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BRINGING POCKETS OF **BRILLIANCE** TO SCALE

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Live happy

Message from Sara McKee

Evermore Founder

For 20 years successive Governments, think-tanks, charities, public and private sector providers have grappled with one of this country's biggest challenges – how to make the NHS and social care both fair and sustainable.

While it's funding that has captured the headlines, examining how two siloed services could work better together to maximise the health and wellbeing of our growing population has been at the heart of this decades-long conversation.

We still don't have a solution and now we're faced with another Green Paper on Social Care.

People don't want papers, they want action. We can't rely on the Government for this, nor can we rely on a few heroic authorities or providers to change the market. In our view, we need to focus our energies on how we can unlock and scale the pockets of brilliance that are happening across the country like Shared Lives Plus and Wigan Council's Community Book.

Included within this document is our prototype for boosting intermediate care in order to keep older people out of hospital, improve their health, wellbeing and opportunity to participate in their community. It's scalable, innovative, do-able and has involved everyone working on it together.

It's a microcosm in a bigger system and doesn't address the full extent of the health and social care integration challenge; this is far bigger than us. However, we believe it provides a test bed for how these two services can work together to best serve their customers and the nation's taxpayers.

Ultimately, what we're trying to get to is a health and social care system that recognises the importance of wellbeing, resilience and human connection.

We're fighting for humanity and ourselves, so let's join together to make sure we're not waiting on another Green Paper in 2037.

Sara McKee

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WHAT IS EVERMORE?

We are a small company, with a big heart and a huge mission. We have plans to change the world's view of ageing, so people can enjoy later life in full colour.

Evermore communities

We are passionate about abolishing institutions and creating spaces that provide physical, mental and emotional nourishment.

Our communities are based on the small household model and provide a family-style environment for older people who are on their own and finding it increasingly difficult to cope without help.

What is the small household model?

Evermore's small household model is based on tried and tested approaches from the US, Scandinavia and Australia.

It involves older people living in a family home setting with a small group of people, usually up to 12. Each person has their own private space but shares communal areas like a kitchen and living room.

In Evermore, customers can rent or buy a one-bedroom apartment with its own living area, kitchenette, separate bedroom and bathroom. Apartments open into a central space with living area and hearth, open plan kitchen and large dining table. There's always an external facing window or balcony, ensuring a connection with the environment.

Companionship and convivium is the central focus of the small household. Residents take part in daily household life, whether its cooking, cleaning or managing the household budget, meals are shared together at a central table, and the universal workers help facilitate access to services as well as the community.

The universal workers operate in self-managed teams that remain in one household so they establish deep relationships with the customers. They are completely autonomous and work with residents to run the household in a way that best meets their needs, rather than the needs of the organisation.

The first Evermore community will be built in Wigan, one of the ten boroughs of Greater Manchester, and is due to be open in Spring 2019.

In the US, The Green House Project has adapted the small household for short-term rehabilitation at John Knox Village in Florida.

The goal is to provide real rehab in a real home, with the ability to imitate not simulate everyday activities. Therapy is provided seven-days a week from a multi-disciplinary team but with a dedicated therapist who gets to know the patient more deeply. In addition, patients are supported by universal workers known as Shabizhim.

The approach has delivered greater cost efficiencies than comparable organisations, and **reduced re-admittance to less than 10%.**

We are neither a retirement village or a care home, but a new way of living in later life where the individual dictates the rhythms of their day, deep relationships are formed, and passions are pursued.

Our staff are integral to this approach. Known as Mulinellos, they are multi-skilled workers whose sole reason for being is to enable older people to live a happy and meaningful life.

The name means whirlwind in Italian and it perfectly describes their multifaceted role. A Mulinello's day encompasses cooking, cleaning, managing the household budget, providing personal support, advocating for our customers and being a companion.

Because our households are small, Mulinellos have time to really get to know every customer and develop a deep understanding of their needs.

They are also self-managed, which means we've eliminated costly back office management and trust our teams to do what is best for our customers.

Evermore@Home

This is our concierge and friendship service for older people who want to remain living in their own home. Our tribe of Mulinellos help to free older people from the household chores that stops them from enjoying life, and also provide companionship for those who might be feeling lonely.

Evermore and the NHS

The flexible design of Evermore's small household model has enabled us to reimagine intermediate and long-term care, working with NHS Trusts to improve the patient experience and tackle challenges like delayed discharges from hospital.

Here's how the small household model works in a healthcare environment:

- Swift discharge from hospital: Mulinellos can collect patients from hospital and take them home to an Evermore setting or a household model deigned for the intermediate care system.
- Recovery in a home-like environment: Allows patients to live as independently as possible so that they can be assessed in near-normal circumstances.
- Holistic support: Provides rehabilitation and reablement alongside nourishment and companionship.

As well as improving the patient experience, this approach increases capacity and delivers greater efficiencies for the healthcare system.

We also work with healthcare providers to develop change and culture programmes that supports the introduction of the small household model.

WHAT WE'RE DOING: A PROTOTYPE IN MANCHESTER

Redesigning Intermediate Care – We All Need to Keep Moving

Few people die in hospital whose mobility improves in the first 48-hours. In contrast, most people (75%) die if their mobility gets worse.

(Source: British Geriatrics Society)

Our older population currently spends way too much time in hospital, either through avoidable admissions or being stranded in hospital beds long after they should have been discharged. It's not good for them, nor is it good for the system.

There is a general recognition that intermediate care has a valuable part to play in improving delayed transfers, patient outcomes and NHS efficiencies. Despite this, intermediate care has not expanded significantly in recent times. According to SCIE, "the potential of intermediate care to reduce the pressure on hospitals and social care is under-utilised." While the 2015 National Audit of Intermediate Care found, "the capacity of intermediate care remains stubbornly stuck, and almost certainly stuck at a level below the threshold for whole system impact." One NHS Trust in Greater Manchester determined to improve its intermediate care service is University Hospital South Manchester (UHSM), now Manchester University NHS Foundation Trust after the merger with Central Manchester NHS Foundation Trust on 1 October.

A growing frail and elderly population has a significant impact on UHSM. Many frail, older people admitted to the Trust's hospitals live alone with little support. As a result, it is often challenging to find a safe route home from hospital, exacerbated by a lack of social care capacity.

In July 2016 Evermore was commissioned by UHSM to develop a new vision for intermediate care, specifically focusing on how to ensure a smooth transition from hospital to home for older people.

The objectives of the project were to:

- Dramatically reduce delayed transfers of care (DTOC), release acute beds and improve flow through the healthcare ecosystem;
- Develop future-proof infrastructure and processes to enhance patient journey, using cost savings achieved through DTOC and other reductions in length of stay and readmissions to finance new innovation and approaches.

As part of the design process, interviews were conducted with clinicians, CCG commissioners and community services which found there was a strong desire for a model that:

- Allows patients in intermediate care to live as independently as possible - preferably in a home-like environment so they can be rehabilitated and assessed in near normal circumstances;
- Provides rehabilitation alongside nourishment of body and soul;
- Provides social interaction that helps these patients to thrive and truly prepares them for going home.

In response, Evermore designed a prototype that will see part of UHSM's day hospital, Buccleuch Lodge, transformed into small households that will provide a step-down service for patients who need support to recover after a hospital stay and a safe route home.

Instead of residing in a bed on a traditional ward, patients will have their own private space while sharing communal areas. In this prototype we will create one small household that will accommodate 14 people.

Defining intermediate care

Short-term care provided free of charge for people who no longer need to be in hospital but may need extra support to help them recover. It generally lasts for a maximum of six weeks and can be provided in someone's home or in a residential setting.

Source: NHS

Staffing models will also be revamped to include a multidisciplinary team to identify the best solutions for ongoing patient care in the community. We will be introducing our small home culture which focuses on giving autonomy for the pattern of daily life to healthcare assistants (HCAs) and their patients.

Hierarchy of staffing is turned on its head as HCAs will have the greatest time and relationship with the patients during their stay. They will support each patient to build their confidence by contributing to daily activities including cooking their own lunch. There is no need for additional staff and we're anticipating greater efficiencies as skilled nursing staff focus on coaching and supervising, instead of getting drawn into personal care; whilst therapists will deliver their support as in-reach rather than being based onsite.

Once the patient is deemed 'therapy fit' the UHSM team will return them home. Any additional reablement will be provided by a team of care workers who have been trained in the same cultural approach as those within the small household.

This prototype is under development and will be launched in Spring 2018 following an immersive culture programme. Once any wrinkles are ironed out, it is anticipated that the small household model can be replicated at scale across the Greater Manchester NHS and Extra Care services.

Benefits of intermediate care

- 70% of people who received intermediate care after a hospital stay, returned to their own home
- 92% maintained or improved their dependency score
- 72% did not move to a more dependent care setting

Source: SCIE

Building Capacity in the Community

Improving intermediate care at UHSM will not solve the delayed transfers of care challenge on its own. The whole system must be examined, looking at where else capacity can be boosted to prevent people entering hospital in the first place, as well as improving long-term independence and reducing re-admissions.

But it's not simply about increasing bed numbers. This is about providing the best environment for rehabilitation and recovery, which includes people having access to great food and great company. It's about meeting wellbeing needs as much as it is about meeting health needs. Buying more beds in institutionalised settings is unlikely to deliver the same results.

In response, Evermore has designed a model which involves buying and refurbishing multiple flats in multiple blocks which would then be available for Discharge-to-Assess, Step-Up, Step-Down and Extra Care. This would be delivered by community-based care teams from NHS, Local Authority and private care providers.

These transition care apartments will be based in the community and provide a short-term transition care option for an average stay of six weeks or longer if required.

These age-friendly apartments will be for patients who have been discharged from hospital but now need short-term support, or further assessment outside of an often chaotic hospital environment. They may be waiting for adaptions to be made to their home or to move into a long-term extra care apartment. The aim is for patients to return to their home rather than enter institutional residential care.

The adapted apartments will be located in retirement or mainstream residential blocks rather than an institutional care setting, providing a more realistic environment to assess independence, as well as a more relaxed environment in which to recuperate.

They will also be integrated with the community so people can continue to access everyday services, and take part in normal life.

Plus, the apartments will be in locations close to patients' existing community, so they can retain connections with family and friends, as well as gain the support of professional therapists and carers. Initial boroughs being explored as locations for the transition care flats are Trafford, Manchester and Stockport.

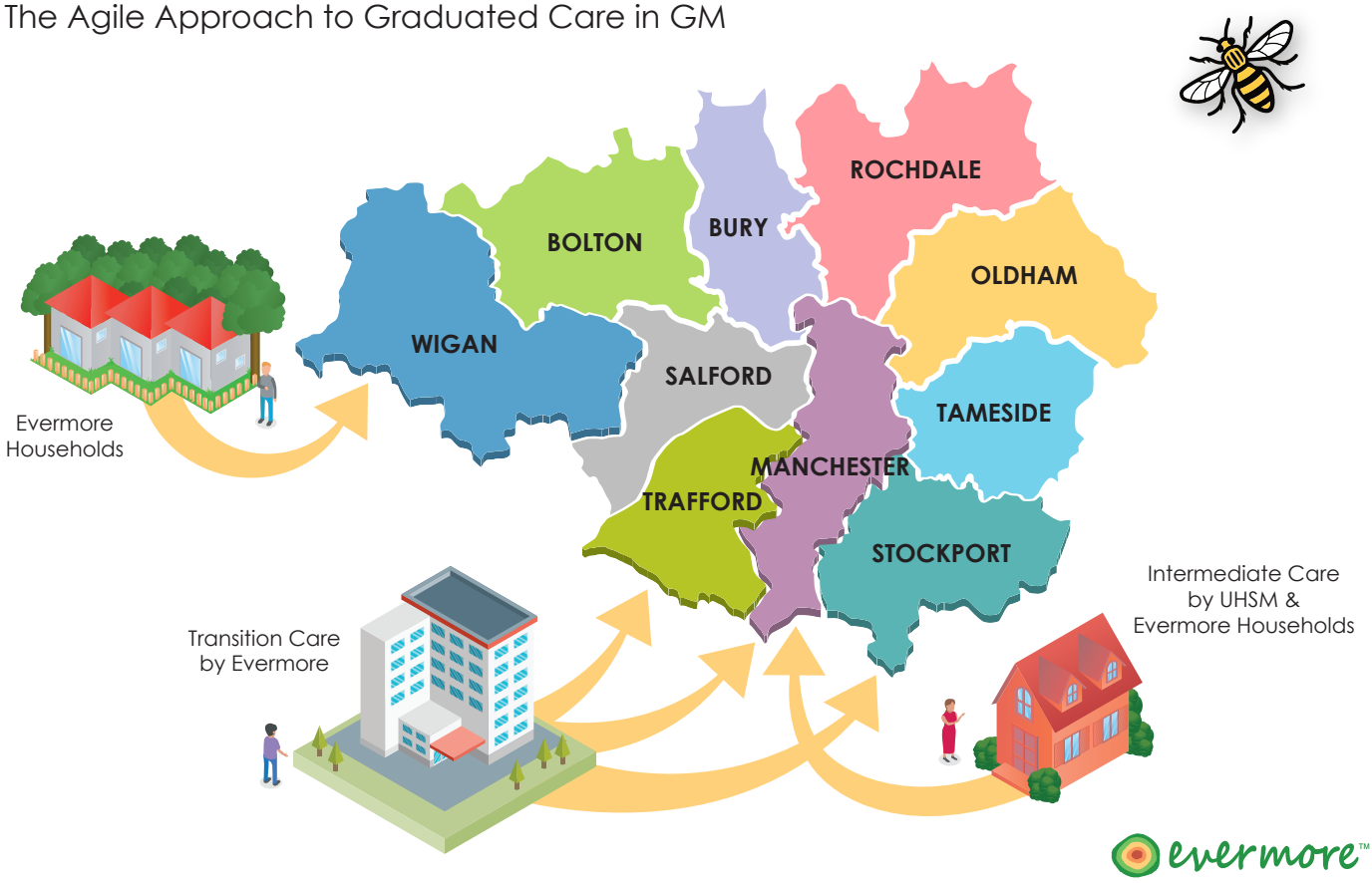
The use of transition care flats has been endorsed by Manchester City Council as part of its plans to expand extra care capacity - *"The provision of transitional units within extra care schemes will both minimise the need for hospital admissions and accelerate hospital discharge through a new step up/down care model."* *(Source: Manchester City Council)*

Currently five flats are being rented by Manchester City Council in the latest extra care community at Village 135, Wythenshawe to test the transitional approach.

A New Approach: Graduated Care

Keep on Moving

The Agile Approach to Graduated Care in GM

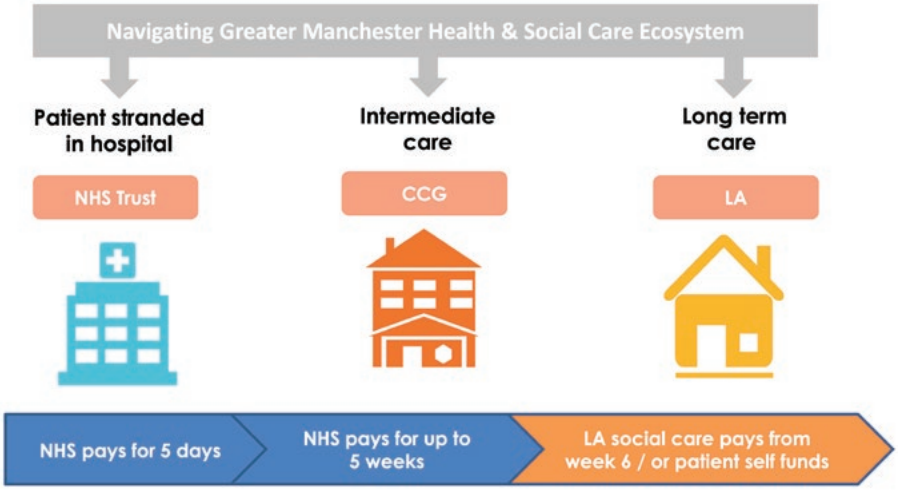


The combination of the intermediate care prototype at UHSM, transition care units and Evermore Households provides a whole system approach to redesigning health and social care for an older population.

Bringing these three strands together boosts capacity across the whole system and offers Manchester commissioners a new option for improving patient flow and continuum of care. It's a scalable model with each apartment block likely to provide a minimum of 60-72 units in households of 10-12 people.

In terms of unlocking the potential, new build developments could include low and high rise blocks to serve:

- Transitional, step up/step down;
- Intermediate, rehab and respite;
- Long-term extra care; and
- End-of-life requirements.



Costs are shared between the NHS and Local Authority and in the case of central Manchester, this will come out of a central budget held by the Local Care Organisation.

For the first time, it offers the potential for true integration of funding for health and social care. This has come about because of the devolution of the health and social care budgets in Greater Manchester.

The region's health and social care strategy, Taking Charge of Our Health & Social Care in Greater Manchester, has ensured everyone has the same focus and roadmap.

It's created a community that is committed to a new way of doing things, trying things out and taking greater risks in order to create an experience that is beneficial to all customers. There is real collaboration happening between the Local Care Organisation, NHS, CCGs, Local Authorities, providers and the third sector.

Greater Manchester's approach has given people permission to try new things and work together. What can we learn and how can we scale it?

WHY WE'RE DOING IT

For those embedded in health and social care, the following section captures what you already know. It's here to serve as a reminder for why we need to transform health and social care, and the factors to take into account in new service design and delivery.

We have a sector on the brink of collapse, constrained by funding, a lack of innovation and a fear of risk. It's impacting services and stranding older people in hospitals where they don't need to be in the first place. We've got a growing public health epidemic in isolation and loneliness, and a housing market that could make a huge difference to the health and wellbeing of older people but doesn't.

In short, we need change.

Sector on Brink of Collapse

It's well-known that both health and social care are under enormous pressure. Years of austerity coupled with a growing population that is living longer than ever has placed the system under severe strain.

> *9 in 10 MPs don't think the current system is fit for purpose.*
>
> *(Source: Independent Age)*

Social care has always been the poorer cousin, but now budget cuts and chronic under funding are severely impacting access to services. The number of people receiving council-funded home care has reduced by nearly a third since 2000. *(LaingBuisson)* And research by Which? found nine in 10 council areas across England could face a shortfall in care home places by 2022.

Older people are among the biggest customers of health and social care services, and potentially those most affected by the cut-backs and closures.

Council cut-backs

- Councils have cut a cumulative total of £5.5 billion from social care budgets since 2010.
- 62% of councils have experienced residential and nursing home closure.
- 57% of councils have had homecare providers hand back contracts

Source: Association of Directors of Adult Social Services

Industry Over Humanity: Lack of Innovation

> *It appears to be increasingly difficult for some providers to deliver the safe, high quality and compassionate care people deserve and have every right to expect. With demand for social care expected to rise over the next two decades, this is more worrying than ever.*
>
> *Andrea Sutcliffe, Chief Inspector of Adult Social Care, Care Quality Commission (Source: State of Adult Social Care Services)*

Projected distribution within the oldest age group (65 and over) between 2014 and 2039, England

	2014 (%)	2024 (%)	2039 (%)
65 to 69	31.2	26.1	22.6
70 to 74	22.9	22.9	22.7
75 to 79	18.7	21.9	19.9
80 to 84	13.8	14.3	14.9
85 and over	13.4	14.8	19.9
Total	**100**	**100**	**100**

Source: Office for National Statistics

Notes: 1. Figures may not sum due to rounding.

Apart from local authority budgets severely restricting capacity in the care market, another factor is the lack of innovation within the industry itself.

The care market is big business. Analysis by LaingBuisson has found the residential care market is worth an estimated £15.7 billion, while home care and supported living is worth around £6.5 billion a year.

The sector has attracted venture capitalists and private equity firms who own some of the largest care providers in the country. Plus, nearly all (97%) of publicly funded home care is provided by the independent sector, mainly by for-profit companies. *(Source: LaingBuisson)*

They are governed by financial returns and demanding shareholders. In Evermore's view, this has led to a change in focus from humanity to industry.

It also means they are incredibly risk averse. They're protecting their investment rather than interested in making changes. Care providers are wedded to their existing structures rather than looking at innovation in the configuration of property and staff. And instead of innovating, they're relying on self-funders to deliver revenue.

This aversion to innovation is contributing to the capacity issues, growing numbers of care home failures, as well as a decline in the level of service experienced by care sector customers.

Health and social care consumers

- Older people account for 62 per cent of all hospital bed days *(National Audit Office 2016)*.
- In 2014/15 local authorities spent £7.23 billion on social care for older people *(Health and Social Care Information Centre 2015)*

A joint report between The King's Fund and Nuffield Trust has said "the possibility of large-scale provider failure is no longer a question of 'if' but 'when' and this would jeopardise the continuity of care for older people."

Social Care Stranding Older Patients

> *In this year's mandate to NHS England, I set a clear expectation that delayed transfers of care (DTOC) should equate to no more than 3.5% of all hospital beds by September.*
>
> *Health Secretary Jeremy Hunt*

The failure in the care market has had a knock-on effect for NHS Trusts and contributed to a significant problem – delayed transfers of care (DTOC). Growing numbers of people are being stranded in hospital because they can't be discharged due to a lack of available support, either at home or in residential care.

While the NHS is responsible for the majority of DTOC, approximately 37% are attributable to social care with a third (33.3%) of these caused by patients waiting on home care packages. *(Source: NHS England, August 2017)*

The cost of DTOC is significant. According to the National Audit Office, the NHS spends around £820m a year treating older patients who no longer need to be there *(Source: Discharging older patients from hospital' (2016), National Audit Office)*.

But it's more than financial cost.

The impact of DTOC on older patients can be catastrophic with delayed transfers contributing to loss in muscle tone, increased risk of infection and can even lead to death. Academics recently claimed DTOC have contributed to the biggest year-on-year rise in mortality for 50 years. *(Source: British Medical Journal)*

As a result, reducing DTOC has become a big focus for the NHS and has moved higher up the political agenda. In July 2017 the Health Secretary of State, Jeremy Hunt, told NHS England that delayed transfers must be reduced to 3.5% of total beds by September.

DTOC impact over 65s

85% of delayed transfers of care are of patients aged 65 or older.

Source: National Audit Office

Better integration between health and social care is essential to tackling DTOC. Poor co-ordination and information sharing has been identified as part of the causes of delayed transfers in addition to capacity. *(Source: National Audit Office)*

The £3.8billion Better Care Fund (BCF) was made available in 2015/16 to support local service integration and has a specific target of reducing delayed transfers. However, a 2017 Public Accounts Committee report on BCF has said the scheme has failed to meet its objectives and was largely redundant.

Growing Public Health Threat of Isolation and Loneliness

Social isolation and loneliness is now recognised as a significant public health problem in England. Loneliness can contribute to a greater risk of coronary heart disease, disability, depression, cogitative decline, dementia and even premature death. *(Source: Campaign to End Loneliness)*

Its' affects are being felt throughout the health and social care system. Earlier this year Professor Keith Willett, director for acute care with NHS England told The Guardian that "the consequences of isolation are increasing with unremitting demand on healthcare which will ultimately cripple the NHS."

For example, anecdotal evidence suggests that the surge in A&E attendances at Christmas time is a symptom of social isolation and loneliness.

With the numbers of over 85s living alone expected to more than double by 2032 *(Source: The King's Fund)*, social isolation and loneliness will continue to impact health and social care.

Consequently, any solution designed to tackle health and social care challenges, such as delayed transfers, needs to take into account people's social infrastructure. As well as moving care closer to people's homes and existing support networks, embedding companionship in service design and delivery is crucial.

How widespread is loneliness?

- 37% of over 65s say they are sometimes or always lonely,
- One million over 65s are always lonely.

Source: Campaign to End Loneliness

What's the difference between social isolation and loneliness?

- Social isolation: separation from social or family contact, community involvement or access to services.
- Loneliness: personal, subjective sense of a lack of family or social contact.

Realising the Potential of Housing

The availability of appropriate housing support is clearly a factor in a significant number of DTOC

– *NHS Providers*.

Housing is intrinsically linked to health and wellbeing outcomes, and can make a significant contribution to delivering efficiencies for the NHS and social care.

A 2016 report by the All Party Parliamentary Group on Housing and Care for Older People found housing designed for older people delivered significant health and wellbeing benefits including tackling isolation and loneliness. While research for the National Housing Federation said housing services made a "real difference to people's lives by helping them to stay well for longer and in reducing pressure on acute services to help achieve substantial savings for the NHS."

Yet, the current options available for older people are limited and older people's housing continues to remain a low priority. For example, two-thirds of local authorities' planning policies have not addressed the housing needs of the growing number of older people. *(Source: Future Care Capital)*

Improving housing for our ageing population is part of a wider conversation about how we can encourage people to plan for retirement and live in housing that helps prevent crisis situations which may result in avoidable hospital admissions.

As Amyas Morse, head of the National Audit Office said in May 2016, "While there is a clear awareness of the need to discharge older people from hospital sooner, there are currently far too many older people in hospitals who do not need to be there."

WHAT DO WE WANT YOU TO DO?

Our work in Greater Manchester has been done on the small scale because we need to be agile. We're trying stuff out and learning as we go. There's no point in doing a prototype if it takes seven years.

Devolution has given us the football pitch to perform on, and there's an opportunity for this approach to be adopted and used across the country. But that's not something one organisation can do, it has to be a partnership and involve collaboration.

We all have a vested interested in moving the conversation about health and social care forward. It's not just about funding, the more important element is what we're going to do with it.

How can we galvanise action, scale pockets of brilliance and get the Government to invest in the right things?

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