shift has reduced their levels of insecurity, enhanced their autonomy, job security and satisfaction. While flexibility is central to a good experience for home care workers and service users, there must be clarity regarding what flexibility means in practice. In the main, HCW experienced this flexibility positively, in that they could utilise discretion and autonomy in the delivery of care. The time and task system put pressure on HCW who spent a lot of their time 'clockwatching' because of the pressure to get to the next call. Whilst flexibility has promoted a better system than 'clock watching' tension exists between the space (downtime) that is required to offer flexible packages of care and how that space (downtime) is then used. Re-organising a 'shopping visit' because a client 'didn't feel up to it' on the day it was scheduled requires flexibility in capacity. **Flexibility should be reflected in the operational planning and delivery of care. Without a consistent system of communication and shared recording system, there is potential for a flexible approach to have a negative impact on HCW and service user experience.**

The OT team has been able to contribute time and flexibility to the pilot. Whilst this model of capacity may not be viable in the long term, it has illustrated the real value of time and flexibility. Their approach has been of benefit to SW who have been stretched beyond capacity; service users who receive timely assessments and reviews and the CA who receive 'functional' assessments of service users, with information written in a way that allows them to better understand service users' needs and allows them to 'hit the ground running'. By working closely with the HCW they have been able to tweak approaches and packages of care in an ongoing way, constantly reviewing what is needed and amending packages of care, sometimes with a reduction in hours.

The findings clearly point to the fact that everyone is in favour of a more flexible approach to delivering care, one that is focussed more on outcomes than on the amount of time spent on a call. **The findings were clear that more time, and time used more flexibly, was key to delivering strength-based, person-centred care. There needs to be a planned approach to flexibility with some boundaries of what can be done, and how this is recorded within an overarching method of intervention and shared recording.**

Theme Two: Support, Communication and Training

The issue of support is multi-dimensional. The evaluation highlighted that HCW feel better supported and respected in their roles. That they get to know their service users better and have a more robust understanding of their service users' needs is being recognised as an important skill. Previous research (Turner, N. and Schneider, J. 2020; UNISON Time to Care 2015) highlighted the extra work HCW provide, over and above what can be done in the allocated time slot, because the amount of time is never enough. This has been evident in the pilot, with HCW planning support and activities in

their own time. Given the domestic and personal nature of the work, HCW invest in the relationships they make with their service users. That this relational aspect of their work is being valued is important in helping HCW reflect positively on their work. The move away from time and task towards a more flexible way of working is having a positive impact on HCW, who report greater levels of satisfaction, that their supportive role is finally being taken seriously, and that they are allocated time to do more than just the basic routine. Support through training helps to equip HCW better.

Increased support was spoken about positively and in a number of different ways. Training in strength-based approaches to care were initially offered to the HCW and was generally well received, despite some logistical issues with training. Much of the training was on-line, which brought with it its own problems of logging on and participating fully, but also there are the perennial issues of insufficient staff to cover and release others for training. The nature of the work and the primary commitment to ensuring service users' needs are met, means training is not a number one priority. Ideally, HCW would be able to share some of the training with their colleagues on 'opposite runs'. Shift pay will allow staff to be trained and be paid for it. HCW reported learning a lot from the training, and it helped them understand more about the ideas underpinning the CBWP. It was clear some ongoing training after the initial pilot introduction would be appreciated and the time to try out what they had learned is an important aspect of their learning. Staff development as part of the recruitment and retention of HCW could be developed. Training is often based in the KSA Model (Knowledge Skills Attitude), variables in service user experience suggest some additional training in approaches to clients would provide a more consistent approach to care. **A flexible model of training that meets the needs of the CA staff is required. This requires consideration for shift patterns and hours and has to build in enough flexibility to meet the conflicting priorities between training teams and CAs.**

A wrap around service lends itself to a wraparound training model. Joint training for HCW OT and SW would support a strong multidisciplinary approach, and create opportunities to understand each of the roles, and their perspectives and limitations. One manager suggested th*at 'shadowing'* other professionals would offer an insight into others' job roles and stressors. The OT and Physios commented on the high level of skill and individual knowledge required to work with some of the service users, particularly in relation to moving and handling and using equipment. They deliver training to the HCW, when they can deliver to a small team of carers it works well. Training and consistency go hand in hand. Throughout the evaluation it became evident that the aims and objectives for the pilot were not interpreted consistently. Other issues impacted on consistency: some of the IT systems are not compatible; review procedures including paperwork and role/responsibility are unclear and the lack of shared clear outcomes has been difficult for multi-disciplinary teams to negotiate together.

Communication was another key theme that emerged from the data. It is clear that such a change in service delivery cannot occur without clear communication, and better forms of communication between all stakeholders. Often it is the simple options that help. Direct line numbers and emails of SW have made a real difference to the CA and the work of the HCW. This was cited as being able to contact a worker directly rather than leave a message on a duty SW answer machine. Conversely, SW communicating directly with a single agency rather than 5 or 10 agencies clearly also aids communication and develops relationships. When there was a breakdown in communication it was mainly down to a lack of unified policy/paperwork and procedures between organisations.

The HCW communication is improving as they take on more responsibility for communicating with each other about the service users, which is very helpful for handovers and getting to know new referrals. Additionally, they are communicating more with other professionals, these communications would have been subject to delays, as they would first have gone to the Office, and then to the social worker. This is a beneficial development which adds value; greater levels of satisfaction about their own roles and responsibilities, greater levels of confidence about their professional knowledge, which at times is overlooked. There are some very practical and important ways in which these greater degrees of communication have proved to be important, and again it puts the HCW central to the job. Now they are relied upon to make contact with a GP or pharmacy, rather than relaying that information up to a Care Manager, and in doing so they are closing the information loop, less is lost in translation and there is no need for more than one conversation, which in turn helps with efficiency and timesaving. Prior to this, one phone call would be made to the office, and then a follow-up to ensure the first call had been acted upon.

Increased communication, particularly direct communication with social workers initially met with a degree of difficulty and sometimes resistance, but over the course of the CWBP most of these niggles were sorted out. Overall, it was felt that there were greater benefits in terms of joined-up thinking and improved communication. Again, the key is direct communication. Often a short and direct email once a problem is identified can prevent a far longer and more complex issue from arising further down the line. The streamlining of services was identified as an important action once the CWBP was established and having a single point of contact was highly valued particularly by extremely busy social workers, the CA and the OT. Further to this, better communication with the Social Prescribers will help build a bridge to access external services directly and remove the need for a SW referral.

One additional issue was highlighted regarding GDPR. Currently CA receive a complete and detailed set of the service user's details, including family and medical history, regardless of whether the CA takes on the service user. Short information about a potential service user's needs is all that is required to match against the capacity of the CA. Additional personal information could be sent once the CA agrees to offer a service.

Although the focus here is specifically on the way in which the Pilot developed forms of communication, it is important to also recognise the ways in which this theme also corresponds directly with increased flexibility and new ways of working. The ways in which enhanced communication supports flexible ways of working is most frequently illustrated by the relationships that have developed between the OT and the HCW and CA. **The clarity and scope of the OT role in relation to the CWBP would benefit from further consideration. The OT were unclear about their role and remit and contribution to the CWBP, but were clear that they were an additional resource, and could not become substitutes for the SW role. Their knowledge base is distinct, but complementary, to that of the SW.**

Theme Three: The Importance of Relationships

“You are more person centred with that person, you know, you’ve got rapport with them, they can talk to you more ‘there are a couple of mine…that sit, and they do talk to you about other things, family matters and, I think if you are just a person going in, doing your job, that’s it. You go out and go onto your next one, because they see you more and more, they do open up to you more’’(HCW)

Relationships are at the heart of all care and social practices, and certainly this was evidenced in this evaluation. Relationship Based Care promotes a methodology and a transformational model that improves quality, service user satisfaction, and staff satisfaction by improving every relationship within organisations. At its heart it includes principles that shape caring behaviours, and these principles guide the transformation of infrastructure, processes, systems, and practices to support those providing the care. The importance of this to HCW can be seen in a variety of ways. Time and time again, HCW went ‘over and above’ their requirements to make life as good as possible for their service users, using their ‘downtime’ flexibly or doing tasks in their own time, regularly making calls on in their time off to their ‘opposites’ to ensure continuity of care. Relationships are a key motivating factor for doing the work and a major stressor when there is insufficient time to build a relationship, do a good job and meet a person’s needs.

Flexibility and consistency was the key to the building of better relationships between HCW and service users. The CWBP has ensured a greater level of consistency of care provision, which has had a dynamic impact. Service users often develop trust and relationships with regular carers. At this point ‘expansion’ happens. Clients can engage more with their lives and external /community engagement possibilities open up. **This process could be facilitated further by adding the sitting service to core HCW rotas creating more opportunity to develop relationships and some ‘social time’ for the HCW with the service user.**

The time and task model resulted in a fragmented, and often impersonal provision of care, with service users often having multiple people in and out of their living spaces. People who they may not know very well, or equally who had very knowledge of their needs or the layout of their personal

spaces. This was frequently the cause of undue anxiety and pressure. The CWBP ensured a greater level of consistency by having two teams operating on opposite runs, with the overall impact that service users now have their care performed by the same people with greater frequency. This has been beneficial for both the HCW who are now getting to know their clients, their preferences, motivations and even their mood swings, and the service users who are confiding more in the HCW.

Consistency underpins high quality care, and the CWBP provided evidence of this. The cornerstone of good person-centred practice is listening and responding to what the service user wants, and the freedom to do this has been beneficial for all. The ability to build positive relationships with service users, but also importantly with family members, who can now also get to know the same people and are now more confident that the care their family member is receiving is good, which brings with it a deeper level of trust in the process and a sense of grief for the service user and the HCW when the relationship ends.

Relationships between SW teams and CA varied. Where they were strong, they were characterised by trust, flexibility, and easy prompt communication from all teams. In the areas where relationships had initially been poor, they developed as a consequence of the CWBP. Working together in fortnightly meetings supported this development and, in some ways, the OT have acted as a bridge by developing strong relationships with the HCW. In making changes to care packages on the suggestion of the CA, the OT have started to develop a new culture where CA and HCW input is regarded as both valid and up to date.

Theme Four: Finances and Potential Savings.

This section on finances and savings is not as robust as the other sections. There was limited baseline data available from Leeds City Council, and the numbers of clients involved in the CWBP made any statistical information that was available too variable to have validity. The evaluation demonstrates (some) improved efficiency and savings although the overarching quantitative picture remains unclear as the data was not collected in a unified manner. The case studies illustrate savings in the most concrete way. In the absence of information on the costs of services locally, we used the 'Unit Costs of Health and Social Care' (Jones, K. & Burns, A. 2021) for the case studies. These are nationally based costings (excluding London). It would be reasonable to expect a reduction in the number of complaints from service users and their families as a result of a better service and a subsequent direct saving to the local authority. Without the 'cost' of a complaint it is impossible to indicate how much a reduction in complaints would save.

Developing clarity about what data needs to be collected to illustrate how much services cost, or what information is required to illustrate a reduction in hospital admissions as a result of better care, is complex and time consuming. Providing good quality care at the intersection of services may well result in cost savings for the NHS or the care home rather than Leeds City Council.

There are many examples where the CWBP is 'likely' to save money in the longer term, either for social services or its external partner agencies. A good example of this cost saving is a move into more suitable accommodation thereby substantially reducing the care package.6i and increasing both short term and long-term independence. Another example is supporting the service user to put their own socks on rather than doing it for them. Again, this helps with maintaining independence and offers an immediate reduction in terms of the costs of care, as well as savings that potentially can be made further down the line. A further example of savings can be evidenced by providing an alternative to the care package. So, for example using meals on wheels rather than the HCW cooking the food.

Over the duration of the CWBP SW had fewer complaints than prior to the pilot. These cost savings are very difficult to quantify. The consistent delivery of care by small teams from limited agencies, and the multi-disciplinary 'wrap around' service that has been created by the CWBP has resulted in undoubtedly resulted in cost savings, but these remain difficult to quantify. For HCW there is an increase in job satisfaction has resulted in a reduction in sickness. This can be attributed to the better relationships being established between HCW and service users, and the desire to 'not let them down'. Stronger partnership working is also supporting SW in their role as tasks that need doing are shared more widely in terms of approach and support. SW don't feel quite so isolated as there is

clearly a more collaborative approach. All of these small, but significant changes help to build staff morale and impact retention in teams.

There were several challenges and possibilities in relation to finance and potential savings. Service users wanted clearer information, process, and timescales regarding financial assessments to fully understand what they would be paying. Additionally, there was a call for shorter visits, service users are fitting into (and paying for) a system with a 30min minimum call time. Their needs are sometimes less than this. They are requesting to only 'pay for what you receive'.

One of the areas that the CWBP highlighted is the need for greater flexibility. Hospital discharges are particularly complex and new or existing service users return home with care needs that can quickly change. Flexibility around reviews and making smooth quick changes to care packages to ensure the package of care continues to be the best fit is crucial for all involved. In this way, resources can be allocated in a timely and cost-effective way. A reduction in care needs which is acted upon swiftly increases the capacity of CA to respond to the pressures on the system.

Summary

The data gathered during the evaluation underlines the CWBP has led to improved outcomes for service users and carers. Service users and carers report that the flexible model of care provision has met their needs and fits into their life seamlessly. Bespoke adaptations to care packages have made sensitive care needs feel as if they are delivered by personal friends and family rather than a distant community care organisation. The CWBP has delivered better and more ambitious care to service users and carers during a period of extended health crises. During a difficult period, when most community organisations closed down, adult social care remained open and proved a valuable and integral support network.

This positive experience for service users and carers has been matched in staff satisfaction for HCWs who have reported greater autonomy and satisfaction with their practice. Despite these overwhelmingly positive notes, the CWBP did encounter difficulties with delivery and implementation. Fragmented services, running a concurrent system of care simultaneously have all taken their toll on HCW, SW and OT. On reflection, future implementation delivered through a unified and consistent model of practice will be required to address these underlying issues. The evidence suggests that HCW have an improved experience of the professional role and the delivery of care at point of contact with service users. This improved experience has resulted in improved retention and recruitment of HCW. There are challenges to this retention and job satisfaction. Currently the HCW career route has little scope for development and the future implementation would need to address this to keep an integral component of community care engaged and proactive. These challenges also need to be understood in the context of a national shortage of HCW.

We cannot make an objective comment on the costs of the CWBP, the data has not been available to us to analyse. There was no single recording mechanism for monitoring the start to end point of the care experience. This is not a criticism but a reflection of the system as it was delivered. However, we have highlighted within our case studies and data collection that real savings can be achieved and that more can be done with less hours. This can be achieved if the approach to care delivery is flexible and based on a strengths-based model that responds to human need rather than a system of risk and time management.

The pandemic and lockdown have made the observation of community based resource use difficult. We cannot make an objective claim on the impact of community based resources, but where possible we have observed and recorded the importance of community based resources in promoting independence and wellbeing. We must remember that during the lockdown community social care services became the foundation and cornerstone of provision. We believe that there is evidence that the pilot is sustainable and transferable, and that the CWBP offers a positive alternative to traditional home care delivery, a delivery that is often scattered and fragmented.

Appendices

Introduction to the Case Studies

This section of the report will present four case studies

Case Study One explores the care delivered to **Muriel**, a BME woman who has complex health needs and dementia.

Case Study Two explores the community care of **Aadesh,** a man from a BME background who has received residential care following a stroke and requires support to begin to live independently, and care for himself, and his mother.

Case Study Three looks at **Anna,** a woman living in sheltered accommodation with complex health needs who is experiencing social isolation and wants to get out more during lockdown.

Case Study Four examines the interaction between adult social care and child safeguarding, through the experience of **Diane**, who is a fifty-year-old white British woman who has complex physical health needs and child welfare issues.

Key Learning from the Case Studies.

Using a qualitative thematic system of analysis (Braun & Clarke, 2022) within the four case studies, has allowed us to identify several key themes for reflection and consideration within the evaluation. These align with the CWBP proposed model of service delivery:

1. co-production of person-centred care
2. wrap-around multi-disciplinary health and care support which draws on, and actively encourages, people to access the existing networks and support in their local communities.
3. Flexibility and a reablement approach in order to enable sustained independence

For the purposes of this report, we have split two of the proposed three service delivery criteria into separate categories. We found 'wrap around support' and 'encouragement to access networks' are both independent of each other and interdependent. The same observation was found in relation to 'flexibility' and 'reablement'

Co- production of person centred care: Has improved relationships, understanding and shared goals. Relationships between service users and HCWs and OTs are stronger and there is less tension delivering the service.

Wrap-around multi-disciplinary health and care support: has been improved under the CWBP, HCWs, OTs and social workers have clearer lines of communication and attend joint meetings together. Where HCWs, OTs and social workers work together adaptations and better care is delivered.

Active encouragement of service users to access the existing networks and support in their local communities: Given the Pandemic, accessing existing networks and support has been often impossible. HCWs have worked to support service users to create new connections often via IT and at some level, become the service themselves.

Flexibility: Consistent HCWs and the CWBP model of strength-based approaches has allowed social workers OTs and HCWs to adapt care in a flexible and agile manner. This has been facilitated by allowing HCWs autonomy to meet need rather than adhere to organisational processes.

Reablement approach in order to enable sustained independence. HCWs often co- working with the OTs have been able to take a reablement approach to providing care and support for service users

In addition to the proposed CWBM of service delivery, the case studies highlight **financial savings.**

Appendix 1

Case Study 1 - Delivering Flexibility, Improving Efficiency and Saving Costs

Key Themes: Co- production of person centred care; Wrap-around multi-disciplinary health and care support; Active encouragement of service users to access the existing networks and support in their local communities; Flexibility; Financial savings.

Muriel.

Muriel is a ninety-two-year-old Jewish woman, she was born and raised in Cairo with her two brothers and two sisters. She moved to England at the age of 24 as the authorities were expelling non-nationals. She has two estranged children and a brother who lives in Israel. There is some telephone contact between her and her brother.

Context of Referral

The package of care for Muriel started at the end of January in 2020. Muriel has a diagnosis of Type II diabetes, osteo-arthritis and heart problems including a number of transient ischaemic attacks (mini strokes). Muriel, since engaging with the CWBP has received a dementia diagnosis. Prior to referral to the CWBP Muriel was undergoing both a physical and mental health crisis, she had made statements that she would stop eating, these distressing communications had culminated in several threats to end her life. It was evident that Muriel's physical and mental health were in crisis and that the care package being delivered was not meeting her needs. The CWBP CA received the referral for Muriel when she was in hospital. The hospital social work team were recommending residential care. Muriel wanted to return home and had the capacity to make that decision, she was then supported by community social work to make a positive decision to remain at home with support of the CWBP, as an alternative to residential care. The crises of hospitalisation acted as a catalyst and opportunity for reimagining Muriel's care within the community. When Muriel returned from hospital there was no food in the house, and she had no access to money to obtain necessities. The house was in some disarray with internal doors locked, and Muriel could not get up the stairs. There was no clean bedding or towels, and her commode was not fit for purpose. The previous model of community care was quite simply not working for Muriel.

'Scattered Services - Unfamiliar faces': Transfer to the Community Wellbeing Pilot.

Muriel has an interesting and varied experience of pre pilot home care. The overarching themes of this care were scattered services and unfamiliar faces. Muriel had experienced multiple CAs and rotating staff in the provision of her care. Prior to moving onto the pilot Muriel had a frayed relationship with her home care providers, she had made numerous complaints and allegations of theft from her house (not substantiated), and her behaviour had become challenging for carers to manage and work with. The response to this complex relationship was increased hours of care to be delivered, this was operationalised without consistent staff who rotated. This care package peaked at twenty-eight hours per week. It can be surmised that the changing nature and increased hours of care staff contributed to some of the social crises which precipitated her entry to hospital. The crises of admission to hospital provided the opportunity to rethink and work in a more flexible manner. The review and referral to the community wellbeing pilot resulted in a reduced and consolidated package of care, with enough hours for care needs plus four hours of social support. The emphasis by the CWBP, was placed on the consistency of the care team and flexibility in responding to Muriel's care needs and social support.

Reducing Costs- Improving Outcomes.

The average cost of twenty-eight hours of home care delivered per week is **£560** worked out at the national average of £20 (NHS, 2022a)

The cost of the pilot care package per hour was £17.68 for twelve hours per week, which is **£212.16**. Highlighting that flexibility and consistency are key factors in reducing costs and improving social outcomes.

Delivering Efficiency & Flexibility

The re-assessment and realignment of care under the CWBP was based upon person centred principles and was directed by Muriel.

The central care outcome for Muriel was to stay at home with three key supporting outcomes detailed below.

- Support with weekly shopping.
- Care and assistance to look after her own personal care needs
- Direct support to go to the bank to withdraw my money.

In reimagining the care relationship within a more flexible, focused, and adaptable context these wishes were developed by community social work in tandem with HCWs to promote a better enhanced way of meeting Muriel's care needs. We will now explore in detail how Muriel's care was enhanced and developed through the CWBP.

Providing Direct Care

Reduced hours increased care and capacity.

The reduction of direct care and enhancement of care provision stems from the ability to respond to and listen to the service users as a person rather than to react to crisis and see an individual as a risk. In facilitating the discharge from hospital, the CWBP diverted Muriel from a residential care admission and reduced her community care package.

The average cost of residential care in the United Kingdom is £600 per week for residential care and £800 per week for a nursing home. (NHS, 2022a)

The cost of the pilot care package per hour was £17.68 for twelve hours per week, which is £212.16.

Post discharge from the hospital; social work and home carers working within the CWBP coordinated a seamless referral working with contractors to secure her house (which was accessed by emergency services) fixing her door and securing her property. HCWs also arranged for food parcels to be provided as an emergency measure, with HCWs making home cooked food to help her resettle at home. Practical care issues such as a new commode was arranged, as well as a coordinated visit to a local pharmacy to arrange and organise medication in a more pragmatic manner, these minor-flexible adjustments supported Muriel to remain healthy and manage her wellbeing at home.

Promoting better physical and mental wellbeing

Within the CWBP Muriel's physical and mental health was also addressed in a coherent and coordinated manner. The beginning of this improvement was the stabilisation of her current physical health with enhanced pharmacy support. Muriel had multiple medications that required support, there were too many tablets and Muriel often lost track of what to take when and what they were for. The community pharmacist with the HCW arranged for a system to be developed to ease this process that was manageable on a daily basis. Once this pattern of support was established, the HCWs recognised that part of Muriel's ongoing issues and, sometimes challenging behaviour, have been compounded by physical pain and low mood. Given this context they arranged and supported access to her G.P to establish improved pain medication in the form of a pain patch, a controlled medicine they were happy to facilitate the use. The HCW and CWBP also supported and assisted the GP in making a referral to community based psychiatric services to address her low mood and provide a more thorough mental state examination. The referral to psychiatry resulted in a diagnosis of Dementia, giving Muriel and her carers a more accurate and comprehensive picture of her physical and mental health issues. Muriel's previous care provider had responded by over provision in response to an emerging crisis. The thorough support offered by the CWBP has resulted in targeted increased care, facilitated by effective advocacy and support within multiple community health and mental health organisations, it is important to recognise that more was done with less, through the consistent home care staff and coordination of community health resources.

Enhancing Social Support & Wellbeing

With the discharge from hospital Muriel received reduced home care with a consistent care team. The consistency of care and being on 'first name' terms was central to reducing Muriel's perceived challenging behaviour and HCWs were never refused entry as had previously happened. Key to Muriel's care was her wish to have support at home to maintain independence. The HCWs established a direct relationship and advocated for and supported Muriel beyond basic acts of selfcare. Due to the consistency of the team, they noticed mood changes and could work out when to engage and support Muriel on her own terms. They identified the good days to do activities that stretched Muriel, such as obtaining the money to go shopping for Muriel and assist her in getting out of the house. The HCW's noticed and communicated with Muriel about her clothes and made adaptations through stitching clothes to mend them, so they fit Muriel and gave her confidence to be out of the house. The HCW's also opened the post for Muriel to help her with her financial independence. Muriel often rang 999 services to report stolen items in her house or issues she was facing, the care and support of HCWs allowed her to find items, remember where they were and reduced the frequent calls to 999 for help and advice. This close social support combined with a consistent relationship picked up on Muriel's difficulties in managing her finances and independent living. The HCWs communicated with Muriel's social worker to look at her capacity and make an application for deputyship, this was only possible due to the enhanced care and social support, and the linking of physical and mental health assessments with social work services. The proximity and consistency of the HCWs were central to this process.

Improved Home Care & Social Work Relationship

The improved relationship between community social work services and HCWs can be located in enhanced communication and flexibility. The CWBP promoted joint meetings and conversations between carers, social workers, and service users. Muriel's case highlights that this enhanced relationship created a flexible dynamic that placed Muriel at the centre of her care. The social worker responsible for Muriel highlighted that the HCWs were agile, they were not working to set tasks, and they responded to the needs in the moment, not creating a future crisis out of a simple 'off task' job or intervention. The HCWs had dealt with-gas leaks, emergency services, forced entry for welfare

checks and provided consistent information and support to advocate for Muriel in the process of application for deputyship by the social worker. The social worker recognised that the information provided by HCWs saved an estimated thirty hours of administrative work for the social worker in collecting information to support the application.

Improved Community Engagement

With Muriel stable and supported at home she was also able to receive extra community support and care from local Jewish welfare services. This support included home visits, food, and a mobile phone to help her remain in contact with her family in Israel.

Summary

The case study highlights that it is possible to do more and improve care with less hours. The improvements that have been made by the CWBP have originated in part from the stabilisation of financial payments for community care services, with full shift payments allowing CAs to maintain and recruit consistent and stable staff. The key to improved care is consistency of home care providers and the ability to create a stable social environment for care to be delivered within. It must also be noted that the collaboration of both social work and community care services are central to this positive process. Enhanced communication, trust and partnership working develop from stable community care arrangements.

Muriel Key Reflective Points

Improved financial payments create stable home care services.

Stable home care services improve service user care experience.

Coordinated working between HCWs, OTs and social work produce more flexible and efficient saving.

Appendix 2

Case Study 2 - Small Adaptations Producing Positive Outcomes

Key Themes: Co- production of person centred care; Wrap-around multi-disciplinary health and care support; Active encouragement of service users to access the existing networks and support in their local communities; Flexibility; Reablement approach in order to enable sustained independence; Financial savings.

Aadesh

Aadesh is a sixty-six-year-old man of Hindu Indian descent, he was born and lived in South Africa and moved to England to work as an engineer. Aadesh was an active man, who after retiring was engaged with home renovation and cared for his mother.

Context of Referral

Aadesh suffered a stroke and was admitted to hospital, during this time Aadesh became depressed and reported that he felt isolated and de-skilled having been moved from his home. The impact of the stroke had reduced his mobility to such an extent that he could not meet his own independent living needs. It was not felt that Aadesh could return home as the house he was renovating was not fit for habitation given his health and care needs. An agreement for his home to be renovated by a friend was made and Aadesh was admitted to a residential care home as an interim measure. Aadesh found that residential care exacerbated his depression, he felt isolated and wanted to return home with support. Prior to entering on the CWBP Aadesh was receiving home care

Transfer to the Community Wellbeing Pilot

Aadesh was transferred to the CWBP when it began in September 2021; the initial referral for care was for thirteen hours a week. The care was to support Aadesh with medication, personal care, meals and drinks, domestic tasks, and a supported visit to his mum. Aadesh was sensitive to his inability to provide self-care and the personal acts of washing and cleaning were a source of contention for him. The home care support was initially agreed at two thirty minute visits per day for direct personal care with three supportive two hour visits for independent living tasks to maintain independence at home.

Working towards independence through flexible approaches to care

Aadesh prior to his stroke and hospitalisation was an independent and creative individual whom also acted as both a carer and support for his mother.

The Social Worker and HCWs worked with Aadesh to identify some person-centred strengths based outcomes.

- To learn new ways to support and meet personal care needs with minimal support from others.
- The ability to undertake domestic tasks and duties independently.
- Joining a local gym to build up strength and fitness levels.
- To undertake outdoor activities such as hiking and walking.

The average cost of residential care in the United Kingdom is £600 per week for residential care and £800 per week for a nursing home. (NHS, 2022a)

The cost of the pilot care package per hour was £17.68 for thirteen hours per week, which is £229.84.

Delivering consistent and adaptive care

The referral to the CWBP highlighted a significant saving in financial costs, due to the high costs associated with residential care. Beyond financial savings the CWBP pilot also highlighted a person-centred focus mapped to the needs and desires of Aadesh.

The care delivered by the CWBP was tailored to his needs, the CWBP way of working allowed for a stable home care team that reduces Aadesh's social anxiety and concerns about care. The consistency of carers is important when we are working with developing self-confidence and self-esteem in the provision of the most intimate acts of selfcare. The CWBP pilot with its system of economic payments had created a wider service provision that nurtured a more consistent home care approach in relation to staffing. Upon referral to the CWBP the home care was adapted and tailored to suit Aadesh's personal needs and wishes.

Flexible adaptations for independent living

The stroke had left Aadesh with a large personal pharmacy that he often struggled to manage due to the weakness in his left side and reduced fine motor skills. One of the coordinated support interventions was for the CWBP HCWs to collaborate with the community pharmacy to provide a manageable dosette box of medication that could be accessed with ease upon his own terms.

Aadesh also struggled with daily activities based around cooking, self-care, and household activities. The CWBP social worker worked in a pragmatic manner with OTs to obtain adaptations such as a perching stool to support Aadesh's domestic activities, and a wet room on the ground floor installed to maintain as much independence with daily care tasks as possible.

Adaptations coordinated between CWBP social work, HCWs and OT's supported Aadesh in obtaining equipment to assist in his preparation of food and beverages. This included a lowered table to assist in the preparation of food which allowed him to make his own food and drinks. This lowered table was not just a simple object, it created an environment where Aadesh had control over his own food preparation, the adaptation provided a shared space where HCW's could share recipes and support him to cook and prepare food in a different manner. The adaptation liberated Aadesh from the constant supervision needed to use the traditional raised kitchen units.

Activities supporting independence and community engagement

Building upon his increased independence within the kitchen the CWBP HCWs helped Aadesh to use his established support network to arrange support and shopping for food and household items.

The CWBP also obtained a referral to a local activity and exercise group for people recovering from strokes. The actual activities were on hold due to the pandemic and Aadesh was waiting for this service to open up later on. Despite the restrictions it was important to facilitate this referral as activity and physical recovery were at the foundation of Aadesh's care plan and community support.

A personal friend of Aadesh who was involved in his extended network highlighted that:

"He is very lucky with the support he has around him. The carers listen and respect his choices. Recently the carer has helped him to attend an important meeting over zoom which he would have missed if the carers weren't there to support".

Another key adaptation to support independence was the flexibility of the delivery of his personal care and support at home. Aadesh, the social worker, family, and friends, alongside HCW's sat down and explored what would work better to promote independent living and nurture a sustained recovery. Aadesh highlighted that as he was progressing in his recovery, the care was impacting upon his social life. The morning and afternoon calls were stopping him from meeting up with people and socialising, which in turn had an impact on his mental wellbeing. After discussion, the hours were condensed to hours mid-morning to increase and enhance his social activities. Aadesh identified that mid-morning he would be awake, feeling better, and happier to undertake tasks in a more autonomous way, doing them 'with the worker' rather than having them 'done to him'. This redesign of care led to a more interactive and enabled system of independent living, and Aadesh became more engaged and took on new tasks such as a supported weekly shop.

Summary

The care offered by Aadesh within the CWBP highlights the principles of a flexible and adaptive approach to community-based support. The adaptations, the care, all represent small truths within a strengths-based approach. The consistency of care delivered by a stable care team, supported by a social worker who coordinates the care with all stakeholders effectively, has been central to this case study. Every aspect of care has been done to promote a recovery that works towards increased confidence and independence within the community. The package has been tailored to the individual's needs rather than organisational goals. As Aadesh himself reports: **"If it wasn't for the carers I wouldn't be at home!"**

Aadesh Key Reflective Points

A flexible approach to care leads to improved outcomes for the service user.

Coordinated working between HCWs, social work and OT produces more flexible and efficient savings.

Reducing hours can improve care experience – if tailored to an individual service user's need.

Appendix 3

Case Study 3 - Reducing Isolation Promoting Wellbeing

Key Themes: Co- production of person centred care; Wrap-around multi-disciplinary health and care support; Flexibility

Anna

Anna is a seventy-seven-year-old woman, she has lived locally within the city for most of her life. Anna has family in the local area, one son. However, she has minimal limited contact with him. Anna currently lives alone in a social housing complex that provides accommodation and has an onsite warden, the supported accommodation also has a telecare alarm system to alert carers if Anna becomes unwell or needs assistance.

Context of Referral

Anna has a range of complex health needs that limit her social mobility. Anna's complex health needs include a diagnosis of terminal bowel cancer, she has type two diabetes, arthritis, and a heart murmur. Anna also reports feeling low in mood, her physical health concerns are often exacerbated by isolation as she has not been able to visit her friends who live locally. The care Anna was receiving pre referral met her daily living needs in a practical way, however the referral to the CWBP provided a more flexible approach to care that would enhance her social support and wellbeing.

Transfer to Community Wellbeing Pilot

The transfer to the CWBP for enhanced flexible care to provide social support came during the formal winter lockdown of 2020. With restrictions easing to Tier 3 during December, some opportunities for social interactions through a support bubble were created. With this restrictive social context in mind some innovative solutions were put in place to support Anna within the community.

Anna identified to the CWBP Social Worker and HCWs the following personal goals for her care:

- To maintain her independence as much as possible.
- Support with completing personal care tasks every morning.
- To build a relationship with her team of carers so that in future goals can be identified.
- Anna identified that she would like to go and see her friend in person who lives in the complex next door
- One of Anna's key priorities was to get outdoors, in particular to go for a walk and get some fresh air.

Socially Distanced Social Support: Physical & Social Activity

The HCW's supported Anna to maintain contact with the wider world during the ongoing isolation and restrictions. The use of traditional telephone communications became a social lifeline for Anna. During lockdown and the tier system Anna was supported by a third sector organisation who provided telephone calls, befriending and conversation to isolated adults. HCWs also supported Anna in undertaking physical activity, walking with her around the sheltered housing complex and providing social interaction, conversation, and company.

Flexibility & Adaptation: Direct Care

HCWs have also provided flexible support to Anna providing her with assistance that has been tailored to her needs. The HCWs assisted her in completing daily living tasks such as cleaning and washing clothes. Anna reported that she was having difficulty hanging out the clothes later on in the

day. The CWBP model promoted a flexible and adaptable way of working, considering this feedback and request, the HCWs adapted how they delivered the care. They split their visit, coming in the morning and afternoon for direct assistance, washing in the morning and then hanging the clothes out on their next visit. Unlike a time and task focused model they could be flexible and act autonomously without creating an administration issue with reviews and re assessment of need. These small acts on a surface level seem insignificant, but it is the small acts of social support that place the service users and at the centre of a person centred care network.

Medical Support & Advocacy

Anna often has medical appointments that are re-arranged or scheduled at short notice due to her complex health needs. The community wellbeing model of working adapted to this with minimum fuss and need for re assessment. The HCWs communicated directly with the social worker, G.P, and hospital medical doctors, moving care hours as needed. This agility was only achieved through the consistency of HCW's and good communication between health and social CAs. This direct support allowed Anna to meet her health appointments with advocates who knew her needs and could support her in obtaining the best medical care possible.

Improved Community Social Engagement

With lockdown restrictions easing off and the community beginning to open up, the CWBP HCW's began to adapt and support Anna to make more social connections, something that Anna was very keen to do. Anna had struggled with the period of social isolation, as she had previously enjoyed the company of her friends and social contacts, as the world opened up in stages, she used her hours flexibly to support a range of experiences.

Central to this was getting back 'outside in the green', spending time in nature and the local park. As soon as outdoor activities were allowed the CWBP HCW's supported Anna by engaging with walking activities in the local park. Anna reported that this had a massive impact on her wellbeing as "she was fed up with being inside". Anna also has a secret passion for fast food and the HCWs took her for a meal out, using the hours flexibly they supported Anna to attend a local restaurant and have a meal outside the housing complex.

HCWs also arranged for Anna to visit the local library and supported Anna to contact the library to organise delivery of books when she could not get out to the library with support from HCWs or friends.

The staff arranged for personal care needs such as hairdressing to be initiated with home visits. These small but fruitful acts of flexible care and wellbeing highlight the importance of being able to react to the needs of service users in a direct and flexible manner. The coordination of hairdressing may be a simple act, but it is one that gives pleasure, confidence and supports self-esteem and wellbeing, all of which are important components of independent living within the community. As Anna and the HCWs highlight below, good care involves many small acts of kindness, compassion, and support; that can only be delivered through a flexible model that sees the person not the task.

Anna felt that the community wellbeing pilot was different, it met her needs without making a big issue over adapting to change, Anna reported that "the team are marvellous"

HCWs also reported that the new way of working was positive they highlighted that "Seeing Anna's mood improve just by taking her out is amazing, she is very grateful for all we do"

Summary

The care received from the CWBP highlighted that a flexible and responsive model could meet the complex health and social needs of Anna, as the world closed down, the flexibility and adaptability of HCWs responding to need prevented a small crisis in Anna's social circumstances, maintaining her independence with support in the community. Central to this success was a consistent and dedicated care team, good communication between social work and community CAs, and an operational model that allowed for the exchange of hours in an agile manner. These small acts of flexibility have a big impact in the experience of both the service user and care team, being able to meet the needs of service users in a meaningful, kind, and compassionate manner is central to good working practice. This case study reminds us in a poignant way, that people are more than time, bigger than a task, and more important than a process.

Anna Key Reflective Points.

Using the allocated hours in a flexible way to deliver small but important acts of social support is key to good care.

Adapting interventions to undertake activities as social situations change is important to promoting independence and wellbeing in the community.

Integrated working between social work and home care is at the core of good practice.

Appendix 4

Case Study 4 - Supporting Adults & Safeguarding Children

Key Themes: Wrap-around multi-disciplinary health and care support; Communication, Flexibility; Co- production of person centred care.

Diane.

Diane is fifty years old and identifies as a white British woman, she lives at home with her husband and daughter, she has complex health issues that limit her ability to live an independent life.

Context of Referral.

Diane is very determined to care for herself and look after her family, she wants to do as much as she can for herself. However, she recognises her complex health needs are limiting her ability to act and live as independently as much as she would like. Diane's complex health needs include a range of allergies, an acute insufficiency fracture (both ankles), diabetes, scoliosis, coproporphyria and peripheral neuropathy. Diane is acutely aware of the additional stress her physical health needs are placing on both her husband and her daughter who has learning difficulties.

Transfer to the CWBP: A Flexible Approach to a Complex Crisis.

Diane was referred to the CWBP after a recent hospital admission. Diane's admission to hospital highlighted some significant health complications, initially it was believed she had sprained both her ankles and she had received physiotherapy. Unfortunately, the physiotherapy intervention exacerbated her issue, her ankles were fractured during the intervention. This resulted in Diane having increased care needs as she was no longer able to weight bear. This restriction required her to have additional care and support to live independently.

Diane returned home with a referral for support from the CWBP. The support package was initially 28 hours per week, this was then reduced to 22.5 hours per week. This reduction was due to adapting call times from thirty minutes to calls between ten and twenty-five minutes, this adaptation was done at the request of Diane and her family. The HCWs provided Diane with support to enable her to undertake her daily routine, assisting her with personal care, and independent living tasks, reducing the stress placed upon her immediate and extended family.

The visits to the family by the HCWs highlighted some significant tension and stress within the family, they observed some child welfare concerns and made a referral to children's social work services. They talked the concerns through with Diane and her family and the referral was made with their informed consent. Although informed consent was not necessary, it was important to work in a collaborative manner to ensure continuity of care. A children's safeguarding assessment was made, and Diane's daughter was placed on a Child Protection Plan. A joint meeting between adult social work, the community care service, and the children's social worker led to a review of the safeguarding assessment. Initially the social worker was concerned, and her daughter was categorised as a Child Protection Case. Due to the integrated working with the HCWs it was recognised that the CWBP offered a significant level of mitigating care and support to the family, leading to a reassessment of risk. Diane's child was placed on the Child in Need category as a result.

Safeguarding Children & Supporting Adults.

To address Diane's care needs within the context of her wider family, a formal supportive intervention was undertaken by Children's Social Care. Diane, her child, and husband, as well as extended family and HCWs were involved in a Family Group Conference (FGC). An FGC is a solution focused system of working with individuals in a restorative approach to build support and maintain independence within the community. Although the FGC was focused upon the care and support for Diane's daughter, it was recognised that Diane's complex health needs were part of an interconnected network that needed to be included to promote the safety and wellbeing of her child. We tend to look at Adult Social Care and Children's Social Care within separate silos, this case demonstrates the

importance of integrated care to meet all needs. With this integrated working in mind the HCW's were present to support and assist Diane during the FGC.

Due to this involvement the HCW were able to adapt Diane's care package to meet her needs as a parent and carer, as well as recognising that she was a service user and someone in need of care and support. This flexibility in how care was provided allowed Diane to have a 'sitter' or carers with her to facilitate respite from the home for her daughter and husband. Diane felt that it was important that her husband and daughter both had some time away from her, and the house, to be able to do some everyday activities for themselves, such as seeing family and friends, popping out for a coffee at lunch, and shopping. The children's social worker viewed this adaptation as positive, and it went a long way to reducing safeguarding concerns and providing much needed respite for her daughter and husband. The flexibility of the CWBP resulted in Diane and her family being allocated four times a week sitting service for social support.

Making Time-Tailoring Support.

Post FGC meeting call times and durations were then analysed by HCW's. Through reducing some of the call durations on the times where Diane had medication administer appointment only, it was calculated the time differences could provide Diane with around eight hours per week of social time, giving Diane and her family the option of how she would like this additional time to be allocated.

This simple act of time and space has reduced the social crises within the wider family and alleviated safeguarding concerns. Initially Diane's husband was concerned that leaving her for any period would be anxiety provoking, and that he reported feeling selfish at having time away from his wife. Diane and the HCW's spoke with her husband and explored the importance of time apart in creating space for one another. The ongoing health issues were creating tension and frayed relationships. Diane wanted her family to be more than just her carers, she wanted them to have a life and activities of their own, Diane did not want to be seen as a burden. This perception of being a burden and reducing the pressure on her family was an important outcome for Diane, the complexity of requiring care and being a parent required subtle, nuanced, and flexible support. The CWBP saw Diane in a holistic way, she was more than a time, task, process, or outcome, but a person with intersecting needs that required care that was flexible and responsive.

The HCW's supported Diane and her husband in undergoing a housing assessment that would reflect their actual needs, this led to a re-evaluation of their housing priority and they used some of their time to assist them in making bids to the local authority housing system. These minor acts of social support highlight the importance of flexible working to promote between welfare advocacy, rather than wait and refer on the HCW's assisted Diane to build her independence and confidence by assisting directly, this type of direct social support is an essential component of good pragmatic care in the community.

Summary

This case study highlights that home care is complex and requires coordination of care beyond the allocated silo of adult social care. The CWBP model provided a flexible, adaptable, and responsive system that met the needs of Diane but also her dependents and close family members. The discussion highlights the interconnected nature of social crises and how a flexible system can be tailored to meet needs, a tailored system can meet complex simultaneous crises to promote better outcomes for the service user and their family. The CWBP represents a system that is more than a process of time and task, it has allowed for HCWs and Social Workers to meet complexity in a fluid and pragmatic manner. Without the intervention of the CWBP and the flexible support the outcomes for Diane and her family may not have been positive.

Diane Key Reflective Points.

Recognising safeguarding concerns (adult and children) responding to them and providing flexible, tailored support is a key component of good care.

Well-coordinated care between adult social care and children's social care is essential for positive social care outcomes.

Being flexible and adapting care to support more complex needs rather than providing basic care tasks has positive outcomes for both wellbeing and safeguarding.

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